



House of Delegates
Session—2012

June 10 and 12, 2012
Baltimore, Maryland

Proceedings of the 64th annual session
of the ASHP House of Delegates
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PAUL W. ABRAMOWITZ, SECRETARY

The 64th annual session of the ASHP House of Delegates was held at the Baltimore Convention Center, in Baltimore, MD, in conjunction with the 2012 Summer Meeting.

First meeting

The first meeting was convened at 1:30 p.m. Sunday, June 10, by Chair of the House of Delegates Gerald E. Meyer. Kathryn R. Schultz, Vice Chair of the Board of Directors, gave the invocation.

Chair Meyer introduced the persons seated at the head table: Diane B. Ginsburg, Immediate Past President of ASHP and Vice Chair of the House of Delegates; Stanley S. Kent, President of ASHP and Chair of the Board of Directors; Paul W. Abramowitz, Chief Executive Officer of ASHP and Secretary of the House of Delegates; and Joy Myers, Parliamentarian.

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

The roll of official delegates was called. A quorum was present, including 197 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 Meyer reminded delegates that the report of the 63rd 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 63rd House of Delegates session were received without objection.

Chair Meyer called on Paul C. Walker for the report of the Committee on Nominations.^a Nominees were presented as follows:

President-elect

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

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

Board of Directors (2012-2015)

John E. Clark, Pharm.D., M.S., FASHP, Manager, Clinical Pharmacare Solutions, Miramar, FL

Kathleen S. Pawlicki, B.S., M.S., FASHP, Administrative Director, Professional Services, Director of Pharmaceutical Services, Beaumont Hospital, Royal Oak, MI

Rita Shane, Pharm.D., FASHP, FCSHP, Assistant Dean, Clinical Pharmacy – UCSF, Director, Pharmacy Services, Cedars-Sinai Medical Center, Los Angeles, CA

Kelly M. Smith, Pharm.D., BCPS, FASHP, FCCP, Associate Dean, Academic and Student Affairs, Associate Professor, Pharmacy Practice and Science, University of Kentucky, College of Pharmacy, Lexington, KY

Chair, House of Delegates

Brian D. Hodgkins, Pharm.D., FCSHP, FASHP, Executive Vice President, Heritage California Accountable Care Org., Coachella Valley & Clinical Operations, Desert Oasis Healthcare, Palm Springs, CA

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

A “Meet the Candidates” session to be held on Monday, June 11, was announced. Chair Meyer also announced the candidates for the executive committees of the five sections of ASHP.

Report of President and Chair of the Board. President Kent 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.

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

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

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

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

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

Lisa M. Gersema, Board Liaison to the Council on Education and Workforce Development, presented the Council’s Policy Recommendations A through G.

A. Preceptor Skills and Abilities

To collaborate with pharmacy organizations on the development of standards to enhance the quality of experiential education and pharmacy residency precepting; further,

To provide tools, education, and other resources to develop preceptor skills.

*B. Qualifications and Competencies Required to Prescribe Medications

To affirm that prescribing is a collaborative process that includes patient assessment, *understanding of the patient’s* diagnoses, evaluation *and selection* of available treatment options, monitoring to achieve therapeutic outcomes, patient education, and adherence to safe and cost-effective prescribing practices; further,

To affirm that safe prescribing of medications, ~~if performed independently or collaboratively,~~ requires ~~a practitioner who is competent and knowledgeable in all these processes, or, if performed collaboratively,~~ requires that competent, ~~interdependent~~ professionals *who* complement each others’ strengths at each step; further,

To explore the creation of prescribing standards that would apply to all who initiate or modify medication orders or prescriptions and that would facilitate development of competencies and training of prescribers; further,

To encourage research on the effectiveness of current educational processes designed to train prescribers.

*C. Qualifications of Pharmacy Technicians in Advanced Roles

To recognize that highly trained and skilled pharmacy technicians working in advanced roles regularly perform complex and critical medication-use procedures, and that a safe and effective medication-use process depends significantly on the skills, knowledge, and competency of those pharmacy technicians to perform those tasks; further,

To reaffirm that all pharmacy technicians should complete an ASHP-accredited training program, be certified by the Pharmacy Technician Certification Board, and be licensed by state boards of pharmacy; further,

To advocate that beyond those requirements pharmacy technicians working in advanced roles should have additional training and should demonstrate *ongoing* competencies specific to the tasks to be performed; further,

To advocate that expansion of pharmacy technician duties into expanded, advanced roles should include consideration of potential risk to patients and that ongoing quality assurance metrics should be established to assure patient safety.

D. *Role of Students in Pharmacy Practice Models*

To encourage pharmacy practice leaders to incorporate students, including those in introductory and advanced pharmacy practice experiences and interns, into active, meaningful roles in new and evolving practice models.

E. *ASHP Statement on the Role of the Medication Safety Leader*

To approve the ASHP Statement on the Role of the Medication Safety Leader.

F. *“P.D.” (Pharmacy Doctor) Designation for Pharmacists*

To discontinue ASHP policy 0217, which reads:

To oppose the use of “P.D.” or any other designation that implies an academically conferred degree where none exists.

G. *Substance Abuse and Chemical Dependency*

To discontinue ASHP policy 0209, which reads:

To collaborate with appropriate professional and academic organizations in fostering adequate education on substance abuse and chemical dependency at all levels of pharmacy education (i.e., colleges of pharmacy, residency programs, and continuing-education providers); further,

To support federal, state, and local initiatives that promote pharmacy education on substance abuse and chemical dependency; further,

To advocate the incorporation of education on substance abuse and chemical dependency into the accreditation standards for Doctor of Pharmacy degree programs and pharmacy technician training programs.

Thomas J. Johnson, Board Liaison to the **Council on Pharmacy Management**, presented the Council’s Policy Recommendations A through H.

A. *Revenue Cycle Compliance and Management*

To encourage pharmacists to serve as leaders in the development and implementation of strategies to optimize medication-related revenue cycle compliance, which includes billing, finance, and prior authorization, for the health care enterprise; further,

To advocate for the development of consistent billing and reimbursement policies and practices by both government and private payers; further,

To advocate that information technology (IT) vendors enhance the capacity and capability of IT systems to support and facilitate medication-related billing and audit functions; further,

To investigate and publish best practices in medication-related revenue cycle compliance and management.

(Note: This policy would supersede ASHP policy 9902.)

*B. ~~Prior Authorization~~ *Payment Authorization and Verification Processes*

To advocate that public and private payers work together and in collaboration with providers to create standardized and efficient ~~prior authorization~~ *strategies for payment authorization and verification processes, such as local and national coverage determinations*, that facilitate communication between patients, providers, and payers prior to therapy; result in timely coverage decisions; and do not disrupt patient care.

*C. *Financial Management Skills*

To foster the systematic and ongoing development of management skills for health-system pharmacists in the areas of (1) health-system economics, (2) business plan development, (3) financial analysis, (4) *metrics for clinical and distributive services*, (5) pharmacoeconomic analysis, (56) diversified pharmacy services, (67) compensation for pharmacists’ patient-care services, and (78) revenue cycle compliance and management; further,

To encourage colleges of pharmacy to incorporate these management areas in course work and ~~clerkships~~ *experiential education*; further,

To encourage financial management skills development in pharmacy residency training programs and new practitioner orientation.

(Note: This policy would supersede ASHP policy 0508.)

*D. *Transitions of Care*

To recognize that continuity of patient care is a vital requirement in the appropriate use of medications; further,

To strongly encourage pharmacists to assume professional responsibility for ensuring the continuity of ~~pharmaceutical~~ care as patients move from one setting to another (e.g., ambulatory care to inpatient care to home care); further,

To encourage the development, *optimization, and implementation* of information systems that facilitate sharing of patient-care data across care settings and providers; further,

To advocate that payers and health systems provide sufficient resources to support effective transitions of care; further,

To encourage the development of strategies to address the gaps in continuity of ~~pharmaceutical~~ *pharmacist patient care services*.

(Note: This policy would supersede ASHP policy 0301.)

E. Value-Based Purchasing

To support value-based purchasing reimbursement models when they are appropriately structured to improve health care quality, patient satisfaction, and clinical outcomes, and encourage medication error reporting and quality improvement; further,

To encourage pharmacists to actively lead in the design and interdisciplinary implementation of medication-related value-based purchasing initiatives.

(Note: This policy would supersede ASHP policy 0708.)

F. Role of Corporate Pharmacist Leadership in Multifacility Organizations

To advocate that a pharmacist must be responsible for leadership and have responsibility for standardization and integration of pharmacy services in multiple business units across the entire pharmacy enterprise of multifacility health systems and integrated delivery networks; further,

To educate health-system administrators about the importance of pharmacy leadership in setting system-wide policy regarding the safe and effective use of medications.

G. Pharmacist's Role in Health Care Information Systems

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

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

To recognize that design and maintenance of medication-use information systems is an interdisciplinary process that requires ongoing collaboration among many disciplines; further,

To advocate that pharmacists must have accountability for strategic planning and direct operational aspects of the medication-use process, including the successful deployment of medication-use information systems.

(Note: This policy would supersede ASHP policy 0921.)

*H. Clinical Decision Support Systems

To advocate for the development of clinical decision support (CDS) systems that are proven to improve medication-use outcomes and that include the following capabilities: (1) *clinical*

decision support, including alerts, notifications, and summary data views, provided to the appropriate people at the appropriate times in clinical workflows, based on (a) a rich set of patient-specific data, (b) standardized, evidence-based medication-use best practices, and (c) identifiable patterns in medication-use data in the electronic health record; (2) audit trails of all CDS alerts, notifications, and follow-up activity; (3) structured clinical documentation functionality linked to individual CDS alerts and notifications; and (4) highly accessible and detailed management reporting capabilities that facilitate assessment of the quality and completeness of CDS responses and the effects of CDS on patient outcomes.

Larry C. Clark, Board Liaison to the **Council on Pharmacy Practice**, presented the Council's Policy Recommendations A through G.

*A. Pharmacist Prescribing in ~~Interdisciplinary~~ Interprofessional Patient Care

To define pharmacist prescribing as follows: *patient assessment and the selection, initiation, monitoring, and adjustment, and discontinuation of medication therapy pursuant to diagnosis of a medical disease or condition; further,*

To advocate that health care *delivery* organizations establish credentialing and privileging processes that delineate the scope of pharmacist prescribing within the hospital or health system and to ensure that pharmacists who prescribe are competent and qualified to do so.

B. Pharmacist's Role in Accountable Care Organizations

To recognize that pharmacist participation in collaborative health care teams improves outcomes from medication use and lowers costs; further,

To advocate to health policymakers, payers, and other stakeholders for the inclusion of pharmacists as health care providers within accountable care organizations (ACOs) and other models of integrated health care delivery; further,

To advocate that pharmacist-provided care (including care coordination services) be appropriately recognized in reimbursement models for ACOs; further,

To advocate that pharmacists be included as health care providers in demonstration projects for ACOs; further,

To encourage comparative effectiveness research and measurement of key outcomes (e.g., clinical, economic, quality, access) for pharmacist services in ACOs; further,

To encourage pharmacy leaders to develop strategic plans for positioning pharmacists in key roles within ACOs.

**C. Pharmacist's Role in Team-Based Care*

To advocate to health policymakers, payers, and other stakeholders for the inclusion of pharmacists as a care provider within team-based care; further,

To recognize that pharmacist participation in interdisciplinary health care teams as the medication-use expert increases the capacity and efficiency of teams for delivering high-quality care; further,

To assert that pharmacists are responsible for coordinating the care they provide with that provided by other members of the health care team and are accountable to the patient and to the health care team for the outcomes of that care; further,

To urge pharmacists on health care teams to collaborate with other team members in establishing quality measures for care provided by those teams.

D. ASHP Statement on the Pharmacist's Role in Medication Reconciliation

To approve the ASHP Statement on the Pharmacist's Role in Medication Reconciliation.

E. New and Emerging Medication Ordering and Distribution Systems

To discontinue ASHP policy 0522, which reads:

To support the use of new and emerging medication ordering and distribution systems (e.g., via the World Wide Web) when such systems (1) enable pharmacists to provide patient care services, (2) ensure that patients will not receive improperly labeled and packaged, deteriorated, outdated, counterfeit, or non-FDA-approved drug products, (3) provide appropriate relationships among an authorized prescriber, pharmacist, and patient, (4) enhance the continuity of patient care, (5) support the pharmacist's role as a patient care advocate, and (6) provide for data security and confidentiality.

F. Role of Pharmacists in Sports Pharmacy and Doping Control

To discontinue ASHP policy 0710, which reads:

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.

G. Pharmacist's Responsibility for Patient Safety

To discontinue ASHP policy 0227, which reads:

To affirm that individual pharmacists have a professional responsibility to ensure patient safety through the use of proven interventions and best practices; further,

To affirm that employee performance measurement and evaluation systems should incorporate measures that support and encourage a focus on patient safety by pharmacists.

Christene M. Jolowsky, Board Liaison to the **Council on Public Policy**, presented the Council's Policy Recommendations A through I.

**A. Pharmacy Technicians*

To advocate that pharmacy move toward the following model with respect to ~~technicians~~ *the evolving pharmacy technician workforce* as the optimal approach to protecting public health and safety: (1) development and adoption of uniform state laws and regulations regarding licensure of pharmacy technicians, (2) mandatory completion of an ASHP-accredited program of education and training as a prerequisite to pharmacy technician certification, (3) mandatory certification by the Pharmacy Technician Certification Board as a prerequisite to licensure by the state board of pharmacy, and (4) licensure of pharmacy technicians by state boards of pharmacy granting the technician permission to engage in the full scope of responsibilities authorized by the state; further,

~~To advocate licensure of pharmacy technicians by state boards of pharmacy; further,~~

To advocate, with respect to certification, as an interim measure until the optimal model is fully implemented, that individuals be required either (1) to have completed an ASHP-accredited program of education and training or (2) to have at least one year of full-time equivalent experience as pharmacy technicians before they are eligible to become certified; further,

To advocate that *all pharmacy functions be performed under the general supervision of a licensed pharmacist and that licensed pharmacists and technicians be held jointly accountable for the quality of pharmacy services provided and the actions of licensed pharmacy technicians under their charge.*

(Note: Licensure is the process by which an agency of government grants permission to an individual to engage in a given occupation upon finding that the applicant has attained the minimal degree of competency necessary to ensure that the public health, safety, and welfare will be reasonably well pro-

tected. Certification is the process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.)

(Note: This policy would supersede ASHP policy 0815.)

B. Opposition to Creation of New Categories of Licensed Personnel

To discontinue ASHP policy 0521, which reads:

To reaffirm the following statement in the White Paper on Pharmacy Technicians (April 1996) endorsed by ASHP and the American Pharmacists Association:

“Although there is a compelling need for pharmacists to expand the purview of their professional practice, there is also a need for pharmacists to maintain control over all aspects of drug product handling in the patient care arena, including dispensing and compounding. No other discipline is as well qualified to ensure public safety in this important aspect of health care.”

Further,

To oppose the creation of new categories of licensed pharmacy personnel; further,

To advocate that all professional pharmacy functions be performed under the supervision of a licensed pharmacist to avoid confusion regarding the roles of pharmacy personnel within health systems.

C. Pharmacy Technicians

To discontinue ASHP policy 8610, which reads:

To work toward the removal of legislative and regulatory barriers preventing pharmacists from delegating certain technical activities to other trained personnel.

D. Collaborative Drug Therapy Management

To pursue the development of federal and state legislative and regulatory provisions that authorize collaborative drug therapy management by pharmacists; further,

To advocate expansion of federal and state legislative and regulatory provisions that optimize pharmacists’ ability to provide the full range of professional services within their scope of expertise; further,

To acknowledge that as part of these advanced collaborative practices, pharmacists, as active members in team-based care, must be responsible and accountable for medication-related outcomes; further,

To support affiliated state societies in the pursuit of state-level collaborative drug therapy management authority for pharmacists.

(Note: This policy would supersede ASHP policy 9812.)

E. Approval of Biosimilar Medications

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

To encourage research on the safety, effectiveness, and interchangeability of biosimilar medications; further,

To support legislation and regulation to allow Food and Drug Administration (FDA) approval of biosimilar medications; further,

To support legislation and regulation to allow FDA approval of biosimilar medications that are also determined by the FDA to be interchangeable and therefore may be substituted for the reference product without the intervention of the prescriber; further,

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

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

To promote and develop ASHP-directed education of pharmacists about biosimilar medications and their appropriate use within hospitals and health systems; further,

To advocate and encourage pharmacist evaluation and the application of the formulary system before biosimilar medications are used in hospitals and health systems.

(Note: This policy would supersede ASHP policy 0906.)

F. Stable Funding for HRSA Office of Pharmacy Affairs

To advocate for a sustainable level of funding, including appropriations, sufficient to support the public health mission of the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs; further,

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

To encourage research on the potential impact of any proposed fees or alternative funding sources for the Office of Pharmacy Affairs.

(Note: This policy would supersede ASHP policy 0911.)

G. Standardized Immunization Authority to Improve Public Health

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

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

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

H. Automated Systems

To discontinue ASHP policy 9205, which reads:

To support the use of current and emerging technology in the advancement of pharmaceutical care; further,

To encourage a review and evaluation of the state and federal legal and regulatory status of new technologies as they apply to pharmacy practice.

I. Medical Devices

To discontinue ASHP policy 9106, which reads:

To support public and private initiatives to clarify and define the relationship among drugs, devices, and new technologies in order to promote safety and effectiveness as well as better delivery of patient care.

Michael D. Sanborn, Board Liaison to the **Council on Therapeutics**, presented the Council's Policy Recommendations A through E.

*A. Criteria for Medication Use in Geriatric Patients

To support medication therapy management, including assessment of physiologic and pharmacokinetic factors, as a central component of providing safe and effective drug therapy to geriatric patients; further,

To oppose use of the Beers criteria *or similar criteria* by the Centers for Medicare & Medicaid Services and other accreditation and quality improvement entities as *an the sole* indicator to assess the appropriateness of prescribing for geriatric patients based on known limitations in the *development of that tool and evidence evaluating the* suggesting a lack of association between

use of medications listed in the Beers criteria and subsequent adverse drug events; further,

To advocate for the development, refinement, and validation of new criteria that consider drug-, disease-, and patient-specific factors and demonstrate the ability to decrease the occurrence of adverse drug events in geriatric patients; further,

To support research to assess the clinical application of existing and proposed criteria, including assessment of their correlation to patient outcomes and strategies for implementation; further,

To encourage inclusion of validated criteria in clinical decision support systems and other information technologies to facilitate prescribing for geriatric patients; further,

To acknowledge that such criteria are intended as a guide and should not replace the clinical judgment of pharmacists and other clinicians.

*B. Medication Adherence

To recognize that improving medication adherence should be a key component of strategies to improve the quality and safety of patient care only when adherence improvement efforts include the following as required elements: (1) assessing the appropriateness of therapy, (2) providing patient education, and (3) ensuring patient comprehension of information necessary to support safe and appropriate use of prescribed therapies; further,

To advocate that pharmacists, because of their distinct knowledge, skills, and abilities, should take a leadership role in multidisciplinary efforts to develop, implement, monitor, and maintain effective strategies for improving medication adherence; further,

To recognize that clinicians, patients, and caregivers share accountability for the outcomes of medication therapies, and that the central role patients and their caregivers have in disease management includes responsibility for following instructions for safe and effective medication use; further,

To encourage development, evaluation, and dissemination of models that improve adherence, including those that combine existing strategies that have demonstrated effectiveness; further,

To discourage mechanisms that inhibit education or lead patients to decline education and clinical information regarding medication therapy; further,

To support the development of mechanisms to document medication adherence interventions, including information technology solutions; further,

To advocate for payment models that facilitate an expanded role for pharmacists in medication adherence efforts.

C. Globalization of Clinical Trials

To encourage the Food and Drug Administration (FDA) to use its existing authority to increase monitoring and inspection of foreign clinical trials to ensure the integrity and quality of those studies; further,

To advocate that the FDA expand its oversight of clinical trials conducted abroad by continuing to pursue innovative strategies, such as increased collaboration with foreign regulatory agencies and changes in domestic regulatory processes that support timely submission of foreign clinical trial information; further,

To encourage the FDA to establish a standardized electronic format and reporting standards that would be required for submission of data from foreign clinical trials; further,

To support the ethical treatment of patients in foreign clinical trials in accordance with international standards designed to protect human subjects; further,

To encourage public and private research to study the impact of the globalization of clinical trials on patient care.

*D. Tobacco and Tobacco Products

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

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

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

To promote the role of pharmacists in tobacco-cessation counseling and medication therapy management; further,

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

(Note: This proposed policy would supersede ASHP policy 0713.)

E. Removal of Propoxyphene from the Market

To discontinue ASHP policy 0723, which reads:

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.

President Kent, on behalf of the Board of Directors, then moved adoption of the policy recommendation from the Section of Clinical Specialists and Scientists, “Board Certification for Pharmacists.” Delegates voted to approve the recommendation.

