House of Delegates Session—2007

June 24 and 26, 2007
San Francisco, California

Proceedings of the 59th annual session of the ASHP House of Delegates June 24 and 26, 2007

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HENRI R. MANASSE, JR., SECRETARY

The 59th annual session of the ASHP House of Delegates was held at the Moscone West Convention Center, in San Francisco, CA, in conjunction with the 2007 Summer Meeting.

First meeting

The first meeting was convened at 2:00 p.m., Sunday, June 24, by Chair of the House of Delegates Teresa J. Hudson. Janet A. Silvester, Vice Chair of the Board of Directors, gave the invocation.

Chair Hudson introduced the persons seated at the head table: Jill Martin, Immediate Past President of ASHP and Vice Chair of the House of Delegates; Cynthia Brennan, President of ASHP and Chair of the Board of Directors; Henri R. Manasse, Jr., Executive Vice President of ASHP and Secretary to 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 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 58th 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 58th House of Delegates session were received without objection.

Board Chair Cynthia Brennan presented the preliminary report on Resolutions. The report, which had been distributed to delegates before the Summer Meeting, consisted of one Resolution from John E. Murphy, Sarah Spinler, and Joe Saseen titled "Requirement for Residency."

Chair Hudson called on David J. Blanchard for the report of the Committee on Nominations.[a] Nominees were presented as follows:

President-elect

Kevin J. Colgan, MA, Senior Vice President, Health Economics & Outcomes Research, EPI-Q, Inc., Oak Brook, IL

Roland A. Patry, M.S., Dr.P.H., FASHP, Chair, Department of Pharmacy Practice, Texas Tech University Health Sciences Center, Amarillo, TX

Board of Directors (2008-2011)

John A. Armitstead, M.S., FASHP, Director of Pharmacy Services, University of Kentucky Chandler Medical Center, Lexington, KY

Janet Mighty, MBA, Assistant Director of Investigational Drug Services, Department of Pharmacy, The Johns Hopkins Hospital, Baltimore, MD

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

Michele Weizer, Pharm.D., BCPS, Pharmacy Automation Manager, Department of Pharmacy Services, JFK Medical Center, Atlantis, FL

Chair, House of Delegates

David S. Adler, Pharm.D., FCSHP, Professor of Clinical Pharmacy and Associate Dean for Academic Affairs, University of California, San Diego, Skaggs School of Pharmacy and Pharmaceutical Sciences, La Jolla, CA

Teresa J. Hudson, Pharm.D., BCPP, FASHP, Associate Director, VA Center for Mental Healthcare and Outcomes Research, North Little Rock, AR

Treasurer

Delegates had been advised before the session of the nomination by the Board of Directors of the following candidates for Treasurer:

Paul W. Abramowitz, Pharm.D., Director of Pharmaceutical Care, Department of Pharmaceutical Care, University of Iowa Hospitals and Clinics, Iowa City, IA

Debra S. Devereaux, MBA, Senior Consultant, Pharmacy Benefits, Gorman Health Group LLC, Washington, D.C.

A "Meet the Candidates" session to be held on Monday, June 25, 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 Brennan referred to the 2006 ASHP Annual Report, "Together We Make a Great Team," which had been distributed to delegates along with summaries of actions taken by the Board of Directors over the past year. She 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.

President Brennan, on behalf of the Board of Directors, then moved adoption of the proposal to discontinue ASHP Policy 0226, Proxy/Absentee Balloting, and ASHP Policy 8216, Annual Meeting Registration Fees for Delegates. Delegates voted to approve discontinuation of both policies.

Report of Treasurer. Marianne F. Ivey 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 recognized retiring ASHP staff: Marla Davis, 31 years of service; Charles Myers, 21 years of service.

Recommendations. Chair Hudson called on members of the House of Delegates for 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.)

Steve Rough (WI), Jim Rinehart (NE): Financial Outcomes Achieved from Pharmacist's Patient Care Services

Recommendation: ASHP should support research and generate evidence on the positive financial value and financial outcomes achieved from the provision of pharmacist patient care service; further, a progress report on this work should be presented to the ASHP membership by 2009 and at a minimum include the following:

- Development of a predictive model to define the total financial return an organization achieves from its investment in pharmacist services (i.e., quantifying the impact of pharmacist patient care services on the total cost of care);
- A summary of the financial value obtained by pharmacist patient care services as defined in current literature;
- Suggested evidence-based methods for effectively structuring a research study to quantify the impact of pharmacist patient care services on overall cost of care; and
- Development and support of new research to generate this evidence

Background: In today's world of increasing hospital costs and declining reimbursement, there is a tremendous need to more clearly establish the financial value of the pharmacist's role on the patient care team for payers and administrators. At the past two Midyear Clinical Meetings, the need for this work has been widely discussed at the Section of Pharmacy Practice Managers roundtable forum.

Philip Lakarosky (KY): Standardization of the Medication Administration Record (MAR)

Recommendation: ASHP, with other heath care organizations, should develop a standardized MAR.

Background: A standarized MAR would greatly improve patient care by having all health care providers familiar with one MAR format regardless of health care facility.

Nancy Korman (CA): Best Practices and Residency Training

Recommendation: The Commission on Credentialing should require ASHP-accredited residency training programs to use ASHP statements, guidelines, and professional policies as an integral part of their training programs.

Background: In the residency accreditation standards, the pharmacy service is evaluated against ASHP's statements, guidelines, and professional policies. However, there is no requirement that preceptors incorporate these standards into the resident's training.

David Blanchard, Michael Blumenfeld, Leigh Briscoe-Dwyer, Debra Feinberg, Ted Friedman, Thomas Lombardi, Bruce Pleskow, Frank Sosnowski, Kimberly Zammit (NY): Pharmacist's Bill of Rights

Recommendation: ASHP should identify, develop, and publish a "Pharmacist's Bill of Rights" as it relates to pharmacy practice to ensure that pharmacists are able to provide safe and effective pharmaceutical care for patients.

Cathy Sasser (Section of Home, Ambulatory, and Chronic Care Practitioners): Chronic Disease Management

Recommendation: To advocate that chronic disease be addressed as a critical concern in the U.S. population that needs to be managed effectively in order to sustain the health system; to educate pharmacists on the severity of the issue and the opportunities that medication therapy management has in improving the outcomes of chronic disease; to advocate with payers, government, health professionals, and patients the important role pharmacists fill in effectively managing chronic disease.

William Yee (CA): Bundling of ASHP and State Affiliate Dues

Recommendation: The ASHP Board of Directors should consider working with interested state affiliates to develop a single bundled membership for both organizations.

Background: Many pharmacists belong to only their state affiliated organization or ASHP. Financial constraints sometimes force a practitioner to weigh the value of one organization versus another. Both ASHP and state affiliates should work together instead of in competition with each other to promote the profession of pharmacy at the state and national level through a bundled membership.

Eric Hola (NJ): Revision of ASHP Guidelines Regarding Vendor Activities in Heath Systems

Recommendation: ASHP should appoint a group to review and revise the current guidelines.

Background: The ASHP Guidelines for Pharmacists on the Activities of Vendors' Representatives in Organized Health Care Systems have not been revised since 1993. With many health care organizations re-examining this issue, and with the PhRMA guidelines recently revised, the Society should update its guidelines.

Douglas Lang (MO): Policy 0108, Nontraditional Pharm.D. Accessibility

Recommendation: Policy 0108 should be referred back to the policy making process to address and incorporate the concept of continuing professional development.

John Murphy (Past President): ASHP Staff Authority to Revise Statements, Guidelines, and Professional Policies

Recommendation: ASHP staff should be given the authority to revise statements, guidelines, and professional policies for the purpose of clarity and accuracy when the purpose of the policy would not be changed.

Background: Statements, guidelines, and professional policies sometimes become inaccurate due to reference to organizations and events that change. For example, there are a number of current policies that refer to the American Council on Pharmaceutical Education, which has changed its name to the Accreditation Council on Pharmacy Education. Changing simple items like this should be accomplished by ASHP staff with notification to the Board of Directors rather than sending this to the House of Delegates.

Robert Ignoffo (CA): Policy Background

Recommendation: The intent of proposed professional policies should be clearly stated in the policy background submitted to delegates.

Background: Policy background currently does not include a clear description of the intent of the policy, which leads to misdirected discussion. By including the intent, the House can clearly focus on the wording and meaning of policy.

Policy Committee reports.

Chair Hudson outlined the process used to generate policy committee reports. She announced that each of the recommended policies 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 recommendations; requests to divide the question are granted unless another delegate objects.

(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.

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.)

Lynnae M.Mahaney, Board Liaison to the **Council on Education and Workforce Development**, presented the council's policy recommendations A through E.

A. Pharmacy Technician Training

To support the goal that pharmacy technicians entering the pharmacy workforce have completed an ASHP-accredited program of training; further,

To encourage expansion of ASHP-accredited pharmacy technician training programs.

**B. Image of and Career Opportunities for Hospital and Health-System Pharmacists*

To sustain *and enhance* the public information program promoting the professional image of hospital and health-system pharmacists to the general public, public policymakers, *payers,* other health care professionals, and hospital and health-system decision-makers; further,

To provide ASHP informational and recruitment materials identifying opportunities for pharmacy careers in hospitals and health systems.

C. Residency Programs

To strongly advocate that all pharmacy residency programs become ASHP-accredited as a means of ensuring and conveying program quality.

**D. ASHP Guidelines, Statements, and Professional Policies as an Integral Part of the Educational Process*

To *advocate that* ~~encourage~~ faculties in colleges *and schools* of pharmacy and preceptors of ASHP-accredited residency training programs ~~to~~ use ASHP statements, guidelines, and professional policies as an integral part of training programs and courses.

E. External Degree Programs and Initiatives for Helping Practitioners Upgrade Skills

To discontinue policy 8508, which reads:

> To encourage the broadest possible consortial approach to developing viable and widely available external degree programs within the shortest possible time; further,
>
> To urge schools of pharmacy to develop flexible mechanisms that permit full-time practitioners to participate in courses in the contemporary curriculum and to urge directors of pharmacy to encourage staff participation in part-time academic work and to develop appropriate and flexible work hours to permit full-time staff to become part-time students; further,
>
> To urge educational consortia, colleges of pharmacy, and other organizations to evaluate options in addition to a formal external degree program that can assist practitioners in upgrading their skills and to encourage these groups to develop a curricular approach to continuing education aimed at improving practice competence; further,
>
> To urge these groups to develop measurable performance criteria for competence.

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

**A. Administering Injectable Medications Supplied Directly to Patients*

To encourage hospitals *and health care systems* not to permit administration of injectable medications brought to the hospital or clinic by the patient or caregiver when storage conditions or the source cannot be verified; further,

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

To *advocate for* ~~support~~ adequate reimbursement for preparation, order review, and other costs associated with the safe provision *and administration of* injectable medications.

B. Standard Drug Administration Schedules

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

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

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

C. Pay-for-Performance Reimbursement

To support pay-for-performance reimbursement models when they are appropriately structured to improve health care quality; further,

To oppose pay-for-performance reimbursement models that do not support an open culture of medication error reporting; further,

To encourage pharmacists to actively lead medication-related pay-for-performance initiatives.

D. Principles of Managed Care

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

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

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

E. Needle-Free Drug Preparation and Administration Systems

To discontinue policy 9202, Needle-Free Drug Preparation and Administration Systems, which reads:

> To encourage manufacturers' efforts to create cost-effective drug preparation and drug administration systems that do not require needles.

Agatha L. Nolen, Board Liaison to the **Council on Pharmacy Practice**, presented the Council's Policy Recommendations A through H.

A. ASHP Statement on the Role of Health-System Pharmacists in Public Health

To approve the ASHP Statement on the Role of Health-System Pharmacists in Public Health.

B. ASHP Statement on Professionalism

To approve the ASHP Statement on Professionalism.

C. ASHP Statement on Racial and Ethnic Disparities in Health Care

To approve the ASHP Statement on Racial and Ethnic Disparities in Health Care.

**D. Role of Pharmacists in Sports Pharmacy and Doping Control*

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

To encourage pharmacists to advise athletic authorities and athletes on medications that are prohibited in competition.

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

E. Institutional Review Boards and Investigational Use of Drugs

To support mandatory education and training on human subject protections and research bioethics for members of institutional review boards (IRBs), principal investigators, and all others involved in clinical research; further,

To advocate that principal investigators discuss their proposed clinical drug research with representatives of the pharmacy department before submitting a proposal to the IRB; further,

To advocate that IRBs include pharmacists as voting members; further,

To advocate that IRBs inform pharmacy of all approved clinical research involving drugs within the hospital or health system; further,

To advocate that pharmacists act as liaisons between IRBs and pharmacy and therapeutics committees in the management and conduct of clinical drug research studies; further,

To strongly support pharmacists' management of the control and distribution of drug products used in clinical research.

**F. Electronic Health and Business Technology and Services*

To *advocate for* ~~encourage~~ pharmacists to assume a leadership role in their hospitals and health systems with respect to strategic planning for and implementation of electronic health and business technology and services; further,

To *advocate that* ~~encourage~~ hospital and health-system administrators ~~to~~ provide dedicated resources for pharmacy departments to design, implement, and maintain electronic health and business technology and services; further,

To advocate the inclusion of electronic health technology and telepharmacy issues and applications in pharmacy school curricula.

**G. Tobacco and Tobacco Products*

To ~~discourage~~ *eliminate* the use and distribution of tobacco and tobacco products in and by pharmacies; further,

To ~~encourage~~ *advocate for* ~~smoke~~ *tobacco*-free environments in hospitals and health systems; further,

To seek, within the bounds of public law and policy, to eliminate the use and distribution of tobacco and tobacco products in meeting rooms and corridors at ASHP-sponsored ~~continuing education~~ events; further,

To promote the role of pharmacists in ~~smoking~~ *tobacco*-cessation counseling; further,

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

H. Human Immunodeficiency Virus Infections

To discontinue policy 8808, Human Immunodeficiency Virus Infections, which reads:

> To seek input in the decisions of government and other organizations to express the concerns of pharmacists with regard to the handling of drugs and drug-related devices for the treatment and prevention of human immunodeficiency virus (HIV) infections; further,
>
> To continue to inform pharmacists about drug and drug-related developments in the treatment of HIV infections.

Diane B. Ginsburg, Board Liaison to the **Council on Public Policy**, presented the Council's Policy Recommendations A through I.

A. Restricted Drug Distribution

To affirm support for the current system of drug distribution in which prescribers and pharmacists exercise their professional responsibilities on behalf of patients; further,

To acknowledge that there may be limited circumstances in which constraints on the traditional drug distribution system may be appropriate if the following principles are met: (1) the requirements do not interfere with the continuity of care for the patient; (2) the requirements preserve the pharmacist–patient relationship; (3) the requirements are based on scientific evidence fully disclosed and evaluated by prescribers, pharmacists, and others; (4) there is scientific consensus that the requirements are necessary and represent the least restrictive means to achieve safe and effective patient care; (5) the cost of the product and any associated product or services are identified for purposes of reimbursement, mechanisms are provided to compensate providers for special services, and duplicative costs are avoided; (6) all requirements are stated in functional, objective terms so that any provider who meets the criteria may participate in the care of patients; and (7) the requirements do not interfere with the professional practice of pharmacists, prescribers, and others; further,

To advocate that the Food and Drug Administration (FDA) be granted the authority to consult with practicing pharmacists and others when the establishment of a restricted distribution system is contemplated for a drug product; further,

To advocate that FDA be granted the authority to require that manufacturers disclose all of the considerations that led to the establishment of a restricted distribution system for a specific product; further,

To advocate that FDA be granted the authority to require that manufacturers include in each restricted distribution system a mechanism that will ensure medication reconciliation and continuity of care as patients transition from one level or site of care to another; further,

To advocate that FDA be granted the authority to require manufacturers to conduct a follow-up assessment of the impact of a restricted drug distribution system.

B. Patient Access to Orphan Drug Products

To encourage continued research, development, and marketing of orphan drug products; further,

To urge health policymakers, payers, and pharmaceutical manufacturers to develop innovative ways to ensure patient access to orphan drug products; further,

To support public policies that ensure that the cost of orphan drug products does not preclude reasonable patient access to these agents.

**C. Regulation of Telepharmacy Services*

To advocate that boards of pharmacy adopt regulations that enable the use of United States-based telepharmacy services for all practice settings; further,

To advocate that boards of pharmacy consider the following when drafting regulations for telepharmacy services:

1. Education and training of participating pharmacists and technicians;
2. Information system requirements;
3. Remote order entry, remote prospective order review, remote double-checking of the completed medication order before dispensing, actual dispensing, and patient counseling and education;
4. Licensure (including reciprocity) of participating pharmacies and pharmacists;
5. Service arrangements that cross state borders;
6. Service arrangements within the same corporate entity or between different corporate entities; and
7. Service arrangements for workload relief in the point-of-care pharmacy during peak periods; ~~further;~~ *and*
8. Pharmacist access to minimum required elements of patient information; further

To advocate to NABP and Boards of Pharmacy to resolve legal and professional issues in the provision of telepharmacy services that cross state lines and jurisdictions.

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

D. Personnel Ratios

To encourage additional research on staffing models that are based on best practices in order to provide safe and effective patient care, further,

To advocate that pharmacist-to-technician and pharmacist-to-patient ratios be determined by local institutions on the basis of acuity of care, breadth of services, quality improvement processes, and historical data~~; further~~, *only when research on staffing models can be developed and validated.*

~~To encourage additional research on staffing models that are based on best practices in order to provide safe and effective patient care.~~

E. Direct-to-Consumer Advertising of Dietary Supplements

To support direct-to-consumer advertising of dietary supplements *only when it* ~~that~~ is educational in nature and includes pharmacists as a source of information; further,

To support direct-to-consumer advertising of dietary supplements only when it includes

1. Evidence-based information regarding safety and efficacy in a format that allows for informed decision-making by the consumer,
2. A clear disclaimer that the product was not evaluated by FDA for safety and effectiveness,
3. A recommendation to consult with a health care professional before initiating use, and
4. Any known warnings or precautions regarding dietary supplement–medication interactions or dietary supplement–disease interactions; further,
5. Full disclosure of all ingredients including USP verification of content and strength; further

To support the development of legislation or regulation requiring that dietary supplement advertising prominently state risks and intended benefits of a product that consumers should discuss with their licensed health care professional.

F. Prohibiting Reuse of Brand Names and Standardizing Prefixes and Suffixes

(No wording change, but the House wanted this to be two distinct policies as noted by F1 and F2.)

F1 To advocate Food and Drug Administration (FDA) authority to prohibit reuse of brand names of prescription and nonprescription drugs when any active component of the product is changed or after any other changes are made in the product that may affect its safe use; further,

F2 To collaborate with others, including the United States Pharmacopeia and FDA, in standardizing and defining the meaning of prefixes and suffixes for prescription and non-prescription drugs to prevent medication errors and ensure patient safety.

G. Medicare Prescription Drug Benefit

To strongly advocate a fully funded prescription drug program for eligible Medicare beneficiaries that maintains continuity of care and ensures the best use of medications; further,

To advocate that essential requirements in the program include (1) appropriate product reimbursement based on transparency of drug costs; (2) affordability for patients, including elimination of coverage gaps; (3) payment for indirect costs and practice expenses related to the provision of pharmacist services, based on a study of those costs; (4) appropriate coverage and payment for patient care services provided by pharmacists; (5) open access to the pharmacy provider of the patient's choice; ~~and~~ (6) formularies with sufficient flexibility to allow access to medically necessary drugs*; and (7) well publicized, unbiased resources are available to assist Medicare beneficiaries enroll in the best possible program based on their medication needs.*

H. 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, 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) accurately document at any point in the distribution chain the original source of drug products and chain of custody from the manufacturer to the pharmacy; further,

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

I. Generic Drug Products

To discontinue ASHP policy 9005, which reads:

> To encourage pharmacists in organized health-care settings to assume a greater leadership role in legislative and other arenas relating to drug product selection and evaluation.

Stanley S. Kent, Board Liaison to the **Council on Therapeutics**, presented the Council's Policy Recommendation A.

A. Removal of Propoxyphene from the Market

To advocate that the Food and Drug Administration remove propoxyphene from the market because of its poor efficacy and poor safety profile and because more effective and safer alternatives are available to treat mild to moderate pain.

Candidates for the position of Chair of the House of Delegates and for the position of Treasurer were given an opportunity to make brief statements to the House of Delegates. The meeting adjourned at 5:30 p.m.

Second meeting

The second and final meeting of the House of Delegates session convened on Tuesday, June 26, at 4:30 p.m. A quorum was present.

Election of House Chair and Treasurer

Chair Hudson announced the appointment of alternate delegates as tellers to canvass the ballots for the election of Chair of the House of Delegates and Treasurer. Those appointed were Tad A. Gomez (GA), Marjorie Shaw Phillips (GA), Charles W. Jastram (LA), Jane S. Tennis (MO), and Bruce A. Pleskow (NY).

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 Brennan presented the Resolution from John E. Murphy, Sarah Spinler, and Joe Saseen on "Requirement for Residency." Following discussion, the Resolution was adopted. It reads as follows:

Requirement for Residency

To support the position that by the year 2020, the completion of an ASHP-accredited postgraduate-year-one residency should be a requirement for all new college of pharmacy graduates who will be providing direct patient care.

Board of Directors duly considered matters. The Board reported on 11 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 26, 2007, to "duly consider" the amended policies. The Board presented its recommendations as follows:

1. Council on Education and Workforce Development, Policy B, "Image of and Career Opportunities for Hospital and Health-System Pharmacists": The Board agreed that the amended language was acceptable.

2. Council on Education and Workforce Development, Policy D, "ASHP Guidelines, Statements, and Professional Policies as an Integral Part of the Educational Process": The Board encouraged delegates to reconsider the original policy proposal. Following a motion to reconsider the original language, the policy was adopted as originally presented. The policy reads as follows:

D. ASHP Guidelines, Statements, and Professional Policies as an Integral Part of the Educational Process

To encourage faculties in colleges of pharmacy and preceptors of ASHP-accredited residency training programs to use ASHP statements, guidelines, and professional policies as an integral part of training programs and courses.

(Note: This policy supersedes ASHP policy 8407.)

3. Council on Pharmacy Management, Policy A, "Administering Injectable Medications Supplied Directly to Patients": The Board agreed that the amended language was acceptable.

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

5. Council on Pharmacy Practice, Policy F, "Electronic Health and Business Technology and Services": The Board encouraged delegates to reconsider the original policy proposal. Following a motion to reconsider the original language, the policy was adopted as originally presented. The policy reads as follows:

F. Electronic Health and Business Technology and Services

To encourage pharmacists to assume a leadership role in their hospitals and health systems with respect to strategic planning for and implementation of electronic health and business technology and services; further,

To encourage hospital and health-system administrators to provide dedicated resources for pharmacy departments to design, implement, and maintain electronic health and business technology and services; further,

To advocate the inclusion of electronic health technology and telepharmacy issues and applications in college of pharmacy curricula.

(Note: This policy supersedes ASHP policy 0233.)

6. Council on Pharmacy Practice, Policy G, "Tobacco and Tobacco Products": The Board agreed that the amended language was acceptable with editorial changes. As edited, the policy reads as follows:

G. Tobacco and Tobacco Products

To discourage the use and distribution of tobacco and tobacco products in and by pharmacies; further,

To advocate for tobacco-free environments in hospitals and health systems; further,

To seek, within the bounds of public law and policy, to eliminate the use and distribution of tobacco and tobacco products in meeting rooms and corridors at ASHP-sponsored events; further,

To promote the role of pharmacists in tobacco-cessation counseling; further,

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

(Note: This policy supersedes ASHP policy 8807.)

7. Council on Public Policy, Policy C, "Regulation of Telepharmacy Services": The Board agreed that the amended language was acceptable with editorial changes. As edited, the policy reads as follows:

C. Regulation of Telepharmacy Services

To advocate that boards of pharmacy adopt regulations that enable the use of United States-based telepharmacy services for all practice settings; further,

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

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

8. Council on Pubic Policy, Policy D, "Personnel Ratios": The Board encouraged delegates to reconsider the original policy proposal. Following a motion to reconsider the original language, the policy was adopted as originally presented. The policy reads as follows:

D. Personnel Ratios

To advocate that pharmacist-to-technician and pharmacist-to-patient ratios be determined by local institutions on the basis of acuity of care, breadth of services, quality improvement processes, and historical data; further,

To encourage additional research on staffing models that are based on best practices in order to provide safe and effective patient care.

9. Council on Public Policy, Policy E, "Direct-to-Consumer Advertising of Dietary Supplements": The Board encouraged delegates to reconsider the original policy proposal. A motion was made to reconsider the original language. During the ensuing debate, the Board of Directors agreed to accept the amendment in the first clause that replaced the word "that" with the words "only when it". The policy reads as follows:

E. Direct-to-Consumer Advertising of Dietary Supplements

To support direct-to-consumer advertising of dietary supplements only when it is educational in nature and includes pharmacists as a source of information; further,

To support direct-to-consumer advertising of dietary supplements only when it includes (1) evidence-based information regarding safety and efficacy in a format that allows for informed decision-making by the consumer; (2) a clear disclaimer that the product was not evaluated by FDA for safety and effectiveness; (3) a recommendation to consult with a health care professional before initiating use; and (4) any known warnings or precautions regarding dietary supplement–medication interactions or dietary supplement–disease interactions; further,

To support the development of legislation or regulation requiring that dietary supplement advertising prominently state risks and intended benefits of a product that consumers should discuss with their licensed health care professional.

10. Council on Public Policy, Policy F, "Prohibiting Reuse of Brand Names and Standardizing Prefixes and Suffixes": The Board agreed that the amended language is acceptable. The two separate policies read as follows:

F1. Prohibiting Reuse of Brand Names

To advocate Food and Drug Administration authority to prohibit reuse of brand names of prescription and nonprescription drugs when any active component of the product is changed or after any other changes are made in the product that may affect its safe use.

F2. Standardizing Prefixes and Suffixes in Drug Product Names

To collaborate with others, including the United States Pharmacopeia and the Food and Drug Administration, in standardizing and defining the meaning of prefixes and suffixes for prescription and nonprescription drugs to prevent medication errors and ensure patient safety.

11. Council on Public Policy, Policy G, "Medicare Prescription Drug Benefit": The Board agreed that the amended language was acceptable with editorial changes. As edited, the policy reads as follows:

G. Medicare Prescription Drug Benefit

To strongly advocate a fully funded prescription drug program for eligible Medicare beneficiaries that maintains continuity of care and ensures the best use of medications; further,

To advocate that essential requirements in the program include (1) appropriate product reimbursement based on transparency of drug costs; (2) affordability for patients, including elimination of coverage gaps; (3) payment for indirect costs and practice expenses related to the provision of pharmacist services, based on a study of those costs; (4) appropriate coverage and payment for patient care services provided by pharmacists; (5) open access to the pharmacy provider of the patient's choice; (6) formularies with sufficient flexibility to allow access to medically necessary drugs; and (7) well-publicized, unbiased resources to assist beneficiaries in enrolling in the most appropriate plan for their medication needs.

(Note: "Fully funded" means the federal government will make adequate funds available to fully cover the Medicare program's share of prescription drug program costs; "eligible" means the federal government may establish criteria by which Medicare beneficiaries qualify for the prescription drug program.)

(Note: This policy supersedes ASHP policy 0410.)

New Business. Chair Hudson announced that, in accordance with Article 7 of the Bylaws, there were no items of New Business to be considered.

Recommendations. Chair Hudson called on members of the House of Delegates for 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.)

Thomas Burnakis (FL): Revision of Policy on Direct-to-Consumer Advertising of Dietary Supplements

Recommendation: ASHP's policy on direct-to-consumer (DTC) advertising of dietary supplements should take the position that the organization will not support this advertising until these products meet the same tests for efficacy and safety required of prescription and non-prescription medications.

Background: The current policy states that ASHP will support DTC advertising if it includes evidence-based information on safety and efficacy. However, marketers of these products have rudimentary data that could meet the letter, if not the intent, of this requirement. Based on these limited, often non-scientific, data, these advertisers could conceivably state in their advertisements "as supported by the American Society of Health-System Pharmacists."

Jamie Wilkins, Elaine Huang (Student Forum): Requirement of an Information Sheet in Packaging of Dietary Supplements

Recommendation: ASHP should advocate the requirement of an information sheet in packaging of dietary supplements. (Refer to background found in Council on Public Policy Report 2006, Policy E: Direct-to-Consumer Advertising of Dietary Supplements)

Background: The aforementioned information sheet should include: (1) Evidence-based information regarding safety and efficacy in a format that allows for informed decision making by the consumer, (2) a clear disclaimer that the product is not evaluated by the FDA for safety and effectiveness, (3) a recommendation to consult with a health care professional before initiating use, and (4) any known warnings or precautions regarding dietary supplement-medication interactions or dietary supplement-disease interactions.

Donna Soflin (NE): Election Procedure for Treasurer and Chairman of the House of Delegates

Recommendation: Consider restructuring the election of the Treasurer to be elected by the general membership and utilize an election time frame for the Chairman of the House similar to the procedure used for the other elected officers, Board members, and Section leaders.

Background: As the Treasurer represents the interests of the entire membership and the Foundation, consideration should be given to election of the Treasurer by the entire membership. Election of the Chairman of the House in a balloting time frame similar to other elected officers and leaders would facilitate a nine-month time frame for orientation and preparation prior to assuming these very important responsibilities, as well as avoid the awkward election atmosphere at the House of Delegates.

Martin J. Goldberg (MA): Definition of Terms

Recommendation: To develop a glossary of terms commonly used in policy to limit the amount of wordsmithing that takes place.

Background: The ASHP councils by and large do a good job of crafting policy language. Debate should center on the intent or implication of policy and not the words.

Paul J. Barrett (ME): Qualified Pharmacy Graduates

Recommendation: ASHP should urge colleges of pharmacy to adequately prepare graduates for patient care responsibilities in health-system pharmacy; further, ASHP should continue to support residency and certification programs that prepare pharmacists for specialized patient care practice.

Background: All pharmacists provide "direct patient care." ASHP's new policy to require a PGY1 residency prior to practice will apply to all new pharmacists in 2020. However, there is a critical need for adequately prepared graduates currently - to work within the "integrated team-based approach" described in policy 0619.

Michael Schlesselman (CT): Strategies To Help Hospitals Introduce/Train Pharmacists in Hospital Pharmacy after Working in a Non-Hospital Environment

Recommendation: ASHP should develop tools and strategies to help hospitals and health systems train and orient pharmacists to hospital practice after working in a non-hospital setting.

Background: Many pharmacy students go to work in the retail setting after school and after a few years desire to move to hospital pharmacy. Especially in light of the new Resolution to require residencies for those who provide direct patient care, there should be a means to bring these new practitioners up to speed so they have the opportunity to provide direct patient care.

Dale English II (Section of Inpatient Care Practitioners): Direct Patient Care

Recommendation: To strongly recommend that ASHP extensively define what is considered "direct patient care."

Background: The Resolution on required residency for pharmacists providing "direct patient care" needs to have more extensive work done in defining specifically what is universally considered "direct patient care." This definition is currently not available and the term can be defined differently by different pharmacists. Virtually any task performed by pharmacists in some manner or form directly affects patient care.

Rosario (Russ) J. Lazzaro (NJ): Review and Revise ASHP Statement on the Use of Dietary Supplements and Its Policy on Direct-To-Consumer Advertising of Dietary Supplements To Include USP Verification of Content and Strength

Recommendation: ASHP should revise these polices and if appropriate include the USP's "seal of approval" and verification as to contents and strength of dietary supplements.

Background: The ASHP Statement on the Use of Dietary Supplements is almost three years old, and the USP has now elected to provide verification as to the content and strength of dietary supplements when requested by a manufacturer. While this is not a FDA-mandated requirement, it provides verification that a product does contain the ingredient stated and that it contains the amount stated. The USP does not endorse the product as to efficacy or safety, just content.

Caryn Bing, Margaret Gordon, Diana Higgins (NV): Replace the Word "Drug" with "Medication" in ASHP Documents

Recommendation: ASHP should review all policies, guidelines, statements and replace the word "drug" with "medication", when appropriate.

Background: This would be consistent with the Joint Commission chapter on Medication Management and avoid the negative connotation that the word "drug" has with the public.

Michael Rubino, Michael Schlesselman, Fei Wang (CT): Reimbursement for Cognitive Services for Inpatient Pharmacist Consultations

Recommendation: Consistent with the ASHP Enhanced Advocacy Initiative, ASHP should advocate for Medicare and other third party reimbursement for cognitive services related to inpatient care, specifically consultative services such as pain management in which pharmacists obtain patient histories directly, write a summary in the medical record, and recommend specific drug therapy.

Background: Pharmacist consultative services in which the pharmacist speaks with the patient, writes a note in the medical record, and recommends specific drug therapy are identical to consultative services provided by physicians and other health professionals for which they receive payment. Pain management is of particular importance because elimination of pain is part of every hospitals' Patient Bill of Rights, and pain assessment is considered the fifth vital sign.

Cathy Sasser (Section of Home, Ambulatory, and Chronic Care Practitioners): Patient-Centered Medication Lists

Recommendation: To encourage hospital and health-system pharmacists to educate patients on the benefits of medication lists as an important tool in improving continuity of care and the medication reconciliation process; to support pharmacists' efforts in improving health care literacy for patients and

their understanding of their medication regimens; to support pharmacist collaboration with other health professionals in the promotion of patient-centered medication lists and the removal of barriers among patients and practitioners; to support pharmacists improving their interdisciplinary role in the transition and integration of medication lists into the electronic personal health record and electronic health record processes.

Background: The World Health Organization and The Joint Commission standards challenge pharmacists to play an active role in the eduction process of patients in their medications and medication use, tracking changes, additions, and discontinuations of therapies prescribed to treat acute and chronic conditions.

Pamela Phelps, John Pastor, Judith Schneider, Lisa Gersema, Craig Else (MN): Pump Library Development

Recommendation: We recommend that ASHP pursue the development of infusion pump library specifications as a marketable product for members of ASHP.

Background: As "smart-pump" technology evolves, hospitals are in the process of developing dose and administration recommendations for specific drug libraries. Hospitals are building these from the ground up, including minimum and maximum doses based on weight, population, etc. Core libraries could be developed as a product line for ASHP for many patient populations (pediatrics, critical care, general, obstetrics, etc).

Cathy Sasser (Section of Home, Ambulatory, and Chronic Care Practitioners), Caryn Bing (NV): Continuity of Services for Parenteral Medications

Recommendation: To recommend that ASHP develop best practices and create educational resources for pharmacists that address the use of parenteral medications and related infusion devices or equipment from the ambulatory or home infusion setting when these are brought into an inpatient or clinic setting by patients.

Background: There is a considerable challenge for patient care continuity when complex therapies (e.g., total parenteral nutrition, chemotherapy, pain management, or medications with limited availability) must be continued at the point that a patient enters the inpatient or clinic setting if the inpatient area or clinic does not allow some method for continued use of appropriately verified parenteral preparations.

Fern Kaufman (PA): Role of Pharmacists in the Use of Drug-Related Devices

Recommendation: To develop a policy to define the role of pharmacists in the use of drug-related devices, such as needles, used in HIV-positive patients.

Background: With the discontinuation of ASHP Policy 8808, Human Immunodeficiency Virus Infections, there currently exists no ASHP policy defining the role of pharmacists in the education and support of hospital staff as it pertains to the use of drug-related devices with HIV patients. An example would be educating nurses in the event of a needle stick while caring for an HIV-positive patient.

Michael Schlesselman, Michael Rubino, Fei Wang (CT): ASHP State Affiliates

Recommendation: ASHP should foster growth and stability of smaller state affiliates.

Background: Many smaller states have limited volunteer and financial resources. These organizations are faced with increased operational costs and membership retention problems. Providing CE programs is increasingly difficult. Leadership succession planning is needed to ensure continued viability of state affiliates.

Robert Ignoffo (CA): Labeling of Dietary Supplements

Recommendation: To encourage the Council on Public Policy to develop a policy on the appropriate labeling of dietary supplements and review and update the ASHP Statement on the Use of Dietary Supplements.

Background: Amended Policy E from the Council on Public Policy was approved at the first meeting of this session of the House of Delegates. However, the Board of Directors did not accept the amended policy and asked for reconsideration. It is important that the issue of full disclosure of ingredients be included in some policy statement related to dietary statements.

John Carbone, Kenneth Schell (CA): Medicare Prescription Drug Benefit

Recommendation: To re-evaluate elements of Medicare prescription drug benefits (Council on Public Policy Recommendation G) policy based on transparency of drug costs.

Background: In the recently passed language replacing policy 0410, reference was made to advocating transparency of drug cost relating to reimbursement. This implies disclosure of confidential contract terms. This language could have a significant effect on medication costs to consumers and the ability to provide affordable health care by health plans and other entities. We respectfully request that the Board refer this policy to the appropriate ASHP body for review and modification.

Mark Siska (Section of Pharmacy Informatics and Technology): Pharmacist Oversight and Responsibilities for Medication Management Systems and Automation Used within Health Systems

Recommendation: ASHP should change existing policies or develop new policies to specify that pharmacists must oversee all the technologies and systems supporting the medication-use process in health systems.

Background: The pharmacist possesses a comprehensive understanding of the safe and effective use of medications and core pharmacy operations and has developed expertise in end-to-end medication-use management. This unique blend of knowledge supports pharmacist oversight of all technologies and automation supporting the medication-use process.

James Dorociak (IL): ASHP Meetings in Smoke-Free Environment

Recommendation: Beginning in 2010, ASHP should consider holding its Summer and Midyear meetings only in cities or states that have enacted smoke-free regulations for public areas.

Background: This action would be consistent with our policy on tobacco products and our 2015 initiative.

Kenneth Schell (CA): Voting Procedures in the House of Delegates

Recommendation: Implement electronic voting in the ASHP House of Delegates.

Background: Procedures for voting in the HOD currently utilzed voice, hand tally, and paper voting. While these procedures are failsafe, they are cumbersome, time consuming, and possibly inaccurate. To optimize the efficiency of the House and ensure accurate vote counts, I recomnend that the BOD investigate the implementation of an electronic voting system in the ASHP House of Delegates no later than 2010.

John Murphy (Past President): Opposition to Unnecessary Depiction of Tobacco Use in the Media

Recommendation: ASHP should examine opportunities to work with other interested organizations to create statements and expressions of opposition to the unnecessary depiction of tobacco use in the media.

Background: The depiction of tobacco use in the media appears to be increasing considerably. This is often not a necessary part of the story being told. Unfortunately, the actions of media stars are often emulated by the public and their influence can be considerable. ASHP should oppose unnecessary depiction as it may influence children and adults to use tobacco products.

William Yee (CA): Further Refinement of Policy on Personnel Ratios

Recommendation: The Council on Public Policy should further review Policy D (Personnel Ratios) for refinement.

Background: The first meeting of this year's ASHP House of Delegates approved multiple amendments to the draft policy, including reversing the order of paragraphs and adding qualifying language. The ASHP Board of Directors did not accept the qualifying language but did not comment on the reversal of paragraphs. It is recommended that the Council on Public Policy re-review the policy for further refinement.

Mark Siska (Section of Pharmacy Informatics and Technology): Consensus Conference for Pharmacy Informatics and Technology

Recommendation: ASHP should support a consensus conference that will confirm the role of pharmacists in the field of pharmacy informatics.

Background: ASHP believes that pharmacists have the unique knowledge, expertise, and responsibility to assume a significant role in medical informatics. This consensus conference will affirm the responsibilities of the pharmacist and the pharmacy informaticist in the field of medical informatics.

Dale English II (Section of Inpatient Care Practitioners): Medication Safety Education

Recommendation: The Section of Inpatient Care Practitioners' advisory group on medication safety believes that ASHP Policy 0608, Interdisciplinary Health Professions Education, should be strengthened to emphasize the need for teaching comprehensive medication safety principles in all colleges of pharmacy.

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 Brennan with an inscribed gavel commemorating her term of office. Dr. Brennan recognized the service of Chair Hudson as Chair of the House of Delegates and a member of the Board of Directors.

Chair Hudson recognized Jill Martin'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: Michael Kelly, Chair of the Section of Clinical Specialists and Scientists; Ernest Dole, Chair of the Section of Home, Ambulatory and Chronic Care Practitioners; Helen Calmes, Chair of the Section of Inpatient Care Practitioners; Steve Rough, Chair of the Section of Pharmacy Practice Managers;

Jamie Wilkins, Chair of the Pharmacy Student Forum; and Sarah Ferrell, Chair of the New Practitioners Forum..

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

Chair Hudson then called on Vice Chair Martin to preside over the House for the remainder of the meeting.

Vice Chair Martin announced that Teresa J. Hudson had been elected as Chair of the House and Paul W. Abramowitz as Treasurer.

Installation. Vice Chair Martin installed Janet A. Silvester as President of ASHP, Kathryn R. Schultz and James G. Stevenson as members of the Board of Directors, Teresa J. Hudson as Chair of the House of Delegates, and Paul W. Abramowitz as Treasurer.

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

Adjournment. The 59th annual session of the House of Delegates adjourned at 5:48 p.m.

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[a]The Committee on Nominations consisted of David J. Blanchard (NY), Chair, T. Mark Woods (KS), Vice Chair, Dan D. Degnan (IN), Risa C. Rahm (TN), Ranee M. Runnebaum (MO), Linda S. Tyler (UT), and Therese M. Wavrin (OR).

ASHP Board of Directors, 2007–2008

Janet A. Silvester,
President and Chair
of the Board

Cynthia Brennan,
Immediate Past-President

Paul W. Abramowitz,
Treasurer

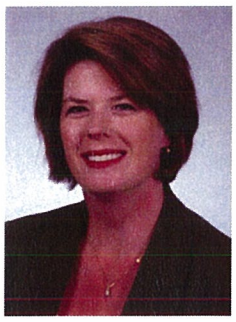
Teresa J. Hudson
Chair, House of Delegates

Diane B. Ginsburg

Stanley S. Kent

Lynnae M. Mahaney

Sheila L. Mitchell



Kathryn R. Schultz

James G. Stevenson

Henri R. Manasse, Jr.,
Secretary

DELEGATES to the 2007 Session of the House

Officers of the House
Teresa J. Hudson, *Chair*
Jill E. Martin, *Vice Chair*
Henri R. Manasse, Jr., *Secretary*

Officers and Board of Directors
Cynthia Brennan, *President*
Janet A. Silvester, *President-Elect*
Jill E. Martin, *Immediate Past-President*
Teresa J. Hudson, *Chair House of Delegates*
Marianne F. Ivey, *Treasurer*
Henri R. Manasse, Jr., *Executive Vice President and Chief Executive Officer*
Diane B. Ginsburg
Stanley S. Kent
Lynnae M. Mahaney
Sheila L. Mitchell
Agatha L. Nolen
Philip J. Schneider

Past Presidents
Paul W. Abramowitz
Daniel M. Ashby[2]
Robert Bogash[2]
Bruce Canaday[2]
Jannet M. Carmichael
Debra S. Devereaux
Fred Eckel
Rebecca Finley
John Gans
Harold Godwin
Mark Hunt
James C. McAllister, III
John E. Murphy
Paul G. Pierpaoli[2]
Cynthia L. Raehl[2]
Philip J. Schneider
Bruce E. Scott
Steven L. Sheaffer[2]
Thomas S Thielke[2]
Sara J. White
T. Mark. Woods
Dave Zilz

STATE DELEGATES

Alabama (3)
Joyce C. Altsman
Brian E. Beckett
Karren G. Crowson

Alaska (2)
Traci C. Gale
Kimberly Poole

Arizona (3)
Larry Dean Anderson
Dianna M. Borowski
Michael D. Katz

Arkansas (2)
Jason C. Dobbs
Carol Diane Long

California (8)
Peter J. Ambrose
John J. Carbone
William C. Gong
Robert J. Ignoffo
Nancy R. Korman
Daniel M. Kudo
Kenneth H. Schell
William P. Yee

Colorado (3)
Erin Hendrick
Paul Nicholas Limberis
Paula Moyers

Connecticut (3)
Michael Rubino
Michael D. Schlesselman
Fei Wang

Delaware (2)
Deborah L. Burgun
Eugene R. Cierniak

Florida (5)
Thomas G. Burnakis
Christine Gegeckas
Thomas E. Johns[1]
Stephen M. Kessinger
Risa C. Rahm[2]
Michele Weizer

Georgia (4)
Patricia Knowles
Deborah R. Mangum
Cynthia Scholl Pangburn
Andrea Gay Roberson

Hawaii (2)
Elwin D. Goo
Joy R. Matsuyama

Idaho (2)
Paul S. Driver
Susan M. Heineman

Illinois (5)
Andrew J. Donnelly
James V. Dorociak
Todd A. Karpinski
Steven E. Marx
Michael McEvoy

Indiana (3)
Dan D. Degnan
Tina Marie Love
Thomas J. Neyer

Iowa (3)
Lisa A. Mascardo
Steven P. Nelson
James A. Wallace

Kansas (3)
Jeffrey A. Pierce
Linda Y. Radke
Suzanne Richter Schrater

Kentucky (3)
Heath Randel Jennings
Philip E. Lakarosky
Michelle L. Wiest Dusing

Louisiana (3)
Helen M. Calmes
Michael B. Cockerham
Tommy J. Mannino

Maine (2)
Paul J. Barrett
Steven C. Townsend

Maryland (4)
Marybeth A. Kazanas
Janet L. Mighty
Vivian Rexroad
James A. Trovato

Massachusetts (3)
Ernest R. Anderson, Jr.
Martin J. Goldberg
Daniel F. Newberg

Michigan (4)
Gary D. Blake
Kathleen S. Pawlicki[1]
Frederick E. Schmidt[2]
Edward G. Szandzik
Paul C. Walker

Minnesota (3)
Craig E. Else
John Pastor
Judith K. Schneider

Mississippi (2)
Jillian James Foster
Deborah K. Minor

Missouri (3)
Nicole M. Allcock
Douglas R. Lang
Ranee Runnebaum

Montana (2)
Dominick Caselnova III
Randy Kuiper

Nebraska (3)
Kenneth Alan Kester
James R. Rinehart
Donna L. Soflin

Nevada (2)
Caryn M. Bing
Margaret Gordon

New Hampshire (2)
David W. DePiero
Stephen G. Kavadias

New Jersey (4)
Charles J. Arrison
Andre J. Emont
Eric T. Hola
Rosario Lazzaro

New Mexico (3)
Amy S. Buesing
Melanie A. Dodd
Phil T. Saucedo

New York (5)
Michael P. Blumenfeld
Debra B. Feinberg
Thomas P. Lombardi
Frank P. Sosnowski
Kimberly Theresa Zammit

North Carolina (4)
Stephen F. Eckel
William T. Giddens
Dennis M. Williams
Jane Younts

North Dakota (2)
Dennis F. Delabarre
Dorothy J. Sander

Ohio (5)
Kathleen D. Donley
Karen L. Kier
Robert M. Parsons
Stephanie C. Peshek
Douglas L. Stillwell

Oklahoma (3)
Mark A. Gales
Barbara Miles Poe
Darin L. Smith

Oregon (3)
Kristina Butler
Margaret E. McGuinness[2]
Therese M. Wavrin

Pennsylvania (5)
Fern B. Kaufman
Ronald E. Lay
Gerald E. Meyer
Jean M. Scholtz
Melissa V. Shiner

Puerto Rico (2)
Carlos A. Mendez

Rhode Island (2)
Christine Marchese
Susan L. Plante

South Carolina (3)
Paul William Bush
James R. Hammett
Robert L. Spires

South Dakota (2)
Jodi K. Johnson
Thomas J. Johnson

Tennessee (3)
Jeanne R. Ezell
William L. Greene
Kothanur Rajanna

Texas (6)
Teri L. Bair
Lourdes M. Cuellar
Julie A. Nelson
Roland A. Patry
Michael D. Sanborn
James P. Wilson

Utah (2)
Dallas Moore
Linda S. Tyler

Vermont (2)
Gail Boundy
Carl J. Possidente

Virginia (4)
Bobby J. Ison
Stephen M. Lahaye
Deborah R. Saine
Robert J. Stoneburner

Washington, D.C. (2)
Vaiyapuri Subramaniam
Michael S. Edwards

Washington State (3)
Julie R. McCoy
Megan K. McMurray
John P. Swenson

West Virginia (3)
James Grant Allman II
Gwendolyn S. Gill
Carol Woodward

Wisconsin (4)
Clyde R. Birringer
James A. Klauck
Steven S. Rough

Wyoming (2)
Kendall D. George
Timothy S. Seeley

Sections and Forums Delegates
Clinical Specialists and Scientists
Ted L. Rice
Home, Amb., and Chronic Care
Cathy L. Sasser
Inpatient Care Practitioners
Dale English, II
Pharm. Informatics & Tech.
Mark H. Siska[2]
Pharmacy Practice Managers
Kathy Pawlicki[2]
Pharmacy Student Forum
Jamie Wilkins
New Practitioners Forum
Sarah E. Ferrell

Fraternal Delegates
U.S. Navy
Ronald Anthony Nosek, Jr
U.S. Public Health Service
Jimmy R. Mitchell
Veterans Affairs
Julio R. Lopez

[1] Sat in Sunday House Meeting only
[2] Sat in Tuesday House Meeting only

Professional policies approved by the 2007 ASHP House of Delegates

San Francisco, CA
July 2, 2007

The new professional policies of ASHP are organized here according to the council or other body that initiated them. Policies proposed by councils or other bodies are first considered by the Board of Directors and then acted on by the House of Delegates, which is the ultimate authority for ASHP positions on professional issues. The background information on these policies appears on the ASHP Web site, www.ashp.org; click on "About ASHP," then on "House of Delegates." The complete proceedings of the House of Delegates will be sent to delegates and will be posted on the ASHP Web site; a printed copy can be requested from the ASHP Executive Office.

Resolution

Requirement for Residency

To support the position that by the year 2020, the completion of an ASHP-accredited postgraduate-year-one residency should be a requirement for all new college of pharmacy graduates who will be providing direct patient care.

Council on Education and Workforce Development

Pharmacy Technician Training

To support the goal that pharmacy technicians entering the pharmacy workforce have completed an ASHP-accredited program of training; further,

To encourage expansion of ASHP-accredited pharmacy technician training programs.

(Note: This policy supersedes ASHP policy 0212.)

Image of and Career Opportunities for Hospital and Health-System Pharmacists

To sustain and enhance the public information program promoting the professional image of hospital and health-system pharmacists to the general public, public policymakers, payers, other health care professionals, and hospital and health-system decision-makers; further,

To provide ASHP informational and recruitment materials identifying opportunities for pharmacy careers in hospitals and health systems.

(Note: This policy supersedes ASHP policy 0214.)

Residency Programs

To strongly advocate that all pharmacy residency programs become ASHP-accredited as a means of ensuring and conveying program quality.

(Note: This policy supersedes ASHP policy 0216.)

ASHP Guidelines, Statements, and Professional Policies as an Integral Part of the Educational Process

To encourage faculties in colleges of pharmacy and preceptors of ASHP-accredited residency training programs to use ASHP statements, guidelines, and professional policies as an integral part of training programs and courses.

(Note: This policy supersedes ASHP policy 8407.)

External Degree Programs and Initiatives for Helping Practitioners Upgrade Skills

(Discontinuation of ASHP policy 8508 was approved.)

Council on Pharmacy Management

Administering Injectable Medications Supplied Directly to Patients

To encourage hospitals and health systems not to permit administration of injectable medications brought to the hospital or clinic by the patient or caregiver when storage conditions or the source cannot be verified; further,

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

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

Standard Drug Administration Schedules

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

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

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

Pay-for-Performance Reimbursement

To support pay-for-performance reimbursement models when they are appropriately structured to improve health care quality; further,

To oppose pay-for-performance reimbursement models that do not support an open culture of medication error reporting; further,

To encourage pharmacists to actively lead medication-related pay-for-performance initiatives.

Principles of Managed Care

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

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

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

(Note: This policy supersedes ASHP policy 0205.)

Needle-Free Drug Preparation and Administration Systems

(Discontinuation of ASHP policy 9202 was approved.)

Council on Pharmacy Practice

ASHP Statement on the Role of Health-System Pharmacists in Public Health

To approve the ASHP Statement on the Role of Health-System Pharmacists in Public Health.

ASHP Statement on Professionalism

To approve the ASHP Statement on Professionalism.

ASHP Statement on Racial and Ethnic Disparities in Health Care

To approve the ASHP Statement on Racial and Ethnic Disparities in Health Care.

Role of Pharmacists in Sports Pharmacy and Doping Control

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

To encourage pharmacists to advise athletic authorities and athletes on medications that are prohibited in competition; further,

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

Institutional Review Boards and Investigational Use of Drugs

To support mandatory education and training on human subject protections and research bioethics for members of institutional review boards (IRBs), principal investigators, and all others involved in clinical research; further,

To advocate that principal investigators discuss their proposed clinical drug research with representatives of the pharmacy department before submitting a proposal to the IRB; further,

To advocate that IRBs include pharmacists as voting members; further,

To advocate that IRBs inform pharmacy of all approved clinical research involving drugs within the hospital or health system; further,

To advocate that pharmacists act as liaisons between IRBs and pharmacy and therapeutics committees in the management and conduct of clinical drug research studies; further,

To strongly support pharmacists' management of the control and distribution of drug products used in clinical research.

(Note: This policy supersedes ASHP policy 0230.)

Electronic Health and Business Technology and Services

To encourage pharmacists to assume a leadership role in their hospitals and health systems with respect to strategic planning for and implementation of electronic health and business technology and services; further,

To encourage hospital and health-system administrators to provide dedicated resources for pharmacy departments to design, implement, and maintain electronic health and business technology and services; further,

To advocate the inclusion of electronic health technology and telepharmacy issues and applications in college of pharmacy curricula.

(Note: This policy supersedes ASHP policy 0233.)

Tobacco and Tobacco Products

To discourage the use and distribution of tobacco and tobacco products in and by pharmacies; further,

To advocate for tobacco-free environments in hospitals and health systems; further,

To seek, within the bounds of public law and policy, to eliminate the use and distribution of tobacco and tobacco products in meeting rooms and corridors at ASHP-sponsored events; further,

To promote the role of pharmacists in tobacco-cessation counseling; further,

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

(Note: This policy supersedes ASHP policy 8807.)

Human Immunodeficiency Virus Infections

(Discontinuation of ASHP policy 8808 was approved.)

Council on Public Policy

Restricted Drug Distribution

To affirm support for the current system of drug distribution in which prescribers and pharmacists exercise their professional responsibilities on behalf of patients; further,

To acknowledge that there may be limited circumstances in which constraints on the traditional drug distribution system may be appropriate if the following principles are met: (1) the requirements do not interfere with the continuity of care for the patient; (2) the requirements preserve the pharmacist–patient relationship; (3) the requirements are based on scientific evidence fully disclosed and evaluated by prescribers, pharmacists, and others; (4) there is scientific consensus that the requirements are necessary and represent the least restrictive means to achieve safe and effective patient care; (5) the costs of the product and any associated product or services are identified for purposes of reimbursement, mechanisms are provided to compensate providers for special services, and duplicative costs are avoided; (6) all requirements are stated in functional, objective terms so that any provider who meets the criteria may participate in the care of patients; and (7) the requirements do not interfere with the professional practice of pharmacists, prescribers, and others; further,

To advocate that the Food and Drug Administration (FDA) be granted the authority to consult with practicing pharmacists and others when the establishment of a restricted distribution system is contemplated for a drug product; further,

To advocate that FDA be granted the authority to require that manufacturers disclose all of the considerations that led to the establishment of a restricted distribution system for a specific product; further,

To advocate that FDA be granted the authority to require that manufacturers include in each restricted distribution system a mechanism that will ensure medication reconciliation and continuity of care as patients transition from one level or site of care to another; further,

To advocate that FDA be granted the authority to require manufacturers to conduct a follow-up assessment of the impact of a restricted drug distribution system.

(Note: This policy supersedes ASHP policy 0114.)

Patient Access to Orphan Drug Products

To encourage continued research, development, and marketing of orphan drug products; further,

To urge health policymakers, payers, and pharmaceutical manufacturers to develop innovative ways to ensure patient access to orphan drug products; further,

To support public policies that ensure that the cost of orphan drug products does not preclude reasonable patient access to these agents.

Regulation of Telepharmacy Services

To advocate that boards of pharmacy adopt regulations that enable the use of United States-based telepharmacy services for all practice settings; further,

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

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

Personnel Ratios

To advocate that pharmacist-to-technician and pharmacist-to-patient ratios be determined by local institutions on the basis of acuity of care, breadth of services, quality improvement processes, and historical data; further,

To encourage additional research on staffing models that are based on best practices in order to provide safe and effective patient care.

Direct-to-Consumer Advertising of Dietary Supplements

To support direct-to-consumer advertising of dietary supplements only when it is educational in nature and includes pharmacists as a source of information; further,

To support direct-to-consumer advertising of dietary supplements only when it includes (1) evidence-based information regarding safety and efficacy in a format that allows for informed decision-making by the consumer; (2) a clear disclaimer that the product was not evaluated by FDA for safety and effectiveness; (3) a recommendation to consult with a health care professional before initiating use; and (4) any known warnings or precautions regarding dietary supplement–medication interactions or dietary supplement–disease interactions; further,

To support the development of legislation or regulation requiring that dietary supplement advertising prominently state risks and intended benefits of a product that consumers should discuss with their licensed health care professional.

FDA Authority to Prohibit Reuse of Brand Names

To advocate for Food and Drug Administration authority to prohibit reuse of brand names of prescription and nonprescription drugs when any active component of the product is changed or after any other changes are made in the product that may affect its safe use.

(Note: This policy supersedes ASHP policy 0613.)

Standardizing Prefixes and Suffixes in Drug Product Names

To collaborate with others, including the United States Pharmacopeia and the Food and Drug Administration, in standardizing and defining the meaning of prefixes and suffixes for prescription and nonprescription drugs to prevent medication errors and ensure patient safety.

Medicare Prescription Drug Benefit

To strongly advocate a fully funded prescription drug program for eligible Medicare beneficiaries that maintains continuity of care and ensures the best use of medications; further,

To advocate that essential requirements in the program include (1) appropriate product reimbursement based on transparency of drug costs; (2) affordability for patients, including elimination of coverage gaps; (3) payment for indirect costs and practice expenses related to the provision of pharmacist services, based on a study of those costs; (4) appropriate coverage and payment for patient care services provided by pharmacists; (5) open access to the pharmacy provider of the patient's choice; (6) formularies with sufficient flexibility to allow access to medically necessary drugs; and (7) well-publicized, unbiased resources to assist beneficiaries in enrolling in the most appropriate plan for their medication needs.

(Note: "Fully funded" means the federal government will make adequate funds available to fully cover the Medicare program's share of prescription drug program costs; "eligible" means the federal government may establish criteria by which Medicare beneficiaries qualify for the prescription drug program.)

(Note: This policy supersedes ASHP policy 0410.)

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, 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) accurately document at any point in the distribution chain the original source of drug products and chain of custody from the manufacturer to the pharmacy; further,

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

(Note: This policy supersedes ASHP policy 0321.)

Generic Drug Products

(Discontinuation of ASHP policy 9005 was approved.)

Council on Therapeutics

Removal of Propoxyphene from the Market

To advocate that the Food and Drug Administration remove propoxyphene from the market because of its poor efficacy and poor safety profile and because more effective and safer alternatives are available to treat mild to moderate pain.

Inaugural address of the President-elect

Pharmacy's way forward: Inspiration through connection

JANET SILVESTER

If just one person can make a difference, think what we can accomplish together.

Good morning!

So here we are in San Francisco, a city that is known as a place where East meets West—a place where people come together from many cultures and where diversity in all forms is celebrated.

It is only fitting that this place, where great connections occur, should be the forum for our meeting this week—the place where we come to reconnect, be inspired, and to share our common mission. These two themes—connection and inspiration—comprise the foundation of what I want to talk to you about today.

But, as I stand before you this morning, I think I understand just how Dorothy must have felt after being dropped into the land of Oz after a whirlwind ride in a cyclone!

"You're not in Kansas anymore" doesn't begin to describe how it feels to assume the ASHP presidency. I am, however, filled with a sense of excitement and optimism about the future of our profession and the journey that lies ahead. I am also incredibly grateful for the opportunities that have led me to this place and to all of the extraordinary people who I have encountered along the way.

Before I begin, I hope you will indulge me for a moment as I recognize a few special people who have provided invaluable support throughout the years.

Thank you to my fellow Board members, past and present, especially Diane Ginsburg, Cindi Brennan, Jill Martin, and my Board buddy Kevin Colgan, for their friendship and inspiration, and to Deb Devereaux, Mark Woods, Dan Ashby, Mick Hunt, Marianne Ivey, Paul Abramowitz, and Sara White for their mentoring and encouragement.

I would also like to recognize my many talented colleagues at Martha Jefferson Hospital, especially the pharmacy staff. Their unwavering dedication and hard work result in the highest possible standards for the care of our patients.

I wish to thank my boss, Amy Black, our chief nursing officer, and all of the executive team at Martha Jefferson, without whose support I would not be here today. They provide an environment that not only

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The following ASHP Reports and information on 2007 ASHP award recipients appear in the online version of this issue (www.ajhp.org):

- The Advocacy Imperative: remarks of outgoing ASHP president Cynthia Brennan, Pharm.D., M.H.A.
- Making ASHP's Work-Force Vision a Reality: remarks of ASHP Executive Vice President and Chief Executive Officer Henri Manasse, Jr., Ph.D., Sc.D.
- ASHP's Financial Strength Provides Opportunity for Bold Initiatives: remarks by outgoing ASHP Treasurer Marianne F. Ivey, Pharm.D., M.P.H., FASHP
- Professional policies approved by the 2007 ASHP House of Delegates
- ASHP Board of Directors, 2007–2008
- ASHP Board of Directors Award of Honor
- ASHP Award of Excellence
- ASHP Honorary Membership

To read more about 2006 Society activities, go to **www.ashp.org/s_ashp/docs/files/ASHP_AnnualReport06.pdf**

values active professional involvement but supports high practice standards at our institution.

Finally, I want to acknowledge my mom and dad, Ginny and John Anderson, who taught me that anything is possible if you believe and work hard; my daughter, Kate, of whom I am so very proud, and her brand new husband Kent; my sisters, Peggy Smith and Sally Ryan; and, of course, my wonderful husband Dr. Michael Silvester, who is the love of my life and my refuge. Thank you for always encouraging me to pursue my dreams and understanding my commitment to this profession.

The beginning

I thought it would be beneficial as I start in this position, to give you my story, my beginning, why I am here today.

When I was 13, my father had a serious car accident. He spent a couple of months as a patient at Virginia Commonwealth University's Medical College of Virginia Hospital. I watched a man who initially bore no resemblance to my dad with tubes everywhere, bruises, and broken bones slowly and remarkably return to the person I knew and loved.

At the time, I did not understand that this transformation was a result of the collaboration of many specialists and great nursing care. I had no awareness of the role that pharmacists had in his care, but I did know that I wanted to be part of a team that could save lives like my father's.

Not long after that experience, I spent a summer babysitting the children of a woman who was our community pharmacist. I started thinking about pharmacy as a career option and committed to that path by my sophomore year in high school.

That is the beginning of my story. Sound familiar? That is because just about everything we do that is meaningful in our lives evolves from a personal relationship—a human connection.

Connecting to heal

I am sure that everyone in this room has experienced a pivotal event or had a relationship that helped to shape his or her personal and professional philosophies of patient care. Let me share two of mine that forever changed my perspective as a pharmacist.

Early in my career, I encountered a 34-year-old mother of two who was being treated for ovarian cancer. At that time, the treatment protocols required the patient to be hospitalized for one week a month, so I had the opportunity to see her often. We spent a lot of time talking, not only about what to expect from her chemotherapy but also about very personal issues that she was confronting.

We talked about how to help her two young children understand what was happening when she lost her hair and about a very scary prognosis and her uncertain future.

Through it all, I was tremendously inspired by her strength and her positive focus. Miraculously, she survived her cancer and still comes to Martha Jefferson Hospital for follow-up more than 20 years later.

The second experience was with a lovely 60-year-old woman who had complications following colon surgery and remained in the hospital for about three months while receiving total parenteral nutrition (TPN). The pharmacists write the orders for TPN at Martha Jefferson, so, for the most part, we interacted with her daily. She was so very grateful for the time and care that she was given and loved having us visit. Because she was with us for so long, we developed a special bond with her. Upon her long-awaited discharge, we even shared a glass of champagne with her to celebrate!

I will never forget these two patients and the lessons they taught me. I learned that if you invest of yourself, beyond checking for therapeutic appropriateness or monitoring laboratory values, you really can impact people's experiences and hopefully make what is an unpleasant reality just a little more tolerable. I learned that when you can touch people in that way, they touch you back.

I was hooked. While I no longer have the same patient care role, I strive to provide an environment that allows each pharmacist to feel the same sense of fulfillment that comes from making a difference in the care of our patients.

We tend to focus so much today on technological innovation, medical research, and how to best utilize the new, complex medications available that we sometimes forget that our value as pharmacists goes beyond technical expertise. And sometimes the most compassionate care can come from the simple kindness of listening.

We must be willing to establish a relationship with patients. At its core, the art of healing comes down to connection. We can heal through connection.

Fighting to stay connected

You know, it seems to me that the definition of *connection* in today's world keeps shifting. I sometimes think that my daughter and I text more than we talk. It is a real challenge in a technologically sophisticated world to find common ground that allows us to work together rather than become more isolated.

But the challenge is not simply to stay connected to scientific and technological advances. We must always be vigilant and ensure that technology solutions are designed and utilized in a way that adds value.

It is impossible to predict exactly where these advances will take us in the next decade. But we do know this: We will need to be at the decision-making table with our fellow health care colleagues to influence how technology is used to improve patient care, and we will need talented professionals to help us leverage technology and automation to ensure patient safety.

Connecting to optimize care

These interdisciplinary relationships, these connections, intersect with one another to create a whole that is greater than its parts. Today more than ever, we have the opportunity to collaborate with other health care providers to optimize patient care.

The benefits of pharmacists participating on care teams cannot be disputed, and the medical literature and regulatory changes are reflecting this reality. But historically, we have been content to sit by quietly, sharing our stories with each other, and then wondering why other people do not know what we do.

In health care, connections have never been more important to the successful completion of our patient care mission. Indeed, the very reason I work in a hospital is the interdisciplinary collaboration we find there. These relationships—between pharmacists, among pharmacists and other health care providers, and between caregivers and patients—provide a platform from which to fulfill our shared commitment to quality care.

I was reminded not too long ago about how far we have come in collaborative care when a very well-respected physician in our hospital sent me a letter. At the time, this physician was serving as president of our medical staff. He shared with me that he had written an order for a patient with peritonitis from a dialysis catheter, using grams instead of milligrams of gentamicin and that the pharmacist had called to question the order.