President Kent, on behalf of the Board of Directors, then moved adoption of the policy recommendation from the Pharmacy Student Forum and the Section of Pharmacy Information and Technology, “ASHP Statement on Use of Social Media by Pharmacy Professionals.” Delegates voted to approve the recommendation, with amendments.

Candidates for the position of Chair of the House of Delegates made brief statements to the House of Delegates. The meeting adjourned at 5:28 p.m.

Second meeting

The second and final meeting of the House of Delegates session convened on Tuesday, June 12, at 4:30 p.m. A quorum was present.

Election of House Chair

Chair Meyer announced the appointment of alternate delegates as tellers to canvass the ballots for the election of Chair of the House of Delegates. Those appointed were Scott Meyers (IL), Jerry Gonzales (CA), and Meghan Davlin Swarthout (IA).

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

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

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

Board of Directors duly considered matters. Pursuant to Bylaws section 7.3.1.1, the Board met on the morning of June 12, 2012, to “duly consider” the amended policies. The Board reported on 13 professional policies that were amended at the first House meeting. The Board presented its recommendations as follows:

Council on Education and Workforce Development, Policy B, “Qualifications and Competencies Required to Prescribe Medications”: The Board agreed that the amended language is acceptable.

Council on Education and Workforce Development, Policy C, “Qualifications of Pharmacy Technicians in Advanced Roles”: The Board agreed that the amended language is acceptable.

Council on Pharmacy Management, Policy B, “Payment Authorization and Verification Processes”: The Board agreed that the amended language is acceptable.

Council on Pharmacy Management, Policy C, “Financial Management Skills”: The Board agreed that the amended language is acceptable.

Council on Pharmacy Management, Policy D, “Transitions of Care”: The Board agreed that the amended language is acceptable.

Council on Pharmacy Management, Policy H, “Clinical Decision Support”: The Board agreed that the amended language is acceptable with editorial changes. As edited, the policy reads as follows:

H. Clinical Decision Support

To advocate for the development of clinical decision support (CDS) systems that are proven to improve medication-use outcomes and that include the following capabilities: (1) alerts, notifications, and summary data views provided to the appropriate people at the appropriate times in clinical workflows, based on (a) a rich set of patient-specific data, (b) standardized, evidence-based medication-use best practices, and (c) identifiable patterns in medication-use data in the electronic health record; (2) audit trails of all CDS alerts, notifications, and follow-up activity; (3) structured clinical documentation functionality linked to individual CDS alerts and notifications; and (4) highly accessible and detailed management reporting capabilities that facilitate assessment of the quality and completeness of CDS responses and the effects of CDS on patient outcomes.

Council on Pharmacy Practice, Policy A, “Pharmacist Prescribing in Interprofessional Patient Care”: The Board agreed that the amended language is acceptable.

Council on Pharmacy Practice, Policy C, “Pharmacist’s Role in Team-Based Care”: The Board agreed that the amended language is acceptable with editorial changes. As edited, the policy reads as follows:

C. Pharmacist’s Role in Team-Based Care

To recognize that pharmacist participation in interprofessional health care teams as the medication-use expert increases the capacity and efficiency of teams for delivering high-quality care; further,

To advocate to policymakers, payers, and other stakeholders for the inclusion of pharmacists as care providers within team-based care; further,

To assert that pharmacists are responsible for coordinating the care they provide with that provided by other members of the health care team and are accountable to the patient and to the health care team for the outcomes of that care; further,

To urge pharmacists on health care teams to collaborate with other team members in establishing quality measures for care provided by those teams.

Council on Public Policy, Policy A, “Licensure of Pharmacy Technicians”: The Board agreed that the amended language is acceptable.

Council on Therapeutics, Policy A, “Criteria for Medication Use in Geriatric Patients”: The Board agreed that the amended language is acceptable with editorial changes. As edited, the policy reads as follows:

A. Criteria for Medication Use in Geriatric Patients

To support medication therapy management, including assessment of physiologic and pharmacokinetic factors, as a central component of providing safe and effective drug therapy to geriatric patients; further,

To oppose use of the Beers criteria or similar criteria by the Centers for Medicare & Medicaid Services and other accreditation and quality improvement entities as the sole indicator to assess the appropriateness of prescribing for geriatric patients based on known limitations in the evidence evaluating the association between use of medications listed in such criteria and subsequent adverse drug events; further,

To advocate for the development, refinement, and validation of new criteria that consider drug-, disease-, and patient-specific factors and demonstrate the ability to decrease the occurrence of adverse drug events in geriatric patients; further,

To support research to assess the clinical application of existing and proposed criteria, including assessment of their correlation to patient outcomes and strategies for implementation; further,

To encourage inclusion of validated criteria in clinical decision support systems and other information technologies to facilitate prescribing for geriatric patients; further,

To acknowledge that such criteria are intended as a guide and should not replace the clinical judgment of pharmacists and other clinicians.

Council on Therapeutics, Policy B, “Medication Adherence”: The Board agreed that the amended language is acceptable with editorial changes. As edited, the policy reads as follows:

B. Medication Adherence

To recognize that improving medication adherence should be a key component of strategies to improve the quality and safety of patient care only when adherence improvement efforts include the following as required elements: (1) assessing the appropriateness of therapy, (2) providing patient education, and (3) ensuring patient comprehension of information necessary to support safe and appropriate use of prescribed therapies; further,

To advocate that pharmacists, because of their distinct knowledge, skills, and abilities, should take a leadership role in multidisciplinary efforts to develop, implement, monitor, and maintain effective strategies for improving medication adherence; further,

To recognize that clinicians, patients, and caregivers share accountability for the outcomes of medication therapies, and that the central role patients and their caregivers have in disease management includes responsibility for following instructions for safe and effective medication use; further,

To encourage development, evaluation, and dissemination of models that improve adherence, including those that combine existing strategies that have demonstrated effectiveness; further,

To discourage practices that inhibit education of or lead patients to decline education and clinical information regarding their medication therapy; further,

To support the development of mechanisms to document medication adherence interventions, including information technology solutions; further,

To advocate for payment models that facilitate an expanded role for pharmacists in medication adherence efforts.

Council on Therapeutics, Policy D, “Tobacco and Tobacco Products”: The Board agreed that the amended language is acceptable.

Pharmacy Student Forum and the Section of Pharmacy Informatics and Technology, “ASHP Statement on the Use of Social Media by Pharmacy Professionals”: The Board agreed that the amended language is acceptable.

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

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

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

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

Chair Meyer recognized Diane B. Ginsburg’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 Meyer then installed the chairs of ASHP’s sections and forums: Lea Eiland, Chair of the Section of Clinical Specialists and Scientists; Steven Riddle, Chair of the Section of Ambulatory Care Practitioners; Lynn Eschenbacher, Chair of the Section of Inpatient Care Practitioners; Kevin Marvin, Chair of the Section of Pharmacy Informatics and Technology; Patricia Killingsworth, Chair of the Section of Pharmacy Practice Managers; Lisa Scherkenbach, Chair of the Pharmacy Student Forum, and Katherine Palmer, Chair of the New Practitioners Forum.

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

Chair Meyer then announced that James A. Trovato had been elected as Chair of the House.

Installation. Chair Meyer installed Kathryn R. Schultz as President of ASHP, Paul W. Bush and Steve Rough as members of the Board of Directors, and James A. Trovato as Chair of the House of Delegates.

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

Adjournment. The 64th annual session of the House of Delegates adjourned at 6:00 p.m.

^aThe Committee on Nominations consisted of Paul C. Walker (MI), Chair; Diane B. Ginsburg (TX), Vice Chair; Kathleen D. Donley (OH); James A. Klauck (WI); Patricia Knowles (GA); Nancy R. Korman (CA); and Jennifer E. Tryon (WA).



Recommendations from the 2012 ASHP House of Delegates

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

Recommendations by Delegates on Sunday, June 10:

1. **Vickie Powell (NY):** *Creation of a Financial Management Skills Certification Program*

Recommendation: ASHP should create a certification program on financial management skills to provide baseline and ongoing competency that is consistent across the health system.

Background: Financial management skills are very important and consistency in training will help assure financial success of the health care enterprise.

2. **Melanie Dodd (NM):** *Updating Terminology in ASHP Policies Referring to "Interprofessional."*

Recommendation: ASHP should replace terms such as "multidisciplinary" and "interdisciplinary" with "interprofessional" in ASHP policies.

Background: The contemporary term that is used to describe multiple professions working collaboratively together is "interprofessional." The term "interdisciplinary" is now used to describe different specialties within a profession working together. The term "multidisciplinary" describes different disciplines working in the same environment, but not necessarily collaboratively. It is recommended that all ASHP policies and statements be reviewed and updated with the contemporary term "interprofessional."

3. **Casey White (TN):** *Transition of Pharmacist Workforce*

Recommendation: ASHP should develop clear, delineated, and implementable guidelines for transition of pharmacists traditionally involved in primarily operational activities to direct patient care roles.

Background: There is a strong movement within ASHP to advance pharmacy technician roles and responsibilities. While this is a favorable stance and must be a long-term goal in health-

system pharmacy practice arenas, there is real danger of a substantial number of pharmacists being left stranded with no clear avenue for role transition. Technician advancement is important, but more important is a well-structured plan for pharmacist transition that would more seamlessly allow for technician advancement.

4. *Allen Flynn (SOPIT): ASHP Certification of the Medication-Use Process in Hospitals and Health-Systems*

Recommendation: The Section on Pharmacy Informatics and Technology recommends that ASHP establish by consensus a medication-use process model with a set of measurable patient-focused criteria for use by ASHP to certify or accredit the medication-use process within hospitals and health systems.

Background: Pharmacists are the medication-use process experts; however, other stakeholders do not universally recognize pharmacy's professional role and responsibility for all aspects of medication-use process, including the management of all medication-use technologies. Further, current efforts to exert positive influence on behalf of the profession within health systems and the technology marketplace are necessary but insufficient, and, as a result, pharmacists continue to practice without the organizational support or the advanced technologies necessary to provide optimum patient care.

5. *Jennifer Tryon, Ian Doyle, Kate Farthing (OR): ASHP Statement on Pharmacy Team Members' Roles in Medication Reconciliation*

Recommendation: ASHP should develop a statement on the roles of pharmacy team members (technicians, students, interns, etc.) in medication reconciliation.

Background: We encourage ASHP to develop an additional statement in support of pharmacy team members (technicians, students, interns, etc.) to advocate, collect data, collect medication lists, and perform other nonclinical functions in the medication reconciliation process. The current statement is specific to the pharmacist's role and should be broadened to encompass the larger pharmacy team.

6. *Dale English II (OH): Patient Medication Education*

Recommendation: ASHP should work with all other interested stakeholders to provide appropriate and accurate information to the general public about their specific rights as patients and the professional obligation of pharmacists to provide them with education about their medications.

Background: Misleading the general public and our patients about their rights for patient education as it pertains to their medications is unequivocally wrong. Patients need to be provided with clear and accurate information that they are signing a document declaring their waiving of rights to medication counseling. We must do everything we can to not condone this

blatant misrepresentation of the facts from occurring. It is in the best interest of our profession and most importantly the best interest of the patients we all serve.

7. *Jennifer Schultz (SICP): Nontraditional Residency Programs*

Recommendation: ASHP should pursue the creation of grants to support nontraditional residency programs and provide a toolkit that demonstrates components of successful nontraditional programs.

Background: Frontline pharmacists who have been established in their practice sites and pharmacists who practice in small and rural settings have limited options for the pursuit of residency training. These pharmacists are requesting access to resources to help them obtain funding for the creation and/or support of nontraditional residency programs. They are also looking for guidance as to how to develop a sound program that will aid in practice advancement.

8. *Jennifer Schultz, Steve Rough, Lynn Eschenbacher (SICP, NC, WI): Centers For Medicare & Medicaid Services (CMS) Language Regarding Pharmacist Credentialing within the Medical Staff*

Recommendation: ASHP should develop a strategy in the form of a toolkit to assist pharmacy leaders in achieving pharmacist credentialing as providers within the medical staff as allowed by the new CMS language.

Background: New CMS language as recognizing pharmacists as providers eligible for inclusion as medical staff within hospitals and critical access hospitals are available. Pharmacy leaders need guidance from ASHP in order to be successful in implementing credentialing and privileging processes within their organizations.

9. *Jennifer Schultz, Steve Rough, Lynn Eschenbacher (SICP, NC, WI): Working within State Boards of Pharmacy*

Recommendation: ASHP should assist state affiliates with strategies for improving relationships and influence with state boards of pharmacy to support practice advancement initiatives.

Background: Many recent CEWD and COPP policies from the Council on Education and Workforce Development and Council on Pharmacy practice will require collaboration with state boards of pharmacy in order to be effectively implemented.

10. *Ken Jozefczyk, Pat Knowles, Megan Freeman (GA): Formation of Multiprofession "Super Boards"*

Recommendation: ASHP should oppose displacement of regulatory and enforcement authority away from state boards of pharmacy.

Background: States, including Georgia, are proposing the creation of “super boards” that have authority for professional licensing and enforcement activities. Pharmacy must retain autonomy for these responsibilities. ASHP should oppose the “super-board” approach.

11. James Hoffman (TN): Communication and Collaboration with Hospital Associations

Recommendation: ASHP should implement a strategy to communicate and collaborate with national and state hospital associations to increase hospital leaders' understanding of contemporary pharmacy services.

Background: Hospital leaders often lack an understanding of pharmacy services, including pharmacists' patient care roles and the value of pharmacy services. Communication and collaboration with hospital associations (and other organizations that hospital leaders are involved in) would enhance hospital administrators' knowledge of contemporary pharmacy practice and facilitate practice model development. The strategy should include equipping state affiliates to work with state associations.

12. Katherine Palmer (NPF): New Practitioners Practicing in Small and Rural Hospitals

Recommendation: ASHP should encourage and facilitate new practitioners to consider practice in small and rural hospitals to help ensure access to direct pharmacist patient care.

Background: Small and rural hospitals comprise a large portion of ASHP's members and are underserved in today's job market while many metropolitan areas are saturated. New practitioners may not be aware of opportunities to work in small and rural hospitals. ASHP should use resources to provide guidance to hospitals to develop programs to recruit new practitioners to practice in these areas. (*Note:* The Oregon and Indiana delegations support this recommendation.)

13. Carrie Sinccak (IL): Development of a Turnkey Technician Training Program for Practice Sites

Recommendation: ASHP should establish a turnkey training program that all pharmacy practice settings can purchase and implement to achieve accreditation at their own practice sites, when technician training accreditation transition to the Accreditation Council for Pharmacy Education (ACPE) has occurred.

Background: There are currently no well-developed and reasonably affordable training resources that pharmacies (hospital, independent or small-chain community, home-care or long-term care) can purchase and implement to establish an institution-specific, accredited training program. ASHP has the staff, talent, and resources to develop such a program, which would create a new revenue stream and improve the level of training and patient care provided by pharmacy departments across the country. Because ASHP is currently the accrediting body, it is not ethical to produce such an available program.

14. Dale English II (OH): Maximizing the Efficiency of the ASHP House of Delegates

Recommendation: ASHP should continue to identify areas of inefficiency and to maximize efficiencies in the current structure, process, function and execution of the ASHP House of Delegates and its associated activities.

Background: The ASHP House of Delegates and associated processes have seen many improvements over the past several years; however, it is important that ASHP continue to work on maximizing all processes associated with the House of Delegates to provide ASHP members with the greatest use of organizational funds. There needs to also be continuous exploration of alternative options to more efficiently allow delegates to the House to be the main governing influence providing overall direction and guiding principles of ASHP.

15. Lisa Scherkenbach (PSF): Student Representation on ASHP Ad Hoc Committees

Recommendation: In consideration of the significant growth in ASHP student membership, ASHP should ensure sufficient representation on any and all existing and future decision-making entities within ASHP as appropriate.

Background: With student membership in ASHP consistently exceeding 10,000, the Pharmacy Student Forum Executive Committee determined that student representation will be integral to the advancement of pharmacy practice. Therefore, students need representation on decision-making entities, including but not limited to the newly formed Board Task Force on Organizational Structure. (Supportive delegations include Minnesota and the New Practitioners Forum.)

16. John Pastor, Paul Krogh, Shane Madsen (MN): Supervision of Pharmacy Technicians

Recommendation: ASHP should, as part of the Pharmacy Practice Model Initiative (PPMI), develop and provide specific tools for pharmacists to improve their ability to effectively supervise technicians.

Background: New and practicing pharmacists frequently feel uncomfortable and inadequately prepared to supervise and provide work direction to pharmacy technicians. Colleges of pharmacy do not generally include this in their curricula, and resident training does not help to close this gap. Because leveraging our technician workforce is critical to the success of the PPMI, these tools are needed by many pharmacists.

17. Diane Fox (TX): Development of House of Delegates Application for Tablets and Laptops

Recommendation: ASHP should develop an application for tablet computers containing all information for the House of Delegates so that it is easily downloaded and updated.

Background: Tablet computers are being used by more professionals. Developing an application that would contain all House of Delegates materials for the meeting that could be easily updated and accessed would help disseminate the information and save many trees.

18. Paul Driver (ID): Consolidation of Immunization/Vaccination Policies

Recommendation: ASHP should review existing ASHP policies on immunization and vaccination (policies 0213, 0601, 0615) for consolidation into the new policy (Council on Public Policy: G. Standardized Immunization Authority to Improve Public Health).

Background: Policies on the ASHP books, with similar content, can create confusion when attempting to advocate a process. Consolidation of policies, where appropriate, will allow for a more concise advocacy.

19. Kerry Haney and Melanie Townsend (MT): Limitations for Pharmacy Benefit Management (PBM) Auditing Practices for Outpatient Pharmacies

Recommendation: ASHP should support regulations to limit PBM auditing practices in outpatient pharmacies, as have other national pharmacy organizations (APhA, NCPA) and several state associations.

Background: The original intent of PBM auditing was to reduce fraudulent practices and waste in outpatient pharmacies. Current auditing practices have been excessive and burdensome to pharmacists and pharmacies and in many cases interfere with patient-care activities. Other national pharmacy organizations (APhA, NCPA) as well as state associations are advocating for regulatory measures to limit current excessive auditing practices and procedures.

20. Brian Marden (ME): Strategic Name Change of Society to Recognize and Foster Greater Engagement of Nonpharmacists

Recommendation: ASHP should consider a change in its name, with resulting changes in scope of mission and vision, from the American Society of Health-System Pharmacists to the American Society of Health-System Pharmacy.

Background: Achieving the highest value in outcomes, within the scope of the pharmacy enterprise, often draws upon the utilization of individuals that are not pharmacists (e.g., pharmacy technicians, pharmacy students, financial managers/analysts, information system specialists, medication safety officers). By changing ASHP's name, we would be boldly affirming the strong value delivered by nonpharmacists and furthermore building a road map to higher levels of engagement of these individuals within the Society. ASHP would have the opportunity to align with current strategic planning efforts in order to appropriately accommodate this name change and bring a higher level of meaning to "Together We Make a Great Team."

21. Brian Marden (ME): *Inclusion of Therapeutic Purpose with All Medication Orders and Prescriptions*

Recommendation: ASHP should consider revisions to policy 0305 with the intent of advocating for mandatory inclusion of therapeutic purpose with all medication orders and prescriptions.

Background: The therapeutic purpose of a medication order or prescription is an essential element required for determination of therapeutic appropriateness, which is mandated by The Joint Commission (TJC) and CMS during the pharmacist review process. TJC's medication management standards require that a therapeutic purpose exists for each medication ordered. CMS, in its Conditions of Participation Surveyor Worksheet for Infection Control, states that "antibiotic order includes an indication for use." There are currently four Hospital Consumer Assessment of Healthcare Provider and Systems (HCAHPS) survey questions focused on the provision of education and patient's understanding of medication purpose in the acute care and home health care settings. Including the therapeutic purpose with all medication orders and prescriptions is critical to ensure access to this essential element throughout the medication-care continuum and thus ensuring safe and effective medication use in addition to optimal patient and family medication education and engagement. ASHP should strengthen its current policy language to be more aligned with the National Association of Boards of Pharmacy's 2001 Resolution, "Medication indication on the prescription," with the aim of being successful in an advocacy effort requiring therapeutic purpose be mandatory with all medication orders and prescriptions.

22. Melinda Throm Burnworth, Carol Rollins (AZ, with CA, NM, MI, NC, NE, and ID):
Pharmacists as Providers with Compensation for Patient-Care Services

Recommendation: ASHP should develop policy to actively pursue legislative changes in the Social Security Act to require CMS to recognize pharmacists as nonphysician practitioners (providers of patient care) with authority to bill Medicare directly for compensation of clinical services in any health-system setting. Further, ASHP should pursue changes in other federal, state, and third-party payment programs to achieve similar recognition.