The physician very patiently explained to the pharmacist that he felt the dose was pretty standard and that there was no risk of further nephrotoxicity.

The pharmacist remained concerned and called again to relay the fact that he could find no protocol for grams of gentamicin.

The physician finally heard grams instead of milligrams and realized the magnitude of his error. He subsequently shared with his colleagues at a medical staff meeting the mistake he almost made, applauding the pharmacist's persistence.

The critical value of the pharmacist was crystallized for this physician, and he is now a true champion for our profession.

Of course, we know that these kinds of interventions are not rare. But this story illustrates that the best outcomes result from each team member providing his or her expertise to ensure that quality patient care is delivered.

This collaboration extends outward as well, to groups that influence how well we can care for patients, to fellow health care organizations like the American Medical Association, to regulatory bodies like the Joint Commission, and all the way to Congress. The connections we forge strengthen and enhance what we can do for our patients.

We must reach out to every stakeholder if we want to be taken seriously as a critical member of the health care team.

ASHP is really a model for how to leverage connections to make a difference. And so it is not surprising that the Society's emerging theme is the phrase, "Together we make a great team."

These words highlight the fact that we need other people to help us complete our mission.

This concept of teamwork, of connectedness, if you will, is the touchstone of my career and the focus of my term as ASHP president.

Connecting via ASHP's membership

Professional organizations like ASHP succeed because they provide a foundation for building relationships. Membership allows us to connect with others who share common interests, needs, and a vision for pharmacy practice. I feel very lucky to be part of an organization like ASHP that allows me to share my passion for pharmacy as part of a greater whole.

One of ASHP's strengths is the diversity of its membership, representing many different practitioners and a variety of practice settings. This exciting community offers so many avenues to get involved, to learn, to share, to inspire, and to be inspired.

Now, you may be sitting there thinking that my perspective is different than yours. And that this role of president is unattainable and perhaps even irrelevant to your day-to-day life.

But I want you to know that I was—not so long ago—right where you may be. I was working in my hospital, unsure how to connect to what the Society was doing on the state or national level.

But I remember very clearly the call I received from my former preceptor Margaret Rosner. She said, "OK, you are finished with school. Now it is time to get involved."

I had a great deal of respect for Margaret and felt so honored to be asked to participate at the state level, that she thought I had something to offer. And I found that once you get connected like that, you never want to disconnect.

I met new people, developed new relationships, and became absolutely inspired by what was going on within our Society. For example, the year I was president of the Virginia Society of Health-System Pharmacists was the year that we took collaborative practice to the legislature.

We did not have a lobbyist, so I spent time meeting with legislators and testifying before Senate and House committees. I realized that all I had to do was show up and tell my story. I never understood before just how powerful one person's voice could be.

We are each a lobbyist for our profession and our patients, whether we are advocating at the Capitol or within our own organizations. We have to show up and speak up. That is really what advocacy is all about.

We can no longer be the "invisible ingredient" if we want to advance pharmacy practice. We each have to be the voice that fights for safer medication-use systems, for access to care, for quality standards, and for our place as the medication-use expert wherever that role is required.

When I first joined the ASHP Board of Directors, I remember thinking to myself, "How is it that I am sharing a table with icons like Marianne Ivey and Henri Manasse?" But I soon realized that we were connected by our mutual practice issues, our concerns about the future of our profession, and our desire to effect change. I learned that one person can make a difference, regardless of whether you practice in a 200-bed hospital like mine or a big academic medical center.

I witnessed the synergy that resulted from combining our best thoughts, establishing a vision for the future and a path by which we can influence medication use and public health. We must set the standard and never find ourselves having to apologize for what we failed to do.

Connecting as a lifelong mantra

I get up each day and look forward to the challenges ahead. I know that my contributions matter and that I will get great satisfaction from making a difference. I know that, through all of my professional connections, I am not alone and that many others share my passion, my values, and my hope for what is possible.

If just one person can make a difference, think what we can accomplish together. Because connections are not just about who you know but how you act.

Pharmacy is not a profession for the faint-hearted or the uncommitted. I tell my students that if you do not go home at the end of every day and feel like you have made a difference, you should make a change—either change how you practice or change where you practice.

Let me give you a great example of how you can be inspired by other people to make a change.

At Martha Jefferson, we just accepted our first two residents into our new postgraduate year 1 residency program. One of the residents, Lisa Deal, is a nurse who decided to go to pharmacy school. When asked why, Lisa said that she was a relatively new nurse and was working in the emergency department (ED) at Johns Hopkins Hospital. She was really impressed by the pharmacist, Keith Thomasset, who worked in the ED—from his interventions in medication therapy, to running codes in the trauma room. She realized that this was the work she was meant to do and became a pharmacist herself. It is amazing the kind of influence you can have on another person without even realizing it.

People are always watching us. Never doubt it. And we must be worthy of the scrutiny.

Closing remarks

The rewards of involvement are great, and I am so fortunate to have been tapped on the shoulder early. Being involved has not been a sacrifice; rather, it has provided me with constant inspiration and motivation, which has sustained me through the most difficult of challenges.

The greatest reward for me, however, has been the development of lifelong friendships that will survive well beyond my term as ASHP president.

The opportunity to be involved in improving our profession has been a gift. So, what are you waiting for?

This gift is there for you, too.

There are so many ways that you can contribute. If you choose to get involved, to get connected, I guarantee that you will get back much more than you give.

The fact that excellence is a choice was reaffirmed for me, personally, when I heard Billy Woodward[1]

deliver his wonderful Harvey A. K. Whitney lecture in 2004. Billy said:

> When the telephone rings in the middle of the night, it is most important that we answer the call with calm confidence. That confidence comes only when we know in our hearts that we have done everything possible to take care of our patients, never failing to take a stand, confront an issue, or lead a battle to ensure that quality care is delivered.

I felt that Billy was speaking directly to me and I became recommitted, reconnected to a cause, to a vision, to a mission that should inspire us all.

You know, being part of the solution really becomes a way of life. I like to ask my pharmacists, "Have you saved any lives today?"

They have so embraced this philosophy of personal accountability that they will often volunteer to share a story of how they have improved the care of their patients.

Now I ask you, have you done everything possible to take care of your patients? If you can live with that assurance every day, then you have achieved the kind of connections that will change the very fabric of health care in this country.

I look forward to sharing new connections with you as we strive together, as a great team, in the service of better patient care, every day.

Thank you.

Reference

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The advocacy imperative

CYNTHIA BRENNAN

I have been looking forward to talking to you today for several reasons. The first, of course, is that I am eager to share with you some of the new initiatives under way at ASHP. The second, you may guess, is that this meeting signals a passing of the baton to my good friend and colleague, Janet Silvester.

It has been a busy year—and I hope you will agree with me—an eventful one.

As a member of this important body, you know that ASHP is committed to providing members with excellent continuing education, timely practice standards and policies, proactive consumer outreach, and up-to-date, accurate drug information.

You also know that ASHP has been working hard to shape the public image of pharmacists to reflect an accurate picture of your role and value in driving safe medication use. We have had some amazing successes in this effort, and millions of consumers have seen our messages in newspapers and magazines, from the *Los Angeles Times* to *Reader's Digest*.

Millions more have heard our messages on radio stations all over the country. And we recently delved into the world of television, with the dissemination of a broadcast public service announcement (PSA) that highlights the unique work of pharmacists in hospitals and health systems.

. . . the secret to our future success, and to the longevity of our profession, lies in our ability to work together, as a team, within ASHP and with others outside the Society.

A television spot, which has also been produced in Spanish, is complemented by a series of print PSAs that we are sending to newspapers and magazines all over the country. We created them to be flexible tools—state affiliates can easily add their logos to these pieces.

These PSAs are a striking example of how the efforts of an organization like ASHP can serve the greater needs of members for recognition and expanded professional opportunities.

It is this House—you, here today, pharmacy leaders from all parts of the nation and all sections and disciplines of our profession—who collectively determine ASHP's positions on important issues related to health-system pharmacy practice and safe medication use.

And so I would like to spend just a few minutes today sharing with you some exciting new developments that I believe will dramatically advance ASHP's mission, including ASHP's activities related to medication reconciliation and a major expansion of our work in the arena of public policy advocacy.

Medication reconciliation

In my inaugural address a year ago, I challenged ASHP members to find ways to provide the value-added, patient care services that only we can provide. That is because I truly believe that these services will help us realize the vision of pharmacy as a clinical profession.

One of these value-added services is medication reconciliation. No one can do it better than we can! To examine this issue in more depth, ASHP formed a Medication Reconciliation/Continuity of Care Task

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Force, composed of ASHP and APhA members and staff. Past President Bruce Canady and I are cochairing this group.

We are focusing on helping pharmacists provide medication reconciliation leadership from the inpatient side—which is required by the Joint Commission—to the ambulatory, home care, and skilled nursing facility sides—which is not be required, but it is the right thing to do.

Together with the ASHP Research and Education Foundation, ASHP was able to secure funding for and host a Continuity of Care Summit in Bethesda in early June.

We brought together experts from nearly every sector of health care to talk about the need for patient medication lists that contain standardized data elements.

The group came to a consensus that medication lists must be very simple, must be kept up-to-date, and must include a patient's personal information, details about allergies and other medicine-related problems, and an accounting of current medications the patient is taking.

This starting point will allow us to conduct further research. It also sets the stage for a national social marketing campaign to educate patients, caregivers, and health care professionals on the importance of integrating patient medication lists into every aspect of the health care process.

Stay tuned for more information as we begin to implement the Summit's recommendations.

Enhanced advocacy

Medication reconciliation is just one of the many areas in which ASHP is actively advocating on behalf of both patients and pharmacists. Your presence as part of this House means that you value this important work.

When many of us think of the word advocacy, we tend to picture testimony before Congress or lobbying on Capitol Hill. But, at ASHP, we define it much more broadly:

- When we push for reforms at the Food and Drug Administration in the design of restricted distribution systems, we are advocating.
- When we encourage the American Medical Association to create permanent billing codes for pharmacists' medication therapy management services, we are advocating.
- When we ask state boards of pharmacy to require standards-based technician education and training, we are advocating.
- When we tell the Joint Commission that we believe emergency departments should use an evidence-based quality improvement plan for medication use to boost patient safety, we are advocating.
- When we conduct a national PSA campaign about pharmacists' role in health care, we are advocating.

But it is time to turn up the volume. The time is right for consideration, by Congress and others, of issues and policies that are important to health-system pharmacists and to patients.

But we cannot do this alone. We must reach out and partner with other professionals and other organizations. And we must be prepared to spend the time and resources it takes to bring about the reforms we seek.

Marianne Ivey will provide the financial details of this new initiative in her Treasurer's Report shortly, but here is what we plan to do in the coming months and years:

- We will be pushing hard to expand third-party payment for the drug therapy management services of pharmacists.
- We will be advocating for the development of quality standards in health care that recognize the capabilities of pharmacists.
- We will be pursuing additional funding mechanisms for pharmacy residency training.
- We will be advocating for the need to establish policies on drug safety that draw on our expertise.
- We will be aggressively advocating for nationally standardized technician education and training.

Maybe you are thinking that this is an ambitious agenda. Well, you are right—it is.

But it is achievable . . . if we devote the appropriate resources to the cause.

Toward that end, we will be recruiting several professionals to assist us with policy analysis and research, reimbursement issues, and grassroots and political action committee (PAC) activities. These individuals will come to work as part of our existing, talented advocacy team.

Now, you may be thinking, "Hey, we have a great advocacy staff—let them work their magic." But this effort is so big that we need help from every member.

We need everyone—chairs of the Sections and Forums, first-time elected delegates, new practitioners, and all past presidents—to get onboard.

You may be asked to make a telephone call. Or write a letter. Or make a presentation. Or donate money to the PAC. And when you are, I hope you will join with us, because this effort is really about designing the very future of our profession.

Conclusion

Over the next few days, I urge you to keep in mind that the secret to our future success, and to the longevity of our profession, lies in our ability to work together, as a team, within ASHP and with others outside the Society. Together, we can make it happen because "together, we make a great team!"

Thank you.

2007 Report of the Executive Vice President and Chief Executive Officer

Making ASHP's work-force vision a reality

HENRI R. MANASSE, JR.

As you have heard, the ASHP Board of Directors recently approved an important report, the "ASHP Long-Range Vision for the Pharmacy Work Force in Hospitals and Health Systems," which was published in the June 15 edition of the *American Journal of Health-System Pharmacy.*[1]

We were motivated to create this vision to help guide the profession—specifically the practice of pharmacy in hospitals and health systems—to ensure an adequate supply of competent pharmacists and pharmacy technicians to meet future medication-use needs.

We were motivated to create this vision to help guide the profession—specifically the practice of pharmacy in hospitals and health systems . . .

Let me share with you some of the major assumptions that ASHP made as we began this work:

The first assumption was that patients in health systems will continue to be prescribed medications in both current and new ways that include drugs, biologicals, vaccines, diagnostic agents, and gene therapies.

The second assumption was that the complexity and volume of medication use will require the input of pharmacists to ensure drug safety and quality. In fact, these issues of safety and quality will continue to drive the priorities of health-system leadership and administrators.

We also recognized that issues of cost and safety will continue to draw the attention of the public. And we expect that the continuing challenge of limited human and financial resources will create pressures to operate efficiently.

Another principle addressed in the vision is the need for every hospital to find the right balance, the right equation, the right phase diagram—if you will—of deploying technicians, automation, and pharmacists appropriately.

Finally, we felt that our environments will increasingly be deluged

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by mechanisms and requirements for performance measurements, as well as accreditation standards, that will continue to focus on safe use of medications and diagnostic agents.

The bottom line is that we must get the job done safely and in a cost-efficient manner, appropriately applying our various partnerships with physicians, nurses, administrators, and patients.

Let me put this into a global perspective for a moment. A statement made by the World Health Organization at its 60th World Health Assembly established this assumption: "Irrational use of medicines continues to be an urgent and widespread problem in the public and private health sector in developed and developing countries with serious consequences in terms of poor patient outcomes, adverse drug reactions, increasing antimicrobial resistance, and wasted resources."[2]

This is the context in which we operate on the global front.

Important questions

In deriving the content for the vision, ASHP also felt that regulation and the roles of licensure and professional credentials will become a bigger policy issue in the broader public.

So, we are left with these questions:

- How do the skills of pharmacists who are graduating from today's pharmacy schools fit patients' needs for safe and appropriate medication use?
- How will the changing demographics of our work force—as noted in the "Report of the ASHP Task Force on Pharmacy's Changing Demographics"—begin to affect the nature and scope of work-force issues?[3]
- How will we come to terms with the roles of pharmacists who either work a less-than-full-time schedule or utilize other nontraditional work models?
- What will be the scope of services provided by technicians, and how will they be trained and credentialed?
- How will health-system pharmacists of the future be credentialed and trained?

Regarding the last point, we are coming to agreement as a profession that licensure alone is not enough and that the license pharmacists receive a month after graduation may not carry them through their entire careers.

We expect that residency will, in fact, become a minimum requirement for work in health systems, particularly for pharmacists who care for patients with complex needs and highly specialized diseases.

More than likely, board certification will be required for the fields in which it exists. In addition, privileging and credentialing in institutions will continue to expand to include our pharmacy work force.

It is clear that continuing professional development will be required to refresh our credentials, and it is likely that the 15 continuing-education hours per year currently required by pharmacy boards may take a different shape. For example, perhaps credentials to demonstrate knowledge and competence will be required of pharmacy managers to ensure that health systems do not wind up with "accidental" leadership.

Lastly, we expect that departments led by pharmacists, but perhaps not managed in all areas by pharmacists, will be a defining feature of our future.

As I have indicated, technicians are an important part of this formula. Indeed, this House of Delegates recognized the critical role of technicians when it passed a three-pronged pharmacy technician policy several years ago that advocates for the completion of an ASHP-accredited training program, certification by the Pharmacy Technician Certification Board, and for pharmacy technicians to be registered by state boards of pharmacy to ensure public accountability.

How can we implement the vision?

What are "next steps" to achieve this vision? This is, after all, a big vision—a vision that can take a long time to achieve and will probably have unintended consequences, as most visions do. We understand that. But there is no doubt that we all must work together to figure out how to implement it.

ASHP is discussing the vision with a number of external stakeholders. In fact, we recently met with the American Hospital Association and the Joint Commission, and we will share our vision with colleagues at the Joint Commission of Pharmacy Practitioners.

We are also meeting with several medical specialty organizations, reaching out to nursing organizations, talking to the American College of Healthcare Executives, and making contact with the association representing the nation's hospital fiscal officers.

But in order to figure out the best phase diagram for pharmacy's work force, we need good leadership. Certainly, ASHP's Center for Health-System Pharmacy Leadership is a key part of this work, as it focuses on the best mechanisms for fostering and cultivating new leaders for the future.

But leadership does not end there. And it does not only include pharmacy directors. This concept includes everyone, because everyone has a leadership stake in moving the vision along. So, we are calling for new partnerships. We are looking for pharmacy leaders in every institution to study the vision, to share it with their staff members and contemplate how to implement it within their institutions, and, most importantly, for you, as ASHP members, to extend the

vision beyond your institution and bring it to your state.

The vital implementation role of members

And that brings me to ASHP's state affiliates. The Society has 49 affiliated state organizations...*49*. This is probably the most powerful organizational group in the world with respect to advocating for hospital and health-system leadership.

We believe that state affiliates, in key partnership with ASHP, can provide continuing education on this leadership vision, support efforts to gain appropriate regulatory and legislative directions around the Society's pharmacy technician policy, and articulate how ASHP should lead nationally on this issue. We seek your participation and your leadership.

Finally, I want to say a few words about ASHP's great Board of Directors. This group has worked very hard over the past 18 months to finalize this vision. We are paying attention to the context of the vision by collaborating with the external world and working toward political consensus. And our membership is playing a crucial role as a driving force for change.

In our advocacy efforts with the Joint Commission, the Food and Drug Administration, the Centers for Medicaid and Medicare Services, and in congressional offices, your work and its importance is continuously on the front burner. It is work that has crucial importance across the entire spectrum of health care. For example, I examined many of the same issues as part of an advisory committee for the Association of Academic Health Centers. We wrestled with what the future health professional work force will look like and concluded that we will face a serious problem across all health professions as our aging population needs more care and work-force shortages continue. To help manage these challenges, we must examine the leadership of our academic health science centers, especially their pharmacy directors, to ensure that we are all on the same page in terms of dealing with future work-force issues.

Remember that this is a vision. It is not going to be implemented today or tomorrow and perhaps not even in 10 years. But we hope that you will embrace this vision and be visionary people.

I want you to know that I firmly believe that we can accomplish this vision. My hope is that every pharmacy department and every single one of you will get engaged in talking about this vision. I also hope that every pharmacy school will discuss this as part of their Introduction to Health Care courses. I hope that all of us can share this vision with our colleagues outside of pharmacy so that the dialogue can expand beyond our own profession.

References

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2. World Health Organization. Progress in the rational use of medicines. www.who.int/gb/ebwha/pdf_files/WHA60/A60_R16-en.pdf (accessed 2007 Jun 1).
3. Report of the ASHP Task Force on Pharmacy's Changing Demographics. *Am J Health-Syst Pharm.* 2007; 64:1311-9.

2007 Report of the ASHP Treasurer

ASHP's financial strength provides opportunity for bold initiatives

MARIANNE F. IVEY

We are stronger . . . because the Board has demonstrated its willingness to commit the Society's resources to advancing and supporting the professional practice of pharmacists.

The Society's financial year runs from June 1 through May 31 to coincide 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 2006), (2) current year (2007) projected performance, and (3) budget for the fiscal year ending May 31, 2008.

The audit of the 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 can be obtained by contacting the ASHP Executive Office.

Fiscal Year Ended May 31, 2006—Actual

Last year I reported that the Society was expecting a $1.717 million surplus for the 2006 fiscal year. We actually ended the year with a $5.147 million surplus: $1.655 million from core operations and $3.492 million from the program development budget (Figure 1). A greater-than-expected return in our long-term investment portfolio and a $1.841 million credit removing a minimum pension liability recorded in prior years accounted for 82% of the difference between our actual and forecasted year-end results. With the $5.147 million surplus, the Society's net worth increased to $41.706 million (Figure 2), or 91% of total ASHP and 7272 expense. (7272 expense represents the expense of the Society's wholly owned subsidiary, the 7272 Wisconsin Building Corp.) Our policy is to maintain net worth at 75% of total ASHP and 7272 expense, with a ceiling of 90% and a floor of 60%.

The Society's May 31, 2006, year-end balance sheet was as impressive as the statement of revenue and expense. Our asset-to-liability ratio rose to $4.18:$1.00, up from the May 31, 2005, ratio of $4.12:$1.00.

Fiscal Year Ended May 31, 2007—Projected

This year's financial performance is projected to be better than budget in both the core and program development budgets (Figure 1). A $3.637

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million surplus in the program development budget and a $466,000 deficit in the core (a $516,000 deficit was budgeted) are expected. If we achieve our year-end projections, the Society's projected net worth at May 31, 2007, will be $44.877 million, 94% of total ASHP and 7272 expense.

Fiscal Year Ending May 31, 2008—Budget

The Society's 2008 budget reflects the Board's commitment to expanding membership services while continuing to fund new products and services. Expenses in the Society's core budget for 2008 exceed revenue (Figure 1). However, rather than cut programs to produce a balanced budget, the Board chose to use excess investment income to fund the anticipated gap between revenue and expenses. Included in the 2008 program development budget is more than $824,000 that will be used for the new Section of Pharmacy Informatics and Technology, Web development, and enhancing membership services. The program development budget also includes $1.288 million in second-year expenses for updating the Society's technology capabilities. Among other benefits, the new technology will include more flexible software applications and provide increased support for personalization and customization of member communications.

Programs Funded from Net Worth

Taking advantage of the Society's strong financial condition, the Board of Directors has approved two programs outside the budget process, both to be funded from the Society's net worth. The first is a three-year program of up to $2.70 million to enhance the AHFS product line, strengthening its marketplace position and increasing its value to users. The second, also a three-year program, provides funding (up to $405,000) for 50% of the cost of the ASHP Research and Education Foundation's new Center for Health-System Pharmacy Leadership, which addresses the looming crisis in filling practice leadership positions. The funding will give the Center the solid financial base it needs to begin its important work. After funding these programs, the Society's net worth will still be in excess of 70% of total ASHP and 7272 expense.

As this report was being finalized, the Board was also considering using net worth to fund the initial phase of enhanced ASHP advocacy, which would allow the Society to be bolder and more effective in advancing our interests with quality-improvement organizations and the government. This initiative would be consistent with the results of ASHP's strategic planning, which has identified numerous changes in national health care policies that are needed to foster better alignment of pharmacists with patients' needs related to safe, effective, and cost-conscious use of medicines. Whatever we initiate in this important arena, we want it to be sustainable over the long haul. This will most likely require us to take

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

	Actual Fiscal Year Ended May 31, 2006	Budget Fiscal Year Ended May 31, 2007	Projected Fiscal Year Ended May 31, 2007	Budget Fiscal Year Ended May 31, 2008
CORE OPERATIONS				
Gross revenue	$38,485	$38,328	$39,165	$40,928
Operating expense	(39,339)	(39,277)	(40,164)	(42,604)
Operating Income	$ (854)	$ (949)	$ (999)	$(1,676)
Provision for income taxes	$ (234)	$ (400)	$ (350)	$ (300)
Other expense	(350)	(290)	(340)	(290)
Earnings from subsidiary	1,124	1,000	1,100	1,150
Investment income subsidy	128	123	123	123
Pension adjustment	1,841	—	—	—
Core Net Income	$ 1,655	$ (516)	$ (466)	$ (993)
PROGRAM DEVELOPMENT				
Investment income	$ 4,639	$2,703	$ 5,762	$ 3,896
Program expenses	(1,147)	(1,986)	(2,125)	(2,903)
PD Net Income	$ 3,492	$ 717	$ 3,637	$ 993
ASHP Net Income	$ 5,147	$ 201	$ 3,171	$ —

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

	Actual as of May 31, 2005	Actual as of May 31, 2006
ASSETS		
Current assets	$ 3,993	$ 4,792
Fixed assets	1,658	1,388
Long-term investments at market	39,234	43,900
Investment in subsidiary	3,367	3,144
Other assets	22	1,588
Total Assets	$48,274	$54,812
LIABILITIES		
Current liabilities	$10,508	$12,587
Long-term liabilities	1,207	519
Total Liabilities	$11,715	$13,106
NET ASSETS		
Net assets	$36,559	$41,706
Total Net Assets	$36,559	$41,706
Total Liabilities and Net Assets	$48,274	$54,812

Figure 3. 7272 Wisconsin Building Corp. (ASHP subsidiary) statement of financial position and statement of activities for fiscal year 2006 (in thousands).

	Actual as of May 31, 2006
Assets	
Current assets	$ 1,448
Property and plant (net)	19,364
Other assets	1,743
Total Assets	$22,555
LIABILITIES	
Current liabilities	$ 672
Mortgage payable	18,448
Other liabilities	291
Total Liabilities	$19,411
NET ASSETS	
Net assets	$ 3,144
Total Net Assets	$ 3,144
Total Liabilities and Net Assets	$22,555

	Fiscal Year Ended May 31, 2006
REVENUE and EXPENSE	
Gross revenue	$ 5,885
Operating expense	(4,075)
Operating Income	$ 1,810
Provision for income taxes	$ (686)
Increase in Net Assets	$ 1,124
Owner's distribution and capital contributions	$(1,346)
Net Increase in Net Assets	(222)

an all-resources approach toward funding, using reserves, investment income, margin from products and services, savings from discontinuing less important activities, and dues. We will be updating members on our advocacy initiatives at the regional delegate conferences and the Summer Meeting.

Conclusion

Six years ago you honored me by electing me your treasurer. For my last report to you, I am extremely pleased to tell you that the Society is stronger financially today than when I began. We are stronger not because we have stockpiled our earnings, but because the Board has repeatedly demonstrated its willingness to commit the Society's resources to advancing and supporting the professional practice of pharmacists. Today membership is at record numbers. Attendance at the national meetings has never been higher. New programs are being developed to assist current members and attract new practitioners. Our commitment to students and the student societies is unwavering. I can say with confidence that ASHP is a strong and vibrant organization from both a membership and a financial viewpoint.

With that, I say thank you. Thank you for giving me the opportunity to serve as your treasurer. We've looked back, and now we need to look forward. As I leave my position, I know the Society is well positioned to meet your needs and the needs of pharmacy practice.

House of Delegates Session—2007

Board of Directors Reports on Councils

ASHP councils met in Bethesda, Maryland, September 19–20, 2006.

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 Technician Training
B. Image of and Career Opportunities for Hospital and Health-System Pharmacists
C. Residency Programs
D. ASHP Guidelines, Statements, and Professional Policies as an Integral Part of the Educational Process
E. External Degree Programs and Initiatives for Helping Practitioners Upgrade Skills

6 Council on Pharmacy Management

A. Administering Injectable Medications Supplied Directly to Patients
B. Standard Drug Administration Schedules
C. Pay-for-Performance Reimbursement
D. Principles of Managed Care
E. Needle-Free Drug Preparation and Administration Systems

10 Council on Pharmacy Practice

A. ASHP Statement on the Role of Health-System Pharmacists in Public Health
B. ASHP Statement on Professionalism
C. ASHP Statement on Racial and Ethnic Disparities in Health Care
D. Role of Pharmacists in Sports Pharmacy and Doping Control
E. Institutional Review Boards and Investigational Use of Drugs
F. Electronic Health and Business Technology and Services
G. Tobacco and Tobacco Products
H. Human Immunodeficiency Virus Infections

23 Council on Public Policy

A. Restricted Drug Distribution
B. Patient Access to Orphan Drug Products
C. Regulation of Telepharmacy Services
D. Personnel Ratios
E. Direct-to-Consumer Advertising of Dietary Supplements
F. Prohibiting Reuse of Brand Names and Standardizing Prefixes and Suffixes
G. Medicare Prescription Drug Benefit
H. Pharmaceutical Product and Supply Chain Integrity
I. Generic Drug Products

28 Council on Therapeutics

A. Removal of Propoxyphene from the Market

House of Delegates Session—2007

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.

Lynnae M. Mahaney, Board Liaison

Council Members

Michele Weizer, Chair (Florida)
Lea S. Eiland, Vice Chair (Alabama)
J. Chris Bradberry (Nebraska)
Michael Gulseth (Minnesota)
Amy J. Hatfield (Maryland)
Thomas J. Johnson (South Dakota)
Miriam A. Mobley-Smith (Illinois)
Teresa I. Pounds (Georgia)
Vickie L. Powell (New York)
Rafael Saenz, New Practitioner (Pennsylvania)
Laura Michelle Smith, Student (Indiana)
Donna S. Wall (Indiana)
Charles E. Myers, Secretary

Policy Recommendations

A. Pharmacy Technician Training

To support the goal that pharmacy technicians entering the pharmacy workforce have completed an ASHP-accredited program of training; further,

To encourage expansion of ASHP-accredited pharmacy technician training programs.

(Note: This policy would supersede ASHP policy 0212.)

Background

This is a revision of ASHP policy 0212. The Council and Board believed that it would be valuable to continue this policy but that the wording should clearly state that the policy refers to *pharmacy* technicians and *ASHP*-accredited training programs. The latter idea is important because accreditation by other organizations could emerge. Policy 0212 reads:

> To support the goal that technicians entering the pharmacy workforce have completed an accredited program of training; further,
>
> To encourage expansion of accredited pharmacy technician training programs.

B. Image of and Career Opportunities for Hospital and Health-System Pharmacists

To sustain the public information program promoting the professional image of hospital and health-system pharmacists to the general public, public policymakers, other health care professionals, and hospital and health-system decision-makers; further,

To provide ASHP informational and recruitment materials identifying opportunities for pharmacy careers in hospitals and health systems.

(Note: This policy would supersede ASHP policy 0214.)

Background

This is a revision of ASHP policy 0214. The Council and Board believed that it would be valuable to continue this policy but that the verb "expand" should be replaced by "sustain," and "health systems" should be expanded to "hospitals and health systems." Policy 0214 reads:

> To expand the public information program promoting the professional image of health-system pharmacists to the general public, public policymakers, other health care professionals, and health-system decision-makers; further,
>
> To provide ASHP informational and recruitment materials identifying opportunities for pharmacy careers in health systems.

C. Residency Programs

To strongly advocate that all pharmacy residency programs become ASHP-accredited as a means of ensuring and conveying program quality.

(Note: This policy would supersede ASHP policy 0216.)

Background

This is a revision of ASHP policy 0216. The Council and Board believed that it would be valuable to continue this policy but that the policy should make clear that it refers to *ASHP*-accredited residency programs. Other accreditation programs could emerge, and clarity about ASHP's stance on this issue is essential. Policy 0216 reads:

> To strongly advocate that all pharmacy residency programs become accredited as a means of ensuring and conveying program quality.

D. ASHP Guidelines, Statements, and Professional Policies as an Integral Part of the Educational Process

To encourage faculties in colleges of pharmacy and preceptors of ASHP-accredited residency training programs to use ASHP statements, guidelines, and professional policies as an integral part of training programs and courses.

(Note: This policy would supersede ASHP policy 8407.)

Background

This is a revision of ASHP policy 8407. The Council and Board believed that this policy is still appropriate but that the term "practice standards" has acquired a specific legal connotation. The Council and Board believed that the intent of the policy was to use ASHP's statements, guidelines, and professional policies in education and that the policy should be revised to incorporate that terminology. Policy 8407 reads:

> To encourage faculties in schools of pharmacy and preceptors of ASHP-accredited residency training programs to use the ASHP standards of practice as an integral part of training programs and courses.

E. External Degree Programs and Initiatives for Helping Practitioners Upgrade Skills

To discontinue policy 8508, which reads:

> To encourage the broadest possible consortial approach to developing viable and widely available external degree programs within the shortest possible time; further,
>
> To urge schools of pharmacy to develop flexible mechanisms that permit full-time practitioners to participate in courses in the contemporary curriculum and to urge directors of pharmacy to encourage staff participation in part-time academic work and to develop appropriate and flexible work hours to permit full-time staff to become part-time students; further,
>
> To urge educational consortia, colleges of pharmacy, and other organizations to evaluate options in addition to a formal external degree program that can assist practitioners in upgrading their skills and to encourage these groups to develop a curricular approach to continuing education aimed at improving practice competence; further,
>
> To urge these groups to develop measurable performance criteria for competence.

Background

The Council and Board noted that schools and colleges of pharmacy experimented with nontraditional degree programs for several years. The number of such programs peaked in 2000 and has declined since then. Further, they believed that policy 0108 adequately addresses the subject and that, therefore, policy 8508 should be discontinued. Policy 0108 reads:

> To encourage colleges of pharmacy to continue to develop innovative ACPE-accredited programs that meet the professional advancement needs of practitioners, using distance learning and other advanced technologies where appropriate; further,
>
> To identify and publicize mechanisms available to baccalaureate-degree pharmacists for overcoming barriers to the attainment of the Pharm.D. degree.

Board Actions

ASHP Long-Range Vision for the Pharmacy Workforce in Hospitals and Health Systems. The Council recommended and the Board approved the ASHP Long-Range Vision for the Pharmacy Workforce in Hospitals and Health Systems. Development of the vision was based on existing ASHP policies, in-depth literature review, Council and Board discussions, extensive comments from members in response to a draft posted for eight months on the ASHP Web site and in response to a draft published in the *American Journal of Health-System Pharmacy* (*AJHP*), input from ASHP's Section and Forum leaders, an open forum conducted during the 2006 Summer Meeting, and the work of the ASHP Task Force on Pharmacy's Changing Demographics. The collective comments strongly affirmed that patient safety and public accountability are major drivers of the need for a qualified pharmacy workforce in hospitals and health systems. Further, sound credentials increasingly will be essential for pharmacy staff in hospitals and health systems. The vision document is intended as

- An expression of ASHP's continuing aim to support the development of competence-building, sound credentials, and credentialing and privileging processes for pharmacists and pharmacy technicians in hospitals and health systems;
- A guide to ASHP in its long-term development of policies, education, publications, and activities to help pharmacists and pharmacy technicians develop and maintain the competence and credentials needed for hospital and health-system work; and
- An advocacy tool to stimulate public policymakers, external quality standards groups, hospital and health-system trustees and administrators, hospital and health-system pharmacy directors, and leaders in other collaborative health professions to ensure that the pharmacy workforce in hospitals and health systems is appropriately competent, has the appropriate credentials, and is appropriately privileged on the basis of credentialing processes.

All of the ASHP councils contributed to the assumptions that are stated in the vision document.

Health Care Workforce Reforms in the United States. The Council recommended and the Board agreed

> To seek opportunities to develop a shared vision with other professions and patients about health care workforce reforms in the United States that will best ensure sufficient patient access to quality care with respect to medication use in hospitals and health systems.

As context for agenda items pertaining to workforce matters, the Council made the following observations:

- As scientific advances increase, people will live longer and will have chronic conditions for which they will use more medications, necessitating greater numbers of qualified pharmacists.
- More-potent medications will be marketed. Competent professionals must be available to oversee their safe and effective use.
- The inherent hazards of medications will become increasingly apparent to the public.
- The public will express its desire for health workers to help them use medications safely and effectively. The public will not care which professional discipline(s) these workers occupy; it will, however, expect the workers to be competent.
- To the extent that the public perceives it as useful, laws governing scope-of-practice distinctions among health disciplines will become more relaxed.
- The U.S. public will expect medication-related workers to show evidence of their competence in the form of sound credentials.
- Professional health education in the United States will become more multidisciplinary, and the scope of practice of graduates will be broadened.

The Council believed that a shared vision with other disciplines and the public is crucial to the implementation of the desired workforce reforms. Reforms will occur, with or without such a vision. Absent such a vision, however, they may not be configured to ensure that patients have access to qualified hospital and health-system pharmacists and pharmacy technicians. The Council believed that creating and sustaining an adequate, qualified pharmacy workforce for hospital and health systems is essential. Simply producing more pharmacists is not an adequate response.

Interdisciplinary models for workforce reforms in academic health centers and other hospital and health-system settings should be developed, researched, and documented. These models should include the expanded use of qualified pharmacy technicians. The Council believed the ASHP Long-Range Vision for the Pharmacy Workforce in Hospitals and Health Systems will be central in ASHP's advocacy with other groups with respect to reforms.

Representatives of the public (patients) should participate in reconfigurations of the health care workforce. One objective of such reconfigurations should be the logical deployment of those workers with the most knowledge about medications, i.e., pharmacists, to work on preventing and solving patients' medication-related problems. Deploying pharmacists to technical tasks that do not directly address those problems and deploying workers from other disciplines who lack the necessary knowledge and full-time interest to address those problems are not logical workforce configurations, and they are not in the public's best interest. Workforce reforms should not interfere with the freedom of hospital and health-system pharmacies to make appropriate use of workers from disciplines other than health care whose expertise may be helpful in ancillary tasks. These may include experts in management, finance, personnel administration, quality assurance, informatics and technology, and logistics, provided that they are under the supervision of pharmacists. The work of the Task Force on Pharmacy's Changing Demographics is highly relevant to workforce reforms.

Relationship of the Content of Doctor of Pharmacy Degree Programs and ASHP-Accredited First-Year Residencies. The Council recommended and the Board agreed

> To pursue with the colleges of pharmacy a shared vision about the relationship of the content of Doctor of Pharmacy degree programs and ASHP-accredited postgraduate-year-one residencies.

ASHP members appreciate the Doctor of Pharmacy (Pharm.D.) education delivered by schools and colleges of pharmacy. However, they often have been disappointed in the inability of many of these institutions to fully prepare graduates for immediate performance in ASHP-accredited first-year residencies. Residency program directors have asked the schools and colleges to do better. The schools and colleges have responded that they are, realistically, doing all they can do in the limited time available before graduation. The Council believed that a shared vision is needed about the relationship between the content of Pharm.D. programs and ASHP-accredited first-year residencies. Without a shared vision, the Council believed, dysfunction will prevail. Hospital and health-system pharmacies may be less willing to accept graduates of some schools and colleges into their accredited residency training programs, and residents who are accepted will continue to have to invest time in becoming oriented to the hospital and health-system environment, thereby delaying their full immersion in action learning. Among the areas that warrant particular attention are the development of communication skills, the development of clinical knowledge sufficient for individual patient care, the application of practice skills, and service commitment and pharmacy operations.

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.)

- Substance Abuse and Chemical Dependency (0209)
- Image of and Career Opportunities for Pharmacy Technicians (0211)
- Pharmacists' Role in Immunization and Vaccines (0213)
- Educational Program Resources for Affiliated State Societies (0215)
- "P.D." (Pharmacy Doctor) Designation for Pharmacists (0217)
- Career Counseling (8507)

Other Council Activity

A Pharmacy Technician Membership Component in ASHP's Membership Structure. During its sunset review of policies related to pharmacy technicians, the Council acknowledged the value of sections and forums as components of ASHP's membership structure and recommended that ASHP launch a pharmacy technician membership component. At its meeting in January 2007, the Board deferred consideration of this recommendation. The Board intended to review a number of strategic issues related to pharmacy technicians at its April 2007 planning retreat, with participation by the chairs of the executive committees of the ASHP sections and forums.

Privileging Processes. Stimulated by a recommendation in the 2006 session of the ASHP House of Delegates, the Council agreed

> To develop guidance about privileging processes for pharmacy practitioners in hospitals and health systems.

The Council discussed the need for public recognition of sound credentials for pharmacists in hospitals and health systems, particularly for those pharmacists engaged in drug therapy management. Specific credentials are not required for medication therapy

management services under the Medicare part D provisions, and pharmacists are not yet recognized as providers under Medicare part B. A major advocacy priority for ASHP is to achieve provider status for Medicare reimbursement to hospitals and health systems for pharmacists' services (beyond product dispensing). The government may require that these services be delivered by pharmacists with sound credentials. Achieving provider status would be an effective means of creating public recognition and expectation that sound credentials are required for drug therapy management. The Department of Veterans Affairs has been experimenting with credentialing and privileging for pharmacists to perform some tasks.

Sound credentials for pharmacists (and pharmacy technicians) have been identified by the Council on Credentialing in Pharmacy (CCP). More credentials may be recognized in the future. CCP is developing a scope-of-work paper that will, it is hoped, identify appropriate credentials for specific types of work. It is likely that the differences in the scopes of practice for pharmacists and other professionals will become less distinct as the overall health care system attempts to overcome chronic workforce shortages by implementing interdisciplinary education and corresponding regulatory reforms.

Increasing public expectations of safety and quality in health care will stimulate the development of local credentialing and privileging processes. Some local policies may, with good reason, allow privileges for some pharmacists (and pharmacy technicians) who lack specific formal credentials; some of these practitioners may have well-documented experience and competence. More documentation is needed that care provided by an individual with sound credentials leads to better patient outcomes. ASHP should seek opportunities to research and document this. The envisaged guidance, combined with local credentialing processes, would better inform administrators, public policymakers, and payers about pharmacists' knowledge and competence.

Credentials and Credentialing for Hospital and Health-System Pharmacy Work. All of the ASHP councils were asked to advise ASHP about the extent to which ASHP should exert greater leadership with respect to credentials and credentialing specifically for hospital and health-system pharmacy work. The discussion of each council was summarized for the benefit of the ASHP Board of Directors as it continues to address this strategic issue.

Influence of Continuing Education on Practice Changes. The impact of continuing education (CE) on practice changes is a matter of debate. Some have suggested that accrediting bodies should require that CE providers document the effect of their programs on practice. Neither the Accreditation Council for Continuing Medical Education (ACCME) nor the Accreditation Council for Pharmacy Education (ACPE) requires such documentation. ACCME believes evidence already exists that CE influences practice changes. For example, a review of the Cochrane database led to the conclusion that CE can result in practice change *if the learning is interactive* (The Cochrane Collaboration. Continuing Education Meetings and Workshops: Effects on Professional Practice and Health Care Outcomes. John Wiley & Sons, Ltd. Hoboken, New Jersey. 2006). ASHP is increasingly incorporating interactive learning into its CE programs. Action learning, in which people learn by doing and are held accountable for their actions, is even more effective than interactive learning and is a hallmark of ASHP-accredited residencies and the traineeships of the ASHP Research and Education Foundation.

Accreditation of Pharmacy Technician Continuing Education Providers. For pharmacists, there long have been (1) ACPE standards for education, (2) a national examination for licensure, and (3) ACPE accreditation standards for the providers of pharmacist continuing education. In order for CE credits to be applied to fulfill state licensure requirements, states typically require that the CE be vetted in some way. For example, a state may stipulate that the CE must be provided by an ACPE-accredited provider or must meet requirements spelled out in state statutes, regulations, or administrative procedures. ACPE requires that accredited providers ensure that any CE they offer meets specified quality characteristics.

For pharmacy technicians, there are (1) standards for pharmacy technician education in the form of ASHP's accreditation standards for pharmacy technician training programs and (2) a national examination for certification—the Pharmacy Technician Certification Board (PTCB) examination. However, until recently, there has been no explicit accreditation process for the providers of pharmacy technician CE. Such a process now exists through ACPE. The Council believed that accreditation should occur for providers of pharmacy technician continuing education.

Access and expense are important considerations for CE for pharmacy technicians. For this reason, the Council encouraged a pragmatic and flexible approach in ACPE's accreditation requirements. The Council believed ASHP should invite ACPE, PTCB, and possibly others to collaborate to develop criteria for CE programming for pharmacy technicians. A mechanism for identifying programs that meet those criteria would be helpful.

Continuing Professional Development. The Council reviewed the status of continuing professional development (CPD). Through CPD, practitioners repeatedly identify and take part in CE and experiential learning opportunities that might be most useful in sustaining and expanding their competence. They can use the knowledge gained to acquire and maintain credentials. Credentials, in turn, can be useful in securing local privileges, which typically must be renewed periodically. CE is an important component of this cycle. Pilot programs are under way in five states to teach volunteer participants to use a CPD process. ASHP should monitor and report on the outcomes of those programs.

In addition to tracking progress in CPD within the United States, the Council believed ASHP should monitor national CPD experiences in countries such as Canada and the United Kingdom, which are in the early stages of experimenting with government-mandated and government-monitored CPD. Government-monitored CPD, if it evolved in the United States, would probably generate legally discoverable information about individual practitioners' self-assessments of their competencies. CPD is used to some degree in medicine; however, there has been little demand for CPD among hospital and health-system pharmacists.

The Council encouraged ASHP to continue to inform members about CPD. ASHP specifies in the goals and objectives for accredited residencies that residency preceptors should engage in a CPD process as a modeling behavior. Faculty in schools and colleges of pharmacy should engage in CPD for the same reason. Hospitals and health systems are environments in which evidence-based practices must be adopted as soon as possible. For this reason, their staff must continually update their knowledge and skills. Pharmacy department directors should foster CPD and encourage CE for their staff members. The Council encouraged the ASHP Research and Education Foundation, in its planning for a Center for Health-System Pharmacy Leadership, to foster the concept of CPD. The Pharmacist Self-Assessment Mechanism offered by the National Association of Boards of Pharmacy is a general, case-based assessment that pharmacists can use in planning aspects of their professional development.

Center for Health-System Pharmacy Leadership. The Council offered a number of observations and suggestions related to the establishment of the Center for Health-System Pharmacy Leadership by the ASHP Research and Education Foundation.

Identifying Professional Traits during Student Admission to Schools and Colleges of Pharmacy. The Council acknowledged recent American Association of Colleges of Pharmacy publications about cultivating professionalism among students. On the basis of a recommendation from the ASHP Pharmacy Student Forum, the Council on Pharmacy Practice is developing a statement on professionalism. ACPE requires pharmacy schools and colleges to engage in admission processes that ". . . take into account necessary scholastic accomplishments, as well as other desirable qualities (such as intellectual curiosity, leadership, emotional maturity, empathy, ethical behavior, motivation, industriousness, and communication

abilities) that support the student's potential to become a self-directed lifelong learner and an effective professional. . . . In-person standardized interviews of applicants, including evaluation of verbal communication skills, understanding of the pharmacy profession, and commitment to patient care, must be part of the admission process."

The Council acknowledged that it is impossible to develop completely reliable mechanisms for identifying professional traits during the college admission process. Nonetheless, Council members noted that pharmacy school applicants who have a commitment to the welfare of others and who have already worked in a pharmacy may be attracted to the profession if they feel their personal values are aligned with pharmacy's mission. Preadmission work in a pharmacy, therefore, may be an indication that a candidate holds professional promise. After student admission, practitioners, professional associations, and student professional organizations share responsibility for helping to cultivate professionalism. Many schools and colleges have professional behavior policies for enrolled students that foster desired behaviors and attitudes.

Emerging Techniques and Technologies in Education. As follow-up to a brief discussion in 2005 and a recommendation in the 2006 session of the ASHP House of Delegates, the Council acknowledged that distance learning and satellite campuses of pharmacy schools offer certain advantages. Such learning also presents challenges; namely, it provides less opportunity for direct contact with instructors and for professional socialization. Some evidence suggests that distance learners are often more mature than other learners; they have jobs, families, and homes in places other than central college campuses. There is some evidence that these students perform academically as well as, or better than, learners based on campus. It is not yet clear how well such students become professionally socialized. The Council believed ASHP could have a role in fostering their professional socialization via educational meetings and engagement in association activities.

Some U.S. pharmacy schools and colleges have distance learners in other countries (e.g., Korea, Germany, and the United Arab Emirates–Dubai). ASHP should seek opportunities to inform members about these developments in *AJHP*, on the Web, and through educational programs.

House of Delegates Session—2007

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.

Sheila Mitchell, Board Liaison

Council Members

Tad A. Gomez, Chair (Georgia)
Wayne S. Bohenek, Vice Chair (Ohio)
David J. Blanchard (New York)
Kim A. Donnelly (Washington)
Paul S. Knecht (Louisiana)
Andrew P. Laegeler, Student (Texas)
Joe E. Ness (Washington)
Douglas R. Smith (Illinois)
Rodney L. Stiltner (Virginia)
Jennifer Tryon, New Practitioner (Oregon)
Jasper W. Watkins (Georgia)
Douglas J. Scheckelhoff, Secretary

Policy Recommendations

A. Administering Injectable Medications Supplied Directly to Patients

To encourage hospitals not to permit administration of injectable medications brought to the hospital or clinic by the patient or caregiver when storage conditions or the source cannot be verified; further,

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

To support adequate reimbursement for preparation, order review, and other costs associated with the safe provision of injectable medications.

Background

In recent years, payers have increasingly been contracting with specialty pharmacies for the provision of certain high-cost injectables to patients. Initially limited to therapy administered in the home, these contracts now cover therapies administered in a clinic as well. As a result, specialty pharmacies are shipping select high-cost medications to increasing numbers of patients. These patients take the products to their clinic appointments and ask that they be infused.

This practice, which has come to be known as "brown bagging," has created safety challenges for hospital and physician clinics, since the source of these products and the conditions under which they were stored cannot be verified. The practice also creates a financial burden for the provider, who is often expected to prepare these products with no reimbursement for time and overhead. Medication reconciliation can also be compromised, since these therapies may not be included in traditional record keeping systems.

The Council discussed the safety issues engendered by a system in which the integrity of the supply chain cannot be assured. If hospitals accept infusion therapy brought from home, there is nothing to prevent patients from buying their drugs on the Internet or elsewhere and bringing them in for infusion. Council members reported cases in which patients arrived at the clinic not only with their medications but also with special infusion devices with which the nurses were not familiar; this creates additional safety and liability concerns. Some hospitals require patients to sign a release of liability before they administer any drug or use any device that the hospital does not provide.

The Council noted that arrangements for securing high-cost drugs must be made when hospitals are negotiating contracts with payers. Pharmacy directors should be proactive in working with their institutions' contracting departments on these issues. Members also noted that contracts often do not use the term "specialty pharmacy," but wording is included that allows payers to use such pharmacies' services. Everyone involved with these models needs to understand them and to appreciate their impact on safe patient care. This will require a concerted educational effort. Council members suggested that ASHP meet with payers and specialty pharmacies to discuss how these programs compromise systems designed to safeguard patient care.

In a related matter, members noted that state Medicaid programs are contracting with specialty pharmacies in order to better manage costs associated with these therapies. Some programs require that the product be shipped directly to the pharmacy for preparation in order to ensure that it remains in a controlled supply chain.

The Joint Commission has indicated that physicians should not bypass the pharmacy and take their own supplies of medications into the hospital. The Council also stressed the need for the Joint Commission to consider the compromises to safety that are introduced when patients take injectable products to hospital clinics.

B. Standard Drug Administration Schedules

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

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

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

Background

Hospitals have had policies on standard drug administration times for many years. In many settings, pharmacists and nurses collaborate to establish standards, and actual drug administration times are then assigned through the pharmacy computer system with each new medication order. The growth in information technology, such as the electronic health record, computerized prescriber order entry, and electronic medication administration records, has brought the issue of administration times back to the fore. Many of these systems shift responsibility for setting medication administration times away from the established policy. In many systems, nurses or physicians are setting or adjusting administration times directly with the patient and are failing to consider the implications of this practice for overall hospital or health-system operations. Optimal therapeutic benefit could be compromised if appropriate attention is not paid to the coordination, as well as the timing, of medication administration.

The Council discussed the importance of coordination of administration times and emphasized that interdisciplinary collaboration is required. At many hospitals, the pharmacy and therapeutics committee oversees this function. Concurrence needs to be established on a therapeutic basis per drug or drug class, and on whether an order such as "QID" means "four times a day" or "every six hours." Timing of first doses, especially of antibiotics and other urgent drugs, needs to be established and agreed on by all disciplines. The timing of insulin doses with meal delivery is also important. Some hospitals have established times not only for standard drug administration but also for administration of first doses and for scheduling of subsequent doses given in the first day of therapy.

The timing of administration can also have an impact on pharmacy medication cart delivery and on preparation times for batches of intravenous drugs. Council members noted that a single administration time can create problems with access to computer terminals during periods of peak demand. Patient- and family-centered care models also create challenges, because one of their key principles is making every effort to ensure that patients receive six hours or more of uninterrupted sleep. This is difficult with medications administered every four or six hours. Some hospitals try to accommodate the schedules patients have used for medication administration at home. Such adjustments can often be made, but they need to be identified as part of the medication reconciliation process, and procedures must be in place to identify these exceptions.

The Council members concluded that interdisciplinary collaboration and education are critical, but they also believed that drug administration times should be assigned through the pharmacy so that all critical factors can be considered.

C. Pay-for-Performance Reimbursement

To support pay-for-performance reimbursement models when they are appropriately structured to improve health care quality; further,

To oppose pay-for-performance reimbursement models that do not support an open culture of medication error reporting; further,

To encourage pharmacists to actively lead medication-related pay-for-performance initiatives.

Background

Numerous changes in reimbursement methods have occurred in recent years. Greater emphasis is now placed on aligning reimbursement with acquisition cost (using average sales price or other indices) and quality of care (pay-for-performance and similar initiatives). Such methods have been adopted by the Centers for Medicare and Medicaid Services (CMS) for both inpatient and outpatient prospective pricing system reimbursement, and they are likely to be adopted by other payers. These changes challenge many principles upon which hospital financial systems are based, and they could have ramifications for pharmacy services.

Council members discussed pay-for-performance initiatives being pilot tested by CMS. Most agreed that these programs present a tremendous opportunity for pharmacy. Data from the pilot programs thus far have shown substantial improvements in the quality of patient care, suggesting that such initiatives are likely to continue. The Council noted that many of these initiatives are tied to medication use and therefore have great potential for pharmacy leadership. ASHP members need to be aware of how to capitalize on the opportunities these programs present.

The Council also discussed models that penalize hospitals when a medical error has been associated with a hospital stay. Members expressed concern that financial penalties would encourage hospitals to revert to a culture of hiding or underreporting errors. They also noted that it is sometimes difficult to differentiate between inadequate therapy and treatment failure. For example, in some cases, deep-vein thrombosis (DVT) might be the result of a failure to recognize the risk and provide prophylactic therapy; in others, DVT is unpredictable and occurs for reasons beyond the provider's control.

The Council believed that more information about these programs should be provided at the ASHP Midyear Clinical Meeting and the ASHP Summer Meeting and in the *American Journal of Health-System Pharmacy* (*AJHP*). Pharmacists should also look to other organizations, such as the American Health Quality Association, for information about these programs.

D. Principles of Managed Care

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

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

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

(Note: This policy would supersede ASHP policy 0205.)

Background

As part of sunset review, the Council reviewed existing ASHP policy 0205, which reads:

> To assume a leadership role as a membership organization in meeting the unique needs of pharmacists practicing in managed care settings (e.g., health maintenance organizations, preferred-provider organizations, pharmacy benefit management companies, and independent practice associations).

The Council discussed the important role of ASHP in serving members who practice in managed care settings and noted the role of other pharmacy organizations that focus primarily on this practice setting. Although the Council recommended discontinuation of policy 0205, the Board concluded that the principles of managed care have many applications in hospital and health-system pharmacy practice and, for that reason, that policy 0205 should be recast to emphasize practitioner needs related to managed care pharmacy in ASHP's primary area of focus.

E. Needle-Free Drug Preparation and Administration Systems

To discontinue policy 9202, Needle-Free Drug Preparation and Administration Systems, which reads:

> To encourage manufacturers' efforts to create cost-effective drug preparation and drug administration systems that do not require needles.

Background

The Council reviewed policy 9202 as part of sunset review. Needle-free systems have become the standard in health care for both industry and practice. They are required by regulatory bodies, accreditation bodies, and numerous guidelines for safe patient care. On the basis of this widespread adoption, the Council concluded that this policy is no longer needed.

Board Actions

Restricted Drug Distribution Systems. The Council recommended and the Board voted

> To develop an ASHP Web-based resource center on restricted drug distribution programs.

The Council discussed the effects of the expanding number of restricted drug distribution systems (RDDSs) on hospitals and health systems. More than half of all hospitals now have patients enrolled in one or more of these systems, and most pharmacists report challenges with program compliance and paperwork. The programs often delay therapy and divert pharmacists from direct patient care. Patients, prescribers, and others must be educated on how the programs are structured. Meanwhile, the extent to which these systems actually reduce risks associated with the administration of potentially toxic or dangerous drugs is uncertain. The Council discussed the need to balance additional steps that would improve the safe use of these drugs against the burdensome systems that are put into place to manage them.

Council members also debated whether treating RDDSs as non-traditional distribution processes with greater structure, similar to that of an investigational drug service, would be of value. They expressed support for centralizing resources related to RDDSs in a single location, such as the ASHP Web site, that would provide links to manufacturers, the Food and Drug Administration (FDA), and other resources.

Medications Brought to the Hospital by Patients. The Council recommended and the Board voted

> To provide education for pharmacy managers and others on the problems encountered when medications are brought to the hospital by patients for administration, including suggested policies and procedures to safeguard patients and protect the institution from liability and contracting strategies to prevent and address these issues.

The Council discussed the rapid evolution of specialty pharmacy drug distribution and the impact on traditional systems of care (see Policy Recommendation A). The members agreed that the impact of these systems on patient safety, hospital finances, and pharmacy systems is not universally well understood by pharmacy managers. The Council concluded that ASHP should seek ways to provide education and information to help pharmacy managers address the implications of specialty pharmacies in their setting.

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.)

- Staffing for Safe and Effective Patient Care (0201)
- Performance Improvement (0202)
- Pharmacist's Role in Electronic Patient Information and Prescribing Systems (0203)
- Reimbursement for Unlabeled Uses of FDA-Approved Drug Products (0206)
- Product Reimbursement and Pharmacist Compensation (0207)

Other Council Activity

Emergency Management Planning. The Council voted

> To develop an ASHP guideline on emergency management planning for pharmacy services.

Many hospitals have found it difficult to maintain services after recent natural disasters. Furthermore, many hospitals are not fully prepared to handle other potential disasters, such as acts of bioterrorism and pandemic influenza. Hospitals must have plans for both a short- and a long-term emergency response.

The Council affirmed a need for template policies, checklists, and other resources that would enable hospitals to plan for any type of emergency. This would help hospitals think more broadly about disasters that are not traditionally included in their emergency plans.

Outsourcing of Sterile Compounding. The Council voted

> To develop an ASHP guideline on the outsourcing of sterile compounding.

With the advent of *USP* Chapter 797, many pharmacy departments are evaluating the adequacy of their facilities for preparation of high-risk sterile products. Limited space, limited resources, or low demand often makes it impossible for a hospital to prepare high-risk products. As pharmacy directors consider outsourcing as an option, they have limited information on how to evaluate the facilities, the integrity of compounded products, licensure, and the qualifications of pharmacies offering these services.

The Council noted that many pharmacy directors need guidance on how to verify the qualifications of compounding pharmacies before forming a contractual relationship. The need to revisit facilities to ensure ongoing compliance was noted.

The degree of FDA and state board of pharmacy oversight was also discussed. Council members expressed limited confidence that current levels of oversight are adequate to ensure that compounding facilities meet proper quality standards. The lack of state board expertise and resources was cited as a limitation of inspection and licensure. The Council concluded that an ASHP guideline, along with other related resources and tools made available on the ASHP Web site, would be of great help.

ASHP Guidelines on Managing Drug Product Shortages. The Council voted

> To revise the ASHP Guidelines on Managing Drug Product Shortages.

The Council reviewed the ASHP Guideline on Managing Drug Product Shortages as part of sunset review. Although the document was considered to be very good, members thought that several aspects, including the references, should be updated.

Impact of Medicare Part D on Health-System Pharmacy Services. The Council discussed the many changes brought about by Medicare Part D, notably, the addition of a prescription drug benefit and a requirement for medication therapy management services. Implications of the new Medicare Part D provisions for manufacturer patient assistance programs and for reimbursement for self-administered medications (such as in emergency departments) were also discussed. The numerous issues now arising may have implications for pharmacy. For example, as beneficiaries exhaust their Medicare Part A coverage, providers may now move to Part D to recover the medication portion of the patient's bill. Patients who are taking self-administered medications and those needing long-term care are also presenting challenges as a result of changes in Medicare Part D.

Implications of New Medicaid Billing Requirements. Several states have begun requiring that hospitals include National Drug Code (NDC) numbers on bills submitted for outpatient services so that they can seek Medicaid rebates from drug manufacturers. Council members noted that this new billing requirement is being adopted, for example, by Georgia, Kansas, and Illinois.

Many pharmacy computer systems do not have the ability to capture the NDC on the patient bill and must add the NDC manually. This creates challenges because hospitals may stock more than one brand of a generic product and the brand billed may not be the same as the one administered. This is especially true when contracts change or when a drug is out of stock and a generic alternative is purchased. Complicating the process is the fact that state Medicaid agencies have supplied little information on how the billing information should be provided.

Council members suggested that ASHP work with the National Association of State Medicaid Directors to help resolve these issues, while continuing its advocacy work with CMS. Members suggested that implementation of the requirement for NDCs be delayed until the details and possible solutions can be worked out. They also suggested that ASHP survey members in order gain a better understanding of the problems associated with including NDC numbers on hospital bills.

Credentials and Credentialing for Hospital and Health-System Pharmacy Work. All of the ASHP councils were asked to advise ASHP about the extent to which the Society should exert greater leadership with respect to credentials and credentialing in hospital and health-system pharmacy work. The discussion of each council was summarized for the benefit of the ASHP Board of Directors as it continues to address this strategic issue.

Billing for Clinical Pharmacy Services. The Council discussed billing for clinical pharmacy services. Members voiced concern about the inconsistent manner in which hospitals and clinics are billing for these services, noting that some facilities do not bill for these services at all. The appropriate use of new current procedural terminology (CPT) codes for pharmacy medication therapy management was discussed. Information on CPT code use will be valuable as hospitals set up these programs. Members called on ASHP to provide education and guidance with respect to CPT codes.

Process Improvement Training for Pharmacy Managers. The Council discussed the need for additional training on process improvement for managers. As pharmacy managers become more accountable for the quality and safety of medication use beyond the pharmacy, it is critical that they understand the methods for undertaking process change. Implementing complex systems across disciplines requires the ability to use process mapping and to lead cross-functional groups. The pharmacists charged with leading or managing these systems often have little training on how best to implement change. A program on this topic planned for the 2007 Summer Meeting was described. Additional education through ASHP meetings and publications would be helpful.

House of Delegates Session—2007

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.

Agatha L. Nolen, Board Liaison

Council Members

Michael D. Sanborn, Chair (Texas)
Lisa M. Gersema, Vice Chair (Minnesota)
Andrew D. Barnes (Washington)
Jay B. Blake (Florida)
Francesca E. Cunningham (Georgia)
Stephen F. Eckel (North Carolina)
John B. Hertig, Student (Massachusetts)
James M. Hoffman (Tennessee)
Edward M. Jai (California)
Rima A. Mohammad, New Practitioner (Michigan)
Deborah R. Saine (Virginia)
Jamie S. Sinclair (Minnesota)
Kasey K. Thompson, Secretary

Policy Recommendations

A. ASHP Statement on the Role of Health-System Pharmacists in Public Health

To approve the ASHP Statement on the Role of Health-System Pharmacists in Public Health (Appendix A).

Background

The Council and Board of Directors believed that this statement could be a useful framework within which to describe to the public and to health care stakeholders the roles health-system pharmacists can play in public health awareness and outreach efforts.

B. ASHP Statement on Professionalism

To approve the ASHP Statement on Professionalism (Appendix B).

Background

The Council and Board of Directors believed that this statement could serve as the basis for various ASHP activities relating to respectful communication, relationship building, and commitment to the patient. The Council and Board acknowledged the leadership of the ASHP Pharmacy Student Forum in introducing a new business motion during the 2004 House of Delegates session calling for the development of a policy on professionalism. The Council suggested that ASHP develop commentaries, editorials, and educational programs based on the elements of this statement.

C. ASHP Statement on Racial and Ethnic Disparities in Health Care

To approve the ASHP Statement on Racial and Ethnic Disparities in Health Care (Appendix C).

Background

In June 2003, the ASHP Board of Directors established the Ad Hoc Committee on Ethnic Diversity and Cultural Competence. The committee was charged with studying the current and projected ethnic and racial composition of health-system pharmacy practitioners; developing a statement on ethnic and racial diversity in health-system pharmacy and in ASHP; recommending mechanisms to foster ethnic and racial diversity within the ASHP membership; recommending mechanisms to foster ethnic and racial diversity within the ASHP Board of Directors, committees, councils, commissions, other component groups, and the ASHP staff; discussing ways to raise awareness of the importance of cultural competence in the provision of patient care so that optimal therapeutic outcomes are achieved in diverse populations; and identifying additional factors that contribute to disparities in health care so that optimal therapeutic outcomes are achieved in diverse populations.

Having implemented the recommendations of the ad hoc committee, ASHP devotes ongoing attention to nurturing culturally competent pharmacy practitioners, engaging racial and ethnic minority members in ASHP affairs, and creating a diverse ASHP workforce. ASHP's efforts to advance pharmacy practice in this area can be seen in several examples. ASHP collaborated with the Association of Black Health-System Pharmacists to provide a two-hour educational session at the 2006 Midyear Clinical Meeting on therapeutic issues in minority populations. The *American Journal of Health-System Pharmacy (AJHP)* publishes articles on health disparities and cultural competence. A health disparities resource center on the ASHP Web site was launched in March 2007. In educational sessions, advocacy

efforts with key stakeholders, and *AJHP* articles, ASHP continues to stress the importance of health literacy and cultural competence in the development of medication therapy management (MTM) services. In addition, the ASHP Research and Education Foundation (REF) is funding a health literacy study at Emory University, and a member of the REF staff is a consultant for two studies of health literacy funded by the Agency for Healthcare Research and Quality. Also, ASHP staff members are working with the University of Alabama Center for Education and Research on Therapeutics on a paper relating health disparities and affordability.

Responding to a suggestion from the ad hoc committee, in September 2005 the Council on Professional Affairs recommended development of an ASHP statement on racial and ethnic health disparities. The Council indicated that the statement should focus on areas in the domain of pharmacists, particularly medication management of disease. Council members believed that pharmacists would become more involved in organizational efforts to eliminate racial and ethnic health disparities if they had a better understanding of how those problems relate to their practice.

D. Role of Pharmacists in Sports Pharmacy and Doping Control

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

To encourage pharmacists to advise athletic authorities and athletes on medications that are prohibited in competition.

Background

The Council reviewed articles affirming that pharmacists are well positioned to advise athletes against the use of performance-enhancing drugs and to help prevent them from inadvertently consuming banned substances. Council members believed that hospital and health-system pharmacists can play an important role in community outreach by educating athletes on the risks associated with performance-enhancing drugs. The Council noted that this proposed policy is part of a broader public health agenda. It recommended that ASHP publish an *AJHP* article and develop educational programming on the topic. Council members also suggested that ASHP seek ways to make antidoping groups and organizations aware of the role pharmacists can play in advising and educating athletes about performance-enhancing drugs.