Background: Currently, ASHP policy 0207, Product Reimbursement and Pharmacist Compensation, references pharmacists as providers. While the intent of the policy is to advocate for pharmacy compensation, the current policy does not sufficiently convey that pharmacists should be viewed as providers and may suggest that pharmacist compensation be intertwined with product reimbursement rather than based on disease state management (i.e., pharmacists as providers).

23. Christina Rivers (IL): *Transition of Technician Training Accreditation to ACPE*

Recommendation: ASHP should continue and accelerate discussions with ACPE to move the Technician Training Accreditation program to ACPE so that all pharmacy-related education accreditation is housed within ACPE.

Background: Currently, ACPE is the accrediting body recognized by the U.S. Department of Education for accreditation of pharmacist professional degree programs, pharmacist continuing education providers, and pharmacy technician continuing education providers. Because the current ASHP pharmacy technician training program accreditation process, rightly or wrongly, is perceived as being a hospital-based training accreditation program, and because ASHP is not recognized by the U.S. Department of Education, it makes sense to move this final educational accreditation process to ACPE.

24. Lynn Eschenbacher (NC, SICP): *Development of National Medication Safety Metrics*

Recommendation: ASHP should re-examine the 2002 Summit on Measuring Medication Safety with recent technological advances and *just culture* to develop a consensus statement of two or three national medication safety metrics to demonstrate safety in hospitals.

Background: The measurement of medication safety is very difficult because there is not one single way to measure. The variation has led to confusion among those involved in medication safety as to what is important to measure, and how. The goal is to define metrics that are meaningful and feasible to collect. Often, what is easy to collect doesn't adequately demonstrate what is intended, but what would be most desirable to measure might take so much effort that it is impossible to collect without overwhelming resources. This is the question most asked by directors of pharmacy and medication safety leaders regarding improvement in medication safety.

25. Jason T. Strow (WV): *Use of Controlled Substance Prescription Databases*

Recommendation: ASHP should consider updating its policies concerning controlled substances to reflect the availability and appropriate use of controlled-substance prescription databases.

Background: Over the past decade, various states have developed controlled-substance databases to assist practitioners in safe and appropriate use of controlled substances by their patients. National consensus has not been reached on how to use these databases in an effective way while ensuring effective pain management and protecting patient privacy. Additionally, in many in health care settings there is minimal uptake due to lack of consensus on and definition of the pharmacist's roles in these endeavours.

26. Jason T. Strow (WV): *Creation of Inpatient Rehabilitation Facility Section Advisory Group*

Recommendation: ASHP should create a Section Advisory Group for Inpatient Rehabilitation Facilities (IRFs) to facilitate best practice development and advocacy for pharmacists practicing in this setting.

Background: IRFs are classified separately by CMS, and their payment models vary widely in many cases from other acute-care facilities. Additionally, measures of quality and other ORYX measures do not follow those of other acute-care hospitals. Typically, IRFs are smaller hospitals

but do not sufficiently fall under the blanket classification of small and rural hospitals. Pharmacy best practices are limited for IRFs due to lack of a single advisory and advocacy group.

27. Melinda Throm Burnworth, Carol Rollins (AZ, with CA, NM, MI, NC, NE, and ID): *Education and Research Related to Pharmacists as Providers of Patient-care Services*

Recommendation: ASHP should investigate opportunities to further strengthen available literature that supports the proven value of pharmacists as providers and to educate and assist pharmacists in their efforts to continue to strengthen available literature to receive compensation for patient-care services.

Background: It is important to continue to support research efforts documenting how pharmacists can improve patient outcomes while reducing health care expenses and to continue to educate pharmacists on how to further strengthen research on the value of pharmacists as providers. At the Phoenix Regional Delegates Conference, there was concern that pharmacists may not be aware of grants available and key research questions to further strengthen the value for pharmacists as patient-care providers (independent of team care).

28. John B. Hertig and Daniel D. Degnan (IN): *ASHP Endorsement of a Medication Safety Credential*

Recommendation: ASHP should further explore and endorse a credential that deems a pharmacist an expert in the field of medication safety.

Background: ASHP has long recognized the value of specialty certification. As medication therapies and the processes surrounding their delivery become more complex, certification -- based on experience, a defined skill set, and psychometrically valid examination -- is needed to assure the public and fellow health care professionals of a level of competence, quality, and consistency among pharmacists specializing in medication safety.

29. Steve Novak (NC): *Formalization of a Resource Center for Revenue Cycle Compliance and Financial Management*

Recommendation: ASHP should expand, update, and improve accessibility of its current website resource offerings under the Pharmacy Practice Managers Section, and then formalize and maintain those as an ASHP resource center for revenue cycle compliance and financial management.

Background: It is becoming extremely difficult for pharmacy directors to ensure regulatory compliance and optimize revenue cycle management. This has been recognized by ASHP with creation of two new policies on revenue cycle compliance and financial management. Resources on ASHP's website on these subjects are difficult to find (under the Section of

Pharmacy Practice Managers/Quality and Compliance Resources/Reimbursement for Drugs), and are not current.

30. Steve Novak (NC): *Development of Drug Enforcement Regulations on Health-System Central-Fill Pharmacies*

Recommendation: ASHP should work with the Drug Enforcement Administration (DEA) to seek revisions in the Controlled Substance Act to develop regulations for health-system central-fill pharmacies that enable centralized repackaging, dispensing, or distribution of all controlled substances to hospitals within a system and do not require registration of hospital or health-system pharmacies as manufacturers.

Background: The current DEA regulations do not recognize central-fill facilities for health-system pharmacies and need to be updated. Central-fill pharmacies within a single health system, but at different addresses, are constrained by DEA regulations that limit repackaging, dispensing, or distribution to 5% of controlled substances or require those pharmacies to register as manufacturers. Advances in technology (e.g., IV robotics, carousel/ADC systems, and remote medication order processing) provide highly efficient systems but are severely restricted by current, out-of-date DEA regulations.

31. Brian O'Neal (KS): *Guidelines for Controlled Substances Diversion Prevention and Detection*

Recommendation: ASHP should create ASHP guidelines for controlled substance diversion prevention and detection.

Background: My travels and conversations with peers have led me to believe that many of our institutions are doing the bare minimum (if anything at all) to detect diversion by nurses, pharmacists, technicians, and physicians. I recommend that ASHP convene a group of experts on the topic to pen guidelines that can educate and guide our peers to ultimately protect our staff and patients. If selected I would like to participate in this effort.

32. Julie Lenhart (CA): *Review of Policy 0710 (Role of Pharmacists in Sports Pharmacy and Doping Control)*

Recommendation: ASHP should review policy 0710 for its continued relevance, and, to specifically expand the section on education to include medications (e.g., over-the-counter [OTC] medications and dietary supplements) that may impact doping control results.

Background: The California delegation believes that this policy is still relevant and should stand alone. The ASHP Statement on the Pharmacist's Role in Substance Abuse Prevention, Education, and Assistance does not adequately address this area. We have pharmacists in California that educate athletes and the public about the use of performance-enhancing medications and prescriptions, OTC medications, and dietary supplements that may impact doping control results.

33. Ernest Dole (NM): Third-Party Payer Accountability for Delay in Therapy

Recommendation: ASHP should develop policy that advocates for accountability by third-party payers for delay in therapy.

Background: Via obstructive processes such as prior authorization, third-party payers are delaying administration or causing the withholding of medications prescribed to patients (i.e., “prescribing by omission”) and should be held accountable. By instituting a process designed for only those sophisticated enough, or who have time enough to navigate a cumbersome process, third-party payers have designed a system in which care is provided only to those who survive attrition of these cumbersome process. The end result is that the third-party payers do not have to provide the medications to their patients, and they should be held accountable for any negative outcomes related to their actions.

34. Jeanne Ezell (TN): Model Curriculum for Technician Training

Recommendation: ASHP should develop a model technician training program curriculum to provide easier access to affordable training throughout the country.

Background: There are not enough ASHP-accredited technician training programs available in the U.S. to provide affordable, convenient training for future or current technicians. A model curriculum could greatly enhance flexibility in training, particularly in rural areas, and consistency in program content. State pharmacy organizations could promote use of the model curriculum in all types of settings and organizations and help accomplish the goal of achieving a well-trained pharmacy technician workforce.

35. Jeanne Ezell (TN): Leadership Development for Technicians

Recommendation: ASHP should implement a leadership development program for technicians focused on management skills needed to fulfill the role of pharmacy operations manager.

Background: As health systems change their practice models, there is a critical need for more technicians to fulfill leadership roles. The pharmacy operations manager role can be ideally filled with technicians who have management skills and abilities, but such individuals are hard to find. ASHP’s Pharmacy Leadership Academy is an excellent model for development of a technician leadership program. Technicians might choose to stay in pharmacy if more management career paths were available.

36. James Rinehart, Kathy Donley (IN, OH): Establishment of Uniform Workload and Productivity Measures for Health-System Pharmacy

Recommendation: ASHP should expand upon the Council on Pharmacy Management’s support of uniform workload and productivity measures and to establish a minimum of three such measures by the time of the 2014 ASHP Summer Meeting.

Background: Evidenced-based, uniform workload and productivity measures that quantify the operational, financial, and clinical value of services provided by health system pharmacists do not exist. This has been a topic of high interest, concern, and importance to health-system pharmacists for many years. It has been reported the Council on Pharmacy Management believes strongly that there is a need to develop measures even if they are not perfect. A minimum of three measures should be established by the 2014 ASHP Summer Meeting.

37. Patricia Kienle and Nastasha Nicol (PA, SC): ASHP: The Organization for Medication Safety Leaders

Recommendation: ASHP should develop an appropriate component group to represent health-system medication safety leaders of all disciplines.

Background: Several commercial entities and organizations are used by medication safety leaders as their primary reference point. A single organization that represents medication safety leaders of all disciplines (i.e., pharmacists, nurses, physicians, risk managers, etc.) would create synergy, standardize position descriptions and resources, and continue to elevate the role of medication safety leaders in organized health care systems.

38. Bonnie Kirschenbaum (CO): Risk Evaluation and Mitigation (REMS) Resource Center

Recommendation: ASHP should continue to fund its REMS Resource Center and keep it updated at least on a monthly basis.

Background: Compliance to REMS is essential as is a centralized repository of information. ASHP should support this resource as a necessary service for its members.

HOUSE OF DELEGATES

Gerald Meyer, Chair

Diane Ginsburg, Vice Chair

Baltimore, Maryland

June 10 and June 12, 2012

FINAL

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Puerto Rico (2)	
Rhode Island (2)	Jonathan Mundy Brian Musiak
South Carolina (3)	Christopher Fortier Natasha Nicol Gregory Nobles
South Dakota (2)	Mark Burggraff Erin Christensen
Tennessee (3)	Jeanne Ezell James Hoffman Casey White
Texas (6)	Lourdes Cuellar Diane Fox Harold Habeger Tricia Meyer Julie Nelson James Wilson
Utah (3)	Melissa Duke Robert Nahoopii Michelle Wheeler
Vermont (2)	Mike Carroll Salvatore Morana
Virginia (4)	Lisa Deal Lisa Hammond Stephen LaHaye Rodney Stiltner
Washington, D.C. (2)	Mary Binghay Michael Edwards
Washington State (4)	Andrea Eberly Janice Hoyt – 2 nd Craig Pedersen – 1 st Steven Riddle Jeffrey Rochon

STATE	DELEGATES
West Virginia (2)	Jason Strow Carol Woodward
Wisconsin (4)	Terry Audley Arlene Iglar James Klauck Steven Rough
Wyoming (2)	Linda Gore-Martin Kirsi Ludwig
SECTIONS AND FORUMS	DELEGATES
Ambulatory Care Practitioners	Pamela Stamm
Clinical Specialists and Scientists	Erin Fox
Inpatient Care Practitioners	Jennifer Edwards-Schultz
Pharmacy Informatics and Technology	Allen Flynn
Pharmacy Practice Managers	Michael Powell
New Practitioners Forum	Katherine Palmer
Pharmacy Student Forum	Lisa Scherkenbach
FRATERNAL	DELEGATES
U.S. Airforce	Christine Tolbert
U.S. Army	
U.S. Navy	Angelica Klinski
U.S. Public Health Service	Cedric Guyton
Veterans Affairs	Julie Groppi

ASHP Board of Directors, 2012–2013

Am J Health-Syst Pharm. 2011; 68:e36



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Professional Policies Approved by the 2012 ASHP House of Delegates

BALTIMORE, MD
JUNE 12, 2012

Am J Health-Syst Pharm. 2012; 69:e30-5

The new professional policies approved by the ASHP House of Delegates at its June 2012 session are listed below. Policies proposed by councils or other ASHP bodies are first considered by the Board of Directors and then acted on by the House of Delegates, which is the ultimate authority for ASHP positions on professional issues.

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

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

1201

Preceptor Skills and Abilities

Source: Council on Education and Workforce Development

To collaborate with pharmacy organizations on the development of standards to enhance the quality of experiential education and pharmacy residency precepting; further,

To provide tools, education, and other resources to develop preceptor skills.

1202

Qualifications and Competencies Required to Prescribe Medications

Source: Council on Education and Workforce Development

To affirm that prescribing is a collaborative process that includes patient assessment, understanding of the patient's diagnoses, evaluation and selection of available treatment options, monitoring to achieve therapeutic outcomes, patient education, and adherence to safe and cost-effective prescribing practices; further,

To affirm that safe prescribing of medications, performed independently or collaboratively, requires competent professionals who complement each others' strengths at each step; further,

To explore the creation of prescribing standards that would apply to all who initiate or modify medication orders or prescriptions and that would facilitate development of competencies and training of prescribers; further,

To encourage research on the effectiveness of current educational processes designed to train prescribers.

1203

Qualifications of Pharmacy Technicians in Advanced Roles

Source: Council on Education and Workforce Development

To recognize that highly trained and skilled pharmacy technicians working in advanced roles regularly perform complex and critical medication-use procedures, and that a safe and effective medication-use process depends significantly on the skills, knowledge, and competency of those pharmacy technicians to perform those tasks; further,

To reaffirm that all pharmacy technicians should complete an ASHP-accredited training program, be certified by the Pharmacy Technician Certification Board, and be licensed by state boards of pharmacy; further,

To advocate that beyond those requirements pharmacy technicians working in advanced roles should have additional training and should demonstrate ongoing competencies specific to the tasks to be performed; further,

To advocate that expansion of pharmacy technician duties into expanded, advanced roles should include consideration of potential

risk to patients and that ongoing quality assurance metrics should be established to assure patient safety.

1204

Role of Students in Pharmacy Practice Models

Source: Council on Education and Workforce Development

To encourage pharmacy practice leaders to incorporate students, including those in introductory and advanced pharmacy practice experiences and interns, into active, meaningful roles in new and evolving practice models.

1205

Revenue Cycle Compliance and Management

Source: Council on Pharmacy Management

To encourage pharmacists to serve as leaders in the development and implementation of strategies to optimize medication-related revenue cycle compliance, which includes billing, finance, and prior authorization, for the health care enterprise; further,

To advocate for the development of consistent billing and reimbursement policies and practices by both government and private payers; further,

To advocate that information technology (IT) vendors enhance the capacity and capability of IT systems to support and facilitate medication-related billing and audit functions; further,

To investigate and publish best practices in medication-related revenue cycle compliance and management.

This policy supersedes ASHP policy 9902.

1206

Payment Authorization and Verification Processes

Source: Council on Pharmacy Management

To advocate that public and private payers work together and in collaboration with providers to create standardized and efficient strategies for payment authorization and verification processes, such as local and national coverage determinations, that facilitate communication between patients, providers, and payers prior to therapy; result in timely coverage decisions; and do not disrupt patient care.

1207

Financial Management Skills

Source: Council on Pharmacy Management

To foster the systematic and ongoing development of management skills for health-system pharmacists in the areas of (1) health-system economics, (2) business plan development, (3) financial analysis, (4) metrics for clinical and distributive services, (5) pharmacoeconomic analysis, (6) diversified pharmacy services, (7) compensation for pharmacists' patient-care services, and (8) revenue cycle compliance and management; further,

To encourage colleges of pharmacy to incorporate these management areas in course work and experiential education; further,

To encourage financial management skills development in pharmacy residency training programs and new practitioner orientation.

This policy supersedes ASHP policy 0508.

1208

Transitions of Care

Source: Council on Pharmacy Management

To recognize that continuity of patient care is a vital requirement in the appropriate use of medications; further,

To strongly encourage pharmacists to assume professional responsibility for ensuring the continuity of care as patients move from one setting to another (e.g., ambulatory care to inpatient care to home care); further,

To encourage the development, optimization, and implementation of information systems that facilitate sharing of patient-care data across care settings and providers; further,

To advocate that payers and health systems provide sufficient resources to support effective transitions of care; further,

To encourage the development of strategies to address the gaps in continuity of pharmacist patient care services.

This policy supersedes ASHP policy 0301.

1209

Value-Based Purchasing

Source: Council on Pharmacy Management

To support value-based purchasing reimbursement models when they are appropriately structured to improve health care quality, patient satisfaction, and clinical outcomes, and encourage medication error reporting and quality improvement; further,

To encourage pharmacists to actively lead in the design and interdisciplinary implementation of medication-related value-based purchasing initiatives.

This policy supersedes ASHP policy 0708.

1210

Role of Corporate Pharmacist Leadership in Multifacility Organizations

Source: Council on Pharmacy Management

To advocate that a pharmacist must be responsible for leadership and have responsibility for standardization and integration of pharmacy services in multiple business units across the entire pharmacy enterprise of multifacility health systems and integrated delivery networks; further,

To educate health-system administrators about the importance of pharmacy leadership in setting system-wide policy regarding the safe and effective use of medications.

1211

Pharmacist's Role in Health Care Information Systems

Source: Council on Pharmacy Management

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

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

To recognize that design and maintenance of medication-use information systems is an interdisciplinary process that requires ongoing collaboration among many disciplines; further,

To advocate that pharmacists must have accountability for strategic planning and direct operational aspects of the medication-use process,

including the successful deployment of medication-use information systems.

This policy supersedes ASHP policy 0921.

1212

Clinical Decision Support Systems

Source: Council on Pharmacy Management

To advocate for the development of clinical decision support (CDS) systems that are proven to improve medication-use outcomes and that include the following capabilities: (1) alerts, notifications, and summary data views provided to the appropriate people at the appropriate times in clinical workflows, based on (a) a rich set of patient-specific data, (b) standardized, evidence-based medication-use best practices, and (c) identifiable patterns in medication-use data in the electronic health record; (2) audit trails of all CDS alerts, notifications, and follow-up activity; (3) structured clinical documentation functionality linked to individual CDS alerts and notifications; and (4) highly accessible and detailed management reporting capabilities that facilitate assessment of the quality and completeness of CDS responses and the effects of CDS on patient outcomes.

1213

Pharmacist Prescribing in Interprofessional Patient Care

Source: Council on Pharmacy Practice

To define pharmacist prescribing as follows: patient assessment and the selection, initiation, monitoring, adjustment, and discontinuation of medication therapy pursuant to diagnosis of a medical disease or condition; further,

To advocate that health care delivery organizations establish credentialing and privileging processes that delineate the scope of pharmacist prescribing within the hospital or health system and to ensure that

pharmacists who prescribe are competent and qualified to do so.

1214

Pharmacist's Role in Accountable Care Organizations

Source: Council on Pharmacy Practice

To recognize that pharmacist participation in collaborative health care teams improves outcomes from medication use and lowers costs; further,

To advocate to health policymakers, payers, and other stakeholders for the inclusion of pharmacists as health care providers within accountable care organizations (ACOs) and other models of integrated health care delivery; further,

To advocate that pharmacist-provided care (including care coordination services) be appropriately recognized in reimbursement models for ACOs; further,

To advocate that pharmacists be included as health care providers in demonstration projects for ACOs; further,

To encourage comparative effectiveness research and measurement of key outcomes (e.g., clinical, economic, quality, access) for pharmacist services in ACOs; further,

To encourage pharmacy leaders to develop strategic plans for positioning pharmacists in key roles within ACOs.

1215

Pharmacist's Role in Team-Based Care

Source: Council on Pharmacy Practice

To recognize that pharmacist participation in interprofessional health care teams as the medication-use expert increases the capacity and efficiency of teams for delivering high-quality care; further,

To advocate to policymakers, payers, and other stakeholders for the inclusion of pharmacists as care providers within team-based care; further,

To assert that pharmacists are responsible for coordinating the care they provide with that provided by other members of the health care team and are accountable to the patient and to the health care team for the outcomes of that care; further,

To urge pharmacists on health care teams to collaborate with other team members in establishing quality measures for care provided by those teams.

1216

Pharmacy Technicians

Source: Council on Public Policy

To advocate that pharmacy move toward the following model with respect to the evolving pharmacy technician workforce as the optimal approach to protecting public health and safety: (1) development and adoption of uniform state laws and regulations regarding pharmacy technicians, (2) mandatory completion of an ASHP-accredited program of education and training as a prerequisite to pharmacy technician certification, (3) mandatory certification by the Pharmacy Technician Certification Board as a prerequisite to licensure by the state board of pharmacy, and (4) licensure of pharmacy technicians by state boards of pharmacy granting the technician permission to engage in the full scope of responsibilities authorized by the state; further,

To advocate, with respect to certification, as an interim measure until the optimal model is fully implemented, that individuals be required either (1) to have completed an ASHP-accredited program of education and training or (2) to have at least one year of full-time equivalent experience as pharmacy technicians before they are eligible to become certified; further,

To advocate that all pharmacy functions be performed under the

general supervision of a licensed pharmacist and that licensed pharmacists and technicians be held accountable for the quality of pharmacy services provided.

(*Note:* Licensure is the process by which an agency of government grants permission to an individual to engage in a given occupation upon finding that the applicant has attained the minimal degree of competency necessary to ensure that the public health, safety, and welfare will be reasonably well protected. Certification is the process by which a non-governmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.)

This policy supersedes ASHP policy 0815.

1217

Collaborative Drug Therapy Management

Source: Council on Public Policy

To pursue the development of federal and state legislative and regulatory provisions that authorize collaborative drug therapy management by pharmacists; further,

To advocate expansion of federal and state legislative and regulatory provisions that optimize pharmacists' ability to provide the full range of professional services within their scope of expertise; further,

To acknowledge that as part of these advanced collaborative practices, pharmacists, as active members in team-based care, must be responsible and accountable for medication related outcomes; further,

To support affiliated state societies in the pursuit of state-level collaborative drug therapy management authority for pharmacists.

This policy supersedes ASHP policy 9812.

1218

Approval of Biosimilar Medications

Source: Council on Public Policy

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

To encourage research on the safety, effectiveness, and interchangeability of biosimilar medications; further,

To support legislation and regulation to allow Food and Drug Administration (FDA) approval of biosimilar medications; further,

To support legislation and regulation to allow FDA approval of biosimilar medications that are also determined by the FDA to be interchangeable and therefore may be substituted for the reference product without the intervention of the prescriber; further,

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

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

To promote and develop ASHP-directed education of pharmacists about biosimilar medications and their appropriate use within hospitals and health systems; further,

To advocate and encourage pharmacist evaluation and the application of the formulary system before biosimilar medications are used in hospitals and health systems.

This policy supersedes ASHP policy 0906.

1219

Stable Funding for HRSA Office of Pharmacy Affairs

Source: Council on Public Policy

To advocate for a sustainable level of funding, including appropriations, sufficient to support the public health mission of the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs; further,

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

To encourage research on the potential impact of any proposed fees or alternative funding sources for the Office of Pharmacy Affairs.

This policy supersedes ASHP policy 0911.

1220

Standardized Immunization Authority to Improve Public Health

Source: Council on Public Policy

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

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

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

1221

Criteria for Medication Use in Geriatric Patients

Source: Council on Therapeutics

To support medication therapy management, including assessment of physiologic and pharmacokinetic factors, as a central component of providing safe and effective drug therapy to geriatric patients; further,

To oppose use of the Beers criteria or similar criteria by the Centers for Medicare & Medicaid Services and other accreditation and quality improvement entities as the sole indicator to assess the appropriateness of prescribing for geriatric patients based on known limitations in the evidence evaluating the association between use of medications listed in such criteria and subsequent adverse drug events; further,

To advocate for the development, refinement, and validation of new criteria that consider drug-, disease-, and patient-specific factors and demonstrate the ability to decrease the occurrence of adverse drug events in geriatric patients; further,

To support research to assess the clinical application of existing and proposed criteria, including assessment of their correlation to patient outcomes and strategies for implementation; further,

To encourage inclusion of validated criteria in clinical decision support systems and other information technologies to facilitate prescribing for geriatric patients; further,

To acknowledge that such criteria are intended as a guide and should not replace the clinical judgment of pharmacists and other clinicians.

1222

Medication Adherence

Source: Council on Therapeutics

To recognize that improving medication adherence should be a key

component of strategies to improve the quality and safety of patient care only when adherence improvement efforts include the following as required elements: (1) assessing the appropriateness of therapy, (2) providing patient education, and (3) ensuring patient comprehension of information necessary to support safe and appropriate use of prescribed therapies; further,

To advocate that pharmacists, because of their distinct knowledge, skills, and abilities, should take a leadership role in multidisciplinary efforts to develop, implement, monitor, and maintain effective strategies for improving medication adherence; further,

To recognize that clinicians, patients, and caregivers share accountability for the outcomes of medication therapies, and that the central role patients and their caregivers have in disease management includes responsibility for following instructions for safe and effective medication use; further,

To encourage development, evaluation, and dissemination of models that improve adherence, including those that combine existing strategies that have demonstrated effectiveness; further,

To discourage practices that inhibit education of or lead patients to decline education and clinical information regarding their medication therapy; further,

To support the development of mechanisms to document medication adherence interventions, including information technology solutions; further,

To advocate for payment models that facilitate an expanded role for pharmacists in medication adherence efforts.

1223
Globalization of Clinical Trials

Source: *Council on Therapeutics*

To encourage the Food and Drug Administration (FDA) to use its existing authority to increase monitoring and inspection of foreign clinical trials to ensure the integrity and quality of those studies; further,

To advocate that the FDA expand its oversight of clinical trials conducted abroad by continuing to pursue innovative strategies, such as increased collaboration with foreign regulatory agencies and changes in domestic regulatory processes that support timely submission of foreign clinical trial information; further,

To encourage the FDA to establish a standardized electronic format and reporting standards that would be required for submission of data from foreign clinical trials; further,

To support the ethical treatment of patients in foreign clinical trials in accordance with international standards designed to protect human subjects; further,

To encourage public and private research to study the impact of the globalization of clinical trials on patient care.

1224
Tobacco and Tobacco Products

Source: *Council on Therapeutics*

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

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

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

To promote the role of pharmacists in tobacco-cessation counseling and medication therapy management; further,

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

This policy supersedes ASHP policy 0713.

1225
Board Certification for Pharmacists

Source: *Section of Clinical Specialists and Scientists*

To support the principle that pharmacists who practice where a pharmacy specialty has been formally recognized by the profession should become board certified in the appropriate specialty area; further,

To recognize the Board of Pharmacy Specialties (BPS) as an appropriate organization through which specialties are formally recognized and specialty pharmacy certification should occur; further,

To advocate prioritization for recognition of new specialties in those areas where sufficient numbers of postgraduate year two residency training programs are established and where adequate numbers of pharmacists are completing accredited training programs to prepare them to practice in the specialty area; further,

To advocate for standardization of credentialing eligibility and recertification requirements to include consistent requirements for advanced postgraduate residency training; further,

To promote a future vision encouraging accredited training as an eventual prerequisite for board certification; further,

To encourage BPS to be sensitive to the needs of current practitioners as prerequisites evolve; further,

To actively encourage and support the development of effective training and recertification programs that prepare specialists for certification examination and ensure the maintenance of core competencies in their area of specialization.

1226
ASHP Statement on the Role of the Medication Safety Leader

Source: *Council on Education and Workforce Development*

To approve the ASHP Statement on the Role of the Medication Safety Leader.*

1227
ASHP Statement on the Pharmacist's Role in Medication Reconciliation

Source: *Council on Pharmacy Practice*

To approve the ASHP Statement on the Pharmacist's Role in Medication Reconciliation.*

1228
ASHP Statement on Use of Social Media by Pharmacy Professionals

Source: *Pharmacy Student Forum and Section of Pharmacy Informatics and Technology*

To approve the ASHP Statement on Use of Social Media by Pharmacy Professionals.*

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

DOI 10.2146/sp120008

ASHP REPORT

*Inaugural address of the President-elect and Vice Chair of the Board***Being the most valuable pharmacist**

KATHRYN R. SCHULTZ

Am J Health-Syst Pharm. 2012; 69:XXX-X

I am very excited about the wonderful opportunity that you have given me to serve as ASHP's next president.

I would like to begin by acknowledging a few key people in my life. First, my family . . . my mom and dad are my number one cheerleaders. They have been wonderful role models for me because of their compassion for others and their desire to make their community a better place to live. Although they could not be here with us today in person, I know they are here in spirit.

I have two sons. John was eight years old when I began pharmacy school, and Patrick was born during spring break of my second year. You can say that they grew up in this profession with me! I love you guys, and I am so proud of you both. Patrick is here with us today.

I'd like to recognize my husband and partner for the past 31 years, Mark Schultz. He is indeed my rock, and Mark, I love you very much.

I want to thank Mary Beth O'Connell and Bruce Scott for being the best mentors and friends that

We all need to be most valuable pharmacists, or MVPs, on our respective health care teams. We need to be MVPs because our patients need us more than ever.



anyone could have. Thanks to Paul Abramowitz for writing a letter of recommendation for me when I was applying to pharmacy school. Who knew we'd end up here together?

To Kevin Colgan, thanks for being so encouraging on my journey. Kevin provided me with the theme of today's address when he encouraged me to run for the ASHP Board of Directors in 2005, saying "You don't get a hit if you don't swing the bat!"

I also thank those who have

preceded me as ASHP president, especially Dan Ashby, Janet Silvester, Cindi Brennan, Lynnae Mahaney, Diane Ginsburg, and Stan Kent . . . all wonderful and caring role models who have welcomed me to the role of ASHP leadership with open arms.

Thanks to my HealthEast Care System pharmacy leadership team members here today, including Jamie Sinclair, my most valued friend and colleague, and Brandon Ordway, Ondrea Levos, Jerry Ja-

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Presented at the ASHP Summer Meeting, Baltimore, MD, June 12, 2012.

The author has declared no potential conflicts of interest.

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DOI 10.2146/sp120003

cobson, and Julie Most. I'd like to welcome my boss, who is here from HealthEast Bethesda Hospital, Lia Christiansen, operations executive, who is so supportive of me and my role with ASHP. I would also like to thank Darrin Ciaschini, our extremely talented clinical manager, who is back home as we expect a Joint Commission survey any day. And a special welcome to three of our HealthEast pharmacy interns: Nicole Grimmer, Bryant Torkelson, and Eric Palm. Thank you all for being here.

To all of my Minnesota friends and colleagues, especially my fellow ASHP board members, Lisa Gersema and Chris Jolowsky, thank you for your friendship and support.

Finally, I want to express my deep gratitude to every member of the ASHP staff—too many to name personally—but I want you to know how much I appreciate all the great work that this high-energy, high-performing team does every day for our members.

Getting from there to here

I'd like to take just a moment to tell you a bit about myself. I grew up in a small town of just over 2500 people called Spooner, Wisconsin. I am fortunate to have been a pharmacy student and practitioner in Minnesota, a great state with a strong affiliate chapter and progressive role models in health-system pharmacy practice.

I am director of pharmacy at Bethesda Hospital, a 130-bed, long-term, acute care facility—one of four hospitals in the HealthEast Care System in St. Paul. Bethesda's slogan is "Reinventing Lives," and this is exactly what we do every day.

We deliver specialized, extended, aggressive medical care through an interprofessional care team model. Our patients have experienced life-changing illnesses or injuries, such as respiratory or multiple-organ failure or traumatic accidents involving spinal cord damage or brain injury, or

they have other very complex medical problems. The average length of stay is 27 days, and our typical patient takes 28 medications. This means that all of our pharmacists need to be at the top of their game.

Of course, we couldn't do what we do without strong relationships. Bethesda Hospital's pharmacy staff are valued members of the care team, which makes our work very rewarding.

The eternal optimist

In addition to being a small-town girl from the Midwest, I'm also an optimist. Today, I'd like to talk to you about two concepts that have optimism at their heart: first, the value of setting a goal and pursuing it relentlessly, and, second, the importance of being the MVP, or most valuable pharmacist, on the health care team.

Baseball, America's pastime, has always been a big part of my family's life. Our sons played everything from T-ball to Babe Ruth League. Since our children were born 10 years apart, my husband and I spent a total of 21 years cheering in the stands. I even had the chance to catch the game at Camden Yards this past Friday night!

I inherited my love for baseball from my mom, who is now 88 years old. Born and raised in Chicago, she used to skip school to watch Cubs games. Today, although she is in poor health, nothing cheers her up more than watching her "Cubbies" play on television. I am a Cubs fanatic as well. If you know anything about baseball, you know that makes me the eternal optimist!

The Cubs started as the Chicago White Stockings in 1876, as one of eight charter members of the National League. I'm sad to say that the last time the Cubs won a World Series was over a century ago in 1908! For those of us who keep on dreaming and rooting for the Cubs, this demonstrates the importance of loyalty and believing in your team, even in bad times.

In preparing for today, it occurred

to me that the baseball metaphor was perfect. We all need to be most valuable pharmacists, or MVPs, on our respective health care teams. We need to be MVPs because our patients need us more than ever.

The numbers bear this out.

Over the past decade, we have seen a rise in preventable adverse drug events. One study of 400 patients at an academic medical center found that close to 20% had adverse events after discharge.¹ Of these, adverse drug events were the most common type—at 66%. Of those adverse drug events, nearly half were preventable, and many could have been avoided with simple medication therapy management strategies.

The costs associated with medication errors and preventable hospital readmissions are stunning. For example, 30-day hospital readmission rates for Medicare recipients run as high as 20% and cost almost \$17.4 billion a year.²

The Agency for Healthcare Research and Quality found that the quality of health care is starting to improve³; yet, far too many patients do not feel that they've had a quality experience in our hospitals.

So what are we missing here?

I believe we are in need of a new level of intensity for how we approach our jobs, how we see patients and patient care, and how we exercise our power to change things for the better. We as pharmacists must step up to the plate, embrace change, and become accountable for the care we provide. We must become MVPs.

On deck: Becoming an MVP

Not all the news is discouraging. There is considerable literature demonstrating how pharmacists improve patient care, reduce costs, and contribute to efficiency.

One meta-analysis of nearly 300 different clinical studies found that when pharmacists provided direct patient care, patients had measurable, favorable effects.⁴ Another study

found that patients treated by teams that included clinical pharmacists had shorter hospital stays and required fewer returns to the intensive care unit.⁵ Yet another study found that when patients were counseled by a pharmacist during the discharge process, readmission rates were much lower.⁶

So the data are clear. When pharmacists are included on the health care team, patients receive better care.⁶

HealthEast's leadership recognizes that pharmacists are uniquely qualified to review and reconcile medication lists—catching problems before they occur—and provide medication teaching at discharge. We have been able to add staff to do this at all four of our hospitals. At HealthEast, pharmacists definitely are MVPs!

Examples of the positive effect of pharmacists in patient care occur every day at my hospital, just like they do at yours.

One of my colleagues, Mark Hay, was reviewing a patient's admission orders. This is no small feat, given that orders for a typical Bethesda patient are often at least 10 pages long. Mark noticed that the admission orders for this patient with endocarditis were missing the antibiotics that would commonly be prescribed. He made sure that appropriate orders were written and that the patient received the needed medications. Mark is an MVP because he took ownership of that patient's medication regimen and made sure no one "dropped the ball."

Another colleague, Tim Dulac, was looking over the International Normalized Ratios for all of his patients on warfarin. He noticed that the laboratory test results were a bit unusual compared to the previous day's reports. He contacted the laboratory, and the laboratory staff determined that there was a problem with the instrumentation, something that even their usual quality checks would not have caught. Tim was re-

cently commended by the Minnesota Hospital Association with a "Good Catch" award for his actions.

Up to bat: Traits of an MVP

If we are going to change patient care for the better, we all must become MVPs on our respective teams, like Mark Hay and Tim Dulac. But how? Clearly, becoming an MVP is not an easy process. It takes years, a complete devotion to your "sport," loyalty to the team, and a number of personal and professional traits that I'd like to share with you.

The first of these traits is that MVPs have a winning mindset. They own both their successes and their failures. MVPs see failures as lessons learned, building on the knowledge of what went wrong to make improvements. In that way, MVPs are both optimists and realists.

MVPs also have an ability to change up the plays. They continually look for innovative ways to contribute to the team. What can you do today to adapt to your changing workplace?

MVPs continue to work on their skills and knowledge of the "game." Ernie Banks, or "Mr. Cub," was the most famous most valuable player in Chicago Cubs history. Ernie was chosen to play in 11 All-Star Games, was twice voted National League most valuable player, and hit 512 home runs during his 19-year career. Ernie's signature phrase, "Let's play two!" showed how much he loved the game.⁷

Ernie never stopped working on his skills and knowledge of baseball. In the same way, we need to continually show our love of pharmacy by being lifelong learners, like Ernie. And isn't that what we are doing here this week?

MVPs are good sports. When my sons were small, one of the hardest things to teach them was to be positive and supportive of the opposing team, even if you fail to win. I think we all struggle with that, even

as adults. If we are "good sports" as MVPs, we know that we will have some setbacks, but we will keep focused on what's important: our patients.

MVPs keep their cool. As a society, we don't typically admire athletes who throw tantrums. We instead look up to the players who remain calm under pressure, but this doesn't mean you shouldn't be passionate about what you do. It does mean that you should strive to maintain your balance when you get thrown a curve ball.

MVPs take care of their team. They motivate fellow team members, inspiring others to take action. Ernie Banks was quoted as saying, "Awards mean a lot, but they don't say it all. The people in baseball mean more to me than statistics."⁸ No matter what your position is, be sure that the people who are on your team know that they are valued.

Finally, MVPs know how important fans are to the game. As pharmacists, we have a number of different stakeholders in our "stands," the most important being our patients. We must make fans out of our patients and their families. Every patient who comes into the hospital needs to know that pharmacists are there and ready to improve their health care.

At Bethesda, we developed a meet-and-greet program for all patients newly admitted to our hospital. Our interns introduce themselves to patients and families and describe our pharmacy services. We want all patients to know the important work that the pharmacy staff does for them.

We also must make fans out of fellow health care providers and the corporate suite. We can't take for granted that administrators know who we are, what we do, and the value that we bring to the team.

We need to educate them! That is how we were able to hire new pharmacists to perform medication

reconciliation at HealthEast. ASHP is building stronger connections to health care executives at an organizational level, but we all must do our part in our own settings.

Finally, we must make fans out of legislators and regulators, because they influence pharmacists' scope of practice. Our ability to do all we can for patients is directly connected to laws and regulations. One way to make sure your legislators understand pharmacists' value is to invite them to your work site. Once they see you in action and what you do for patients, they will become your biggest fans.

“Put me in, coach. I’m ready to play!”

I’ve laid out a case for the importance of becoming the MVP within your institution. Now, how will you become an MVP?

First, I believe we all need to realize that with our experience, our unique skills and knowledge, and our passion for patient care . . . we are ready to play. We can’t wait for validation by other people to get into the batter’s box.

Whitney award recipient Bill Zellmer, ASHP’s longtime deputy executive vice president, had a profound way of saying step up to the plate when he said: “We can lead the change that we believe in, or we can just position ourselves to be forced to accept the change being put on us by others.”⁹

Here are six specific suggestions to help you on your path to becoming an MVP:

1. *Ask for duties outside of your comfort zone.* Every pharmacist at Bethesda is a registered preceptor. This was a big step for some, but they all play a part in educating our future practitioners, and they do a great job.
2. *Track your interventions to see how you are improving patient care.* Share this information with your administrative team to demonstrate that pharmacists

3. *Continually develop and refine your capabilities and skills.* Practitioners, seek more education in an area that you really love or where you need to strengthen your skills. As you gain experience, it’s important to differentiate yourself and your skills. One effective way to do that is to pursue specialty certifications. ASHP has long been an advocate in this realm, sponsoring review courses and recertification programs on its own and with other pharmacy organizations. Students, complete a residency. You’ll sharpen your critical thinking skills as part of an interdisciplinary team, and you’ll be exposed to the different facets of pharmacy practice.
4. *Build and manage your team.* ASHP’s vision is that by 2020, all new pharmacists providing direct patient care will have completed an accredited residency. Did you know that more than 4200 pharmacy students and new practitioners participated in ASHP’s Resident Matching Program this year? I’m so encouraged to see this professionwide move to residency training because it will produce better pharmacists and improve patient care. If your practice site does not currently have a residency program, it’s time to get into the game. For those of you who may already manage a residency program, I urge you to expand it to its fullest capacity. ASHP is working hard to help meet the capacity demands for residency training, but the bulk of the effort must come from our team members in hospitals and health systems.
5. *Seek leadership opportunities within your practice setting, with your state affiliate, and with organizations like ASHP.* There is no better way to expand your horizons than to network with others.
6. *Embrace practice model change.* No matter what your job or the size of your hospital, there is so much we can all do to determine where our practice gaps are and begin to close them. When we have full adoption of the Pharmacy Practice Model Initia-

tive, we will be able to say we’ve hit a home run.

Concluding remarks

I challenge each of you to step up to the plate for better patient care. Remember that MVPs have a winning mindset. They are optimistic in the face of difficult odds and work hard to make sure that they have the skills and knowledge to make the best plays at the right time.