E. Institutional Review Boards and Investigational Use of Drugs

To support mandatory education and training on human subject protections and research bioethics for members of institutional review boards (IRBs), principal investigators, and all others involved in clinical research; further,

To advocate that principal investigators discuss their proposed clinical drug research with representatives of the pharmacy department before submitting a proposal to the IRB; further,

To advocate that IRBs include pharmacists as voting members; further,

To advocate that IRBs inform pharmacy of all approved clinical research involving drugs within the hospital or health system; further,

To advocate that pharmacists act as liaisons between IRBs and pharmacy and therapeutics committees in the management and conduct of clinical drug research studies; further,

To strongly support pharmacists' management of the control and distribution of drug products used in clinical research.

(Note: This policy would supersede ASHP policy 0230.)

Background

The purpose of revising this policy is to clarify that the pharmacy department should be involved in planning clinical drug research before such studies are submitted for IRB review.

Policy 0230 reads as follows:

> To support mandatory education and training on human subject protections and research bioethics for members of institutional review boards (IRBs), principal investigators, and all others involved in clinical research; further,
>
> To advocate that IRBs include pharmacists as voting members; further,
>
> To advocate that IRBs inform pharmacy of all approved clinical research involving drugs within the hospital or health system; further,
>
> To advocate that pharmacists should act as liaisons between IRBs and pharmacy and therapeutics committees in the management and conduct of clinical drug research studies; further,
>
> To strongly support pharmacists' management of drug products used in clinical research.

F. Electronic Health and Business Technology and Services

To encourage pharmacists to assume a leadership role in their hospitals and health systems with respect to strategic planning for and implementation of electronic health and business technology and services; further,

To encourage hospital and health-system administrators to provide dedicated resources for pharmacy departments to design, implement, and maintain electronic health and business technology and services; further,

To advocate the inclusion of electronic health technology and telepharmacy issues and applications in pharmacy school curricula.

(Note: This policy would supersede ASHP policy 0233.)

Background

The Council and the Board of Directors believed that this policy should be revised to include the need for dedicated resources for pharmacy technology applications.

Policy 0233 reads as follows:

> To encourage pharmacists to assume a leadership role in their health systems with respect to strategic planning for and implementation of electronic health and business technology and services; further,

To advocate the inclusion of e-health technology and telepharmacy issues and applications in pharmacy school curricula.

G. Tobacco and Tobacco Products

To discourage the use and distribution of tobacco and tobacco products in and by pharmacies; further,

To encourage smoke-free environments in hospitals and health systems; further,

To seek, within the bounds of public law and policy, to eliminate the use and distribution of tobacco and tobacco products in meeting rooms and corridors at ASHP-sponsored continuing education events; further,

To promote the role of pharmacists in smoking-cessation counseling; further,

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

(Note: This policy would supersede ASHP policy 8807.)

Background

The Council and the Board of Directors believed that this policy should be revised to support the contemporary movement to create smoke-free environments on the premises of hospitals and health systems. The Council and Board also believed that the role of pharmacists in smoking-cessation counseling, which is included in the ASHP Health System-Pharmacy 2015 initiative and other ASHP documents, should be noted in the revised policy.

Policy 8807 reads as follows:

To discourage the use and distribution of tobacco and tobacco products in and by pharmacies; further,

To seek, within the bounds of public law and policy, to eliminate the use and distribution of tobacco and tobacco products in meeting rooms and corridors at ASHP-sponsored continuing education events; further,

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

H. Human Immunodeficiency Virus Infections

To discontinue policy 8808, Human Immunodeficiency Virus Infections, which reads:

To seek input in the decisions of government and other organizations to express the concerns of pharmacists with regard to the handling of drugs and drug-related devices for the treatment and prevention of human immunodeficiency virus (HIV) infections; further,

To continue to inform pharmacists about drug and drug-related developments in the treatment of HIV infections.

Background

The Council and Board of Directors noted that the knowledge and science associated with the safe handling of HIV drug therapies have changed dramatically since this policy was approved in 1988. Further, the Council and Board believed that information about drug-related developments in the treatment of HIV is well integrated into ASHP educational programs and publications.

Board Actions

Pharmacists' Services in Small and Rural Hospitals. The Council recommended and the Board of Directors voted

To enhance efforts to improve patient safety and quality in small and rural hospital settings; further,

To undertake a comprehensive assessment of the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation for Hospitals in the interest of developing and recommending revisions to CMS; further,

To explore government funding options for pharmacy services that are consistent with models currently in place for physicians and nurses, such as loan forgiveness and other incentives to attract health professionals to practice in rural settings.

The Council strongly believed and the Board agreed that ASHP should enhance its efforts to improve patient safety and health care quality in small and rural hospitals. The Council recognized problems of access to pharmacists in these hospitals and noted that many of these facilities lack the resources to hire pharmacists.

The Council and Board acknowledged that many small hospitals will continue to be served by community pharmacists, with the hospital pharmacies open for only a limited number of hours. The Council and Board believed ASHP needs to take steps to ensure that the community pharmacists who provide these services have the necessary education, credentials, competencies, and resources they need to maintain high-quality medication-use processes in hospital settings.

The Council reviewed the CMS conditions of participation (COPs) for pharmaceutical services and compared them with the COPs for nursing and medical care. The Council concluded and the Board agreed that the COPs for pharmaceutical services are inadequate to ensure high-quality, safe, and effective pharmacy services. The Council suggested and the Board agreed that ASHP should assess the COPs in the interest of developing and recommending revisions to CMS.

The Council noted that there are distinct differences between small and rural hospitals and critical-access hospitals in terms of fee-for-service reimbursement. The Council suggested and the Board agreed that ASHP should explore models through which critical-access hospitals could be reimbursed for hiring pharmacists.

The Council suggested and the Board agreed that ASHP should explore government funding options for pharmacy services that are consistent with models currently in place for physicians and nurses, such as loan forgiveness and other incentives that might attract health professionals to practice in rural settings.

The Council recommended and the Board agreed that ASHP should do all it can to inform administrators of small and rural and critical-access hospitals about medication-use safety and quality-of-care issues and about the roles that pharmacists can play in addressing them.

Acuity Index and Triggers for Pharmacist Patient Care. The Council recommended and the Board voted

> To encourage the ASHP Research and Education Foundation to support research on the development of an acuity index to prioritize pharmacist direct patient care services.

The Council and the Board believed a system is needed for evaluating patients on the basis of valid and reliable clinical indicators and, when necessary, triggering a comprehensive pharmacy intervention. The Council and Board agreed that such a system would help pharmacy department leaders allocate staff to high-acuity areas and patients. It was noted that such triage criteria currently exist for dietary, respiratory, and nursing services.

Council members were aware of the performance indicators and intensity scoring used by some consulting firms, but they did not believe these are adequate to achieve the intent of this action. ASHP policy 0406, Workload Monitoring and Reporting, is closely aligned with the Council's thinking and should be considered in efforts to develop an acuity index for pharmacist patient care. Policy 0406 reads:

> To advocate the development and implementation of a pharmacy workload monitoring system that analyzes the impact of pharmacy services on patient outcomes; 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 on the value of pharmacists' services and on the use of valid and reliable data to assess pharmacy workload and staffing effectiveness; 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 use of comprehensive pharmacy workload and staffing effectiveness measurements.

The Council and Board believed that all patients should receive a common level of pharmacy service but that certain patients should receive more comprehensive MTM and education by pharmacists. An acuity index would help pharmacy departments allocate limited staff resources to the areas of greatest need. The Council and Board recognized that developing reliable, valid, and useful indicators will not be easy; they noted that a logical first step would be to convene a committee of experts to develop an agenda for further research.

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

- Pharmacist's Responsibility for Patient Safety (0227)
- Appropriate Dosing of Medications in Patient Populations with Unique Needs (0228)
- Clinical Investigations of Drugs Used in Elderly and Pediatric Patients (0229)
- Pharmaceutical Waste (0231)
- Pharmacist's Role in Drug Procurement, Distribution, Surveillance, and Control (0232)
- Pediatric Dosage Forms (9707)
- Interventions to Reduce HIV Risk Behavior in Intravenous Drug Users (9711)
- Primary and Preventive Care (9407)
- Expiration Dating of Pharmaceutical Products (9309)
- Tamper-Evident Packaging on Topical Products (9211)
- Nondiscriminatory Pharmaceutical Care (9006)
- Elimination of Apothecary System (8613)
- ASHP Guidelines on Pharmacist-Conducted Patient Education and Counseling
- ASHP-endorsed document Principles of a Sound Drug Formulary System

Other Council Activity

Team-Based Patient Care. The Council voted

> To develop a statement on team-based patient care.

Various health care groups have stated that patient care is most effectively provided by teams of health professionals with distinct knowledge, skills, abilities, and qualifications. However, for a variety of reasons, disparities in the implementation of team-based care models continue.

The absence of widespread adoption of interdisciplinary team models can be attributed in part to the health care culture and the hierarchical model in which the physician is expected to be the all-knowing and completely accountable team leader. Other limiting factors include financial and human resources. Antiquated government and private-payer payment systems do not reflect the fact that patient care is delivered by providers in various disciplines who assume different responsibilities for key aspects of patient care.

The Council agreed that health care is best provided by integrated teams. Teamwork is optimal not only in the care-giving process itself but in the development of organizational policies for safe and effective medication use. The Council emphasized that each team member needs to be accountable for the aspects of patient care for which he or she is responsible.

International System of Units. The Council voted

> To conduct further research on policy 8612, International System of Units.

After reviewing the materials that served as a basis for the original policy, the Council asked ASHP staff to research the current policies of the American Medical Association and other groups on this matter.

ASHP Statement on the Pharmacist's Role in Hospice and Palliative Care. The Council voted

> To request that responsibility for the ASHP Statement on the Pharmacist's Role in Hospice and Palliative Care be reassigned to the Section of Home, Ambulatory, and Chronic Care Practitioners.

The Council believed that the primary expertise on the issues covered in this statement resides in ASHP's Home, Ambulatory, and Chronic Care Section. Therefore, the Council suggested that the ASHP Staff Policy Team assign responsibility for review of this statement to that Section.

Organizational Approaches to the Evidence-Based Use of IVIG. The cost, availability, and appropriate use of intravenous immunoglobulin (IVIG) are matters of longstanding concern to hospitals and health systems. IVIG is recognized as a mainstay of evidence-based therapy for various immunodeficiency diseases. IVIG is also widely used for a number of other conditions, even though few data other than individual case reports support this.

IVIG has at times been in short supply. This is not the case at present. However, there are practical issues with the availability

of preferred products such as lyophilized forms of IVIG, access to above-allocation quantities of IVIG at prime vendor contract and 340B pricing, and cost shifting from outpatient clinics to hospitals because of reductions based on the manufacturer's average sales price under the Medicare Modernization Act. There are also concerns about interchangeability between the lyophilized and aqueous dosage forms of IVIG. These issues, combined with the frequent prescribing of IVIG for off-label indications, have created problems for many hospitals and health systems.

The Council believed various policy issues involving this product should be investigated. ASHP might consider developing a therapeutic position statement on IVIG product interchangeability; calling for the creation of a national registry of IVIG use in disorders for which evidence is lacking, in order to facilitate randomized controlled clinical trials (Kumar A, et al. Intravenous immunoglobulin: Striving for appropriate use. *Int Arch Allergy Immunol.* 2006; 140:185–98); and exploring the legality of some manufacturers' failure to provide IVIG at 340B pricing.

Public Relations Efforts by Pharmacy Practitioners. The Council reviewed key public relations efforts undertaken since 1997, when the House of Delegates called on ASHP to make significant investments aimed at enhancing the public's knowledge and perception of hospital and health-system pharmacists. The Council discussed various ways in which to harness the ability of every hospital and health-system pharmacist to speak with individual patients about what pharmacists do to improve patient care.

Prescribing Authority for Pharmacists. The Council reviewed and discussed recent changes to laws in the United Kingdom that have given pharmacists and nurses prescribing authority, as well as U.S. laws that have given similar authority to nurse practitioners and optometrists. The Council also examined current ASHP strategies in advocacy for provider status under the Social Security Act, state collaborative drug therapy management (CDTM) legislation, and privileging to allow pharmacists in acute care settings to provide broader patient care services.

The Council believed that ASHP was on the right track in terms of provider status, CDTM, and privileging. For political and practical reasons, ASHP should not at this time advocate independent prescribing authority for pharmacists. The Council reflected on comments by a deputy commissioner of the Food and Drug Administration about trends that point to the potential need for an intermediate class of federally sanctioned, pharmacist-prescribed drugs. The Council believed that such an approach would be complementary to provider status and CDTM.

The Council pointed to the growing number of pharmacist-managed clinics in specialized areas such as organ transplantation, HIV, anemia management, and medication adherence. Council members saw these as areas that would be well served by privileging and provider status for pharmacists.

The Pharmacist–Patient Relationship. The concept of the physician–patient relationship is ingrained in the fabric of our society and is regarded as sacred and inviolable. This relationship is viewed as a covenant between physician and patient that is essential to optimal care. The physician–patient relationship is rooted in autonomy. It is generally seen as a two-way relationship that does not recognize the value of team-based care, which focuses on shared accountability among team members and on the role of the patient.

The Council reviewed articles from the medical literature describing the physician–patient relationship and compared the philosophical concepts expressed therein with ASHP documents such as the Statement on Pharmaceutical Care, the Code of Ethics for Pharmacists, and the newly developed Statement on Professionalism. Council members concluded that the pharmacy literature provides a strong foundation of support for the pharmacist–patient relationship. The challenge now is to persuade individual pharmacy practitioners to apply the concepts expressed in these documents in their daily practice.

Sterile Compounding Tools and Resources. The Council discussed this issue in light of the recent public comment period on proposed changes to *U.S. Pharmacopeia* (USP) Chapter 797. Council members debated whether ASHP should continue to develop and publish its own guidelines on quality assurance for pharmacy-prepared sterile products. The Council noted that ASHP has been the leader in developing such guidance and that groups such as USP have embraced concepts and practices originally developed by ASHP. The Council believed that ASHP is still the most credible source of guidance and education on sterile compounding issues.

ASHP Policy Implications of Recent IOM Reports. The Council reviewed the executive summaries of recent Institute of Medicine (IOM) reports on the Future of Emergency Care in the U.S. Health System and on Preventing and Identifying Medication Errors, to identify implications for pharmacy practice and to determine whether any new ASHP policies might be needed to respond to recommendations set forth in these reports.

With respect to the report on medication errors, the Council encouraged ASHP to be at the table during any follow-up discussions on the development of a national patient safety plan. The Council recommended that ASHP keep patient safety a top priority and believed it essential that ASHP be an active participant in establishing a national medication-use safety and quality agenda. Members discussed information technology as a tool for improving patient safety. They believed ASHP needs to continue to identify ways to engage leaders regarding the role pharmacists play in the provision of safe and effective information systems.

Members noted that the IOM report on the future of emergency care did not cover pharmacy-related issues to any significant degree. However, they suggested that the ASHP REF might support research that would address and help resolve problems related to medication safety and quality in emergency departments.

Credentials and Credentialing for Hospital and Health-System Pharmacy Work. All of the ASHP councils were asked to advise ASHP about the extent to which the Society should exert greater leadership with respect to credentials and credentialing for hospital and health-system pharmacy work. The discussion of each council was summarized for the benefit of the ASHP Board of Directors as it continues to address this strategic issue.

Appendix A—Draft ASHP Statement on the Role of Health-System Pharmacists in Public Health

Position

Pharmacists who practice in hospitals and health systems ("health-system pharmacists") play a vital role in maintaining and promoting public health. The American Society of Health-System Pharmacists (ASHP) believes that all health-system pharmacists have a responsibility to participate in global, national, state, regional, and institutional efforts to promote public health and to integrate the goals of those initiatives into their practices. Furthermore, health-system pharmacists have a responsibility to work with public health planners to ensure their involvement in public health policy decision-making and in the planning, development, and implementation of public health efforts.

Background

Purpose. The primary objectives of this statement are to 1) increase awareness of health-system pharmacists' contributions to public health, 2) describe the role of health-system pharmacists in public health planning and promotion, and 3) identify new opportunities for health-system pharmacists' involvement in future public health initiatives. This statement does not provide an exhaustive review of health-system pharmacists' public health activities. Its intent is to stimulate dialogue about the role health-system pharmacists can play in providing care that improves public health in the United States.

Definition of Public Health. Public health has been defined simply as "what we as a society do to assure the conditions in which people can be healthy."[1] In contrast to medicine, public health initiatives "emphasize the prevention of disease and the health needs of the population as a whole."[2]

Public health services have been characterized as occurring on two levels: the planning (or "macro") level and the implementation ("micro" or "provider") level.[3] Macro-level public health services focus on the well-being of the population as a whole and emphasize assessment and prioritization of a community's health-related needs as well as planning to address those needs. Such services include working with community representatives in identifying health-related community problems; setting community health priorities; formulating community health programs and policies; managing, administering, and evaluating community health-promotion programs; educating the community in ways that promote public health; and researching, presenting, and publishing information about public health activities.[3] These "macro-level" activities are carried out by public health professionals with varying backgrounds, degrees, and interests.

Micro-level public health services include all the activities required to implement public health initiatives. Many of these services are performed on a provider-to-patient or a program-to-population basis, usually with a specific health-related outcome in mind.[4] Examples of such services include disease screening, immunization, counseling at-risk populations, and offering tobacco cessation programs.

One concept underlying many public health activities is prevention, which is commonly categorized into three types: primary prevention (reducing the actual incidence and occurrence of diseases, injuries, and disability); secondary prevention (decreasing the severity or progression of the disease, injury, and disability); and tertiary prevention (treatment or rehabilitation to return the disease, injury, or disability to the initial or baseline state).[5] Public health efforts on the macro and micro levels can fall anywhere along the prevention spectrum and can reinforce each other. For example, Healthy People 2010 (a macro-level public health policy) aims to reduce the number of hospital admissions due to drug therapy management problems (primary prevention).[6] Policies implemented by individual hospitals (on the micro level) will allow clinicians to quickly identify such adverse drug events (ADEs) and prevent them from worsening (secondary prevention), as well as treat the affected patients (tertiary prevention). Pooling and evaluation of these clinical experiences can lead to the development of dispensing guidelines or utilization studies that could be used as a primary prevention tool on the macro level.

The health-system pharmacist's role in public health, and the distinction between individualized patient care and public health efforts, can be illustrated by several examples. Providing optimal pharmacotherapy to a single patient has great value. Nonetheless, lessons learned from the management of individual patients can have even greater impact when they result in practice guidelines or health policies that affect the larger population. Such policy development requires careful evaluation and synthesis of health information using epidemiologic principles. Similarly, identification of a specific ADE is an important patient care service routinely performed by health-system pharmacists. The pharmacoepidemiologic study of ADEs across a population, coupled with action to prevent or mitigate such events, can have a significant impact on public health. Counseling a patient on proper utilization of a medication helps that patient. When that knowledge is systematically evaluated and used to develop better behavioral outcomes, general public health can be improved. Finally, a health-system pharmacist who dispenses medications as a member of an emergency response team has a limited impact on public health. However, the same health-system pharmacist working with emergency preparedness planners to develop policies and programs that ensure proper utilization of the full range of pharmacy services during a disaster can have enormous impact on the health of the affected population.

Public Health Activities of Health-System Pharmacists

In 1981, the American Public Health Association (APHA) outlined the public health role of the pharmacist in a pioneering statement.[7] This succinct policy position, building upon a previous APHA publication,[8] declared that pharmacists were an underutilized resource in promoting public health and described an array of functions that could be performed by pharmacists, from providing direct personal health care services to planning for health care for communities or wider geographic areas. In 2004, the American Association of Colleges of Pharmacy (AACP) recognized the important role pharmacists can play in public health by including population-based care and public health in its Center for Advancement in Pharmaceutical Education (CAPE) Educational Outcomes.[9] The outcomes also emphasized the pharmacist's role in the public health components of "health improvement, wellness, and disease prevention," and the need for pharmacist involvement to ensure the "availability of effective, quality health and disease prevention services" as well as the urgency to "develop public health policy."[9]

The public health duties that an individual health-system pharmacist performs will vary, based on the individual's experience, abilities, training, and work setting. ASHP believes that all health-system pharmacists, working alone or in collaboration with health care colleagues and administrators, can contribute to the promotion of public health. ASHP believes that health-system pharmacists have specific public-health related responsibilities in infection control[10]; substance abuse prevention, education, and treatment[11]; immunization[12]; tobacco cessation[13]; and emergency preparedness and response.[14] The following are examples of other activities that health-system pharmacists can engage in to promote public health:

- providing population-based care;
- developing disease prevention and control programs (including medication safety programs) in their institutions and communities;
- developing health education policies and programs within their institutions that address the needs of patients, other health care professionals, community leaders, and the public;
- collaborating with state and local authorities, including local and state health departments and boards of health, to address local and regional health care needs (including environmental hazard and emergency preparedness programs);
- advocating for sound legislation, regulations, and public policy regarding disease prevention and management; and
- engaging in population-based research and initiating campaigns to disseminate new knowledge.

Population-based care. The Institute of Medicine, in *Crossing the Quality Chasm,* [15] presented the problems of health care quality in the United States and provided recommendations for change. Subsequent follow-up reports, including *Priority Areas for National Action,*[16] have provided additional direction related to population-

based care. The CAPE Outcomes recommended that pharmacists engage in both patient-centered and population-based care, suggesting that a core competency of pharmacists is the ability to develop "population-specific, evidence-based disease management programs and protocols based upon analysis of epidemiologic and pharmacoeconomic data, medication use criteria, medication use review and risk reduction strategies."[9]

Over the past two decades, the expanding role of health-system pharmacists in patient care has allowed them to support public health efforts by designing and providing disease management programs. ASHP urges health-system pharmacists to build upon this foundation by leading their institutions' efforts to provide population-based care. Working with their health care colleagues through such institutional mechanisms as the pharmacy and therapeutics committee, and using tools such as medication use evaluation, health-system pharmacists can contribute to population-specific, evidence-based disease management programs tailored to fit the needs of the institutions and communities they serve. Health-system pharmacists can participate in quality reviews and ensure that evidence-based treatments are used for all patients to help alleviate health care disparities.

Disease prevention and medication safety. Health-system pharmacists can be involved in disease prevention and control in many ways. For example, they can help develop institutional screening programs to check immunization status and to identify undiagnosed medical conditions (e.g., hypertension, diabetes, hyperlipidemia, depression). The health-system pharmacist's role in medication safety and error prevention is in keeping with the national public health goals outlined in the federal government's Healthy People 2010 initiative,[6] which include reducing the number of hospital admissions resulting from drug therapy mismanagement and fostering programs to intercept counterfeit medications. Medication reconciliation programs are one example of the tools pharmacists can encourage their facilities to use to achieve these goals.

Health education. Health-system pharmacists can promote public health by developing patient education programs on safe and effective medication use[17] as well as other public health-related topics such as tobacco cessation, exercise, and healthy nutrition. Pharmacists should support the education and training of the population at an early age, such as through school health programs, to develop good health behaviors that can continue into adulthood. Furthermore, health-system pharmacists can improve society's use of medications by educating their healthcare colleagues regarding safe and effective medication use. Health-system pharmacists can also use their knowledge and expertise to educate community leaders (e.g., legislators, regulators, public officeholders, school officials, and religious leaders) about and involve them in public health initiatives.

Public health policy. Health-system pharmacists should be encouraged to participate in public health policy development, from local health boards to national programs. By linking disease prevalence, drug utilization, and the determinants of disease, health-system pharmacists can place prevention within a larger context. Drugs play a central role in health, and health policy, especially policy directed at chronic disease, must be formulated with better understanding of the relationship of drug therapy to the many other factors that affect disease outcomes. Since medication use increases as patients age, health-system pharmacists will face increasing responsibilities to ensure appropriate and cost-effective medication use as the average age of the U.S. population rises.

Health-system pharmacist participation in emergency planning and service delivery is critical. Requirements for new and enlarged inventories of specialized pharmaceuticals to provide prophylaxis and treatment to communities during emergencies are growing. The Centers for Disease Control and Prevention (CDC) Strategic National Stockpile (SNS) program, for example, includes 12-hr push packs, vendor managed inventory, Chempacks, vaccines, and medical supplies. Hospital and health-system pharmacies are essential in planning for accommodation of supplies such as antibiotics and antidotes needed in the initial 24 hours following a crisis, before state and federal assets become available. Community-based planning efforts for mass immunization, prophylaxis, and treatment, including pandemic response to biological, chemical, radiological, or explosive agents, are an ongoing process, as is planning for utilization of the SNS. Medication management is a critical component of all these contingencies, yet many of the plans do not address pharmacy participation. Involvement of health-system pharmacists is critically important to reliably address medication issues.

ASHP encourages pharmacists to serve on National Disaster Medical System (NDMS) Assistance Teams (http://ndms.dhhs.gov), the National Pharmacy Response Team (http://www.ndms.dhhs.gov/nprt.html), or on local units of the Medical Reserve Corps (http://www.medicalreservecorps.gov) to assist in distributing emergency supplies of pharmaceuticals, dispensing and administering medications and immunizations, and managing the drug therapy of individual victims.[14] Development, implementation, and revision of local emergency operations plans, which includes public health management of emergencies, require pharmacist input. Health-system pharmacists need to be actively involved in planning for procurement, distribution, and dispensing of medications as well as ongoing management of patient medication issues.

Pharmacists should also work with health-system administrators to develop policies and initiatives that heighten awareness of the applicable laws and best management practices in the proper handling and disposal of hazardous drugs.

As medication-use experts and experienced health-system administrators, health-system pharmacists can and should contribute to the development of public health-related legislation and regulation and should be involved in public program oversight and administration. Legislators, regulators, and program managers at all levels of government should be educated to utilize this expertise. Health-system pharmacists, as individuals and through their professional associations, state and local boards of health, and state boards of pharmacy, are encouraged to participate in legislative, regulatory, and oversight processes.

Research and training. To assume a greater responsibility in public health, health-system pharmacists must receive adequate education and training. Pharmacy curricula should include advanced coursework in public health and research design. Health-system pharmacists need to be proficient in research methodology, pharmacoepidemiology, and biostatistics, and their applications to public health decision-making. Knowledge and experience in the design, conduct, and interpretation of clinical studies (both observational and experimental) is essential. Health-system pharmacists have the opportunity to participate in collaborative research and serve on institutional review boards, data monitoring and safety committees, and expert medication advisory committees. Experiential and didactic training for practicing health-system pharmacists, students, residents, and research fellows should include exposure to research in public health policy, pharmacoepidemiology, pharmacoeconomics, health-related quality of life, and evidence-based medicine. Health-system pharmacists should also work directly with public health policy makers and other key stakeholders such as professional organizations, medical centers, academic institutions, governmental agencies, and third-party payers to promote optimal pharmacotherapy.

Future Roles

Revolutionary progress in basic biomedical sciences, including human genomics, stem cell biology, immunology, biomedical engineering, and bioinformatics, has provided an unprecedented supply of information for improving human health. The rapidly emerging fields of population genetics and pharmacogenomics highlight the significance of molecular techniques in the clinical diagnostic laboratory and the potential for application in patient-directed pharmacotherapy. Medication-prescribing decisions will increasingly rely on the results of genotyping of drug-metabolizing enzymes. New technology and practices will allow health-system pharmacists to reduce treatment failures and prevent adverse drug reactions through the proper application of pharmacogenetic principles.[18] Advances in informatics will permit aggregation and application of population and patient-specific clinical data in ways that will encourage development of population-specific, evidence-based disease management programs. As medication-use experts, health-system pharmacists will need to apply these new tools not simply to improving patient-

specific pharmacotherapy but also to advancing public health. Similarly, innovations in medication delivery technology will allow more complex therapies to be administered outside institutional settings. Patients, caregivers, and health professionals will require education about the safe use of such technologies, as will the legislators and other officials responsible for regulating their use.

Conclusions

Health-system pharmacists play a vital role in maintaining and promoting public health. ASHP believes that all health-system pharmacists have the responsibility to participate in global, national, state, regional, and institutional efforts to promote public health and to integrate them into their practices, and that health-system pharmacists should be involved in public health policy decision-making and in the planning, development, and implementation of public health efforts. Health-system pharmacists can improve public health by providing population-based care; developing disease prevention and control programs; providing health education; collaborating with state and local authorities to address local and regional health care needs, including emergency preparedness and response; advocating for sound legislation, regulations, and public policy regarding disease prevention and management; and engaging in public health research.

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Resources

Pharmacists looking for further involvement in public health have many options. First, training and competence in public health disciplines are invaluable in understanding the field of public health and its applications to pharmacy practice. Accredited schools of public health offer traditional didactic classes, and some have courses or continuing education available on-line that will give the beginner a clearer understanding of the four traditional areas of public health practice: health administration and policy, health education, biostatistics, and epidemiology. Pharmacists who wish to pursue a degree in public health can also do so on-line at a growing number of schools of public health (http://www.asph.org/document.cfm?page=718). Pharmacists with an interest in federal public health initiatives can start with one of three main points of access. The first is the Center for Disease Control and Prevention (www.cdc.gov), the largest repository of documents, program descriptions, and contacts in the realm of prevention. Major efforts aimed at disease surveillance, infectious disease control, immunization, health education, chronic disease maintenance, and disease-related data management provide an ample and readily available source of information. The second major source of information is the Office of Disease Prevention and Health Promotion (http://odphp.osophs.dhhs.gov), which provides access to Healthy People 2010, a health information clearinghouse, national dietary guidelines, and information about health observances. Finally, the Agency for Healthcare Research and Quality (www.ahrq.gov) provides information on evidence-based clinical practice, the Guide to Clinical Preventive Services (http://www.ahrq.gov/clinic/pocketgd.htm), and quality measurement of health care. Virtually the entire realm of public health within the U.S. Public Health Service can be accessed or linked via these three websites.

State government websites provide public health information for their respective states. State entities serve as the main policy-making entity for public health priorities and strategies, provide a conduit for Federal public health dollars, and are the main point of health information and data for the state. States often organize a range of advisory groups, task forces, and planning committees whose output shapes their public health agenda. These are also the entities that provide input and direction for state legislative bodies to address, legislate, and fund.

On the local level, the Board of Health serves as the main government entity involved with the public's health. Besides their usual routine of immunizations and restaurant inspections, these Boards serve as the policy-makers for disaster response and provision of primary care to underserved populations. They receive Federal and state dollars that are used in public health efforts. They are closest to the general population both in their makeup and in their efforts at improving the public's health. Pharmacists interested in learning more about public health and the types of activities that community public health agencies are involved in can register for a free interactive tutorial at http://www.nynj-phtc.org/orientation/.

Below is a list of websites that provide information related to public health.

Public Health Organization Sites

- World Health Organization – http://www.who.int/
- Pan American Health Organization – http://www.paho.org/
- American Public Health Association – http://www.apha.org/
- Association of State and Territorial Health Officials – http://www.astho.org/
- National Association of County and City Health Officials – http://www.naccho.org
- Public Health Foundation – http://www.phf.org/
- Association of Schools of Public Health – http://www.asph.org/

Federal Health Agencies

- U.S. Department of Health and Human Services (HHS) – http://www.dhhs.gov/
- HHS, Office of the Surgeon General, Public Health Priorities – http://www.surgeongeneral.gov/publichealthpriorities.html
- U.S. Centers for Disease Control and Prevention – http://www.cdc.gov/
- U.S. Food and Drug Administration – http://www.fda.gov/
- Health Services and Resources Administration – http://www.hrsa.gov/
- National Institutes of Health - http://www.nih.gov/
- Agency for Healthcare Research and Quality – http://www.ahcpr.gov/
- U.S. Environmental Protection Agency – http://www.epa.gov/

Appendix B—Draft ASHP Statement on Professionalism

Position

Pharmacy is a profession. Despite the challenges to professionalism presented by changes in health care, pharmacists must embrace the responsibilities that stem from their profession's guiding principles. Among those responsibilities are advancing the well-being and dignity of their patients, acting with integrity and conscience, collaborating respectfully with health care colleagues, and seeking justice in the distribution of health care resources. ASHP encourages pharmacy practitioners, administrators, faculty members, preceptors, and students to advance patient care and strengthen the pharmacy profession by promoting professionalism in everyday practice. ASHP urges pharmacists to dedicate themselves to serving the interests of their patients, and to practicing with compassion and respect for patients and their families. Pharmacist should commit to working cooperatively and with respect for other health care providers and to seeking to improve the quality of health care received by the communities in which they work and live. ASHP encourages pharmacists to serve as mentors to students, residents, and colleagues in a manner that fosters the adoption of high professional aspirations for pharmacy practice, high personal standards of integrity and competence, a commitment to serving humanity, habits of analytical thinking and ethical reasoning, and a commitment to lifelong learning.

Background

Between 1995 and 2005, the number of PubMed-indexed articles on professionalism quadrupled, from 50 to approximately 200 per year.[1] Professional associations from the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) to the American College of Dentistry have convened task forces, developed white papers and charters, and initiated programs to increase the professionalism of their members.[2-6]

The rising interest in professionalism has been attributed to the perception that changes in health care delivery are eroding the professional standards of health care providers.[2] Among the changes confronting the pharmacy profession are managed care's continuing emphasis on cost containment[7]; increased demand for systems that ensure the safety of medication use[8]; technology-driven changes in pharmacy's core responsibilities, the most important of which is an expansion of the pharmacist's role in patient care[7,9,10]; and a prolonged shortage of pharmacists.[11] Faced with such challenges, it is in the best interest of our profession and the public we serve to reaffirm our foundational principles. Hospital and health-system pharmacists must therefore define for themselves the principles that will guide them in their unique practice settings.

Guiding Principles and Responsibilities for Health-System Pharmacy

The use of the term "profession" to describe a group of individuals pursuing an occupation or career is based on the idea that these individuals profess a common purpose.[12] The common purpose of pharmacists is eloquently stated in the eight principles of the Code of Ethics for Pharmacists.[13]

Professing these principles creates responsibilities for pharmacists. Foremost among these responsibilities is the obligation to place the well-being of patients at the center of pharmacy practice. Many of the other principles flow from the covenantal relationship between the pharmacist and the patient. To provide the best possible care, pharmacists dedicate themselves to maintaining professional competence through lifelong learning and contemplation. Professional education and advancing standards of practice can only be achieved through a profession's collective efforts; pharmacists therefore commit themselves to serve not only their patients but also their profession. Finally, pharmacists commit themselves to improving health care institutions not simply for the well-being of individual patients but for the benefit of society as a whole.

Incorporating Professionalism into Practice

ASHP encourages practitioners, administrators, faculty members, preceptors, and pharmacy students to contemplate and to incorporate into their practices the guiding principles set forth in the Code of Ethics for Pharmacists[13] and the following ten characteristics of a professional:

1. knowledge and skills of the profession,
2. commitment to self-improvement of skills and knowledge,
3. service orientation,
4. pride in and service to the profession,
5. covenantal relationship with the patient,
6. creativity and innovation,
7. conscience and trustworthiness,
8. accountability for his or her work,
9. ethically sound decision making, and
10. leadership.[6]

Practicing and aspiring hospital and health-system pharmacists should develop a personal plan for professional development, encourage their colleagues to do the same, and share the results. Continuing education should be viewed as an opportunity to enhance one's practice rather than an obligation to be fulfilled in the most expedient manner.

Much could be done to make practice sites more conducive to professional behavior. Institutions can develop personnel recruitment, orientation, and evaluation systems that encourage professional development (e.g., by offering benefit packages that emphasize professional development rather than salary or by incorporating characteristics of professionalism into job descriptions).[14] Administrators and pharmacists can promote professionalism by improving the pharmacy practice area to reduce environmental barriers to professionalism (e.g., cluttered, isolated, outdated, or cramped working quarters).

One of the fundamental services of a professional is recruiting, nurturing, and securing new practitioners to that profession's ideals and mission.[15] For hospital and health-system pharmacists, professional socialization is especially important because the principles of institutional pharmacy practice are not emphasized in typical pharmacy curricula. Above all else, hospital and health-system pharmacists need to prevent "inconsistent socialization,"[16] in which the principles of professionalism instilled in pharmacy students are undermined by a lack of professionalism in the role models they encounter when they enter practice. Pharmacy departments can avoid inconsistent socialization by promoting a culture of professionalism in the workplace through personnel recruitment and evaluation systems that emphasize professional development.[16] Regardless of the level of support they receive, however, hospital and health-system pharmacists must commit themselves fully to their mentorship responsibilities.

ASHP urges practicing pharmacists to serve as mentors to students, residents, and colleagues in a manner that fosters the adoption of high professional aspirations for pharmacy practice, high personal standards of integrity and competence, a commitment to serve humanity, habits of analytical thinking and ethical reasoning, and a commitment to lifelong learning. Practice sites should designate preceptors, implement preceptor training programs, encourage preceptor adherence to the highest professional standards, solicit student feedback on preceptorship programs, and reward those who participate.[6] Hospitals and health systems should also explore other ways to promote mentorship relationships among staff. Hospital and health-system pharmacists and students can participate in ASHP's Virtual Mentoring Exchange.[17] ASHP encourages pharmacists, particularly new practitioners, to actively seek mentors.

Finally, hospital and health-system pharmacists can advance the cause of professionalism in health care by reinvigorating the mission development processes of their institutions, encouraging those institutions to revise their mission statements to describe how they will

address such ethical issues as the treatment of patients, employees, and staff; institutions' responsibilities to their communities, to other institutions, and to their own futures; the need to honor founding traditions and sustaining principles; and the complex interactions of legal and ethical responsibilities and their obligations to meet legislatively and socially defined needs.[18] In 1976, Anderson called on hospital pharmacists to "create a code that reflects our relationships with all of the different people and conditions under which we practice."[15] The time has come for hospital and health-system pharmacists to join forces with other health care providers and patients to engage what has been called "the new authorities of health care"[18] to attain the kind of health care system our patients deserve and our society demands.

Conclusion

The pharmacy profession's guiding principles are eloquently stated in the Code of Ethics for Pharmacists.[13] Despite the challenges to professionalism presented by changes in health care, pharmacists must embrace the responsibilities that stem from their profession's guiding principles.

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Appendix C—Draft ASHP Statement on Racial and Ethnic Disparities in Health Care

Position

Health disparities continue to be a major public health problem confronting the U.S. health care system. These disparities arise from a complex set of factors, including social and economic inequality, cultural and linguistic barriers, and persistent racial and ethnic discrimination. Evidence continues to emerge, however, that some health disparities are attributable to differences in the quality of health care provided to different racial and ethnic groups. The American Society of Health-System Pharmacists (ASHP) believes that all patients, regardless of race, ethnicity, sex, age, sexual orientation, religion, physical or mental disability (or impairment), education, socioeconomic status, diagnosis, or limitations in access, have the right to high-quality health care that reflects knowledge of, sensitivity to, and respect for their differences.

Pharmacists who practice in hospitals and health-systems ("health-system pharmacists"), working individually and in coordination with interested organizations and other health care professionals, can play a leading role in building culturally competent systems of care to reduce racial and ethnic disparities in health care by:

- increasing awareness of these disparities among health care providers, health-system administrators, legislators, regulators, third-party payers, and the public;
- promoting a more diverse and culturally competent health care workforce and environment;
- ensuring effective communication with patients and among providers;
- fostering consistent use of multidisciplinary teams and evidence-based guidelines for patient care;
- collecting and reporting data on health care access, utilization, and outcomes by racial and ethnic minorities, and measuring progress toward reducing health care disparities; and
- researching, identifying, and disseminating best practices for providing culturally competent care and reducing disparities in health care.

Background

The Institute of Medicine (IOM) defines racial and ethnic disparities in health care as "racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention."[1] The IOM states that "evidence of racial and ethnic disparities in healthcare is. . .remarkably consistent across a range of illnesses and healthcare services."[1] More than 600 articles have been published in the last three decades documenting racial or ethnic variations in health care.[2] With the majority of U.S. population growth between now and 2050 expected to come from racial and ethnic minority Americans and immigrants, our health care system must soon learn how to address the effects that race and ethnicity can have on health care. Eliminating health disparities is so important that it is one of only two overarching goals for the United States Healthy People 2010 Objectives.[3]

Culture has been defined by the IOM as "the accumulated store of shared values, ideas (attitudes, beliefs, values, and norms), understandings, symbols, material products, and practices of a group of people."[1] Ethnicity refers to "a shared culture and way of life, especially as reflected in language, folkways, religious and other institutional forms, material culture such as clothing and food, and cultural products such as music, literature, and art."[1] An ethnic group is a collection of people "socially distinguished or set apart, by others or by itself, primarily on the basis of cultural or national-origin characteristics."[1] Like ethnicity, race has been described as a sociocultural concept used to distinguish groups of people that share certain physical characteristics and treat them differently.[1]

ASHP recognizes the need to address all forms of health disparities and believes that health-system pharmacists can take an important step in addressing these broader disparities by assuming a leadership role in the national campaign to eliminate racial and ethnic disparities in health care. Health-system pharmacists, like other health professionals, have espoused a tradition of nondiscriminatory health care practice.[4,5] Because medication therapy management is central

to many of the disparities cited in the IOM report (e.g., treatment for pain, HIV infection, diabetes, end-stage renal disease and kidney transplantation), health-system pharmacists have opportunities to directly address these disparities. As health-system administrators and members of multidisciplinary health care teams, health-system pharmacists have an important role to play in implementing the institutional changes necessary to eliminate racial and ethnic disparities in health care. ASHP believes that health-system pharmacists have a professional and moral responsibility to address racial and ethnic disparities in health care.

General Principles

The following three principles should guide the actions of health-system pharmacists in efforts to eliminate racial and ethnic disparities in health care.

I. All patients have the right to high-quality care. A long-standing policy position of ASHP holds that "all patients have the right to. . .high-quality pharmaceutical care."[4] ASHP believes that all patients have the right to receive care from pharmacists and that health-system pharmacists should play a leadership role in ensuring patient access to pharmacists' services.[6] The Code of Ethics for Pharmacists states that the pharmacist "places concern for the well-being of the patient at the center of professional practice" and "seeks justice in the distribution of health resources."[5] Racial and ethnic disparities in health care are antithetical to the core principles of pharmacy and must be eliminated.

II. Medication-use practices should reflect knowledge of, sensitivity to, and respect for the race and culture of the patient. Culture strongly influences how a person interacts with the world. Failing to account for the patient's race or cultural beliefs and values in health care decisions can lead to negative health consequences. Providers may miss screening opportunities because they are unfamiliar with the prevalence of conditions among racial or ethnic groups. They may fail to consider different responses to medications that exist in different populations. Potential harmful interactions between medications and traditional remedies used by the patient may be overlooked. Finally, miscommunication due to cultural, linguistic, or literacy differences between providers and patients regarding symptoms, medications, supplements, or use of devices may lead to faulty diagnoses, unnecessary laboratory testing, medication-related errors, decreased adherence to therapy, or missed opportunities for early detection and preventive measures.[7]

The Code of Ethics for Pharmacists states that "in all cases" the pharmacist "respects personal and cultural differences among patients."[5] Clinicians who want to provide the best care for their patients must understand the role of culture and its potential impact on health outcomes and the provider-patient relationship.

III. Health-system pharmacists have a vital role to play in eliminating racial and ethnic disparities in health care. In their roles as medication-use experts, patient care providers, and health-system administrators, health-system pharmacists have the knowledge, skills, and opportunities to contribute to efforts to eliminate racial and ethnic disparities in health care.

Pharmacists' Roles in Eliminating Disparities

IOM has made recommendations to eliminate racial and ethnic disparities in health care.[1] The six IOM recommendations most relevant to health-system pharmacists are listed in Appendix A. ASHP would add to that list that pharmacists can and should engage in research on disparities in health care. ASHP encourages all health care professionals and administrators to embrace these recommendations and urges health-system pharmacists to take the following actions to help eliminate health disparities.

Increase awareness of disparities. One elemental barrier to eliminating racial and ethnic disparities in health care may be lack of awareness of their existence and their impact on society. Polls report that a significant majority of Americans believe that African Americans receive the same quality of health care as whites,[1,8] despite ample evidence to the contrary.[1] Efforts to eliminate racial and ethnic disparities in health care must begin with the acknowledgement that there is a problem. Health-system pharmacists should lead efforts to increase awareness of health disparities among health care providers, health-system administrators, legislators, regulators, third-party payers, and the public. Pharmacists can increase awareness of health disparities by encouraging their health care organizations to make the elimination of disparities in health care a key component of the organization's mission. They can help their institutions foster an environment that promotes input from and involvement by all members of the organization in addressing this component of the organizational mission. In addition, pharmacists can help develop in-house and community programs to promote cultural understanding and appreciation of the importance of diversity. They can also partner with community groups, governmental agencies, health care provider organizations, payers, and others to increase awareness of specific diseases among certain populations and encourage innovation and creativity in evaluating and disseminating approaches to eliminating disparities in health care.

Create a more diverse health care workforce. Increased racial and ethnic diversity among health care professionals may be associated with improved access to care for racial and ethnic minority patients, greater patient choice of and satisfaction with health care professionals, more effective patient-clinician communication, and enhanced educational experiences for students in the health professions.[9] Racial and ethnic diversity in the health care workforce has been well correlated with the delivery of quality care to diverse patient populations. For minority patients, racial concordance between patient and physician is associated with greater patient satisfaction and higher self-rated quality of care.[10] Spanish-speaking patients, for example, report more satisfaction with care from Spanish-speaking providers.[11]

In 2002, the American Hospital Association's Commission on Workforce for Hospitals and Health Systems reported that although the national labor force is becoming more diverse, hospital employees remain disproportionately female and Caucasian.[12] The Commission recommended working aggressively to develop a workforce that more fully represents changing U.S. demographics.[12] The IOM has also cited a continuing shortage of minorities among health care professionals.[9]

ASHP is committed to developing a diverse workforce of health-system pharmacists.[13] In June 2003, the ASHP Board of Directors established the Ad Hoc Committee on Ethnic Diversity and Cultural Competence, which has recommended six major goals and developed long-term strategic action plans for each goal.[14] ASHP members are encouraged to participate in these efforts and to monitor their progress at ASHP's Health Disparities Web Resource Center.

Promote culturally competent care and services. Many cultures take a different approach to health than is found in allopathic ("western") medicine. Perceptions of illness and disease vary by culture, and culture may influence a person's health-seeking behavior, approach to seeking out health care providers, and treatment preferences. As allopathic medicine increasingly emphasizes evidence-based approaches, health care practitioners will more frequently confront the cultural divide between the demands of their profession and the closely held beliefs of their patients. Cultural competency is rapidly becoming a quality and risk management issue for hospitals and health-systems. ASHP is committed to developing a culturally sensitive, competent, and respectful workforce.[15]

The Department of Health and Human Services (HHS) states that a culturally competent health care practitioner is:

- Knowledgeable about cultural differences and their impact on attitudes and behaviors;
- Sensitive, understanding, non-judgmental, and respectful in dealings with peoples whose culture is different from one's own;
- Flexible and skillful in responding and adapting to different cultural contexts and circumstances.[16]

HHS's Office of Minority Health has developed a set of standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) to provide a consistent and comprehensive approach to cultural and linguistic competence in health care.[17] These standards offer a framework for implementation of services and organizational structures to help health care organizations and providers, including pharmacists, respond to the cultural and linguistic issues presented by diverse populations. ASHP believes these standards should be used

to assess staff competence and to guide organizations' educational programming and strategic planning. Education on cultural competency issues is encouraged in preceptor training sessions, residency standards, and in leadership orientation at ASHP and affiliate levels. The Accrediting Council on Pharmaceutical Education now requires that schools and colleges of pharmacy include cultural competency in their curricula.[18] Approaches to the subject could include stand-alone courses in health disparities and cultural competence, inclusion of traditional healers in the educational process, and infusion of the concept of cultural competence throughout the curriculum (e.g., through case studies that include diverse populations). ASHP believes that experiential learning should also include practice experiences with racial and ethnic minorities, medically underserved populations, and patient populations whose cultures incorporate use of traditional healers and complementary or alternative medicine (e.g., folk medicine and home remedies).

The Code of Ethics for Pharmacists states that "A pharmacist maintains professional competence."[5] ASHP believes that cultural competence is among the competencies pharmacists, residents, fellows, students, and technicians have an obligation to develop and maintain.

Ensure effective communication with patients and between providers. The Code of Ethics for Pharmacists states that "a pharmacist communicates with patients in terms that are understandable."[5] ASHP guidelines recommend that pharmacists "know about their patients' cultures, especially health and illness beliefs, attitudes, and practices" and "adapt messages to fit patients' language skills and primary languages, through the use of teaching aids, interpreters, or cultural guides if necessary."[19] Persons with the most health problems and the greatest need for self-management skills often have the poorest health literacy. Health-system pharmacists providing direct patient care should be able to assess the health literacy of patients and provide appropriate education.[20]

Lack of interpretation services and/or culturally and linguistically appropriate health education materials is associated with patient dissatisfaction, poor comprehension and compliance, and ineffective or lower quality of patient care.[21-23] Health care providers rely heavily on the use of the written word to communicate, which contributes to health care disparities.[1] When interpretation services are used, practitioners should ensure their quality. Fluency in language is not necessarily sufficient to provide adequate interpretation of the complex concepts involved in medical decision-making. Interpretation by family members also raises issues of patient confidentiality and autonomy.

Communication with patients needs to be culturally as well as linguistically appropriate. For example, although Spanish is the primary language of many cultures, simply translating educational material into Spanish may not provide the cultural context to make the education effective.

Health-system pharmacists should also utilize their medication-use expertise to help their institutions and communities develop culturally and linguistically appropriate public education campaigns. These campaigns could address health risks prevalent in racial and ethnic minority populations served by the hospital and explain preventive measures and health care services available to those populations.

Health care professionals also need to recognize that racial and cultural differences may affect communication among providers. Health-system pharmacists should take steps to ensure that provider-to-provider communication is effective and reflects the respect for colleagues expressed in the Code of Ethics for Pharmacists.[5]

Utilize multidisciplinary teams and evidence-based guidelines. Multi-disciplinary team approaches to health care improve health outcomes for majority and minority patients being treated for a range of diseases.[1] ASHP believes pharmacists should be integral participants in the development of multidisciplinary action plans for patient care, disease-management plans, and health-management plans.[24] Evidence-based guidelines "offer the advantages of consistency, predictability, and objectivity,"[1] but their use must be balanced with the need for clinical flexibility, especially when there is evidence of different outcomes or responses among racial or ethnic groups.

Collect and monitor data on health disparities. Standardized collection of data regarding access to medications, drug utilization, and medical and cost-effectiveness outcomes from medication therapy management by racial and ethnic minorities would promote research on disparities in health care and help institutions monitor the progress of their efforts to eliminate those disparities.[25] Pharmacists should be active partners with health care administrators and other health professionals in developing measures of progress against health care disparities in institutional performance measures, which should be a key component of the organization's mission.[26]

Research disparities in health care. Health-system pharmacists can research, identify, and disseminate best practices for providing culturally competent care and reducing disparities in health care. Priority areas for research include racial and ethnic groups' access to medications, drug utilization, and medical and cost-effectiveness outcomes from medication therapy management. Pharmacists must keep pace with research regarding disparities in health care, programs to provide culturally competent care to patients, and new educational approaches to improving patient care. It is also important that pharmacy develop researchers to investigate health care disparities and cutting-edge practitioners to translate those research findings into practice.

Conclusion

ASHP believes racial and ethnic disparities in health care are antithetical to the core principles of pharmacy. All patients have the right to high-quality health care that reflects knowledge of, sensitivity to, and respect for their differences. Health-system pharmacists, working individually and in coordination with interested organizations and other health care professionals, can and must play a vital role in efforts to eliminate racial and ethnic disparities in health care.

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Appendix A. IOM Recommendations Most Pertinent to Hospital and Health-System Pharmacy Practice[1]

House of Delegates Session—2007

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.

Diane B. Ginsburg, Board Liaison

Policy Recommendations

A. Restricted Drug Distribution

To affirm support for the current system of drug distribution in which prescribers and pharmacists exercise their professional responsibilities on behalf of patients; further,

To acknowledge that there may be limited circumstances in which constraints on the traditional drug distribution system may be appropriate if the following principles are met: (1) the requirements do not interfere with the continuity of care for the patient; (2) the requirements preserve the pharmacist–patient relationship; (3) the requirements are based on scientific evidence fully disclosed and evaluated by prescribers, pharmacists, and others; (4) there is scientific consensus that the requirements are necessary and represent the least restrictive means to achieve safe and effective patient care; (5) the cost of the product and any associated product or services are identified for purposes of reimbursement, mechanisms are provided to compensate providers for special services, and duplicative costs are avoided; (6) all requirements are stated in functional, objective terms so that any provider who meets the criteria may participate in the care of patients; and (7) the requirements do not interfere with the professional practice of pharmacists, prescribers, and others; further,

To advocate that the Food and Drug Administration (FDA) be granted the authority to consult with practicing pharmacists and others when the establishment of a restricted distribution system is contemplated for a drug product; further,

To advocate that FDA be granted the authority to require that manufacturers disclose all of the considerations that led to the establishment of a restricted distribution system for a specific product; further,

To advocate that FDA be granted the authority to require that manufacturers include in each restricted distribution system a mechanism that will ensure medication reconciliation and continuity of care as patients transition from one level or site of care to another; further,

To advocate that FDA be granted the authority to require manufacturers to conduct a follow-up assessment of the impact of a restricted drug distribution system.

(Note: This policy would supersede ASHP policy 0114.)

Background

This is a proposed revision of policy 0114. At its 2006 meeting, the Council discussed recent drug approvals that require the use of restricted drug distribution systems (RDDSs) to ensure safe use. The use of RDDSs has evolved over the past 15 years. In recent years, RDDSs have become part of a broader FDA drug safety initiative that utilizes risk management plans. The Council noted that manufacturers now propose RDDSs to FDA as a part of the new drug application process.

The Council discussed proposed drug safety legislation that would establish a process by which FDA would require RDDSs for certain drugs as a condition of approval. The Council also reviewed

recommendations by the Institute of Medicine and the Government Accountability Office that FDA be given more authority and resources to improve its premarketing and postmarketing drug safety activities. In light of this review, the Council recommended revising policy 0114 by inserting additional clauses to reflect recent legislative proposals to strengthen FDA's authority in balancing the benefits and risks of medications.

The Council recommended no changes in the first two clauses of policy 0114. Those two clauses support the traditional system of drug distribution, delineate principles for restricted systems when such systems are necessary, and advocate a role for pharmacists.

The third clause of policy 0114 was deleted and replaced by three new clauses. In the new clauses, the Council and the Board noted the need for pharmacist involvement in the design of RDDSs because of the impact of such systems on patient safety, access, and the medication-use system. In particular, the Council and the Board noted the need for FDA to require disclosure of the decision-making process for each RDDS. Council and Board members also believed that RDDSs should include a mechanism for medication reconciliation in all settings.

Finally, the Council and Board thought it was important for FDA to require an assessment of each RDDS for effectiveness. This recommendation is reflected in the sixth and final clause.

ASHP's policy on this issue has evolved. The original policy was adopted in 1991; in response to FDA approval of clozapine with an RDDS, the Council, the Board, and the House of Delegates developed and approved policy 9104. That policy was reaffirmed in 1997. In 2001, the policy was revised, with the addition of the first two principles in the second clause of policy 0114. Policy 0114 was reaffirmed in 2005.

Policy 0114 reads as follows:

> To reiterate support for the current system of drug distribution in which prescribers and pharmacists exercise their professional responsibilities on behalf of patients; further,
>
> To acknowledge that there may be limited circumstances in which constraints on the traditional drug distribution mechanism may be appropriate if the following principles are met: (1) the requirements do not interfere with the continuity of care for the patient; (2) the requirements preserve the pharmacist–patient relationship; (3) the requirements are based on scientific evidence fully disclosed and evaluated by physicians, pharmacists, and others; (4) there is scientific consensus that the requirements are necessary and represent the least restrictive means to achieve safe and effective patient care; (5) the cost of the product and any associated product or services are identified for purposes of reimbursement, mechanisms are provided to compensate providers for special services, and duplicative costs are avoided; (6) all requirements are stated in functional, objective terms so that any provider who meets the criteria may participate in the care of patients; and (7) the requirements do not interfere with the professional practice of pharmacist, physicians, and others; further,
>
> To strongly encourage the pharmaceutical manufacturers and the Food and Drug Administration to consult with practicing pharmacists when they contemplate the establishment of a restricted distribution system for a drug product.

B. Patient Access to Orphan Drug Products

To encourage continued research, development, and marketing of orphan drug products; further,

To urge health policymakers, payers, and pharmaceutical manufacturers to develop innovative ways to ensure patient access to orphan drug products; further,

To support public policies that ensure that the cost of orphan drug products does not preclude reasonable patient access to these agents.

Background

Council and Board members underscored the unique patient benefits derived from access to orphan drug products and noted the lack of ASHP policy on this issue. Manufacturers receive special market exclusivity and tax credits as an incentive to develop and market these products, each of which is estimated to serve 200,000 or fewer patients in the United States. Council and Board members were concerned about the high cost of these products and their impact on patient finances, on an employer's ability to provide health insurance to its entire workforce, and on third-party payer premiums.

As initial steps in implementing this policy, the Council and Board believed it will be important to provide ASHP members with an overview of this topic and to identify issues that warrant further discussion.

C. Regulation of Telepharmacy Services

To advocate that boards of pharmacy adopt regulations that enable the use of United States-based telepharmacy services for all practice settings; further,

To advocate that boards of pharmacy consider the following when drafting regulations for telepharmacy services:

1. Education and training of participating pharmacists and technicians;
2. Information system requirements;
3. Remote order entry, remote prospective order review, remote double-checking of the completed medication order before dispensing, actual dispensing, and patient counseling and education;
4. Licensure (including reciprocity) of participating pharmacies and pharmacists;
5. Service arrangements that cross state borders;
6. Service arrangements within the same corporate entity or between different corporate entities; and
7. Service arrangements for workload relief in the point-of-care pharmacy during peak periods; further,

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

Background

In the light of continuing advances in technology, the Council and Board discussed renewed interest in state board regulation of the provision of pharmaceutical care services from off-site locations through electronic technology (telepharmacy). These sites could be in other locations in the same state, in other states, or even overseas. The Council assessed various pilot projects and demonstration projects now under way in both rural and urban locations. Specifically reviewed were projects in North Dakota and Minnesota. Members of the Council and Board believed it important to acknowledge the regulatory purview of a state board with respect to the use of telepharmacy and emphasized that the intent of such regulations should be to provide patient access to pharmaceutical care while protecting the public health. The Council identified and the Board concurred with a number of elements that state boards should consider in drafting such enabling regulations. They believed that such regulations should allow for various arrangements across state borders and within or between health systems. The Council and Board noted that telepharmacy should be allowed during peak periods when the pharmacy is open as well as when it is closed. Finally, the Council and Board observed that telepharmacy services from an international location may be feasible but that more study and discussion are needed before a specific policy can be developed.

D. Personnel Ratios

To advocate that pharmacist-to-technician and pharmacist-to-patient ratios be determined by local institutions on the basis of acuity of care, breadth of services, quality improvement processes, and historical data; further,

To encourage additional research on staffing models that are based on best practices in order to provide safe and effective patient care.

Background

The Council discussed the notion of specific patient-to-pharmacist and technician-to-pharmacist ratios. It noted recent experience with nursing ratios mandated in California, as well as proposals in other states for limits on numbers of prescriptions dispensed by a pharmacist.

Council members believed that any ratios should be determined by the local institution and should not be mandated by any regulatory body. The chief reason is that factors relevant to such decisions (e.g., patient acuity, services provided, historical use) are best assessed by each institution. The Council noted that ASHP policy 0201, Staffing for Safe and Effective Patient Care, makes reference to the need for such local determination.

E. Direct-to-Consumer Advertising of Dietary Supplements

To support direct-to-consumer advertising of dietary supplements that is educational in nature and includes pharmacists as a source of information; further,

To support direct-to-consumer advertising of dietary supplements only when it includes

1. Evidence-based information regarding safety and efficacy in a format that allows for informed decision-making by the consumer,
2. A clear disclaimer that the product was not evaluated by FDA for safety and effectiveness,
3. A recommendation to consult with a health care professional before initiating use, and
4. Any known warnings or precautions regarding dietary supplement–medication interactions or dietary supplement–disease interactions; further,

To support the development of legislation or regulation requiring that dietary supplement advertising prominently state risks and intended benefits of a product that consumers should discuss with their licensed health care professional.

Background

The Council considered a delegate recommendation in 2006 that ASHP develop a policy concerning direct-to-consumer advertising of herbal products and dietary supplements. The recommendation was prompted by the adoption in 2006 of policy 0609, which covers direct-to-consumer advertising of prescription and nonprescription drugs. The Council and Board noted that use of these products is increasing and emphasized that hospital and health-system pharmacists must include these products in patient profiles.

The Council and Board believed it was important that ASHP have a separate policy on dietary supplements because those products are regulated under the Dietary Supplement Health and Education Act and are subject to different labeling and claims requirements than prescription and nonprescription drugs. Moreover, advertisements for dietary supplements are regulated by the Federal Trade Commission, not FDA. Despite these differences, the Council applied the same concepts in developing the new policy as it had in developing policy 0609.

F. Prohibiting Reuse of Brand Names and Standardizing Prefixes and Suffixes

To advocate Food and Drug Administration (FDA) authority to prohibit reuse of brand names of prescription and nonprescription drugs when any active component of the product is changed or after any other changes are made in the product that may affect its safe use; further,

To collaborate with others, including the United States Pharmacopeia and FDA, in standardizing and defining the meaning of prefixes and suffixes for prescription and nonprescription drugs to prevent medication errors and ensure patient safety.

(Note: This policy would supersede ASHP policy 0613.)

Background

This is a proposed revision of policy 0613. The Council considered a recommendation from the 2006 House of Delegates to prohibit the use of prefixes and suffixes in brand names of nonprescription products. The Council noted that problems also arise from the use of prefixes and suffixes in the names of prescription drug products.

Council members observed that because of the lack of standardization, practitioners and patients are forced to guess what a prefix or suffix means. Although the prefixes and suffixes often are consistent with other names in a manufacturer's product line, the public is not aware of this. Moreover, the use of prefixes and suffixes is not consistent among all manufacturers. Given these considerations, the Council and Board revised ASHP policy 0613 by adding a clause concerning collaboration with the United States Pharmacopeia, as well as with FDA, to standardize the meanings of prefixes and suffixes.

Policy 0613 reads as follows:

> To advocate that the Food and Drug Administration prohibit reuse of brand names when any active component of the product is changed, or after any other changes are made in the product that may affect its safe use.

G. Medicare Prescription Drug Benefit

To strongly advocate a fully funded prescription drug program for eligible Medicare beneficiaries that maintains continuity of care and ensures the best use of medications; further,

To advocate that essential requirements in the program include (1) appropriate product reimbursement based on transparency of drug costs; (2) affordability for patients, including elimination of coverage gaps; (3) payment for indirect costs and practice expenses related to the provision of pharmacist services, based on a study of those costs; (4) appropriate coverage and payment for patient care services provided by pharmacists; (5) open access to the pharmacy provider of the patient's choice; and (6) formularies with sufficient flexibility to allow access to medically necessary drugs.

(Note: "Fully funded" means the federal government will make adequate funds available to fully cover the Medi-

care program's share of prescription drug program costs; "eligible" means the federal government may establish criteria by which Medicare beneficiaries qualify for the prescription drug program.)

(Note: This policy would supersede ASHP policy 0410.)

Background

This is a proposed revision to policy 0410. The Council analyzed the impact on patients if drug product prices were negotiated by the Centers for Medicare and Medicaid Services (CMS) for prescription plans under Medicare Part D. The Council concluded and the Board concurred that although patients might then have lower drug costs, they would also be likely to have less choice. In addition, Council and Board members expressed concern about cost shifting to payers and patient populations outside Medicare. The Council and Board reviewed policy 0410 and added a new point in the second clause indicating the need to eliminate the gap in coverage and make the Part D benefit more affordable. They also added a final point calling for formularies to be sufficiently flexible to allow access to medically necessary medications. Council and Board members underscored the need for a benefit that is cost-effective, affordable, and understandable by the beneficiary.

Policy 0410 reads as follows:

> To strongly advocate a fully funded prescription drug program for eligible Medicare beneficiaries that maintains the continuity of patient care and ensures the best use of medications; further,
>
> To recommend that the program should at a minimum contain the following: (1) appropriate product reimbursement based on transparency of drug costs; (2) payment for indirect costs and practice expenses related to the provision of pharmacy services, based on a study of those costs; (3) appropriate coverage and payment for patient care services provided by pharmacists; and (4) open access to the pharmacy provider of the patient's choice.
>
> (Note: "Fully funded" means the federal government will make adequate funds available to fully cover the Medicare's program's share of prescription drug program costs; "eligible" means the federal government may establish criteria by which Medicare beneficiaries qualify for the prescription drug program.)

H. 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, 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) accurately document at any point in the distribution chain the original source of drug products and chain of custody from the manufacturer to the pharmacy; 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 0321.)

Background

The Council discussed a 2006 House of Delegates decision to reject a policy recommendation that would have supported federal licensing of wholesalers. At the time, legislative proposals were being developed to authorize this in lieu of action by states to strengthen their laws. In addition, FDA decided not to extend a stay on regulations requiring a sales history (pedigree) for prescription drugs. Thus, effective December 1, 2006, a pedigree is required unless the product is obtained from a manufacturer or an authorized distributor of record. Portions of the FDA regulation are currently under judicial review. The Council and Board revised policy 0321 to emphasize the role of the states in enforcing the integrity of the supply chain and to ensure that the policy clearly applies to all products entering the supply chain.

Policy 0321 reads:

> To encourage the Food and Drug Administration (FDA) to take the steps necessary to ensure that (1) all drug products entering the country 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, or non-FDA-approved products; further,
>
> To encourage FDA 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) to accurately document at any given point in the distribution chain the original source of drugs and chain of custody from the manufacturer to the pharmacy; further;
>
> To urge Congress to provide adequate funding or authority to impose user fees to accomplish these objectives.

I. Generic Drug Products

To discontinue ASHP policy 9005, which reads:

> To encourage pharmacists in organized health-care settings to assume a greater leadership role in legislative and other arenas relating to drug product selection and evaluation.

Background

The Council reviewed policy 9005 and determined that it is embodied in policies 0222, which deals with advocacy for greater access to generic drugs, and 0102, which addresses the pharmacoeconomic decision-making aspect of formulary management.

Policy 0222 reads as follows:

> To support legislation and regulations that promote greater patient access to less expensive generic drug products.