MVPs care passionately about what they do. And they understand that fans are always watching and rooting for their success. It isn’t easy, but it is a highly rewarding role to play.

As my dear friend and ASHP Past President Diane Ginsburg said, “We, as pharmacists, are a blessed and privileged few. We must use our power to improve pharmacy practice and better serve those who are under our care.”

I challenge each and every one of you to become an MVP. What is the one thing that you can do when you get back to work to become an MVP? That one base hit can be the start of a cascade of events at your practice site that leads to a grand slam in terms of patient care. It is time to knock it out of the park for our patients—they deserve nothing less.

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ASHP REPORT

Strategy and mission: ASHP's focus on the future

STAN KENT

Am J Health-Syst Pharm. 2012; 69:eXX-X

As I conclude my presidential year, I want you to know what a great honor it has been to serve the Society. I especially want to acknowledge and thank all of you in this House of Delegates for your involvement and commitment to our organization and profession.

As I look back over my term in office, I am amazed at what a busy year it was. We began to roll out tools and resources for members to apply the recommendations of ASHP's Pharmacy Practice Model Summit; as an organization, we started to come out of the grip of the recession; we achieved some significant advocacy victories; and, as we approach ASHP's 70th anniversary this August, it is notable that we'll do so with a new chief executive officer (CEO) in place.

On Tuesday, you'll hear from Paul Abramowitz in his new capacity as ASHP's CEO. But I think it is appropriate to reflect on the successful outcome of the historic decision that the Board and its search and screen committee made.

As Paul will no doubt attest, taking the helm of a venerable institution such as ASHP is no easy task. But, for those of you who know Paul, you know that he doesn't shrink from a challenge and his previous

Whether it is the policy on pharmacist prescribing, the need for state board licensure of pharmacy technicians, or the recommendation that pharmacists practicing in specialty areas become board certified, we are seeing policy born out of the need for practice model change.



accomplishments in pharmacy attest to that.

Paul comes to ASHP with an impressive diversity of experience and accomplishments. In addition to being a former chief pharmacy officer and associate hospital director at the University of Iowa Hospitals and Clinics and a tenured professor at the University of Iowa College of Pharmacy, Paul served as ASHP's 50th president and as treasurer. All of this makes Paul uniquely positioned to understand the needs of ASHP members. He is truly a practitioner, with 34 years of experience working in hospitals and health systems. He

understands all aspects of pharmacy practice and has creativity and a real talent for motivating staff to do the best work they can for ASHP and its members.

Paul hit the ground running in January, and he hasn't looked back. These days, you'll often find Paul in the hallways at headquarters, conversing with staff and stimulating activity. You will also see Paul attending state society meetings, visiting our members at their practice sites, and bringing what he hears back to ASHP to help us continue to shape our services to match your needs.

Paul will share more with you

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Presented to the ASHP House of Delegates, Baltimore, MD, June 10, 2012.

The author has declared no potential conflicts of interest.

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about his personal goals for what ASHP can achieve in the next 5–10 years. But I can tell you that in the short span that Paul has been at the helm, he’s already set the tone and direction for a future that takes ASHP and the practice of pharmacy to an even higher level. He has made a real impact on ASHP members, staff, and other pharmacy organizations. I’m looking forward to hearing his perspective on the first six months in the job.

Strategic plan

In April, the Board and key staff members participated in a special strategic planning exercise. We took a fresh look at ASHP’s professional priorities and the kinds of new revenue development initiatives that could support ASHP’s mission-driven activities.

We started with a variety of assumptions about the future, based on the kinds of environmental scans that ASHP conducts on a regular basis. These assumptions focused on the pharmacy work force, the nation’s health care delivery system, payment system and health care expenditures, the current and near-future political environment, and the pharmaceutical supply chain.

We also took into consideration what members have told us about the types of products and services they need from ASHP to help them be effective practitioners. It was especially nice to have the chairs of our Sections and Forums at the retreat, as they offered a unique perspective from the practice areas they represent.

We talked about a lot of factors affecting practice today, including the increasing professionalization and changing roles of pharmacy technicians, the growing number of pharmacists who will be providing direct patient care services in primary and ambulatory care clinics, the move toward interprofessional team-based patient care, and the increasing number of pharmacists who are complet-

ing residencies and becoming certified in pharmacy specialties.

We discussed unmet member needs and talked about new products and services that ASHP could provide its members to help address those needs. The retreat was a good reminder that in order for ASHP to continue to provide the vast array of services that it does for its members, we must continue to innovate and develop new products that help support the membership mission.

The two-day retreat was incredibly productive, and breakout groups made a variety of recommendations to support new concepts for our organization’s vision. Once the Board approves the new vision this summer, we will create a new ASHP strategic plan.

We are approaching this exercise in a rational, methodical way to ensure that our strategic priorities capture and reflect ASHP’s best thinking in terms of where practice is moving and what members can expect to receive from their professional organization. When the new strategic plan is finalized, we will share it broadly with members to enhance transparency about what ASHP is doing for members on a daily basis and to work with members to make the strategic plan a reality.

Update on the Pharmacy Practice Model Initiative

One of ASHP’s greatest strategic priorities today is to provide our members with the help they need to meet the recommendations set forth at the Pharmacy Practice Model Summit. At its heart, the Pharmacy Practice Model Initiative (PPMI) aims to ensure that pharmacists are positioned and recognized as the health care professionals who are accountable for medication-use outcomes.

Member involvement in translating the Summit recommendations into practice is critical to achieving practice model change, and ASHP

and the ASHP Research and Education Foundation are working hard to create the kinds of tools and resources that help members do just that. For example, this year, we partnered with the Pharmacy Society of Wisconsin to develop the Hospital Self-Assessment (HSA) tool, which allows each hospital to determine where practice and care gaps exist and to develop a list of priorities. We also created a National Dashboard that aggregates data from hospitals across the country via ASHP’s national survey to help members measure their own progress.

We want all hospital pharmacy departments in every institution in this country to take the HSA. I am pleased to report to you that more than 500 hospitals have completed the HSA, and many others have started the process. That is a great start, and we expect to see this number grow rapidly. We have to know where the patient care gaps are before we can begin to close them, so I ask all of you to make sure that your hospital has completed the HSA and to work with your state affiliate to encourage others to complete it as well.

Another tool that will help members serve the most complex patient cases is on the way. Over the past year, ASHP and the ASHP Research and Education Foundation convened an interdisciplinary panel to recommend what should be included in a patient complexity index. Once developed, this index will enable pharmacists to prioritize hospitalized patients who require more intensive, pharmacist-provided drug therapy management. This summer, the Foundation will be requesting proposals for the development and initial testing of the index.

An important piece of this equation, of course, is the availability of a well-qualified and competent pharmacy technician work force. ASHP continues our partnership with state affiliates as part of our Pharmacy Technician Initiative, advocating for

a single standard for accredited training, certification, and recognition by state boards of pharmacy.

Finally, we are gathering case studies from members across the country who have successfully implemented one or more PPMI recommendations within their institutions. The first of these case studies has been posted on the PPMI website, and they are truly some of the most inspiring stories you'll ever read about how to affect real, permanent change that improves patient care. I urge you to take a look at the website (www.ashpmedia.org/ppmi/index.html) and share what you find with your colleagues.

Accountable Care Organization Task Force

One of the assumptions we used in our strategic planning retreat was that more and more pharmacists in health systems will be working in ambulatory care settings in the future. We believe that the demand for pharmacists who are residency trained and board certified will be high in clinic settings and that the number of pharmacists who are providing direct patient care services in primary care settings will grow quickly. Interprofessional, team-based patient care will be the primary mode of health care delivery in outpatient settings.

ASHP as an organization, as well as our membership, must be ready for this evolution. We have to be poised to offer the kinds of services and resources that members who practice in these environments require.

Accountable care organizations, or ACOs, are the new vehicles for delivering team-based care. Health systems and physician groups across the country are working to create ACOs that improve patient outcomes and reduce health care costs. Because medication and chronic disease management are cornerstones of this process, pharmacists are perfectly

positioned to help meet this challenge.

Later this summer, ASHP will convene an ACO Task Force to identify opportunities for and potential barriers to pharmacy involvement in this care model.

Specifically, the task force will study how pharmacy can enhance its contribution to patient care in the ACO model, reimbursement issues, examples of successful ACOs (including how pharmacy programs are implemented), and how ASHP can support pharmacists in these models.

Watch the ASHP website for more information as the task force begins its important work.

Work-force issues

You know, I often hear from young practitioners about their worries about the job market and the economy. With so many students who have just graduated and most residents finishing their positions at the end of June, the ability of the job market to absorb new practitioners is, understandably, "top-of-mind." An economy slowly coming out of a recession combined with a growing number of new graduates has created new pressures for pharmacists seeking positions. While we continue to see more pharmacy graduates each year, we also see some growth in pharmacist positions in hospitals, as well as growth in residency positions.

ASHP has made expanding the number of residency positions a high priority, and we've done several things to promote residencies over the past few years. The PPMI has laid out a vision for residency capacity expansion to help improve services to patients while preparing our work force for the future.

We have continued to advocate for the expansion of residency programs after hosting a Pharmacy Residency Capacity Stakeholder's Conference in February 2011. A Commission on Credentialing retreat in March also

focused on ways to facilitate increasing the number of residency positions, including allowing new training models that would accommodate more residents at each site.

In terms of tools and resources, we created a new preceptor skills development resource center on ASHP's website, and we provide online learning modules to help members understand ASHP's accreditation standard for residency training. A new tool, called RUPReady, can be used by hospitals and health systems to either launch new residencies or prepare for an ASHP accreditation visit.

The Accreditation Services Division continues to offer workshops at our major meetings, including this Summer Meeting, about the process of starting and growing residency programs. And our National Residency Preceptors Conference this August has specific programming on residency expansion.

This year, we are also launching a new Web-based residency application tool, called PhORCAS, that streamlines the residency application process, similar to the Pharmcas system for applying to pharmacy schools. It will allow residency programs to prescreen applicants for eligibility and electronically track the application process, allowing applicants to submit just one online application that is then disseminated to multiple programs.

The ASHP Research and Education Foundation, with the help of funding from Amgen, has developed Pharmacy Residency Expansion Grants for postgraduate year 1 (PGY1) and postgraduate year 2 (PGY2) residency programs across the country. This year, 16 grants of up to \$40,000 each were awarded to institutions from Maine to Hawaii.

This concentrated effort, together with our continuing advocacy with members and health systems to expand capacity, is having an effect. The results of the 2012 ASHP Resident Matching Program are

particularly revealing. More than 4,200 graduating pharmacy students and new practitioners participated in “The Match” this year. We saw an 11% increase in filled PGY1 positions and a 15% increase in the number of filled PGY2 positions. My hope is that one day we will have enough residency positions so that every pharmacist who wants to complete a residency will be able to do so.

In terms of work-force capacity, ASHP continues to support our new pharmacist members by offering educational sessions on networking, resume development, and job interview skills. At this meeting, we are also offering a session on leadership development skills to help prepare new practitioners to lead the profession into the future. ASHP is absolutely committed to doing what

we can to help our youngest practitioners find jobs, establish residencies, and foster new health care roles.

Conclusion

Although what I’ve reported on here today is by no means an exhaustive list of all ASHP’s initiatives over the past year, it should give you a sense of our priorities and the many ways in which ASHP works to support health-system pharmacists and improve patient care.

Your work here marks the culmination of a yearlong deliberation over policies inspired by PPMI Summit recommendations. Whether it is the policy on pharmacist prescribing, the need for state board licensure of pharmacy technicians, or the recommendation that pharmacists practicing in specialty areas become board

certified, we are seeing policy born out of the need for practice model change.

This is both a challenging and exciting time to be a health-system pharmacist. It is even more exciting to be a part of this House of Delegates and to lead policy change for the profession. There is no organization in the world that does more to encourage safe and effective medication use than ASHP, and I hope that you are as proud as I am to be a part of this work.

This past year has been an awesome personal and professional experience, and a humbling privilege! Thank you for allowing me to serve as your president.

2012 Report of the Chief Executive Officer

Beginning a new era: Building on the past and changing for the future

PAUL W. ABRAMOWITZ

Am J Health-Syst Pharm. 2012; 69:eXXX-X

I am so happy to be standing here before you today as ASHP's new chief executive officer (CEO). While I have been extremely busy, it has also been enjoyable and energizing, and I wish to convey my thanks to all of you for putting your trust in me.

First, however, I would like to introduce several distinguished people, and I'm going to ask them to please stand and be recognized. We have with us Joseph Oddis, who served as ASHP's second CEO, and Henri Manasse, who served as our third CEO. I would like to acknowledge the assistance and guidance that they have provided to me.

I would also like to introduce Mr. Chris Jerry, CEO of the Emily Jerry Foundation. This foundation was established in the memory of Chris's daughter, Emily, whose death was due to a tragic medication error. His foundation is dedicated to improving the medication-use system, with particular emphasis on enhancing the education, training, and certification

While ASHP remains a strong organization with a growing membership and reputation for quality and integrity, we must keep pace with the changing times.



of pharmacy technicians.

My first six months at ASHP have proven to be incredibly exciting and informative, both from an organizational and a professional point of view. I have been busy meeting with ASHP staff members, listening to their ideas, concerns, and thoughts on how to take ASHP forward into the future.

I have also made it a priority to get out and visit with our state affiliates

to do the same. The power we hold as an organization is generated through the relationships that we have with each other. At both the national and state levels, we have shared values and goals, and we support and nurture each other.

To ensure that I have a finger on the pulse of our state affiliates, I plan to visit at least five state societies by the end of my first year and, by doing so, meet and listen to many of

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Presented to the ASHP House of Delegates, Baltimore, MD, June 10, 2012.

The author has declared no potential conflicts of interest.

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our members across the nation. I believe that nothing can fully replace a personal bond and relationship to enhance what we can achieve.

I have also spent considerable time since September meeting with the chief executive officers of our partner national pharmacy organizations to collaborate and work toward our many shared goals. In addition, I have been meeting with the CEOs of other health care organizations and will continue to do so.

As President Stan Kent mentioned, we have begun the process of developing a new integrated strategic plan for ASHP. In addition, we recognize that to succeed as a professional society and meet the mandate of our members and the profession, we must develop new products that both enhance our ability to provide care and generate the financial capability to provide the services our members need and desire. We held a strategic planning retreat with the Board and staff in April to focus on these important topics.

Changing to achieve the vision

This Summer Meeting, like all ASHP educational meetings, highlights the very real value that pharmacists bring to patient care. We, as a profession, are on the cusp of true change.

Because of this, we have to prepare ourselves to provide care consistently and comprehensively to all patients. We need to work to close the patient care gaps that exist in medication use today. And we have to embrace a future that will place us both at the bedside and in the clinic, face-to-face with our patients.

To achieve this, the elements and provision of services outlined in ASHP's Pharmacy Practice Model Initiative must become universal in all hospitals, health systems, clinics, and ambulatory care centers. Collaborative practice must evolve even further to capitalize on the pharmacist's therapeutic expertise. Furthermore,

pharmacists must achieve provider status with all payers so that we are recognized for what we contribute to patient care and are able to provide the services that our patients desperately need. This will take the collective power of all of our national pharmacy organizations and other health care partners, as well as public support.

I am pleased to share that, just last month, the Centers for Medicare and Medicaid Services (CMS) made a change that allows hospitals to include pharmacists on the medical staff as nonphysician practitioners to practice in accordance with state laws. ASHP lobbied CMS for this change, and this significant step will add additional credibility to the role of pharmacists as members of interdisciplinary patient care teams. This will help us in our long-term advocacy to have Congress amend the Social Security Act and add pharmacists to the list of practitioners recognized by CMS to provide services and receive payment.

To support this and other elements of practice change, patients will need to better understand what we do as pharmacists and insist that their health care teams always include a pharmacist. To help achieve this shift in our nation's health care system, ASHP must continue to work to increase public awareness of the pharmacist's role. ASHP has been working hard to do just that. We have been building strong relationships with the media; as a result, ASHP is consistently quoted in news articles about many medication-related issues.

Our public service announcements have reached millions of people and continue to be heard on the radio today. We've made great strides, but there is still more to do.

ASHP can help us meet all of our goals by changing and evolving to ensure that we support the needs of all of our members, from those working in 25-bed critical access

hospitals in rural and small communities to those in 1000-bed hospitals in cities. We also must be positioned to assist members who practice in ambulatory care clinics of all sizes, which may become the fastest growing segment of our membership. Our goal is for ASHP to become the association to which ambulatory care clinic pharmacists turn to meet their professional, advocacy, and educational needs.

Drug shortages

President Kent discussed how ASHP has been working very hard to solve the national problem of drug shortages. We have seen shortages in all drug classes. These shortages have been especially problematic for anticancer drugs, anesthesia agents, and critical care drugs, among others.

We are concerned on a number of fronts. The shortages are putting some of our most vulnerable patients at risk for serious complications or even death. They are contributing to medication errors, as health care staff sometimes are forced to use unfamiliar products. And shortages are forcing pharmacy departments across the country to spend an inordinate amount of time seeking drug supplies, determining therapeutic alternatives, and even rationing, taking time away from providing other necessary care.

This continues to be a problem. Unfortunately, under current law, manufacturers are not required to report to the Food and Drug Administration (FDA) when they experience an interruption in production unless the agency deems that drug to be medically necessary. The same holds true whenever a manufacturer plans to discontinue a product.

Our constant advocacy on Capitol Hill, to FDA, and throughout the executive branch has not gone unnoticed. For example, last September we briefed Kathleen Sebelius, the Secretary of the Department of Health and Human Services (HHS), as well as

other HHS officials, and we worked closely with FDA in organizing a public workshop on the issue. And in October, President Obama signed an Executive Order directing FDA and other agencies to address the issue.

At ASHP, we have kept up a constant drumbeat of media coverage, becoming the go-to organization for reporters who want to write about shortages. ASHP and ASHP members were quoted or mentioned in more than 12,000 news stories on drug shortages between November 2010 and December 2011. This represented 70% of all drug shortage stories. We basically own the airwaves and printed press about this issue.

Because of ASHP's reputation as a credible, evidence-based organization, Congress asked us to testify three times in 2011 on the issue of shortages. We also have been working closely, in a bipartisan manner, with staff and members of the House Energy and Commerce Committee and the Senate Health, Education, Labor, and Pensions Committee to draft legislative language that includes an early-warning system requiring manufacturers to alert FDA so that the agency can help avert a shortage. After countless e-mails, meetings, briefings, advocacy advertisements, and grass-roots alerts, I have great news to report.

Due in large part to ASHP's leadership and the involvement of our members and the dedication of our staff, the House and Senate have each passed legislation to reauthorize the Prescription Drug User Fee Act, which now includes measures addressing drug shortages. All of this occurred in a political environment that is increasingly partisan and polarized. What remains is for Congress to combine the two versions of the bill and send it to the President for his signature. There is overwhelming bipartisan support for this legislation, as evidenced by a 96 to 1 vote in the Senate and a 387 to 5 margin in the House.

This is a huge win for our patients, for our members, and for ASHP. It also gives us additional credibility with policymakers, which will translate into our ability to influence other important ASHP policy priorities.

I want to thank all of our members who have participated in our grass-roots push on this issue, as well as others who have joined in our advocacy, including the American Hospital Association and individual hospital systems, the American Medical Association, the Institute for Safe Medication Practices, the American Society of Clinical Oncology and other oncology groups, and the American Society of Anesthesiologists.

Other pharmacy colleagues who also collaborated include the American Pharmacists Association (APhA), the American College of Clinical Pharmacy (ACCP), the Academy of Managed Care Pharmacy, the Hematology/Oncology Pharmacy Association, and the National Community Pharmacists Association. From the manufacturing sector, Hospira also joined this advocacy effort. Thank you, also, to our longtime partners at the University of Utah, including Erin Fox, Linda Tyler, and their team for their work with us on ASHP's Drug Shortages Resource Center.

As I stand here today, I can't help but reflect upon what a wonderful example this is of the real and important work we do in this House of Delegates. Just one year ago, this body passed a policy advocating for FDA to have more authority to deal with drug shortages. And here I stand before you today, reporting to you that ASHP took your call for action and, with the help of our members, was able to secure a great step forward to help bring resolution to this public health crisis.

That was one year ago. I would like you to think about this historic session of the ASHP House of Delegates where we just passed policies regarding pharmacist prescribing,

technician licensure, and board certification and think about how that will help advance patient care and our profession. Give yourselves a round of applause.

Task Force on Organizational Structure

As I mentioned earlier, ASHP must be poised to meet the challenges of the 21st century and be ready to serve a changing membership. To ensure that we are aligned properly to provide the right services and resources for health-system pharmacists, ASHP is convening a Task Force on Organizational Structure.

It has been 12 years since ASHP convened such a group. The findings of the former task force led to the expansion of ASHP's Sections and Forums.