Policy 0102 reads as follows:

> To declare that decisions on the management of a medication formulary system (1) should be based on clinical, ethical, legal, social, philosophical, quality-of-life, safety and pharmacoeconomic factors that result in optimal patient care, and (2) must include the active and direct involvement of physicians, pharmacists, and other appropriate health care professionals; further,
>
> To declare that decisions on the management of a medication formulary system should not be based solely on economic factors.

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 were found to be still appropriate. (No action by the House of Delegates is needed to continue these policies.)

- Intermediate Category of Drugs (0220)
- Greater Access to Less Expensive Generic Drugs (0222)
- Drug Samples (9702)
- Manufacturer-Sponsored Patient Assistance Programs (9703)
- Automated Systems (9205)
- Drug Testing (9103)
- Medical Devices (9106)
- Employee Testing (9108)
- Codes on Solid Dosage Forms of Prescription Drug Products 8709)
- Pharmacy Technicians (8610)
- Pharmacist Conscience and Capital Punishment (8410)
- Size, Color, and Shape of Drug Products (8310)
- Pharmacist Recruitment and Retention (0218)

Other Council Activity

Pharmacist Right of Conscience and Patient's Right of Access to Therapy. The Council discussed a delegate recommendation in response to policy 0610, adopted in 2006. A group of Council members agreed to provide input for a document (statement or guideline) that would assist pharmacists who are dealing with this issue. Such guidance would be similar to the ASHP Statement on Pharmacist's Decision Making on Assisted Suicide. In addition, Council members suggested other ASHP actions, including practitioner interviews and commentaries in the *American Journal of Health-System Pharmacy (AJHP)*, presentations at meetings, and possible Web-based seminars.

Impact of Acquisition-Based Pricing. During its discussion of Part D and other Medicare programs, the Council noted the continued trend toward product reimbursement using an acquisition cost-based formula. Members observed that such changes in reimbursement formulas will increase pressure on hospital profit margins and pharmacy departments. Council members underscored the negative effect on patient access, services, and safety if sufficient compensation for services is not factored into reimbursement formulas. Council members also noted that inaccuracies in data submitted by hospitals may have an impact on the payment set by CMS for a particular product. In addition, the data submitted are not up-to-date and do not reflect actual market experience. Although the Council reviewed policy 0207 (Product Reimbursement and Pharmacist Compensation) and believed it was sufficient, it strongly suggested that members be educated about the importance of submitting accurate data to CMS. Council members also suggested that the impact of the Deficit Reduction Act be reviewed and that policy 0207 be revised as necessary.

National Licensure of Pharmacists. The Council discussed proposals to create a pharmacist license that would be recognized in multiple states or perhaps nationwide. Council members acknowledged that such a proposal would allow for more rapid movement of pharmacists between states. At the same time, they noted that state boards might oppose the loss of enforcement jurisdiction to protect the public if a pharmacist were able to practice in multiple states with a single license. Council members noted the recently passed policy 0612, which responds to a pharmacist's need for temporary licensure while applying for reciprocal licensing. Council members also acknowledged the rapid response by state boards during Hurricane Katrina, which enabled pharmacists to practice temporarily in devastated areas. On the basis of these discussions, the Council concluded that ASHP should continue to monitor this issue but that existing policy was sufficient.

State-Mandated Health Insurance. The Council discussed a Massachusetts law that requires nearly every resident to have health insurance. Members noted that the demographics in Massachusetts are different from those in other states and that these differences might affect success if the new law were replicated in other states. Important factors include the level of employer-sponsored coverage, number of people uninsured because of limited income, employment rates, and immigration status in a particular state. The Council observed that in the absence of federal action in this area, other states may follow the Massachusetts example. At present, the Council believed that policy 0512, which advocates full health insurance coverage for all persons living in the United States, was adequate, but it did recommend continued monitoring of state actions.

Patient Medication Information. The Council discussed the quality and utility of information provided to patients. It noted the requirement to distribute MedGuides for certain medications and the logistical challenges involved. Members believed that patients and pharmacists run the risk of information overload; they emphasized the importance of providing individualized information.

Method-of-Use Patents and Unlabeled Use of Brand-Only Indication. The Council discussed the precedent-setting potential of a patent that has been granted for a certain method that uses sodium bicarbonate to treat contrast agent-induced nephropathy. Council members concluded that hospitals and other providers would have to challenge the validity of this patent; they believed it goes against the spirit of method-of-use patents.

The Council also discussed patent-infringement issues with respect to the use of generic adenosine in myocardial perfusion imaging. Use of generic versions is allowed only in patients with paroxysmal supraventricular tachycardia. Patent protection still exists for the method of use of the brand Adenoscan for myocardial perfusion imaging.

Council members noted that ASHP members need to be educated about these issues and the broader trends of which they are a part. Council members suggested news stories in *AJHP* to bring this to the attention of practitioners.

Credentials and Credentialing for Hospital and Health-System Pharmacy Work. All of the ASHP councils were asked to advise ASHP about the extent to which the Society should exert greater leadership with respect to credentials and credentialing for hospital and health-system pharmacy work. The discussion of each council was summarized for the benefit of the ASHP Board of Directors as it continues to address this strategic issue.

House of Delegates Session—2007

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.

Stan S. Kent, Board Liaison

Policy Recommendations

A. Removal of Propoxyphene from the Market

To advocate that the Food and Drug Administration remove propoxyphene from the market because of its poor efficacy and poor safety profile and because more effective and safer alternatives are available to treat mild to moderate pain.

Background

After its introduction in the United States in 1957, propoxyphene became widely prescribed.[1] In 1977, the drug was assigned to Schedule IV of the Federal Controlled Substances Act because it had been linked to numerous deaths.[2] Adverse effects from recommended dosages of propoxyphene include dizziness, lightheadedness, sedation, somnolence, paradoxical excitement, and insomnia. Nausea, anorexia, vomiting, abdominal pain, and constipation may also occur.

Roughly one fourth of a propoxyphene dose undergoes first-pass hepatic metabolism by *N*-demethylation to norpropoxyphene.[1,3,4] The half-life of norpropoxyphene is considerably longer than that of the parent drug, and toxicity from propoxyphene may be attributable to accumulation of norpropoxyphene. At high concentrations, norpropoxyphene can cause cardiotoxicity (increased PR interval, QRS prolongation, and delayed atrioventricular conduction).[4]

The kidneys are the primary route of elimination of norpropoxyphene and unchanged propoxyphene.[4] Dosage adjustment should be considered for patients with renal or hepatic impairment because both the parent drug and the metabolite can accumulate in patients with renal or hepatic impairment.[4,5]

Propoxyphene has been used for mild to moderate pain; it is inadequate for managing severe pain.[4,6] The relative efficacy of various analgesic agents has been determined by comparing the number needed to treat (NNT) for one patient to achieve at least 50% pain relief over four to six hours in randomized, double-blind, single-dose, placebo-controlled studies of patients with moderate to severe postoperative pain.[7,8] A lower NNT indicates greater efficacy. The NNT for propoxyphene 65 mg was 7.7.[8] The NNT for propoxyphene 65 mg plus acetaminophen 650 mg (4.4) was comparable to that for tramadol 100 mg (4.8), acetaminophen 600 mg or 650 mg (4.6), aspirin 600 mg or 650 mg (4.4), and codeine 60 mg plus acetaminophen 600 mg or 650 mg (4.2).[7] The NNT for ibuprofen 400 mg was 2.4, suggesting that it is a more effective analgesic agent than propoxyphene 65 mg plus acetaminophen 650 mg.[7]

A meta-analysis of 26 randomized, controlled studies of 2231 patients with postoperative pain, arthritis, or musculoskeletal pain was performed to compare the analgesic efficacy of acetaminophen plus propoxyphene, acetaminophen alone, and placebo.[9] The results of the meta-analysis suggest that adding propoxyphene napsylate 100 mg to acetaminophen 650 mg offers no advantage over using acetaminophen alone.

Propoxyphene has been associated with many nonfatal overdosages and deaths, including both unintentional and intentional self-poisonings.[2,10–14] Death from propoxyphene poisoning usually is the result of respiratory depression and cardiotoxicity (i.e., delayed atrioventricular conduction, cardiac arrhythmias, circulatory impairment, and cardiorespiratory arrest).[2,15] Seizures, pulmonary edema, delusions, hallucinations, and confusion also may occur.[1,3,15] The drug was linked to 7109 deaths, including 2110 accidental deaths, in the United States between 1981 and 2002.[13] Propoxyphene played a role in 18% of drug-related suicides in England and Wales during the years 1997 to 1999.[2]

The lethal dose of propoxyphene is low (750 mg as the hydrochloride salt or 1150 mg as the napsylate salt), especially when the drug is combined with alcohol or central nervous system depressants.[1] Death can occur within as little as 1 hour after drug ingestion.[2]

Propoxyphene use is associated with tolerance, physical and psychological dependence, withdrawal symptoms, and abuse.[3,4,16-18] Dependence may develop during usual therapeutic use by patients not considered to be at risk for dependence.[16] Dependence on propoxyphene often is a sequela of legitimate drug use in patients with chronic pain.[16,17] Withdrawal symptoms include tremor, insomnia, anxiety, agitation, diaphoresis, tachycardia, fever, abdominal cramps, dizziness, nausea, vomiting, headache, and seizures.[16,17] Detoxification and prolonged abstinence from propoxyphene are difficult to achieve; relapse with a need for repeated detoxification is common.[17]

Propoxyphene is often prescribed for elderly patients, especially those living in nursing homes.[19,20] In 21,380 elderly (65 years of age or older) residents of nursing homes in 10 states who had persistent pain, propoxyphene was the second most commonly used analgesic after acetaminophen, with 18% of patients receiving propoxyphene.[19] In a national sample of 9851 community-dwelling and 1099 institutionalized Medicare beneficiaries (i.e., 65 years of age of older), propoxyphene was used by 7% of community-dwelling beneficiaries and 16% of institutionalized beneficiaries.[20]

Advanced age affects the pharmacokinetics of propoxyphene and norpropoxyphene. Compared with the younger subjects, in elderly subjects the half-lives of both the parent drug and the metabolite are reported to be significantly longer, and the area under the plasma concentration–time curve for the parent drug is greater after both single and multiple doses. The pharmacokinetic changes associated with aging raise concerns about accumulation of the parent drug and norpropoxyphene and the potential for toxicity in the elderly.[21] In a study of 1608 community-dwelling elderly persons 75 years of age or older, the risk of a first hip fracture was increased twofold by propoxyphene use compared with nonuse.[22]

Propoxyphene (alone and in combinations) is among the drugs and drug classes determined by the Beers criteria to be potentially inappropriate for older adults, because it offers few advantages over acetaminophen but has adverse effects associated with opiate analgesics.[23] The Beers criteria were established through consensus based on an extensive literature review, with input from experts in geriatric care, clinical pharmacology, and psychopharmacology.

A review of 1117 patient medical records in 15 nursing homes revealed that propoxyphene use was significantly associated with adverse health outcomes (i.e., hospitalizations, emergency department visits, or deaths).[24] The risk of at least one adverse health outcome was increased more than twofold by propoxyphene use compared with no propoxyphene use.

Having a low lethal dose, propoxyphene is associated with both accidental and intentional poisonings. Dependence can develop even during recommended therapeutic use, and detoxification is difficult to achieve. The drug is subject to abuse, although it is difficult to predict which patients will abuse it. Elderly patients may be particularly vulnerable to harm from propoxyphene. Finally, the efficacy of propoxyphene for mild to moderate pain is questionable.

The Council members and the Board of Directors agreed that other medications can treat mild to moderate pain more effectively and safely than propoxyphene and that propoxyphene should be removed from the market. Other, less dangerous analgesic medications (e.g., acetaminophen alone for mild or moderate pain) with greater efficacy should be used instead in patients of all ages. Propoxyphene should not be used to treat severe pain.

The Council believed that health care providers and patients would benefit from a guidance document on the use of propoxyphene and voted to develop a therapeutic position statement on the safety and efficacy of propoxyphene for treating mild to moderate pain.

Board Actions

ASHP Therapeutic Position Statement on the Identification and Treatment of *Helicobacter pylori*-Associated Peptic Ulcer Disease in Adults. The Council recommended and the Board of Directors voted

> To discontinue the ASHP Therapeutic Position Statement on the Identification and Treatment of *Helicobacter pylori*-Associated Peptic Ulcer Disease in Adults.

This document was approved by the Board of Directors in November 2000 and published in the February 15, 2001, issue of the *American Journal of Health-System Pharmacy (AJHP)*. The Council believed that this therapeutic position statement (TPS) should be discontinued because it does not include the most recent information on the identification and treatment of *Helicobacter pylori (H. pylori)*-associated peptic ulcer disease in adults. Development of the statement was sparked by the publication in 1994 of a National Institutes of Health consensus statement on antimicrobial therapy to eradicate *H. pylori* in the treatment of peptic ulcer. The role of antimicrobial agents in the treatment of this condition was not well understood at that time. The Council noted that understanding of the role of antimicrobial agents in the treatment and eradication of *H. pylori* in patients with peptic ulcer disease has improved. For that reason, the Council did not support a revision of the TPS.

Other Council Activity

Safety and Efficacy of Propoxyphene. The Council supported the development of a TPS on the safety and efficacy of propoxyphene for treating mild to moderate pain. The Council believed that health care providers and patients would benefit from guidance on the safety and efficacy of propoxyphene in the treatment of mild to moderate pain. Elderly patients may be particularly vulnerable to harm from propoxyphene, and its continued use in such patients poses a substantial risk. In addition, the relative efficacy of propoxyphene for mild to moderate pain is questionable. The Council believed that safer analgesic medications (e.g., acetaminophen) with greater efficacy should be used to relieve mild to moderate pain in patients of all ages.

The Council has proposed policy advocating that the Food and Drug Administration (FDA) remove propoxyphene from the market because of its poor efficacy and poor safety profile and because more effective and safer alternatives are available to treat mild to moderate pain.

Quality Drug Information Resources. The Council supported the development of a statement on evaluating the quality of drug information resources. The Council believed that a statement emphasizing the essential components of quality drug information resources (in both hard-copy and electronic formats) would be valuable to institutions and practitioners. The quality of drug information reference resources varies widely, and the differences have important implications for patient care. Health care organizations and professionals often are not aware of the relative quality of these resources and have no way of evaluating them.

Assessing and applying drug information are core competencies of pharmacists in hospital and health-system practice. The Council

believed that certain characteristics are essential to the integrity of a high-quality drug information resource; among the most important are controlled content development, a well-established expert-review process, and independence from pharmaceutical manufacturers, health insurers, and others that may have a conflict of interest. Another important feature is a clear method for updating and maintaining the currency of information. An independent editorial process is essential. Finally, a resource should include new, evidence-based uses and doses that are not included in the FDA-approved labeling.

The Council believed that this statement should be developed in conjunction with other stakeholders and should be available in both print and electronic formats. Potential partners include the American Medical Association, the U.S. Pharmacopeia, the Health Information and Management Systems Society, the American Medical Informatics Association, and the Evidence-based Center for Oregon.

Safe Use of Pharmacotherapy for Obesity Management in Adults. The Council reviewed the ASHP Therapeutic Position Statement on the Safe Use of Pharmacotherapy for Obesity Management in Adults. This document was approved by the Board of Directors in April 2001 and published in the September 1, 2001, issue of *AJHP*. The Council believed that this document still provides valuable guidance but that it should be updated. The Council recommended keeping the current TPS active while the revision is in progress.

Safety of Thimerosal as a Preservative in Vaccines. In 2004, the Institute of Medicine reported finding no evidence "conclusively" connecting the preservative thimerosal to increased risk for neurodevelopmental disorders. However, some sources still express concern that children who are exposed to thimerosal, a mercury-containing compound used as a preservative in vaccines, have an increased risk for neurodevelopmental disorders such as autism, attention-deficit hyperactivity disorder, and speech or language delays. Vaccine manufacturers have been urged to reduce or eliminate thimerosal in vaccines and are making progress in this effort.

The Council noted that no vaccine is 100% safe or effective. Nevertheless, childhood immunization remains one of the most effective tools for preventing millions of cases of disease and death. The risk of developing neurodevelopmental disorders as a result of being vaccinated with a product that contains thimerosal is not based on concrete evidence; on the other hand, the risks associated with not properly vaccinating children are well documented. After considering this issue from both sides, Council members agreed that the benefits of vaccination outweigh the risk of an adverse event that could be associated with thimerosal. The Council also believed that an educational program for pharmacists focusing on the facts about thimerosal would prepare them to respond to patient or health care provider questions.

Use of Short-Acting Beta Agonists for Asthma and Chronic Obstructive Pulmonary Disease (COPD). The Council noted a need for educational programs presenting evidence for the efficacy and safety of short-acting beta (2)-adrenergic agonists (e.g., albuterol, levalbuterol). Such programs should include substantial clinical findings; statistical findings from drug therapy trials may not always be clinically relevant or have a direct impact on morbidity and mortality. The Council believed that an evidence-based review, published in *AJHP* and containing an interpretation of clinical as well as statistical findings, would be beneficial.

Effectiveness of Nonprescription Cough Suppressants. The Council believed that evidence does not support the effectiveness of nonprescription cough suppressants in adult or pediatric patients. Nonetheless, because many patients seek guidance on how to manage a cough caused by a respiratory infection, the Council suggested developing a consumer piece on safe and effective use of nonprescription cough suppressants.

Evidence for Benefit of Vitamins. The Council noted that annual spending on vitamin supplements is significant; it totaled an estimated $7 billion in the United States in 2005. Overuse of supplements has no clear benefit and may pose a risk to patient safety. For example, vitamin supplementation has been associated with poor outcomes and harm in patients with cancer. Vitamin and supplement manufacturers continue to make unsupported claims about their products. The Council suggested that *AJHP* publish an article on the use of vitamin supplements.

The Council believed that the ASHP Statement on the Use of Dietary Supplements appropriately addresses pharmacists' concerns that the current regulatory framework does not provide consumers or health care providers with sufficient information on which to make informed decisions about the safety and efficacy of vitamin supplements.

Promoting Research and Access to Information about Minimum Effective Dose for Drug Therapy. The Council reviewed current ASHP policy on minimum effective doses (0602) and believed it is appropriate as written. The policy advocates that FDA require manufacturers to identify minimum effective doses and to make this information available to health care providers. The intent of the policy is to identify minimum effective doses in the general population. ASHP has other polices that advocate postmarketing safety studies, mandatory registry of clinical trials, and increased enrollment of elderly and pediatric patients in clinical trials (policies 0515, 0516, 0229, respectively). These policies collectively suggest that more information is needed about drug doses and dosing in general and in special populations.

Access to FDA Product-Approval Data. The review packets submitted by applicants seeking approval for medical products are posted on the FDA Web site. The packets may contain individual reviews, correspondence between the company and FDA, administrative documents, recommendations for labeling, and data collected from preclinical trials. The Council noted that the FDA site is hard to navigate and that it is difficult to find and retrieve information on the review packets submitted by applicants. Proprietary information is often not available. The Council believed it would be beneficial to form a subcommittee to explore the current process for posting drug approval information and the ease of access and availability of Web content. Feedback from the subcommittee would help the Council to determine if specific action is needed by ASHP to assist members in retrieving product approval data.

U.S. Pharmacopeia Policy on Naming Drugs (Salt versus Moiety). ASHP submitted comments in response to the U.S. Pharmacopeia (USP) call for comments on its policy of identifying the active moiety, and not the salt and active moiety, when referring to a drug entity. (USP terms this the "salt nomenclature policy.") Council members noted that dropping the salt name from the name of the official dosage form monograph could lead to inappropriate dosing, contribute to problems with solubility, and camouflage the use of a salt that may be deleterious to the patient's condition. Furthermore, health care providers have not been educated about the salt nomenclature policy. In view of these concerns, the Council expressed an overall lack of support for the salt nomenclature policy.

Poison Control Center Telephone Number (800-222-1222) on the Labels of All Nonprescription Medications. In 2005, the Commission on Therapeutics withdrew its recommendation to the Board for ASHP policy advocating that FDA require manufacturers to include the 1-800-222-1222 Poison Control Center telephone number on the labels of all nonprescription medications. One concern was the effect such a policy might have on the volume of calls received at poison control centers. ASHP contacted the American Association of Poison Control Centers (AAPCC) to discuss the implications for poison control center call volume and resources. ASHP will continue to collaborate with AAPCC on this topic.

ASHP Therapeutic Guideline on Antimicrobial Prophylaxis in Surgery. The revision of this guideline is a multiorganizational effort led by ASHP in partnership with the Infectious Diseases Society of America, Surgical Infection Society, and Society for Healthcare Epidemiology of America. The revision is in progress.

TPSs Currently Under Development. The Council reviewed the following TPSs that are in various stages of development:

- Prevention and Treatment of Osteoporosis
- Smoking Cessation
- Antithrombotic Therapy in Chronic Atrial Fibrillation
- Criteria for an Intermediate Category of Drugs
- Use of Perioperative Antibiotic Irrigations to Prevent Surgical Site Infections

Credentials and Credentialing for Hospital and Health-System Pharmacy Work. All of the ASHP councils were asked to advise ASHP about the extent to which the Society should exert greater leadership with respect to credentials and credentialing for hospital and health-system pharmacy work. The discussion of each council was summarized for the benefit of the ASHP Board of Directors as it continues to address this strategic issue.

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House of Delegates Session—2007

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 23–24, 2006, to review the past year's activities and plan for the coming year. The committees met again on January 10, 2007, 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.

ASHP Section of Clinical Specialists and Scientists

The mission of the Section of Clinical Specialists and Scientists (SCSS) 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's Executive Committee has developed a strategic plan linked to the mission and goals of the Section. The goals include (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.

SCSS continues to grow significantly in membership. Strong interest in the Section among students and new practitioners continues; students account for 31% of the Section membership. Approximately 60% of SCSS members select the Section as their primary section.

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 2006–2007 committee is developing more than 12 hours of educational programming on drugs with novel mechanisms of action and on advances in cardiology, infectious diseases, immunology, neurology, and critical care. The committee developed an educational track for the 2006 ASHP Midyear Clinical Meeting (MCM) on "Integrating National and International Guidelines into Clinical Practice"; the four sessions focused on the use of evidence-based guidelines in the management of various diseases and the application of guidelines in current and future clinical practice. The committee also planned a session devoted to debates in areas of therapeutic controversy and coordinated the Clinical Pearls session. In collaboration with the ASHP Research and Education Foundation and the New Practitioners Forum, the Section once again provided a six-hour session at the MCM on developing research skills, aimed at new researchers. Among the topics covered in this session were study coordination, statistical analysis, and practical aspects of dealing with institutional review boards.

The Section's electronic NewsLink is distributed biweekly to more than 8000 ASHP members, providing news and current information on medical research, regulatory and health policy issues, health care, and therapeutics. The Section's e-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 1000 members participate. The discussion group is also used to communicate urgent information on clinical specialty practice.

The Section has 16 specialty networks encompassing most areas of specialty pharmacy practice. The networks meet regularly at the MCM. 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 e-discussion group, NewsLink, networking meetings, and other avenues. The facilitators serve ASHP and its members as therapeutic experts and contribute to ASHP advocacy and educational efforts.

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 has created a virtual journal club on the Web site to enhance communication and participation among members with different specialties. This tool provides informal online discussion of advances in various therapeutic areas, with the purpose of applying evidence-based medicine to practice. In addition, the Section is creating a new clinical column in the *American Journal of Health-System Pharmacy* for discussion of cutting-edge issues. The column will cover therapeutic controversies and provide recommendations on handling specific pharmacotherapeutic problems. A preceptor information area on the ASHP Web site is a new resource developed jointly with the New Practitioners Forum. It includes helpful information such as advice on becoming an effective preceptor, improving oral and written communication skills, and encouraging the development of student skills. Although developed for preceptors, its resources are useful to all practitioners. The Section has also created advisory groups on emergency care and investigational drug pharmacy services to develop resources for practitioners; e-discussion groups in these areas have been created to enhance networking.

Advocacy. The Section continues to support ASHP activities in collaborative drug therapy management, compensation for pharmaceutical care services, recognition of pharmacists as health care providers, residency and fellowship training, and credentialing for pharmacists. In each of these areas, the Section leadership provides input and recommendations to the Board of Directors and ASHP staff. The Section continues to work on the issues of clinical privileging and credentialing for pharmacists; currently available on the Section Web site are templates for establishing credentialing and privileging for clinical services in health systems and a companion document outlining a stepwise approach for implementing these processes. A collaborative effort between SCSS and the Section of Home, Ambulatory, and Chronic Care Practitioners will produce additional tools, resources, educational programming, and publications.

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 belongs to all pharmacists and pharmacy departments. The Section collaborated with the Council on Public Policy in creating a position statement regarding the use of placebos in clinical practice. The policy states that patients should be informed when receiving placebos as a treatment component and that placebo use without informed consent is inappropriate. Sample policies and procedures have been posted on the Section Web site to encourage health care facilities to address this issue.

Specialty Practice and Credentialing. SCSS represents ASHP's continued commitment to meeting the needs of pharmacists in specialty practice settings and those working in the science of pharmacy practice. Members of the Section's Executive Committee believe that stakeholders from all of the pharmacy credentialing and certificate-granting programs should discuss an organized and rational model for pharmacist specialty practice. Discussions should address the utility of these credentials in privileging processes, and a plan should be developed for examining the processes for recertifying or maintaining specialty credentials to demonstrate continuing competence in the specialty.

Conclusion. 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.

Committee on Nominations
Susan Goodin, Chair (New Jersey); William L. Greene (Tennessee); Mary Hess (South Carolina); Rita K. Jew (California); Michael D. Katz (Arizona); Edith A. Nutescu (Illinois); Susan J. Skledar (Pennsylvania)

Programming Committee
Melinda Neuhauser, Chair (Illinois); Curtis D. Collins (Michigan); Kevin Garey (Texas); Cherry W. Jackson (Georgia); Karla Miller (Tennessee); Mark A. Ninno (Florida); Michael Oszko (Kansas); Jean M. Scholtz (Pennsylvania)

Committee on Qualified Provider Models
Christene M. Jolowsky, Chair (Minnesota); Melissa Blair (South Carolina); Cynthia Brennan (Washington); Jannet M. Carmichael (Nevada); Karen E. Gorman (Colorado); Patricia C. Kienle (Pennsylvania); Philip T. Rodgers (North Carolina); Kim Thrasher (North Carolina); Elizabeth W. Young (North Carolina); Rita K. Jew, Executive Committee Liaison (California)

Advisory Group on Emergency Care
Danie P. Hays, Chair (New York); Umbreen Idrees, Vice Chair (Maryland); Roshanak Aazami (California); Elizabeth A. Clements (Michigan); George Delgado (Michigan); Karen Gurwitch (Texas); Todd D. Lemke (Minnesota); Frank P. Paloucek (Illinois); Maria I. Rudis (California); James A. Trovato, Executive Committee Liaison (Maryland)

Advisory Group on Investigational Pharmacy Services
Bobby G. Bryant, Chair (Alabama); Joseph T. Dye (Georgia); Tricia Meyer (Texas); Ronald Seto (Toronto, Canada); Kathleen Truelove (Maryland)

Network Facilitators
Anticoagulation: Snehal Bhatt (Massachusetts)
Cardiology: Michael Gulseth (Minnesota)
Drug Information/Pharmacoeconomics: Mark A. Ninno (Florida)
Emergency Medicine: Daniel P. Hays (New York)
Geriatrics: Michelle Fritsch (North Carolina)
Hematology/Oncology: Kamakshi Rao (North Carolina)
Immunology/Transplant: David I. Min (California)
Infectious Diseases: Curtis Collins (Michigan)
Investigational Drugs/Critical Research: Bobby G. Bryant (Ohio)
Nutrition Support: Caitlin S. Curtis (Wisconsin)
Pain Management: Christopher M. Herndon (Illinois)
Pediatrics/Obstetrics–Gynecology/Neonatal: Anita Siu (New Jersey)
Pharmacokinetics: Rosa Yeh (Texas)
Primary Care/Pharmacotherapy: Alan J. Zillich (Indiana)
Psychopharmacy/Neurology: Sheila R. Botts (Kentucky)
Surgery/Anesthesiology: Eric L. Chernin (Florida)

ASHP Section of Home, Ambulatory, and Chronic Care Practitioners

In 2006, the Section membership elected Ernest Dole to serve as Chair-elect; he immediately began to serve in that capacity. The members also elected Barbara Petroff to a two-year term as director-at-large. The Section's Committee on Nominations for 2007, chaired by Carol Rollins, will present a slate of candidates for one director-at-large position and for Chair-elect.

Led by its Executive Committee, the Section of Home, Ambulatory, and Chronic Care Practitioners focused on pain management and palliative care, reimbursement for cognitive services, and continuity of care. The Section's Midyear Clinical Meeting (MCM) programming and other activities described in this report addressed challenges and pharmacists' role in these areas. The 2006 MCM programs were well attended. The Section chose Aging in Place as its theme for the 2007 MCM and will repeat its Cutting Edge in Ambulatory Practice presentation.

During 2006, the Section grew by nearly 11%, to a total primary and secondary membership of 7603.

Pain Management and Palliative Care. The Section's Executive Committee identified pain management and palliative care as underserved areas in which there is potential for growth through the education of students and new practitioners, and in which ASHP might provide resources to support practice. These areas include the management of acute and chronic pain and the provision of end-of-life care. The Section's Pain Management and Palliative Care Task Force provided a well-attended workshop at the 2006 MCM, which will be repeated in 2007. The task force also contributed comments on documents prepared by the ASHP Government Affairs Division and the National Quality Forum.

Reimbursement for Cognitive Services. With the changing health care environment and the introduction of medication therapy management (MTM) programs, the Section's Advisory Group on Cognitive Reimbursement Resources was formed to review current practices, provide advice on educational needs, and develop member resources. The group organized the 2006 MCM Ambulatory Care Workshop, which focused on documentation, collaborative drug therapy management agreements, and obtaining grants. The workshop will be repeated in 2007. In addition, the advisory group is generating articles for the *American Journal of Health-System Pharmacy* (*AJHP*) on reimbursement for cognitive services, the first of which was published in the January 15, 2007, issue.

Continuity of Care. "Continuity of Care in Medication Management: Review of Issues and Considerations for Pharmacy," prepared by the Section, was published in the August 15, 2005, issue of *AJHP*. That document has been used by the Section as a guide for strategic planning and education. In addition, the document was listed as a resource in Joint Commission's February 2006 *Sentinel Event Alert* titled "Using Medication Reconciliation to Prevent Errors." Sessions organized by the Section's Programming Committee for the 2006 MCM emphasized continuity of care; included was a six-hour case study of a patient's journey from the emergency department to ambulatory care.

Medicare Modernization Act. Practice models for MTM services under Medicare Part D were the topic of the Section's Cutting Edge in Ambulatory Care session at the 2006 MCM. Also in 2006, an *AJHP* question-and-answer column on the Medicare Modernization Act was initiated.

Executive Committee

Cathy L. Sasser, Chair (Georgia)
Ernest Dole, Chair-elect (New Mexico)
Carol Rollins, Immediate Past Chair (Arizona)
Timothy R. Brown (Ohio)
Sandra L. Chase (Michigan)
Barbara J. Petroff (Michigan)
Lynnae M. Mahaney, Board Liaison (Wisconsin)
David F. Chen, Secretary

Practice Area Networks. The Section's networks focus on the unique needs of Section members in various practice areas. The network in each practice area (i.e., home, ambulatory, and chronic care) has two facilitators. Network forums were begun at the 2005 MCM and repeated at the 2006 MCM.

Advocacy. Many Section members are active in committees representing ASHP in various settings nationwide. The section has provided member experts to the Pharmacy Quality Alliance, the National Quality Forum and its ambulatory care project and substance abuse treatment project, the Joint Commission Professional and Technical Advisory Committees on Ambulatory and Home Care, and the SOS-Rx Coalition/National Consumers League and its patient medication education project. These members bring the pharmacist's perspective to discussions that have an impact on national patient care issues. In addition, in cooperation with the National Home Infusion Association, a Web-based seminar was conducted to obtain feedback from members in support of ASHP's comments on the proposed USP Chapter 797 standards.

Conclusion. The Section of Home, Ambulatory, and Chronic Care Practitioners had a very productive year as it fulfilled members' needs and continued to strive to provide leadership and value for its members through its members.

Committee on Nominations

Carol J. Rollins, Chair (Arizona); Leona J. Dombroske (California); Mary Ann Kliethermes (Illinois); Mae Kwong (California); Barbara S. Prosser (New Hampshire)

Programming Committee

Melissa Blair, Chair (North Carolina); Kimberly A. Binaso (New Jersey); Michelle A. Fritsch (North Carolina); Katie V. Lai (Washington); Kimberly B. Lloyd (Alabama); Tracy A. Martinez (Michigan); Michele L. Matthews (Massachusetts); Edward P. Sheridan (Indiana); Pamela L. Stamm (Alabama); Anita Thomas (Indiana)

Advisory Group on Cognitive Reimbursement Resources

Robert Wayne Blackburn (California); Seena Zierler-Brown (Florida); Timothy R. Brown (Ohio); Kelly T. Epplen (Ohio); Roger S. Klotz (California); Sandra Leal (Arizona); Edith Nutescu (Illinois); Laura D. Roller (Utah); Ronald F. Smetana (Utah); Hoai An Truong (Maryland); Anne T. Jarrett, Section of Pharmacy Practice Managers Advisory Group on Financial Management/Reimbursement Liaison (North Carolina)

Task Force on Pain Management and Palliative Care

Doug Nee, Co-Chair (California); James B. Ray, Co-Chair (Pennsylvania); Sondra Adkinson (Florida); Thomas Bookwalter (California); Christopher Herndon (Illinois); Kenneth C. Jackson II (Utah); Mary Lynn McPherson (Maryland); Suzanne A. Nesbit, ASHP Network Facilitator on Pain Management (Maryland); Lori Reisner (California); Jennifer Strickland (Florida); Cathy L. Sasser, Executive Committee Liaison (Georgia)

ASHP Section of Inpatient Care Practitioners

The Section of Inpatient Care Practitioners, now in its fourth year, 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 successful educational sessions at the 2006 Midyear Clinical Meeting (MCM). For the first time, a day of programming for pharmacists working in small and rural hospitals was offered. Topics included medication safety, innovations, and clinical services. 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 technology for the inpatient care practitioner, a practical approach to evidence-based medicine, and medication reconciliation. The Programming Committee, chaired by Paul Mangino, met at the 2006 MCM and selected topics for Section programming at the 2007 MCM.