But a lot can happen in more than a decade. Pharmacy practice has diversified, multiple new specialties have emerged, and the complexity of patient care and drug therapy continues to grow. Roles of pharmacists and technicians are changing, and ASHP must reflect these changes.

In light of these challenges, it is our belief that we need to examine ASHP's governance, policymaking process, and membership structure anew. While ASHP remains a strong organization with a growing membership and reputation for quality and integrity, we must keep pace with the changing times.

Task-force members with a diversity of experience in ASHP governance and policy have been appointed, and the group will begin its work in July. I am happy to announce that Past President Sara White has agreed to chair this task force. From end to end, we expect the task-force activities to take approximately 18 months.

Stay tuned as this group begins its work. There will be many opportunities for members and affiliates to provide input and feedback, and I expect to see great things arise out of their recommendations to the Board.

Credentialing and certification

It has been 34 years since the Board of Pharmacy Specialties (BPS) introduced its first certification for nuclear pharmacy. Today, in large part due to ASHP's efforts, pharmacists can pursue board certification in a variety of specialties.

ASHP believes that specialization and credentialing are critical elements in the advancement of pharmacy practice, as evidenced by one of the policies this House just passed. Today's health care environment makes the issue of credentialing even more important.

ASHP continually works with BPS and other stakeholders to explore new specialties and create a sound process for developing new specialty credentials. Starting this year, ASHP is offering a new review course to support members preparing for the pharmacotherapy examination. This new review course, as well as our ambulatory care review course, was conducted right before the Summer Meeting in Baltimore.

ASHP also created recertification programs for both of these specialties. Our ambulatory care program is already approved for recertification

credit, and BPS is currently reviewing a proposal for a recertification program for pharmacotherapy.

Most recently, BPS completed three role-delineation studies and distributed requests for petitions in the areas of critical care and pediatrics. In addition, BPS is currently conducting role-delineation studies for infectious diseases and cardiology pharmacy. BPS decided to pursue these two new studies at the mutual request of ASHP, APhA, ACCP, and, in the case of infectious diseases, the Society of Infectious Diseases Pharmacists.

In the new world of health care, specialty certifications and residencies will be the norm, not the exception. I'm very proud that ASHP is at the forefront of that movement.

Fiscal picture

As we approach our 70th anniversary this August, we do so with an improving financial picture. You heard details of this from ASHP Treasurer Phil Schneider, but I did want to acknowledge that we appear to have turned an important fiscal corner. Through the expansion of membership, the hard work and fi-

nancial sacrifices made by staff, and a growing, exciting line of products and resources, ASHP's finances have improved dramatically. This is truly a testament to the focused work of so many people. ASHP is doing great!

Conclusion

During the interview process for this position, I told the Board of Directors that any professional accomplishments I may have had can be traced to the amazing teams of people that I've worked with over the years. ASHP is no exception. We have a staff that is tremendously dedicated to the work and vision we have for pharmacy. We have leaders, such as all of you and our Board, who give unselfishly of their time and expertise. And we have a strong and growing membership that is poised to enact practice model change on a broad scale.

These are exactly the ingredients we need to accomplish the kinds of improvements in patient care that ASHP has always championed. I am extremely excited about what we can achieve together, and I am humbled by the opportunity to do so.

2012 Report of the ASHP Treasurer

A Fiscally Strong Organization to Support the Membership Mission

PHILIP J. SCHNEIDER

Each year, the ASHP Treasurer has the distinct pleasure of reporting to the membership the financial condition of the Society. The Society's fiscal year is from June 1 through May 31, coinciding with our policy development process and timetable. This report will describe ASHP's financial performance and planning for three periods, providing (1) the final audited prior-year numbers (for fiscal year 2011), (2) current-year (fiscal year 2012) projected performance, and (3) the budget for the fiscal year ending May 31, 2013.

ASHP segregates its finances into two budgets, the core budget and the program development budget. The core budget represents the revenue and expense associated with the core operations of the organization. The program development budget is intended for expenditures that are (1) associated with new, enhanced, or expanded programs; (2) associated with time-limited programs; (3) capital asset purchases; or (4) supplemental operating expenses. The program development budget is funded only from investment income.

I am pleased to report that we were able to hand over the reins of a fiscally sound ASHP to our new Chief Executive Officer. ASHP is a very strong organization. The audit of the May 31, 2011, financial statements of the Society and the Society's subsidiary, the 7272 Wisconsin Building Corp., performed by the firm of Tate & Tryon, resulted in an unqualified opinion. Copies of the audited statements are available by contacting the ASHP Executive Office.

Fiscal Year Ending May 31, 2011—Actual

Last year I reported to you that the continued improvement in the stock market performance was projected to result in positive results again. We were projecting a net income of \$4.8 million, but the actual results were much better. The Society's core operations showed a surplus of \$2.6 million, and the program development budget produced a \$5.3 million surplus from investment income of \$6.8 million (Figure 1).

This investment income represented a 19.9% return in the portfolio for the fiscal year. Combining the surplus from the core and program development budgets, the Society's net income for the year totaled \$7.9 million. Thanks to a decrease in the defined benefit pension plan's unfunded liability, a \$3.7 million positive adjustment was recorded. This adjustment, along with the \$7.9 million net income, increased the Society's net worth by \$11.6 million to \$31.3 million, 67% of total annual expense. Our long-term financial policy is to maintain net worth at 50% of total ASHP and 7272 Wisconsin Building Corp. expenses, with a ceiling of 65% and a floor of 35%.

The Society's May 31, 2011, year-end balance sheet (Figure 2) was as impressive as the statement of revenue and expense. Assets increased by \$5.590 million, and liabilities decreased by \$6.016 million. The asset-to-liability ratio, which had been \$1.75:\$1.00 at May 31, 2010, increased to \$2.45:\$1.00 at May 31, 2011.

Fiscal Year Ending May 31, 2012—Projected

As of February 29, 2012, financial performance in the core budget for the year ending May 31, 2012, is projected to produce a core net income of \$816,000 (Figure 1). The declining market value of the Society's investment portfolio resulted in a projection of no investment income, which will result in a projected loss in the program development fund of \$1.685 million. The Board of Directors authorized spending \$500,000 from net worth for a contribution to the ASHP Research and Education Foundation for the Henri Manasse Legacy fund. If we achieve the year-end projections indicated in Figure 1, the Society's net worth at May 31, 2012, will be \$29.908 million, 63% of the total ASHP and 7272 Wisconsin Building Corp. expense.

Fiscal Year Ending May 31, 2013—Budgeted

The Society's 2013 core budget shows a net income of \$36,169, based on revenues of \$42.041 million and expenses of \$43.335 million (Figure 1). Revenue is

budgeted at a 3% increase over the 2012 budget, and operating expenses are budgeted at an increase of 4% over the 2012 budget. The program development budget shows net income of \$3,253. The projected net worth based on the 2012 projection and the 2013 budget, \$29,947 million, reflects a very strong organization (Figure 1).

7272 Wisconsin Building Corp.

The Society's subsidiary, the 7272 Wisconsin Building Corp., finished the 2011 fiscal year on a positive note, producing net income of \$1.449 million before owner's distribution (Figure 3). The subsidiary owns the headquarters building and derives income from leased commercial and office space.

Conclusion

Although the economy overall is beginning to make a comeback, we continue to manage our resources with caution. While the revenue from and related margins of some of the Society's products and services are declining, the revenue from and margins of other products and services are on the rise. The diversity of the sources of revenue is the strength of ASHP. We continue to seek new sources of revenue and control expenses while providing the core resources necessary to maintain the services and products critically important to our members. The projected net worth based on the 2012 projection and the 2013 budget reflects a very strong organization.

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

	Actual Fiscal Year Ended May 31, 2011	Projected Fiscal Year Ended May 31, 2012	Budget Fiscal Year Ended May 31, 2013
CORE OPERATIONS			
Gross revenue	\$ 41,617	\$ 40,292	\$ 42,041
Total expense	(40,597)	(40,476)	(43,335)
Earnings from subsidiary	1,449	1,000	1,200
Investment income subsidy	133	—	130
Core Net Income	\$ 2,602	\$ 816	\$ 36
PROGRAM DEVELOPMENT			
Investment income	\$ 6,849	\$ —	\$ 1,630
Program expenses	(1,587)	(1,685)	(1,627)
Program Development Net Income	\$ 5,262	\$ (1,685)	\$ 3
Program Funded from Net Worth	\$ —	\$ (500)	\$ —
ASHP Net Income	\$ 7,864	\$ (1,370)	\$ 39
Pension Plan Adjustment	3,742	—	—
ASHP Net Income	\$ 11,606	\$ (1,370)	\$ 39
Net Worth Beginning of Year	\$ 19,672	\$ 31,278	\$ 29,908
ASHP Net Income	11,606	(1,370)	39
Net Worth End of Year	\$ 31,278	\$ 29,908	\$ 29,947
% of Total Expense	67%	63%	59%

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

	Actual as of May 31, 2011	Actual as of May 31, 2010
ASSETS		
Current assets	\$ 4,959	\$ 6,013
Fixed assets	1,741	1,223
Long-term investments (at market)	41,419	35,852
Investment in subsidiary	3,035	2,552
Other assets	384	308
Total Assets	\$ 51,538	\$ 45,948
LIABILITIES		
Current liabilities	\$ 12,934	\$ 14,311
Long-term liabilities	7,326	11,965
Total Liabilities	\$ 20,260	\$ 26,276
NET ASSETS		
Net assets	\$ 31,278	\$ 19,672
Total Net Assets	\$ 31,278	\$ 19,672
Total Liabilities and Net Assets	\$ 51,538	\$ 45,948

Figure 3. 7272 Wisconsin Building Corp. (ASHP subsidiary) statement of financial position and statement of activities for fiscal year 2011 (in thousands).

	Fiscal Year Ended May 31, 2011		Actual as of May 31, 2011
REVENUE AND EXPENSE		ASSETS	
Gross revenue	\$ 6,405	Current assets	\$ 1,368
Operating expense	(4,330)	Property and plant (net)	17,314
Operating Income	\$ 2,075	Other assets	1,770
Provision for income taxes	\$ (626)	Total Assets	\$ 20,452
Increase in Net Assets	\$ 1,449	LIABILITIES	
Owner's distribution and capital contributions	\$ (967)	Current liabilities	\$ 1,014
Net Increase in Net Assets	\$ 482	Mortgage payable	15,873
		Other liabilities	530
		Total Liabilities	\$ 17,417
		NET ASSETS	
		Net assets	\$ 3,035
		Total Net Assets	\$ 3,035
		Total Liabilities and Net Assets	\$ 20,452



SEIZE THE INITIATIVE

ASHP House of Delegates 2012
June 10 and 12, 2012

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SEIZE THE INITIATIVE

ASHP House of Delegates 2012
June 10 and 12, 2012

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.

Lisa M. Gersema, Board Liaison

Council Members

- Lisa L. Deal, *Chair* (Virginia)
- Stephanie D. Sutphin, *Vice Chair* (Kentucky)
- Dale E. English (Ohio)
- David B. Gregornik (New York)
- Becky K. Harvey (Texas)
- Russell K. Hulse (Utah)
- Molly B. Leber (Connecticut)
- Donald E. Letendre (Iowa)
- Jay P. Rho (California)
- Kate M. Schaafsma, *New Practitioner* (Wisconsin)
- Jean M. Scholtz (Pennsylvania)
- Kristine N. Widboom, *Student* (Minnesota)
- Douglas J. Scheckelhoff, *Secretary*

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Policy Recommendations



A. Preceptor Skills and Abilities

- 1 To collaborate with pharmacy organizations on the development of standards to
- 2 enhance the quality of experiential education and pharmacy residency precepting;
- 3 further,
- 4 To provide tools, education, and other resources to develop preceptor skills.

Rationale

The quality of pharmacy education is directly tied to the quality and effectiveness of its preceptors. Growth in the number and size of colleges of pharmacy has increased demand for teaching sites and for qualified preceptors to provide experiential training and residency rotations at those sites. As a result, teaching sites are often selected with little proof of the quality of the site or the ability of its preceptors, and many of those preceptors lack experience or training in teaching and precepting students and residents. Although nearly all colleges of pharmacy try to provide preceptor training, their efforts to develop preceptors are often inconsistent and ineffective due to resource constraints. In addition to improved training of preceptors, the profession needs a mechanism for evaluating the skills of preceptors and teachers.

There has been little coordination of preceptor development at the national level. The quality and effectiveness of preceptors is important to the entire profession and deserves a national platform and dedicated resources.

Background

The Council discussed the importance of precepting and teaching skills and the long-term impact good preceptors have on the readiness of pharmacy and residency graduates. The Council reviewed the resources available for preceptor development from various organizations and concluded there a need for more programs, especially those that focus on increasing effectiveness rather than simply providing a checklist.

The Council also noted that different skills sets are needed to be effective, depending on the type and level of student (i.e., introductory pharmacy practice experience [IPPE] students, advanced pharmacy practice experience [APPE] students, or residents).

The Council stated that the profession also needs a mechanism for evaluating the skills of preceptors and teachers. The Accreditation Council for Pharmacy Education (ACPE) provides guidance on preceptor qualifications, but the Council was not certain that ACPE adequately describes the essential requirements of a preceptor. The Council also discussed how some state boards of pharmacy (currently 24) license or register pharmacist preceptors. Requirements for state recognition of preceptors varies greatly, with many states silent on the quality or

qualifications of the preceptor, requiring only that preceptors be licensed and in good standing with the board. The Council felt strongly that an inconsistent patchwork of state board of pharmacy requirements for preceptor qualifications could deter or complicate the development of more and better-qualified preceptors.



B. Qualifications and Competencies Required to Prescribe Medications

- 1 To affirm that prescribing is a collaborative process that includes patient assessment,
- 2 diagnosis, evaluation of available treatment options, monitoring to achieve therapeutic
- 3 outcomes, patient education, and adherence to safe and cost-effective prescribing
- 4 practices; further,

- 5 To affirm that safe prescribing of medications, if performed independently, requires a
- 6 practitioner who is competent and knowledgeable in all these processes, or, if performed
- 7 collaboratively, requires that competent, interdependent professionals complement each
- 8 others' strengths at each step; further,

- 9 To explore the creation of prescribing standards that would apply to all who initiate or
- 10 modify medication orders or prescriptions and that would facilitate development of
- 11 competencies and training of prescribers; further,

- 12 To encourage research on the effectiveness of current educational processes designed to
- 13 train prescribers.

Rationale

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

Background

The Council discussed whether a minimum level of training should be established in order to prescribe medications. The Council reviewed studies from other countries in which new physician graduates were surveyed on their confidence and readiness to prescribe, along with objective evaluation of new medication prescriptions they had written. A high percentage of respondents did not feel capable of prescribing independently, and the review of their prescriptions showed many errors, some potentially lethal. Unfortunately, these types of studies have not been conducted with U.S.-trained physicians or other prescribers. Anecdotal

evidence suggests that new graduate medical residents make more errors than their experienced counterparts, especially when they first enter practice and start to prescribe medications.

The Council discussed the predicted shortage of physicians, especially in primary care. This shortage, and the long lead time to train more physicians, might result in a need and an opportunity for others who are trained and qualified to prescribe and manage patients' treatment regimens.

The Council discussed the need to describe core competencies needed to prescribe medications but concluded that ASHP is not in a position to do so independently. The need for additional research and identification of data that support the case for medication-specific competencies was also discussed.

The Council also noted that there is a spectrum of prescribing: at one end, independent prescribing, and at the other, team-based approaches to care and medication therapy management. Team-based care models that build on strengths of individual team members have been shown to be most effective in producing the desired therapeutic outcomes. The value of team-based care and the collective benefit from teams would also be important to the broader discussion of prescriber competencies and training.



C. Qualifications of Pharmacy Technicians in Advanced Roles

- 1 To recognize that highly trained and skilled pharmacy technicians working in
- 2 advanced roles regularly perform complex and critical medication-use procedures,
- 3 and that a safe and effective medication-use process depends significantly on the
- 4 skills, knowledge, and competency of those pharmacy technicians to perform those
- 5 tasks; further,

- 6 To reaffirm that all pharmacy technicians should complete an ASHP-accredited
- 7 training program, be certified by the Pharmacy Technician Certification Board, and be
- 8 licensed by state boards of pharmacy; further,

- 9 To advocate that beyond those requirements pharmacy technicians working in
- 10 advanced roles should have additional training and should demonstrate
- 11 competencies specific to the tasks to be performed; further,

- 12 To advocate that expansion of pharmacy technician duties into expanded, advanced
- 13 roles should include consideration of potential risk to patients and that ongoing
- 14 quality assurance metrics should be established to assure patient safety.

Rationale

A growing number of hospitals utilize pharmacy technicians in advanced or specialized roles beyond those traditionally filled by technicians: medication preparation, distribution, and purchasing. These advanced or specialized roles include performing medication reconciliation, collecting laboratory data, and managing automation and technology, among others. While there has been a good deal of discussion about minimum standards for education and training of pharmacy technicians in general, there has been little discussion about technicians in these specialized roles. These advanced roles will require different skills and competencies, and pharmacy technicians will require additional, task-specific training and should demonstrate competency before being allowed to perform such tasks. Hospitals and health systems will need to consider the potential risk to patients of expanding the roles of pharmacy technicians and establish quality assurance metrics to assure patient safety.

Background

The Council discussed a previous recommendation made to the ASHP Board of Directors in 2010 but referred back by the Board so that it could be reconsidered in light of the [recommendations from the Pharmacy Practice Model Initiative \(PPMI\) Summit](#), which occurred after the Council deliberations. The Council reiterated that having pharmacy technicians performing these advanced roles benefits the pharmacy practice model and therefore ultimately benefits patients.

The Council discussed the inconsistencies at the state level regarding pharmacy technician education and training, certification, and registration or licensure, and how this creates challenges for advancing roles and care. The Council stated that a minimal level of training for the core roles of pharmacy technicians is critical, and there was consensus that these training elements are addressed in the [Model Curriculum for Pharmacy Technician Training](#) used as part of program accreditation.

The Council also discussed the need to describe a scope of practice for pharmacy technicians, including boundaries permitting technicians to make “professional” judgments while not being authorized or allowed to make “clinical” judgments. Examples of professional judgments included technicians performing IV drip rounds and using their judgment to determine when the next infusion would be needed and ordering it accordingly, or interviewing patients to obtain a medication list that would be used as part of a medication reconciliation process. Examples of a clinical judgment would be counseling patients on use of their medications or providing advice on which over-the-counter medication was appropriate for their clinical situation.

The Council concluded that pharmacy technicians in these advanced roles should receive additional training specific to the tasks to be performed and should demonstrate task-specific competencies as well. The need to identify additional training elements for nontraditional, advanced roles was also discussed. Finally, the Council noted the importance of having hospitals and health systems consider the potential risk to patients of having pharmacy technicians in advanced roles and establish quality assurance metrics to assure patient safety.



D. Role of Students in Pharmacy Practice Models

- 1 To encourage pharmacy practice leaders to incorporate students, including those in
- 2 introductory and advanced pharmacy practice experiences and interns, into active,
- 3 meaningful roles in new and evolving practice models.

Rationale

Many pharmacy departments are re-evaluating their pharmacy practice models and changing how pharmacists, pharmacy technicians, and automation are utilized in the provision of safe and effective medication use. A few departments have actively sought to incorporate pharmacy students into their practice models, and those that have done so have been able to show a significant improvement in students' IPPE, APPE, and internship experiences. Building in these roles as models are changed will result in benefits not only for the pharmacy department and the patients they serve, but also for students who will learn from having a more engaged, meaningful role in delivering patient care.

Background

The Council discussed PPMI Recommendation B26c, which reads: "Every pharmacy department should develop a plan to allocate pharmacy student time to drug-therapy management services." There was strong support for and concurrence with this recommendation.

Some sites use pharmacy interns as pharmacist extenders, using a structured internship that builds on graduated skill development by the student over time. Upon reaching a certain level of skill, students are permitted, for example, to give counseling for heart failure patients at discharge, facilitate drug conversion programs, perform medication reconciliation, and administer pneumococcal vaccinations. It is important that interns commit to working at the site for a period of time, though, so that the training time and cost is offset during the intern's tenure.

The limited number of currently available internship positions was also discussed. Students are often unable to find available positions, especially in geographic areas that have more than one college of pharmacy and therefore a high concentration of students. Positions are limited in both hospital and community pharmacy settings. A degree of flexibility may be required with internship positions, and this flexibility may need to be considered when institutions are structuring their staffing models (e.g., requiring traditional work shifts each week might not always work). Sites that have addressed this need for flexibility have reported a positive experience with interns. Examples of successful innovations include establishing a structured program that operates in summer months only, thereby avoiding conflict with rotations or classes, and hiring a pool of interns who are able to cover for each other when classes or rotations create a conflict, effectively placing the burden on the intern to see that his or her shift is covered. ASHP should promote those practice models and settings that effectively utilize interns.