Resources for Inpatient Care Practitioners. The Section's page on the ASHP Web site features information pertinent to the needs of frontline pharmacists, including recent news, practical tools, and member spotlights. All Section members receive a bimonthly electronic NewsLink containing information of interest to staff pharmacists and notifying members of opportunities within the Section and ASHP. The Section e-discussion group continues to be an effective networking mechanism. The e-discussion group for small and rural hospitals also continues to be very active, and a resource center on the ASHP Web site provides pertinent information for this component group. In addition, the Section has planned Web-based seminars on remote order entry for members providing or planning to provide this service.

Section Advisory Groups. Section advisory groups (SAGs) advise the Section and ASHP at large on specific issues or areas of practice. The Advisory Group on Small and Rural Hospitals (SRH SAG) maintains an active e-discussion group. It planned a successful educational track and networking sessions at the 2006 MCM and will provide input on proposed ASHP policies dealing with issues faced in small and rural hospitals. The group has suggested that ASHP seek to collaborate with the National Rural Health Association. The Advisory Group on Publications has contributed topics for the Frontline Pharmacist column in the *American Journal of Health-System Pharmacy*. The Advisory Group on Medication Safety, 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 position. The group has discussed publications, contributions to the ASHP Web site, and sessions at the 2007 MCM, and it conducted a successful networking session at the 2006 MCM. The Task Force on Advanced Pharmacy Practice Experiences was formed to provide tools and resources for preceptors and potential preceptors. It plans to develop a toolkit to help preceptors with student rotations.

Advocacy. At the recommendation of the Advisory Group on Small and Rural Hospitals, the Executive Committee suggested that ASHP seek ways to work with external organizations dealing with small and rural hospitals.

Mission and Vision. 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.

Executive Committee

Dale E. English, Chair (Ohio)
Helen M. Calmes, Chair-elect (Louisiana)
Megan K. McMurray, Immediate Past Chair (Washington)
Brian D. Benson (Iowa)
Patricia R. Knowles (Georgia)
Laura C. Wachter (Maryland)
Agatha L. Nolen, Board Liaison
Teresa M. Rubio, Secretary

Programming Committee

Paul D. Mangino, Chair (Kentucky); Catherine Christen (Michigan); Osmel Delgado (Florida); Julie C. Kissack (Georgia); Rick Knudson (Iowa); Joanne Kowiatek (Pennsylvania); Lois F. Parker (Massachusetts); Susan Jean Skledar (Pennsylvania); Linda Spooner (Pennsylvania); Trish Wegner (Illinois); Matt B. Zimmerman (Pennsylvania); Debra L. Cowan, SRH SAG Liaison (North Carolina); Matthew P. Fricker, Jr., SRH SAG Liaison Alternate (Pennsylvania); Laura C. Wachter, Executive Committee Liaison (Maryland); Michelle Abalos, Staff (Maryland)

Advisory Group on Medication Safety

Deb Saine, Chair (Virginia); Paul F. Davern (Connecticut); Lynn Eschenbacher (North Carolina); Rachel R. Forster (Nebraska); Nancy Granger (Tennessee); Nicole L. Mollenkopf (Maryland); Patricia R. Knowles, Executive Committee Liaison (Georgia); Dale E. English II, Ad Hoc Member (Ohio)

Advisory Group on Publications

Tammy Cohen, Chair (Texas); Norberto A. Alberto (New York); Catherine Christen (Michigan); Sandra C. Hennessy (Massachusetts); Bonnie A. Labdi (Texas); Matthew Levanda (New Jersey); Jacqueline L. Olin (New Jersey); Susan Jean Skledar (Pennsylvania); Min Than (New York); Megan K. McMurray, Executive Committee Liaison (Washington); Dale E. English II, Ad Hoc Member (Ohio); Sharon Park, Staff (Maryland)

Advisory Group on Small and Rural Hospitals

DeeAnn W. Oleson, Chair (Iowa); Timothy P. Stratton, Chair-elect (Minnesota); Debby Lynn Painter Cowan (North Carolina); Paul S. Driver (Idaho); Reginald L. Hain (Nebraska); Rachel Hroncich (New Mexico); Paul K. Moore (Arizona); Bruce Thompson (Minnesota); Allen J. Vaida (Pennsylvania); Debra L. Cowan, SRH SAG/Programming Liaison (North Carolina); Matthew P. Fricker, Jr., SRH SAG/Programming Liaison Alternate (Pennsylvania); Helen M. Calmes, Executive Committee Liaison (Louisiana); Dale E. English II, Ad Hoc Member (Ohio)

Task Force on Advanced Pharmacy Practice Experiences

Debbie Sisson, Chair (Minnesota); Loree G. Allen (Ohio); Beth D. Ferguson (Minnesota); T. Kristopher Harrell (Mississippi); Gerald S. Meyer (Pennsylvania); Justin Welch (North Dakota); Dale E. English II, Executive Committee Liaison (Ohio)

ASHP Section of Pharmacy Informatics and Technology

The Section of Pharmacy Informatics and Technology was formed in November 2006 to identify and address the unique needs of pharmacy departments and the personnel associated with pharmacy activities related to informatics, technology, and automation. An interim Executive Committee was appointed to serve during 2006–2007.

The Section has experienced significant membership growth over the past several months and anticipates more growth as interest and involvement in the Section continue to expand.

The interim Executive Committee held its first meeting at ASHP headquarters in January 2007. The committee developed a strategic plan, defining the mission, vision, and goals of the new Section. The major goals are to

- Demonstrate and communicate the value of belonging to the Section,
- Advocate the development of strategic internal and external partnerships,
- Promote implementation of evidence-based medicine and development of best practice standards for informatics and technology,
- Foster education, training, and development opportunities for Section members,
- Expand awareness of the importance of pharmacy informatics in health systems, and
- Promote opportunities for research in pharmacy informatics.

Specific objectives to accomplish these broad goals were also discussed.

Educational and Networking Opportunities. The Section is assessing member needs in order to guide the development of educational programming and advocacy. The Executive Committee was encouraged by the high attendance at informatics sessions at the 2006 Midyear Clinical Meeting (MCM). Topics being evaluated for future programming are project management, clinical decision support and metrics, health information technology legislative updates, bar-code and radio-frequency identification, and technology implementation in critical care. A 2006 MCM "pearls" session titled Informatics Bytes was very well received and will be repeated at the 2007 MCM.

The Section's monthly electronic NewsLink provides information relevant to pharmacy informatics practitioners and notifies members of opportunities within the Section. In addition, the informatics e-discussion group that has existed for several years is now the Section's e-discussion group and will disseminate information to members.

Section Advisory Groups. The Executive Committee discussed the need for advisory groups and decided to complete the development of the Section's goals and objectives before appointing any such groups. The committee is considering the appointment of three task forces to address the following topics: computerized provider order entry guidelines, Web resources, and bar-code medication administration guidelines. There is an increasing need for pharmacy informatics research to support improved patient outcomes. Many members have also expressed a need for informatics-related education at all career levels (student, entry, midcareer, and management). During a conference call, the Executive Committee will discuss the need for other groups.

Nominations. A Committee on Nominations will develop a slate of candidates for the Section's first elected Executive Committee (2007–2008).

Conclusion. The ASHP Section of Pharmacy Informatics and Technology 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 about carrying its mission forward in an area that is quickly changing the face of health care.

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 Executive Committee has developed a strategic plan linked to the mission and goals of the Section. Those goals include (1) serving as the professional community for pharmacy practice managers, (2) fostering education, training, and development opportunities for managers and leaders, (3) recommending professional policy and advocating on issues of importance, (4) fostering the development of pharmacy managers and leaders, (5) developing resources, tools, and services that support members, and (6) helping members improve adherence to ASHP practice standards and other best practices.

During 2006, the Section added more than 1000 new members, a 13% increase from the previous year. About 45% of the Section's members have selected this group as their primary membership group. In the 2006 elections, the Section's membership elected Steve Rough as Section Chair and Scott Knoer as director-at-large; both will be installed at the June 2007 ASHP Summer Meeting. James Stevenson resigned from the Executive Committee in the fall of 2006 following his election to the ASHP Board of Directors, and Christene M. Jolowsky was appointed to fill the director-at-large vacancy.

Educational Programming. Lisa Gersema chaired the Section's 2005–2006 Programming Committee. Four sessions designed for pharmacy managers and directors were presented at the 2006 Midyear Clinical Meeting (MCM). The topics were strategies for advancing the profession, applying new management principles, communicating with the "C-suite," and Management Pearls. All of these sessions were recorded and synchronized with the presentation slides for posting on the Practice Managers section of the ASHP Web site. The Section also planned and implemented networking sessions on five topics: workload and productivity monitoring, financial management and reimbursement, multihospital systems, the 340B program, and new managers.

For the 2007 MCM, the Programming Committee is planning three sessions, on recruitment and retention, new trends affecting pharmacy, and benchmarking, and is once again coordinating a Management Pearls session.

Networking Opportunities. The Section's electronic NewsLink is distributed biweekly to more than 8000 ASHP members. The NewsLink provides current management and business information, along with research, legislative and regulatory facts, and health policy and health care news. In the Section's e-discussion group (EDG), 800 members exchange information and ideas on a wide variety of topics related to pharmacy management and leadership. The EDG list is also used to communicate urgent information from the Centers for Medicare and Medicaid Services, the Food and Drug Administration, and the Joint Commission.

Section Advisory Groups. Through an assessment of the needs of Section members, the Executive Committee and staff identified five areas in which more information would be useful to Section members. Section advisory groups based in those areas were created, as follows:

- Financial Management and Reimbursement
- Leadership Development
- Management Competencies
- Workload and Productivity Monitoring
- Publications

Executive Committee

Andrew L. Wilson, Chair (Maryland)
Steve Rough, Chair-elect (Wisconsin)
David A. Kvancz, Immediate Past Chair (Ohio)
Christene M. Jolowsky, Director-at-Large (Minnesota)
Scott Knoer, Director-at-Large-elect (Minnesota)
Kathleen S. Pawlicki, Director-at-Large-elect (Michigan)
Sheila L. Mitchell, Board Liaison (Tennessee)
Douglas J. Scheckelhoff, Secretary

Each advisory group has identified areas in which additional information is needed and has then developed two or more projects that support members in their day-to-day practice. For example, the Advisory Group on Financial Management and Reimbursement is writing a series of articles for the *American Journal of Health-System Pharmacy (AJHP)* on chargemasters, developing a financial management survey, creating a reimbursement primer for the Section's Web resource center, and designing a revenue optimization self-assessment tool. In addition, this group held a networking session at the 2006 MCM for discussion of issues such as revenue cycling, financial management for health systems, Medicare Part D billing, chargemasters, and cost control per unit of services.

The Advisory Group on Leadership Development is cultivating resources and tools to promote management and leadership as a career path to students and new practitioners and advance the leadership effectiveness of current directors. To this end, the group is creating an online pharmacy leadership resource center, designing a presentation that affiliated state societies can use to inform students about leadership skill development and management career paths, and developing a career coach column, in a question-and-answer format, for use in the New Practitioner and Student EDGs. In addition, the advisory group is developing ways to create awareness of administrative residencies and summer administrative internship programs.

The Advisory Group on Pharmacy Management Competencies plans to contribute an article to the *AJHP* Management Consultation column outlining steps pharmacists can take to help determine their aptitude for a management position in health-system pharmacy practice. Members of the group are also helping to draft ASHP guidance documents related to pharmacy leadership.

The Advisory Group on Workload and Productivity Monitoring is developing a primer titled "The Effective Use of Workload and Productivity Systems in Health-System Pharmacy." The group also continues to work with companies such as Solucient to ensure that their matrices for measuring pharmacy performance will reflect actual performance and outcomes. The advisory group held a networking session at the 2006 MCM featuring roundtable discussions of peer characteristics, external consultants, closed systems, the impact of technology on pharmacy, productivity measurement, and benchmarking systems.

The mission of the Advisory Group on Publications is to help increase the volume and applicability of publications that enhance and promote administrative pharmacy, primarily through contributing articles to the *AJHP* Management Consultation column. The group is currently identifying topics and potential authors.

Conclusion. 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.

Programming Committee

Todd A. Karpinski, Chair (Illinois); Lance Swearingen, Vice Chair (Minnesota); Ryan Forrey (Ohio); Jennifer B. Jastrzembski (North Carolina); Thomas E. Kirschling (Pennsylvania); Heather Kokko (South Carolina); Audrey T. Nakamura (California); Michael C. Nnadi (North Carolina); Rafael Saenz (Pennsylvania); Ellen Williams (North Carolina)

Committee on Nominations

David A. Kvancz, Chair (Ohio); Scott Mark (Pennsylvania); Paul W. Bush (South Carolina); Toby Clark (South Carolina); Jerry Siegel (Ohio); Donna L. Soflin (Nebraska); Douglas J. Scheckelhoff, Secretary

Advisory Group on Workload and Productivity Monitoring

James R. Rinehart, Chair (Nebraska); Michael R. McDaniel Vice-Chair (Alabama); Steve K. Hetey, Immediate Past Chair (Texas); Adam Bauman (Ohio); Michael J. Brownlee (Oregon); Paul Krogh (Minnesota); Kathleen Moorman (Florida); Luke L. Nigliazzo, Jr. (Texas); Karen Nordstrom (Illinois); Steve Rough (Wisconsin); David A. Kvancz, Executive Committee Liaison

Advisory Group on Leadership Development

Niesha L. Griffith, Chair (Ohio); Christopher R. Fortier, Vice Chair (South Carolina); Phil Brummond (Minnesota); Cyndy Clegg (Washington); Brian A. Cohen (Texas); Douglas E. Miller (Georgia); Keith B. Thomasset (Massachusetts); CoraLynn B. Trewet (Iowa); Jennifer Tryon (Oregon); Sara J. White (California); Steve Rough, Executive Committee Liaison

Advisory Group on Publications

Scott M. Mark, Chair (Pennsylvania); Erin C. Hendrick (Colorado); Michael E. McGregory (Michigan); Michael D. Sanborn (Texas); Sylvia M. Thomley (Wisconsin); Michael Todaro (Mississippi); Douglas J. Scheckelhoff, Executive Committee Liaison

Advisory Group on Financial Management/ Reimbursement

Rita Shane, Chair (California); Anne T. Jarrett, Vice Chair (North Carolina); RoseMarie Babbitt, Immediate Past Chair (Texas); Tammy Cohen (Texas); Fred J. Pane (North Carolina); Kuldip R. Patel (Florida); Gregory Polk (Michigan); Nancy T. Nguyen (California); Kathleen S. Pawlicki, Executive Committee Liaison

Advisory Group on Pharmacy Management Competencies

Douglas A. Miller, Chair (Michigan); Frank Briggs, Vice Chair (West Virginia); Michael F. Powell, Immediate Past Chair (Nebraska); John E. Clark (Florida); Nathan E. Hanson (Kansas); Rosario J. Lazzaro (New Jersey); Robert F. Miller (California); Stephanie C. Peshek (Ohio); Andrew L. Wilson, Executive Committee Liaison

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 is an invited participant in the strategic-planning meetings of the Board and serves as a voting new practitioner member of the ASHP House of Delegates. Each Executive Committee member (except the Chair) heads one of the Forum's four 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 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. (3) Enhance awareness of the Forum's educational resources available to new practitioners and graduating students. (4) Promote utilization of section programs and services as related to new practitioners' practice needs.
2. Cultivate professionalism in new practitioners. *Objectives:* (1) Expand collaboration between Forum members and others in ASHP, including section and Student Forum members. (2) Provide career development tools for new practitioners. (3) Promote new practitioner participation and recognition within the Forum and ASHP. (4) Encourage new practitioner involvement on the state affiliate level. (5) Enhance awareness of the ASHP policymaking process through utilization of new practitioner representatives on ASHP policy committees.
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) Cultivate additional opportunities in ASHP for accomplished new practitioner leaders completing their tenure in the Forum.
4. Promote membership and active involvement in the ASHP New Practitioners Forum. *Objectives:* (1) Actively recruit new members and encourage renewal to existing members of the Forum. (2) Enhance visibility and create greater awareness of the Forum through promotion of its initiatives and the accomplishments of its members.
5. Facilitate greater communication in the New Practitioners Forum. *Objectives:* (1) Foster increased communication among Forum members and other members of ASHP. (2) Apply a variety of communication mechanisms to enhance overall promotion of the benefits and services available to Forum members. (3) Create awareness of the role new practitioners can have in legislative and professional policy advocacy.

Landmark achievements consistent with these goals and objectives in 2006–2007 included the launch of the first conference specifically for new practitioners, Great eXpectations, held September 29–October 1, 2006, in Chicago, and the creation of a one-day educational track for new practitioners at the ASHP Midyear Clinical Meeting (MCM). The Forum was also successful in obtaining funding for the second Great eXpectations conference, to be held this fall.

Forum Advisory Groups. The Forum Executive Committee Chair appoints members to advisory groups in June, placing 48 new practitioners in leadership positions. The advisory groups are charged with providing feedback, guidance, and assistance in achieving the Forum's strategic goals.

- The Membership and Outreach Advisory Group is charged with advancing the objectives set forth in strategic goal 4. This year the group changed its purview to include outreach and has concentrated on increasing personal outreach to improve membership renewal and retention, connecting new practitioners with state affiliates, and helping students transition into the New Practitioners Forum after graduation.
- The Communications and Public Affairs Advisory Group is charged with advancing the objectives set forth in goal 5. Priorities this year included increasing involvement in ASHP grassroots advocacy and public relations efforts, creating a grassroots toolkit, and working with the Student Forum on a legislative "how to" book.
- The Education Advisory Group is charged with advancing the objectives set forth in goal 1. Its priorities were identifying educational programming for the second Great eXpectations conference, to be held in the fall of 2007, and for the MCM.
- The Leadership and Career Development Advisory Group is charged with advancing the objectives set forth in goals 2 and 3. Its priorities were identifying content addressing career development for the New Practitioners Forum column in the *American Journal of Health-System Pharmacy (AJHP)* and exploring opportunities to work with the ASHP Foundation's new Center for Health-System Pharmacy Leadership.

Executive Committee

Helen M. Marshall, Chair (North Carolina)
Christopher R. Fortier, Vice Chair (South Carolina)
Tracie M. Balvanz (Nevada)
Ryan A. Forrey (Ohio)
Margie E. Snyder (Pennsylvania)
Stanley S. Kent, Board Liaison
Jill L. Haug, Secretary

Meetings and Programming. The launch of the first-ever conference specifically for new practitioners, Great eXpectations, 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 four learning tracks: Developing Your Clinical Practice, Teaching and Precepting, Management and Leadership, and Personal Career Development. Attendees also had many opportunities to meet fellow New Practitioners from across the country.

The 2006 MCM offered a variety of programs and opportunities for new practitioners, including participation in the residency showcase and personnel placement service. For the first time, a one-day educational track for new practitioners was offered. The highly attended sessions, planned in cooperation with the Forum, included BPS in the Year 2015: The Role and Value of Specialty Certification, Improving Your Pharmacy and Therapeutics Committee: A Primer for the Newly Appointed Member, and a clinical session titled Drugs versus Bugs: A Concise Review of Key Issues in Anti-infective Therapeutics. Also new this year was a reception for new practitioners immediately after these educational sessions. A networking room was available for new practitioners throughout the meeting, giving them a place to meet with peers in an informal setting. Members of the Executive Committee represented the Forum in the ASHP membership booth at the MCM.

Communications. The Forum has its own area on the ASHP Web site, where new practitioners can find information pertinent to their needs: updates on Forum activities, career development resources, information about leadership opportunities, and a personal message from the Forum Executive Committee. To meet new practitioners' varied needs, the site provides clinical information as well as career development, administrative, and management resources. This section of the ASHP Web site also highlights each of the five members of the Executive Committee and enables Forum members to communicate directly with these Forum leaders.

Forum members receive the twice-monthly electronic NewsLink for New Practitioners, which provides information relevant to recent graduates, communicates deadlines, and encourages greater involvement in the Forum. The NewsLink has succeeded in recruiting new practitioner authors and advisory group members and obtaining profiles of new practitioners to highlight on the Web.

New Practitioners Forum Column. The Forum identifies content for a column in *AJHP,* and most contributing authors are members of the Forum. Topics are selected to meet the career development needs of new practitioners. The column offers new graduates the opportunity to learn about writing for a professional journal and also increases awareness of the opportunities available for new practitioners in ASHP.

College of Pharmacy Outreach. Forum members desire to mentor students and share their experiences with peers. To this end, members of the Forum Executive Committee visited colleges of pharmacy 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.

Volunteers represented the Forum at each of the five regional residency conferences in the spring. This was an opportunity to promote the Forum and encourage peers to become involved in the many opportunities ASHP offers for new practitioners.

Section Collaboration. Members of the New Practitioners Forum share common professional and career development needs, but their varied practice needs are addressed through involvement in ASHP sections. Thirteen new practitioners hold positions on section committees and advisory groups. In addition, one new practitioner serves on the expert panel revising the ASHP Guidelines on Formulary System Management, and another represents ASHP on a panel with the Society of Hospital Medicine and the Joint Commission that is addressing the management of diabetes and hyperglycemia. The Forum is also collaborating with the Section of Clinical Specialists and Scientists to designate new practitioner reviewers for the "virtual journal club."

Virtual Mentoring Exchange. The Forum sponsors the ASHP "virtual mentoring exchange," where new practitioners seek guidance and professional development advice from more experienced practitioners. Use of this members-only ASHP benefit continues to grow; 129 mentors and 240 mentees are currently participating.

Conclusion. The New Practitioners Forum continues to rapidly expand its programs and leadership opportunities. Continuation of the Great eXpectations conference and the one-day MCM educational track demonstrate the commitment of ASHP and the Forum to meeting the unique needs of new practitioner members. The continual creation and provision of career development tools, leadership opportunities, and practice resources and identification of opportunities for collaboration with the ASHP practice sections also show support for this membership group. By meeting their 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.

Membership and Outreach Advisory Group
Tracie Balvanz (Nevada), Christine Corsberg (Tennessee), Teresa Hartkemeyer (Ohio), Melanie Hawkins (Illinois), Jennifer Freeburg-Leonard (California), Katherine Marks (Tennessee), Carolyn Morton (Indiana), Minal Patel (North Carolina), Jennifer Seeley (Idaho), Katie Steffenhagen (Wisconsin), Meredith Toma (Kentucky), Marni Williams (Ohio)

Communications and Public Affairs Advisory Group
Christopher Fortier (South Carolina), Scott Bergman (Illinois), Adam Brothers (Wisconsin), Teresa Cavanaugh (Kentucky), Lauren Decloe (Maryland), Jeffery Evans (Louisiana), Lindy Flatau (Missouri), Amanda Hafford (Ohio), Nausheen Hasan (Maryland), Tomasz Jodlowski (New York), Danielle Patrick (Illinois), Todd Reeder (Virginia), Katie Wilson (Kentucky)

Education Advisory Group
Margie Snyder (Pennsylvania), Julie Altman (South Carolina), Cheryl Amin (California), Jill Bates (North Carolina), Cori Brock (Louisiana), Larry Buie (North Carolina), Molly Graham (North Carolina), Christina Madison (Nevada), Aleshea Martin (Kentucky), Paul Setlak (Illinois), Beth Walter (Oregon), Michelle Zingone (Virginia)

Leadership and Career Development Advisory Group
Ryan Forrey (Ohio), Sarah Boyd (Missouri), Rhiannon Fitzsimmons (Maryland), Jillian James Foster (Mississippi), Maria Giannakos (Ohio), Erin Hendrick (Colorado), Jennifer Jastrzembski (Florida), Kathleen Rottman (Alabama), Jeffery Spray (Virginia), CoraLynn Trewet (Iowa), Kyle Weant (North Carolina), Samaneh Wilkinson (Kansas)

ASHP Pharmacy Student Forum

In 2006, five new members were appointed to the ASHP Pharmacy Student Forum Executive Committee by the ASHP President. The Executive Committee is responsible for advising the ASHP Board of Directors and staff on the overall direction of the Forum, including programs, member services, and activities. The Chair of the Executive Committee is an invited participant in strategic planning meetings of the ASHP Board and serves as the voting student representative to the ASHP House of Delegates. In addition, each Executive Committee member serves as Chair of one of the five Forum advisory groups.

The Executive Committee assists in building relationships between ASHP and the 98 colleges of pharmacy. The colleges are divided among the Executive Committee members, who serve as sources of information to the student society leaders on each campus. Communication is mostly via e-mail.

The 2006–2007 Executive Committee's strategic plan contained six goals: to (1) increase students' knowledge about careers and trends in health-system pharmacy practice, (2) cultivate student professionalism, (3) improve the leadership skills of students, (4) enhance student involvement in the formation of ASHP policies, (5) monitor student membership needs and strive to meet them in ways consistent with ASHP priorities and resources, and (6) enhance collaboration among schools, affiliates, and ASHP in addressing the needs of students with respect to career information, leadership development, and organizational involvement. The five Student Forum advisory groups and the Executive Committee worked on many activities related to these priorities. This resulted in new content for the ASHP Web site, personal visits to colleges of pharmacy, a special Midyear Clinical Meeting (MCM) student leadership session, and several suggestions for enhanced benefits and services for student members.

The Executive Committee devoted attention to the development of a new model for the relationship between ASHP and student societies of health-system pharmacy (SSHP). The new model will have two major components: an SSHP recognition program, and enhancement of ASHP's ongoing communication and interactions with faculty liaisons. The model is intended to achieve better synergy between ASHP and its state affiliates in advancing the development of strong SSHPs and encouraging the pursuit of health-system pharmacy careers.

The ASHP Pharmacy Student Forum continually strives to meet the needs of ASHP pharmacy student members. Forum membership continued to steadily increase in 2006 and now stands at more than 10,300 members.

Forum Advisory Groups. The Forum's five advisory groups were formed to increase the opportunity for student leadership at the national level. Each member of the Forum Executive Committee serves as chair of one of the five advisory groups: Membership, Meetings and Programming, Student Society and Leadership Development, Policy and Legislative Affairs, and Technology and Publications. In 2006, 50 students from the first through fourth professional years were appointed to these advisory groups. They met via conference call in October, and in person preceding the MCM in December. The groups communicate mostly via e-mail. One conference call is planned for spring 2007.

The Meetings and Programming Advisory Group attended and evaluated all student sessions offered at the 2006 MCM, made suggestions for future meeting programming, and discussed how ASHP might provide more venues for students to network and socialize. The Membership Advisory Group provided many suggestions regarding promotional materials, communications from ASHP and between SSHPs, and reaching students in their early years of pharmacy school. The Student Society and Leadership Development Advisory Group planned and implemented the student leadership session at the MCM, offered suggestions to ASHP on meeting specific needs of SSHPs related to communications and national service projects, and recommended strategies for helping student members transition to new practitioner membership. The Technology and Publications Advisory Group provided recommendations for enhancing the ASHP Web site, developing tools to assist SSHPs in branding and standardizing official communications to their members, and increasing communication among SSHPs across the nation. The Policy and Legislative Affairs Advisory Group participated in state legislative conference calls and compiled strategies for SSHPs nationwide to use in planning a successful legislative day in state capitals.

Executive Committee

Kathryn Clark, Chair (Ohio)
Jamie Wilkins, Vice Chair (Maryland)
Brandon Deterding (Mississippi)
Jeffrey Gildow (Nebraska)
Jeremy Hampton (Missouri)
Philip Schneider, Board Liaison
Michelle Bonnarens, Secretary

Clinical Skills Competition. Eighty-six colleges and schools of pharmacy throughout the nation competed in the 11th Annual ASHP Clinical Skills Competition. The national title was awarded to Karen Hembree Spry and Julie Long of the Medical University of South Carolina College of Pharmacy. This two-day national competition was held during the 2006 MCM. The event offered students the opportunity to analyze actual 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.

Meetings and Programming. More than 3100 pharmacy students from around the world attended the 2006 MCM. Students took advantage of the residency showcase, career development opportunities such as CareerPharm's Personnel Placement Service, and a full day of student programming. Programs included three sessions on residency training, a residency panel discussion, resume writing and interviewing tips, a panel discussion of career paths in health-system pharmacy, career roundtables, financial management, clinical pearls for students, drug shortages, asthma and chronic obstructive pulmonary disease, and a student leadership session.

Other MCM highlights included a student poster session and the 12th annual student society showcase, where 31 schools presented posters illustrating the activities of their SSHPs. Participants assessed each other's showcases on the basis of depth and breadth of student activities, poster presentation, and professionalism; this encouraged participants to interact and share ideas for membership promotion and fundraising. The University of Arizona Student Society of Health-System Pharmacy was voted the winner and received a congratulatory letter and a plaque.

Communications. In 2006, each member of the executive committees of the Student Forum and the New Practitioners Forum committed to visiting at least one college of pharmacy to speak to students about ASHP membership, the importance of professional organization involvement, and how to become more engaged in professional activities at the local, state, and national level. Ten executive committee visits were planned for the 2006–2007 academic year. The Student Forum looks forward to continuing this outreach effort and involving more ASHP member volunteers to address students in future years.

The twice-monthly electronic ASHP NewsLink for Students continues to be a well-received mechanism for sharing information. It provides links to online information related to upcoming student deadlines; internship, experiential training, and career development opportunities; student programs; personal growth topics; and other items of interest to students. Student members of ASHP are automatically subscribed to this service as a member benefit.

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. In a competitive process, 12 students nationwide are selected annually; four student members in each professional year of pharmacy school, beginning with the second professional year, receive the award, which consists of a plaque, an ASHP drug information reference library, and a cash award provided by the ASHP Research and Education Foundation, funded through the Walter Jones Memorial Student Financial Aid Fund. The primary objective of the award is to foster continued personal and professional development through a formal recognition program. Secondary objectives are to recognize student leader role models who have an interest in health-system practice and to encourage student involvement in professional organizations.

The 2005–2006 ASHP Student Leadership Award recipients were as follows:

- *Class of 2006:* Katherine Arrogancia, University of California—San Francisco; Judy Kwon, University of Maryland; Ronda Machen, University of Washington; Alexander Wilson, Hampton University
- *Class of 2007:* Kathryn Clark, University of Cincinnati; Christie Coggins, University of South Carolina; Tiffany Moriwaki, University of California—San Francisco; Jariat Oyetunji, University of Kansas
- *Class of 2008:* Troy Drysdale, University of California—San Francisco; Brooke Emmons, University of Mississippi; Andrew Laegeler, University of Houston; Tyler Whisman, University of Kentucky

Student Research Award. The Student Research Award of the ASHP Research and Education Foundation 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 2006 recipients were Patrick J. Kiel, Pharm.D., and Amie D. McCord, Pharm.D., BCPS, who completed their project at Midwestern University in Chicago. The project was titled "Pharmacist Impact on Clinical Outcomes in a Diabetes Disease Management Program via Collaborative Practice."

Experiential Education Program. ASHP offers an elective rotation in national association management. The purpose of the experiential education program is to provide the student 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 undergraduate 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 identifies potential leaders in the pharmacy profession. In the 2006–2007 academic year, ASHP hosted Benjamin Anderson from the University of Minnesota—Duluth and Anna Ginzburg from Wingate University.

ASHP Summer Internship Program. The summer internship is a 10-week training program for a pharmacy student, with 1 week conducted at the ASHP Summer Meeting and 9 weeks at ASHP headquarters in Bethesda, Maryland. The program gives pharmacy students an opportunity to gain association experience in the specific areas of membership development and membership marketing at the national association headquarters and provides an understanding of the importance of pharmacy associations to the profession. In 2006, ASHP selected three summer interns who were based in several areas of ASHP, including membership, government affairs, and public health and quality. The 2006 summer interns were Veena Rajanna from the University of North Carolina, Krissy Vaden from Campbell University, and Esin Kadiev from Temple University.

International Pharmaceutical Students' Federation. As a member-in-association of the International Pharmaceutical Students' Federation (IPSF), ASHP helped to support the coordination of the Clinical Skills Event at the 52nd International Pharmaceutical Students' Federation Annual Congress in Cairns, Australia. It was the eighth year that this event, a workshop to familiarize attendees with the clinical skills competition concept and the logistics of implementing the program, was presented.

Conclusion. The year 2006 was a successful year for the Forum, marked by record membership growth, extensive student involvement, and the development of a plan to strengthen the relationship between ASHP and SSHPs across the nation. The ASHP Pharmacy Student Forum continually strives to meet the service and information needs of student members. This includes increasing awareness of career opportunities within health-system practice, providing information on residency training and other postgraduate education programs, enhancing student involvement in the development of ASHP policies, and encouraging professional development by fostering student involvement in ASHP and state and local health-system pharmacy organizations.

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