State laws regarding student roles were discussed as a possible limitation. For example, some states require “direct supervision” of students, potentially limiting the roles students might play. Some states have worked to standardize schedules, goals and objectives, expectations, and logistical considerations for IPPE and APPE students in specific regions. This coordination has facilitated better scheduling and inclusion of students in practice models, and sites are better able to anticipate the skills and abilities of students assigned to them.



E. ASHP Statement on the Role of the Medication Safety Leader

- 1 To approve the ASHP Statement on the Role of the Medication Safety Leader ([Appendix](#)).

Background

At its 2010 meeting, the Council discussed how the role of medication safety officers varies from institution to institution and examined the challenges people working in such positions frequently encounter. The Council voted to develop an ASHP statement on the role and responsibilities of the pharmacist charged with leadership on improving safety of medication-use systems (i.e., the medication safety officer). The Section Advisory Group on Medication Safety of the ASHP Section of Inpatient Care Practitioners convened a workgroup to draft the statement, which was reviewed by more than 30 ASHP members and subsequently endorsed by the Section’s Executive Committee.



F. “P.D.” (Pharmacy Doctor) Designation for Pharmacists

- 1 To discontinue ASHP policy 0217, which reads:
 - 2 To oppose the use of “P.D.” or any other designation that implies an
 - 3 academically conferred degree where none exists.

Background

As part of sunset review, the Council reviewed policy 0217 and concluded it is no longer needed. The use of arbitrary designations to describe pharmacists or imply an academic degree is no longer an issue. The Council agreed that the use of P.D. or similar designations was inappropriate and could lead to confusion. Many of the efforts to establish these designations were in response to the transition to the Doctor of Pharmacy as an entry-level degree. Now that the transition has occurred, proposals to create such designations have subsided, making this policy unnecessary. The Council recommended and the Board voted to discontinue the policy.



G. Substance Abuse and Chemical Dependency

- 1 To discontinue ASHP policy 0209, which reads:
 - 2 To collaborate with appropriate professional and academic organizations in
 - 3 fostering adequate education on substance abuse and chemical dependency
 - 4 at all levels of pharmacy education (i.e., colleges of pharmacy, residency
 - 5 programs, and continuing-education providers); further,
 - 6 To support federal, state, and local initiatives that promote pharmacy
 - 7 education on substance abuse and chemical dependency; further,
 - 8 To advocate the incorporation of education on substance abuse and
 - 9 chemical dependency into the accreditation standards for Doctor of
 - 10 Pharmacy degree programs and pharmacy technician training programs.

Background

As part of sunset review, the Council reviewed existing ASHP policy 0209. There was discussion of whether the policy should be broadened to include education of the public on substance abuse and whether abuse of prescription drugs should be explicitly added. After reviewing the [ASHP Statement on the Pharmacist's Role in Substance Abuse Prevention, Education, and Assistance](#), the Council concluded that the statement was more comprehensive and was sufficient in expressing ASHP's position on the issue and that ASHP policy 0209 was no longer needed. The Council recommended and the Board voted to discontinue the policy.

Board Actions

Sunset Review of Professional Policies

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

- [Requirement for Residency](#) (0701)
- [Pharmacy Technician Training](#) (0702)
- [ASHP Guidelines, Statements, and Professional Policies as an Integral Part of the Educational Process](#) (0705)
- [Image of and Career Opportunities for Pharmacy Technicians](#) (0211)
- [Pharmacists' Role in Immunization and Vaccines](#) (0213)
- [Educational Program Resources for Affiliated State Societies](#) (0215)
- [Career Counseling](#) (8507)

Other Council Activity

Evaluating Competency of Experienced Pharmacists

The Council discussed a House of Delegates recommendation suggesting that ASHP develop guidance for managers on how to evaluate competency and skills of experienced pharmacists. The use of credentials, experience, and training was discussed, but actually measuring competency remains an obstacle. Council members provided examples of individuals who had impressive resumes, with degrees, residencies, board certification, and experience, but yet were not effective clinicians.

The Council concluded with the need to reaffirm the value of an effective privileging and credentialing process and advocate that hospitals and health systems ensure their processes work. Individual use of continuing professional development (CPD) was also considered to be a positive attribute when considering candidates, and the Council suggested ASHP continue to offer [resources and information on CPD](#).

Licensure of Pharmacy Technicians by State Boards of Pharmacy

The Council discussed a recommendation from the ASHP PPMI Summit calling on ASHP to revise its stance from registration of pharmacy technicians by state boards of pharmacy to licensing of pharmacy technicians.

Council members concurred that licensure should be predicated on completion of an ASHP-accredited training program, and while this might not be feasible with the current number of training programs, it should be a goal. Stating why ASHP supports this position will also help in building the case at the state level.

There was recognition that a requirement for licensure would create challenges for health systems and pharmacies in rural areas, where training programs and qualified staff are more difficult to find. Given the important role that pharmacies play in these rural locations, the need for well-qualified pharmacy personnel will be even more acute. Others noted that states that set a requirement for training ultimately witnessed many new training programs emerge to meet the new market need.

The Council discussed the need to better define the roles pharmacy technicians should be able to perform independently and which depend on the oversight of a pharmacist. These roles should be included in a “scope of practice” for pharmacy technicians, and the scope for a licensed pharmacy technician should be distinctly different from that of a registered or unlicensed individual. The Council agreed that both completion of an ASHP-accredited training program and certification by the Pharmacy Technician Certification Board should both be minimum requirements for licensure.

Board Certification of Pharmacists

The Council discussed the new business item on board certification submitted by the ASHP Section of Clinical Specialists and Scientists. The Council generally was in agreement with the new business item but did pose some additional questions and possible revisions.

Regarding the principle that pharmacists should become board certified where certification exists, the Council agreed but concluded that this goal is aspirational and needs to be stated as such. The Council concurred that there is value in specialty certification but also affirmed that the real value was in the training that leads up to certification more than in the certification itself. There was also recognition that goals on certification will take time.

Residency Capacity

The shortage of residency positions in relationship to applicants continues to be an issue for the profession. The Council reviewed the gap between applicants and positions for the most recent residency match and discussed what the needs for residents are likely to be in the future. The need for ASHP to act on recommendations from the stakeholders meeting was reinforced, targeting potential residency sites, providing resources, and assisting new programs in as many ways as possible.

The value of promoting innovative and new models of residency was also wholeheartedly supported by the Council, such as nontraditional programs and an “attending” pharmacist model in which residents and students provide care with oversight.

Education and Training of the Medication-use Systems and Technology (MST) Pharmacy Specialist

The concept of an MST Pharmacy Specialist was discussed by the Council, with the goal of providing feedback on the need for such a position and what its education and training needs might be.

The MST specialist position would have a role in pharmacy operations, distribution oversight, pharmacy automation used for dispensing, medication safety, quality improvement, technology oversight and training, USP 797 compliance, waste stream management, and education and training. There are people in these types of positions in many hospitals, but generally they have developed skills through on-the-job training and have not had a structured method of training and development.

The Council supported the need for these types of positions and concurred conceptually with the residency model proposed. The need to get the right drug to the right patient at the right time has never been more critical, and drug therapy is only becoming more complex.

Council members noted that the MST specialist should be a pharmacist. Some gave examples of hospitals using industrial engineers in a similar role, creating unique challenges because these people don't understand how medication systems work and interface. The Council also discussed likely reporting relationships for such a position, with a clear preference that MST specialist report to the pharmacy director rather than some other department.

Appendix



ASHP Statement on the Role of the Medication Safety Leader

Position

1 The American Society of Health-System Pharmacists (ASHP) believes that medication safety
2 is a fundamental responsibility of all members of the profession of pharmacy. For a
3 medication safety program to succeed, however, it is essential that there be an innovative
4 leader to set a vision and direction, identify opportunities to improve the medication-use
5 system, and lead implementation of error-prevention strategies. The medication safety
6 leader's role includes responsibility for leadership, medication safety expertise, influencing
7 practice change, research, and education. ASHP believes that because of their training,
8 knowledge of the medication-use process, skills, and abilities, pharmacists are uniquely
9 qualified to fill the roles and meet the responsibilities of the medication safety leader in
10 hospitals and health systems.

Background

11 Hospital and health-system pharmacists have improved pharmacy systems over the past 60
12 years to reduce the risk that medications could harm patients. Medication safety was at the
13 heart of such historic innovations in pharmacy services as unit-dose systems, decentralized
14 clinical pharmacy services, and intravenous admixture services. The crucial leadership role
15 of pharmacists in medication safety has been summarized as follows:

16 Pharmacy leadership is the core of a successful medication safety program.
17 Pharmacy leaders can play an enormously important role in performance
18 improvement. They can be part of the senior leadership team's DNA because
19 their impact and view go far beyond the walls of the pharmacy.... Pharmacists
20 can play an important role as leaders to reduce patient safety risks, optimize
21 the safe function of medication management systems, and align pharmacy
22 services with national initiatives that measure and reward quality
23 performance.¹

24 The landmark Institute of Medicine (IOM) report *To Err is Human: Building a Safer Health*
25 *System*² generated major patient safety initiatives by government agencies, regulatory and
26 accrediting bodies, professional and organizational associations, and health care
27 organizations. The Joint Commission (TJC) National Patient Safety Goals (NPSGs)³ are an
28 example of a response to the original IOM report. The Pharmacy Practice Model Initiative
29 (PPMI)⁴ and the National Quality Forum (NQF) Safe Practice 18⁵ incorporate medication
30 safety principles to ensure optimal patient safety and outcomes.

31 The medication safety leader (also referred to as a medication safety officer,
32 medication safety manager, or medication safety coordinator, among other titles) is a
33 clinical practitioner designated by an organization to serve as the authoritative expert in
34 safe medication use. Traditionally, the medication safety leader has been a clinical
35 pharmacist or manager within the department of pharmacy, although the position is

36 sometimes filled by a nurse or physician. The medication safety leader may report to the
37 organization's risk management department, its office of quality, or to a senior
38 administrator (e.g., hospital vice president, chief medical officer, or chief executive officer).
39 Reporting outside the pharmacy department may foster interdisciplinary approaches to
40 medication safety. Medication safety leadership may encompass a single hospital or a group
41 of organizations (e.g., spanning a health system or at a corporate level of a larger
42 organization). Regardless of organization size, it is critical that the fundamentals of
43 medication safety are the central component of the medication safety leader's job function.
44 Although medication safety leaders may have other responsibilities in smaller institutions,
45 medication safety should remain their core responsibility, and they must be strategically
46 positioned and empowered to lead efforts to reduce the risks of medication use.

47 The characteristics of a medication safety leader include:

- 48 1. A strong understanding of the facility's internal systems and processes developed
49 through firsthand experience, observations, medication-use evaluations, interviews,
50 and data analysis for a spectrum of patient populations (e.g., pediatric, geriatric,
51 cardiac, oncology).
- 52 2. Clinical expertise and a broad understanding of health care systems and processes to
53 facilitate accurate interpretation of clinical events.
- 54 3. Knowledge of and experience with all aspects of the medication-use system, including
55 procurement, prescribing, transcribing, preparation, distribution, administration,
56 documentation, and monitoring.
- 57 4. Strong analytical skills and an understanding of statistics, population data, and the
58 concepts of risk and prioritization.
- 59 5. Knowledge of performance improvement methodology and tools, including root cause
60 analysis (RCA), failure mode and effects analysis (FMEA), cause-and-effect
61 diagramming, process-flow mapping, and methods for monitoring projects and
62 measuring the progress of performance improvement initiatives.
- 63 6. Three or more years of post-training health-system practice experience.
- 64 7. Demonstrated leadership skills.
- 65 8. Excellent small and large group presentation skills.
- 66 9. Excellent verbal communication skills, especially the ability to communicate to all types
67 of health care providers, as individuals as well as in small and large groups.
- 68 10. Excellent writing and editing skills.
- 69 11. Strong personal belief that resolving the problem of medication errors is a systems
70 issue and not an individual health care provider issue.
- 71 12. Ability to function proactively rather than reactively.
- 72 13. Strong personal belief in the concept of a "just culture"⁶ that enhances transparency,
73 opens participation to all health care professionals, and fosters a "lessons learned"
74 environment in an organization's medication-error reporting system.
- 75 14. Understanding of concepts and application of safety principles, continuous quality
76 improvement, and human factors engineering.
- 77 15. Appropriate assertiveness.
- 78 16. A passion for medication safety and improving patient outcomes.
- 79 17. Proven success in working with interdisciplinary teams and engaging diverse groups.
- 80 18. Strong personal belief in engaging patients as part of the health care team.

81 19. Eagerness to learn from events outside one's own facility (e.g., through external
82 sources of information) to apply learning about what went wrong in order to identify
83 and remedy possible system weaknesses to prevent patient harm.⁷

84 The scope of a medication safety leader's responsibilities reaches into every corner of the
85 health care system and encompasses many roles, such as educator, preceptor, mentor,
86 detective, compliance officer, risk manager, engineer, accountant, statistician, computer
87 analyst, and counselor. A typical day may include attending safety rounds, precepting
88 pharmacy students and residents, writing policies, reviewing adverse drug reactions and
89 medication error reports, developing error-prevention strategies, leading process
90 improvement teams, implementing action items, reviewing smart pump libraries, ensuring
91 safe use of automated medication dispensing systems, assessing the safety of replacement
92 drug products during drug shortages, orienting new professional staff, assisting with
93 medication reconciliation, conducting tracers to ensure compliance with accreditation
94 standards (e.g., TJC medication management standards and NPSGs), working with
95 practitioners to resolve acute events, attending medical staff meetings, or educating the
96 corporate board on the culture of safety. Most medication safety leaders quickly find
97 themselves involved in many projects and committees as well as serving as the contact
98 person when nursing, pharmacy, or medical staff have questions or problems. The
99 medication safety leader needs a solid understanding of patient safety principles and must
100 have the ability to prioritize work activities to have a positive impact on the safety of patient
101 care. The medication safety leader should strive to acquire additional skills crucial to
102 success, such as presentation and communications skills, as well as expertise in process
103 improvement methodologies such as Six Sigma and Lean. Formalized training in medication
104 safety can be achieved through residency, fellowship, certificate programs, and other
105 methods of continuing education. ASHP supports the expansion of pharmacy education and
106 postgraduate residency training to include an emphasis on medication safety.⁸

Responsibilities of Medication Safety Leaders

107 Medication safety leaders must collaborate with all types of health care professionals,
108 support staff, and management, and consider all components of the medication-use process
109 in both inpatient and clinic settings in order to improve medication safety. The medication
110 safety leader's role includes responsibility for leadership, medication safety expertise,
111 influencing practice change, research, and education.

112 **Leadership.** To provide leadership, the medication safety leader will:

- 113 1. Develop a vision of an ideal safe medication-use system for the organization.
- 114 2. Oversee the planning, creation, review, and refinement of a medication safety plan.
- 115 3. Proactively develop and lead implementation of error-prevention strategies based on
116 practice standards, literature review, medication safety tools, and analysis of the
117 organization's medication safety data.
- 118 4. Participate in the planning, design, and implementation of the organization's
119 medication-use technology and automation systems.
- 120 5. Build a culture of safety through "lesson learned" education and communication across
121 the entire organization.
- 122 6. Oversee processes to collect information on the organization's medication errors and
123 system failures to ensure that they are captured and barriers to reporting are

- 124 addressed.
- 125 7. Ensure compliance with state and federal regulatory and legal requirements relating to
126 medication safety, and assist in the accreditation process by ensuring that the
127 organization's medication-use processes meet applicable medication management
128 standards and NPSGs.

129 **Medication safety expertise.** In the role of medication safety expert, the medication
130 safety leader will:

- 131 1. Serve as an authoritative resource on medication safety for the organization.
- 132 2. Contribute the medication safety perspective for technology initiatives.
- 133 3. Contribute the medication safety perspective to internal and external emergency
134 preparedness planning.
- 135 4. Serve as an internal consultant to investigate medication safety events or issues and
136 develop recommendations for action.
- 137 5. Serve as the chair of the Medication Safety Committee, whose duties may include
138 setting the agenda, reviewing general and specific error reports, and examining the
139 progress of projects and initiatives assigned to the medication safety team.
- 140 6. Be knowledgeable in the application and use of a variety of quality improvement
141 methodologies and tools (e.g., FOCUS-PDCA or Lean methodologies, root cause
142 analysis, failure mode and effects analysis).
- 143 7. Collect, review, and analyze, as the leader of review teams, the organization's
144 medication-use, medication error, adverse drug reaction, and continuous quality
145 improvement data (e.g., markers of adverse drug events, smart pump event data,
146 triggers and surveillance information, and automated dispensing system and bedside
147 barcode scanning reports) and use appropriate data analysis techniques to identify
148 needed improvements and develop high-leverage error-reduction strategies.
- 149 8. Predict and prepare to manage medication safety issues caused by potential or actual
150 drug product shortages and the use of replacement drug products.
- 151 9. Maintain knowledge of trends and developments in the patient safety field through
152 continuous professional development; reading articles, journals, and related material;
153 attending appropriate seminars, conferences, or educational programs; and utilization
154 of information from the Institute of Safe Medication Practices (ISMP) National
155 Medication Error Reporting Program, the Food and Drug Administration (FDA)
156 MedWatch program, and similar programs.
- 157 10. Participate at a local and national level in patient safety and medication safety
158 organizations and initiatives.

159 **Influencing practice change.** To influence practice change, the medication safety
160 leader will:

- 161 1. Collaborate with other departments (e.g., pharmacy, risk management, and patient
162 safety), hospital or health-system senior leadership, frontline staff, and nursing and
163 medical staff leadership to identify and prioritize safety issues and develop risk-
164 reduction strategies using the methods listed above to identify opportunities to
165 improve medication safety.
- 166 2. Manage changes in the medication-use system to enhance medication safety, ensure
167 that appropriate measures are taken to address and resolve medication safety issues,

- 168 and see that hospital staff and faculty are supported in providing safe care for patients.
- 169 3. Work closely with others (e.g., the patient safety officer) to integrate medication safety
- 170 into the overall strategic plan for patient safety and coordinate medication safety
- 171 initiatives with organizational patient safety initiatives.
- 172 4. Participate in or lead multidisciplinary hospital and health-system committees
- 173 concerned with medication errors, adverse drug events and reactions, near misses,
- 174 policy review, safe medication use, new product review, and patient safety to identify
- 175 risk points and prioritize system improvements to reduce the potential for medication
- 176 error and patient harm.
- 177 5. Consult with and advise specific clinical teams and the hospital and health system
- 178 generally on opportunities and strategies to improve patient care.
- 179 6. Encourage organization-wide medication error reporting through an established and
- 180 accepted error reporting system that utilizes appropriate error detection methods
- 181 (e.g., trigger tools) and through other appropriate avenues such as the Pharmacy &
- 182 Therapeutics Committee, Medication Safety Committee, or Patient Safety Committee.
- 183 7. Develop effective methods for spreading best medication-use practices throughout the
- 184 organization.
- 185 8. Use continuous quality improvement principles to assess and report on the status of
- 186 efforts to improve medication safety.
- 187 9. Periodically review and update clinical decision support tools to alert staff to high-risk
- 188 situations and educate staff as needed.

189 **Research and education.** To further research and education regarding medication

190 safety, the medication safety leader will:

- 191 1. Design and assist in the implementation of education and orientation programs in safe
- 192 medication use, including:
- 193 • development of competency assessment for staff tasks related to medication
- 194 safety (e.g., use of smart pumps and automated medication dispensing
- 195 systems);
- 196 • education of health care providers, other pertinent staff, and (as possible)
- 197 patients to ensure they are competent in safe medication-use practices; and
- 198 • provision of effective ongoing programs and presentations related to safe
- 199 medication use to diverse audiences (e.g., nursing, pharmacy, respiratory
- 200 care, and medical staff).
- 201 2. Share information about actual or potential medication errors or harm with safety
- 202 organizations such as the Institute for Safe Medication Practices (ISMP), the FDA, drug
- 203 or product manufacturers, and state error reporting programs.
- 204 3. Conduct medication-use safety research through well-designed, externally validated
- 205 studies, and implement evidence-based practices for medication safety.
- 206 4. Contribute to the literature on medication safety.
- 207 5. Provide medication safety education to pharmacy colleagues, students, and residents,
- 208 as well as other health care professionals.
- 209 6. Integrate medication safety into orientation and training for all health care providers
- 210 who participate in the medication-use process.

Conclusion

211 ASHP believes that pharmacists, as experts on medication use, are uniquely qualified to
212 serve as medication safety leaders. Medication safety leaders articulate the vision and
213 direction for improving the safety of the medication-use system to prevent patient harm.
214 The medication safety leader's role includes responsibility for leadership through direction
215 and prioritization, medication safety expertise, influencing practice change, research, and
216 education. Through analysis of the organization's medication safety data and literature
217 review, the medication safety leader will lead development and implementation of
218 proactive error-prevention strategies and build a culture of safety across the organization.

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SEIZE THE INITIATIVE

ASHP House of Delegates 2012
June 10 and 12, 2012

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.

Thomas J. Johnson, *Board Liaison*

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Policy Recommendations



A. Revenue Cycle Compliance and Management

- 1 To encourage pharmacists to serve as leaders in the development and
- 2 implementation of strategies to optimize medication-related revenue cycle
- 3 compliance, which includes billing, finance, and prior authorization, for the health
- 4 care enterprise; further,

- 5 To advocate for the development of consistent billing and reimbursement policies
- 6 and practices by both government and private payers; further,

- 7 To advocate that information technology (IT) vendors enhance the capacity and
- 8 capability of IT systems to support and facilitate medication-related billing and audit
- 9 functions; further,

- 10 To investigate and publish best practices in medication-related revenue cycle
- 11 compliance and management.

(Note: This policy would supersede ASHP policy 9902.)

Rationale

Pharmacy has an increasingly important role in optimizing revenue capture and avoiding revenue erosion resulting from improper billing or inadequate documentation of medication-related charges. Pharmacy needs to be involved in aspects of medication-related billing, including not just pharmacy drug charges and billing but also contracting and negotiating for carve-outs. Pharmacy leaders need to actively engage senior leadership and collaborate with various departments to ensure organizational success in revenue cycle management.

Recently, organizations have experienced increasing compliance pressures. This pressure comes from many sectors, including Centers for Medicare & Medicaid Services (CMS) programs plus state-specific requirements, third-party payers, and financial intermediaries. These policies impact organizations in two ways: increased requirements before the insurers will pay for a claim, and increased audit pressure to be sure the organizations are billing accurately. The frequency and nature of audits has also been changing. Insurers have increased the use of audits to control costs. Government agencies have also increased the use of audits. CMS has implemented Recovery Audit Contractor (RAC) audits, and the Office of the Inspector General is also auditing organizations. Results of the audits can have significant financial impact on the organization when money needs to be returned based on improper billing or lack of documentation.

Historically, pharmacy departments have great strength in managing supply chain issues. Drug expenditures are typically a significant portion of any hospital's budget. Pharmacy

is a key leader in managing these expenses. However, pharmacy departments are involved in broader revenue cycle management in variable ways. In some organizations, the billing or patient accounting departments handle all billing issues with various degrees of pharmacy involvement. Accurate billing requires integration of the organization's clinical services, pharmacy, billing, and charge master functions. The required elements for proper billing may reside in several systems. As coverage decisions become more complex, pharmacy expertise is increasingly required in the clinical coverage decisions and information integration in order to be successfully reimbursed for services. For the health care enterprise to successfully manage compliance and optimize revenue capture there must be effective collaboration among various departments. Pharmacy knowledge and leadership is increasingly required to ensure organizational success in revenue cycle management.

Each insurer has different requirements for coverage determinations, and coverage decisions have become more complex. More drugs now require prior authorization processes. In some cases, even if the prior authorization process has been used, the charge is denied. Medicare implemented the requirements for self-administered drugs (SADs) several years ago. Diabetic supplies are now handled under durable medical equipment (DME) requirements, which may require different data elements before a bill is processed. Medicaid requires the National Drug Code (NDC) prior to payment, and billing requirements for Medicare and Medicaid programs are not harmonized. Healthcare Common Procedure Coding System (HCPCS) codes also need to be attached where indicated. It is challenging to keep up with all the changes. New International Classification of Disease 10 (ICD-10) codes will further complicate required coding. Current IT solutions are inadequate and do not effectively facilitate effective billing. Current systems are often not designed to capture all necessary information required to properly document and bill. Even when necessary data is captured it often resides in different departmental computer systems that are not integrated and designed to share data. There is a need for more effective IT solutions to facilitate both billing and audits. Greater consistency in billing and reimbursement practices would facilitate greater compliance and enable the development of effective technology solutions to facilitate the billing and reimbursement processes.

Since pharmacy leaders have had variable levels of engagement in revenue cycle management, there is a need for education, tools, and resources related to best practices. Some pharmacy departments have created a business manager position in part to deal with these issues. This position is often not a pharmacist, but a staff member with business education. New roles for pharmacy technicians have also emerged in this area. ASHP and the Section of Pharmacy Practice Managers (SPPM) should seek to develop and share best practices and provide education to support pharmacists in optimizing pharmacy's role in revenue cycle compliance.

Background

The Council voted and the Board agreed to recommend replacing ASHP policy 9902 as follows (underline indicates new text; ~~striketrough~~ indicates deletions):

To encourage pharmacists to serve as leaders in the development and implementation of strategies to optimize medication-related revenue cycle compliance, which includes billing, finance, and prior authorization, for the health care enterprise; further,

To advocate for the development of consistent billing and reimbursement policies and practices by both government and private payers; further,

To advocate that information technology (IT) vendors enhance the capacity and capability of IT systems to support and facilitate medication-related billing and audit functions; further,

To investigate and publish best practices in medication-related revenue cycle compliance and management.

~~To encourage pharmacy managers to identify and resolve medication-related billing issues in government health care programs that could cause challenges under fraud and abuse laws; further,~~

~~To encourage pharmacy managers to establish an internal audit system for medication-related services, in conjunction with their corporate compliance programs, in order to meet the requirements of government health care payment policies.~~



B. Prior Authorization Processes

- 1 To advocate that public and private payers work together and in collaboration with
- 2 providers to create standardized and efficient prior authorization processes that
- 3 facilitate communication between patients, providers, and payers prior to therapy;
- 4 result in timely coverage decisions; and do not disrupt patient care.

Rationale

Prior authorization processes vary considerably and are time consuming. The required data, form of documentation required, submission process, and delivery of approval vary among payers. These processes are often not integrated into the patient-care process and require manual documentation and submission. The lack of timely review and approval may result in delay of patient care. The Council believed that ASHP should advocate for greater standardization of prior authorization processes. These processes should effectively facilitate communication among both patients and providers, should be standardized and automated, and should result in timely decisions that do not disrupt patient care.

Background

The Council discussed prior authorization as a part of a broader discussion of compliance and revenue cycle management. The Council believed that inconsistent and inefficient prior authorization processes were having a negative impact on patient care in hospitals and health systems and that ASHP should establish new policy encouraging more efficient and more standardized processes that facilitate effective patient care. The Council recommended and the Board agreed to this new policy.



C. Financial Management Skills

- 1 To foster the systematic and ongoing development of management skills for health-
- 2 system pharmacists in the areas of (1) health-system economics, (2) business plan
- 3 development, (3) financial analysis, (4) pharmacoeconomic analysis, (5) diversified
- 4 pharmacy services, (6) compensation for pharmacists' patient-care services, and (7)
- 5 revenue cycle compliance and management; further,

- 6 To encourage colleges of pharmacy to incorporate these management areas in course
- 7 work and clerkships.

(Note: This policy would supersede ASHP policy 0508.)

Rationale

Revenue cycle compliance and management represent an increasingly important aspect of the business operations of hospitals and health systems. Pharmacy leaders must exert leadership in managing medication-related revenue cycle compliance in order to ensure financial success of the health care enterprise. Pharmacy leaders must develop and maintain knowledge and skills in this area.

Background

The Council recommended and the Board agreed to revise ASHP policy 0508 as follows (underscore indicates new text; ~~striketrough~~ indicates deletions):

To foster the systematic and ongoing development of management skills for health-system pharmacists in the areas of (1) health-system economics, (2) business plan development, (3) financial analysis, (4) pharmacoeconomic analysis, (5) diversified pharmacy services, ~~and~~ (6) compensation for pharmacists' patient-care services, and (7) revenue cycle compliance and management; further,

To encourage colleges of pharmacy to incorporate these management areas in course work and clerkships.



D. Transitions of Care

- 1 To recognize that continuity of patient care is a vital requirement in the appropriate
- 2 use of medications; further,

- 3 To strongly encourage pharmacists to assume professional responsibility for ensuring
- 4 the continuity of pharmaceutical care as patients move from one setting to another
- 5 (e.g., ambulatory care to inpatient care to home care); further,

- 6 To encourage the development of information systems that facilitate sharing of
- 7 patient-care data across care settings and providers; further,

- 8 To advocate that payers and health systems provide sufficient resources to support
- 9 effective transitions of care; further,

- 10 To encourage the development of strategies to address the gaps in continuity of
- 11 pharmaceutical care.

(Note: This policy would supersede ASHP policy 0301.)

Rationale

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

Background

The Council recommended and the Board approved with amendment revising ASHP policy 0301 as follows (underscore indicates new text):

To recognize that continuity of patient care is a vital requirement in the appropriate use of medications; further,

To strongly encourage pharmacists to assume professional responsibility for ensuring the continuity of pharmaceutical care as patients move from one setting to another (e.g., ambulatory care to inpatient care to home care); further,

To encourage the development of information systems that facilitate sharing of patient-care data across care settings and providers; further,

To advocate that payers and health systems provide sufficient resources to support effective transitions of care; further,

To encourage the development of strategies to address the gaps in continuity of pharmaceutical care.



E. Value-Based Purchasing

- 1 To support value-based purchasing reimbursement models when they are
- 2 appropriately structured to improve health care quality, patient satisfaction, and
- 3 clinical outcomes, and encourage medication error reporting and quality
- 4 improvement; further,
- 5 To encourage pharmacists to actively lead in the design and interdisciplinary
- 6 implementation of medication-related value-based purchasing initiatives.

(Note: This policy would supersede ASHP policy 0708.)

Rationale

[Value-based purchasing](#) is one aspect of a portfolio of health care reform incentives based on pay-for-performance principles. It is currently constructed of 12 clinical outcomes measures and one “measure” of patient experience utilizing the Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS). CMS is expanding its Potential Future Measures for Hospital Value-based Purchasing Program to consider the following measures for the [Hospital Value-based Purchasing Program](#):

- Spending per Hospital Patient with Medicare
- Serious Complications and Deaths
- Hospital Acquired Conditions
- Emergency Department Wait Times
- Heart Patients Given a Prescription for Drugs called Statins at Discharge
- Central Line-associated Blood Stream Infection
- Surgical Site Infections
- Immunization for Influenza
- Immunization for Pneumonia
- Temperature Management for Patients after Surgery

ASHP policy 0708 needs to be broadened to include the concepts of value-based purchasing and incorporate the concepts of clinical outcomes and patient satisfaction in addition to quality. ASHP policy should recognize the pharmacist’s leadership role while explicitly acknowledging the interdisciplinary nature of initiatives designed to achieve value-based purchasing measures.

Background

The Council recommended and the Board agreed to amend ASHP policy 0708 as follows (underscore indicates new text; ~~striketrough~~ indicates deletions):

To support ~~pay for performance~~ value-based purchasing reimbursement models when they are appropriately structured to improve health care quality, patient satisfaction, clinical outcomes, and encourage medication error reporting and quality improvement; 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 in the design and interdisciplinary implementation of medication-related ~~pay for performance~~ value-based purchasing initiatives.



F. Role of Corporate Pharmacist Leadership in Multifacility Organizations

- 1 To advocate that a pharmacist must be responsible for leadership and have responsibility
- 2 for standardization and integration of pharmacy services in multiple business units across
- 3 the entire pharmacy enterprise of multifacility health systems and integrated delivery
- 4 networks; further,
- 5 To educate health-system administrators about the importance of pharmacy leadership in
- 6 setting system-wide policy regarding the safe and effective use of medications.

Rationale

Data from the 2009 American Hospital Association (AHA) annual survey of hospitals indicates that at the time of the survey, 4406 of 5795 hospitals were part of either a system or a network (there may be some overlap among systems and networks). The rate of mergers and acquisitions has been increasing in the last three years, and it has been estimated that by 2013 the number of networks will be reduced from 2200 to approximately 1000. The health care enterprise is evolving from single hospitals to integrated systems and networks. Leadership of the pharmacy must evolve from a department leader in a single facility to an effective corporate leader of medication use across a wide array of business units, care settings, and organizations. The pharmacy enterprise of the future will be more sophisticated and corporate in its nature. Many important decisions that influence medication-use policy will be made at the level of corporate leadership, and it will be critical that pharmacists provide leadership in this corporate decision-making. The ability to demonstrate financial impact of pharmacy services will be critical and the development and implementation of effective drug-use policy across the enterprise will be crucial to success.

Along with increasing consolidation and integration of health systems, the business model for health care is also evolving. Pharmacy leaders will need to become familiar with

changing business imperatives and align the pharmacy business plan with that of the health system. Planning must integrate at both the strategic and tactical level. Pharmacy needs to be envisioned as a service rather than a department.

Background

The Council recommended and the Board agreed to develop new policy.



G. Pharmacist's Role in Health Care Information Systems

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

- 6 To advocate for incentives to hospitals and health systems for the adoption of patient-
- 7 care technologies; further,

- 8 To recognize that design and maintenance of medication-use information systems is an
- 9 interdisciplinary process that requires ongoing collaboration among many disciplines;
- 10 further,

- 11 To advocate that pharmacists must have accountability for strategic planning and direct
- 12 operational aspects of the medication-use process, including the successful deployment
- 13 of medication-use information systems.

(Note: This policy would supersede ASHP policy 0921.)

Rationale

The Council discussed the evolving nature of health IT and the technology requirements for the pharmacy enterprise. The Council believed that current ASHP policy did not clearly describe the successful design and use of technology that supports the medication-use process as an interdisciplinary effort and voted to amend ASHP policy 0921 to reflect the interdisciplinary nature of the medication-use process that requires collaboration in design, implementation, and maintenance. The Council also believed that it was important that pharmacists have accountability for the medication-use process, including the successful deployment of medication-use information systems.

Background

The Council recommended and the Board agreed to amend ASHP policy 0921 as follows (underline indicates new text; ~~strike through~~ indicates deletions):

To strongly advocate key decision-making roles for pharmacists in the planning, selection, design, implementation, and maintenance of ~~pharmacy~~ medication-use

information systems, electronic health records, computerized provider order entry systems, and e-prescribing systems to facilitate clinical decision support, data analysis, and education of users for the purpose of ensuring the safe and effective use of medications; further,

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

To recognize that design and maintenance of medication-use information systems is an interdisciplinary process that requires ongoing collaboration among many disciplines; further,

To advocate that pharmacists must have accountability for strategic planning and direct operational aspects of the medication-use process, including the successful deployment of medication-use information systems.



H. Clinical Decision Support

- 1 To advocate for the development of clinical decision support (CDS) systems that are
- 2 proven to improve medication-use outcomes and that include the following
- 3 capabilities: (1) alerts, notifications, and summary data views based on (a) a rich set of
- 4 patient-specific data, (b) standardized, evidence-based medication-use best practices,
- 5 and (c) identifiable patterns in medication-use data in the electronic health record; (2)
- 6 audit trails of all CDS alerts, notifications, and follow-up activity; (3) structured clinical
- 7 documentation functionality linked to individual CDS alerts and notifications; and (4)
- 8 highly accessible and detailed management reporting capabilities that facilitate
- 9 assessment of the quality and completeness of CDS responses and the effects of CDS
- 10 on patient outcomes.

Rationale

The Council discussed the technology requirements of the pharmacy enterprise and ASHP policies related to technology. The Council believed that one area where a gap in ASHP policy existed was in the area of clinical decision support. Current clinical decision support systems do not provide the functionality that is required in the future practice model that is envisioned by participants at the [Pharmacy Practice Model Initiative](#) (PPMI) Summit. The Council believed that ASHP should advocate for improvements in clinical decision support systems that provide actionable data analytics and support the medication-use process.

Background

The Council and the Section of Pharmacy Informatics and Technology recommended new policy on clinical decision support, and the Board approved the policy with amendment.

Board Actions

Sunset Review of Professional Policies

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

- [Standard Drug Administration Schedules](#) (0707)
- [Staffing for Safe and Effective Patient Care](#) (0201)
- [Performance Improvement](#) (0202)
- [Reimbursement for Unlabeled Uses of FDA-Approved Drug Products](#) (0206)

Other Council Activity

Revenue Cycle Compliance and Management

The Council voted

To develop an ASHP statement on revenue cycle compliance and management.

In addition to recommending new ASHP policy on this subject, the Council voted to develop a formal policy statement on this subject. The Council believed it was important to establish ASHP policy on this issue as noted earlier, but also believed there would be value in ASHP developing a clear policy position on this subject that more clearly articulates the importance of pharmacist participation by providing a more detailed description of the process and role of the pharmacist.

Pharmacists Credentialing and Privileging

The Council voted

To develop ASHP guidelines on credentialing and privileging.

The Council discussed the assessment and documentation of pharmacists' scope of practice. The role of pharmacists is changing as pharmacists become more accountable for patient care. The Council reviewed several papers published in *AJHP* describing the use of credentialing and privileging of pharmacists, the results of the PPMI Summit, a position paper published by the Council on Credentialing in Pharmacy (CCP), and the new business item submitted by the Section of Clinical Specialists and Scientists that was approved at the ASHP House of Delegates.

The Council believed that it would be increasingly important that pharmacists participate in some form of credentialing and privileging process. Physicians and administrators are familiar with board certification and with credentialing and privileging, and the adoption of such models serves to validate pharmacists' knowledge and skills and advance their practices. Several Council members noted that pharmacists in their organizations currently participate in a credentialing and privileging process or that such a process was currently being investigated. It was also noted that these processes varied greatly among organizations and there would be

value in ASHP defining more clearly the core elements of such a process. In some organizations, pharmacists were credentialed by the medical staff committee, while in others the credentialing process for pharmacists occurred through the pharmacy. The Council believed that the pharmacy credentialing and privileging process should be under the oversight of the pharmacy but should be integrated with the medical staff credentialing process. The Council also noted that credentialing and privileging processes for pharmacists may be more important in the future as health systems expand the role of pharmacists in ambulatory practice environments.

The Council voted to develop ASHP guidelines on credentialing and privileging. The Council believed that these guidelines should advocate that credentialing for pharmacists be pharmacist-led but should integrate with medical staff credentialing programs and include medical staff review. The position should encourage credentialing and privileging for advanced roles, especially in the area of collaborative practice. The guidelines should also define standardized elements of a pharmacist credentialing and privileging process in hospitals and health systems. The Council also believed that faculty who practice in hospitals or health systems should also participate in the organization's credentialing and privileging process.

The Council also discussed the New Business Item from the Section of Clinical Specialists and Scientists. The Council was supportive of all elements of the New Business Item and also supported the concept that a vision for the future should be that specialty training would at some point become a prerequisite for board certification. The Council recognized that there remains confusion in the profession about the development of specialties and the difference between specialties and other types of certifications and encouraged ASHP and the Section to educate members. The Council also acknowledged that it would be many years before the profession would reach a point where pharmacy specialists would be both trained and certified and recognized that the profession would need to plan for a transition that did not exclude talented pharmacy professionals who are already engaged in specialty practice.

Effective Use of Consultants

The Council voted

To develop ASHP guidelines on the effective use of consultants within the pharmacy enterprise.

Based on a recommendation from the House of Delegates, the Council discussed the effective use of consultants. The Council noted that there are many different types of consultants that may be engaged by the health system that may provide advice regarding the pharmacy enterprise. In addition to finance and business consultants, these may include IT experts, human resource specialists, and quality improvement consultants. The effective use of consultants can assist the pharmacy enterprise in advancing patient care. This is especially true as the complexity of the medication-use process increases and expertise outside of pharmacy is necessary to implement systems or technology. The Council noted that most of the problems stemming from the use of consultants occurred when financial and business consultants are hired without input from the pharmacy. In many cases, these consultants are engaged to identify cost reductions. In these circumstances, the pharmacy is often not involved in defining

the scope of work or reviewing the qualifications of the consultant relative to the scope of work. The results of the consultants' work also often report benchmarks relative to other peer groups, but the pharmacy director is not provided with peer group data necessary to assess the validity of the peer group. The Council believed it would be valuable for ASHP to develop guidelines that clearly define the key elements of an effective consulting relationship, including expertise relative to the scope of work, clearly defined scope of work, clear and transparent objectives, and access to peer group data and metrics.

The Council also again discussed the appropriate use of workload and productivity measures for the pharmacy enterprise. The Council acknowledged the work of the Section of Pharmacy Practice Managers and ASHP in developing useful publications and providing education on this topic. However, the Council believed that this should remain a high priority for ASHP. Council members noted that pharmacy managers will increasingly be required to establish valid metrics related to pharmacy's organization performance. ASHP must take a leadership role in establishing these metrics and educating members about how to effectively measure and apply them. Council members noted that there is a need to establish metrics related to the care pharmacists provide, to pharmacists' functions that relate to patient satisfaction, and to those that affect readmissions. Council members also believed that such metrics will need to be simple and easy to understand. Health-system executives are not going to place their trust in measures that are complex and difficult to understand. ASHP should also seek opportunities to partner with American College of Healthcare Executives (ACHE) in the development of effective measures.

ASHP Statement on the Roles and Responsibilities of the Pharmacy Executive

The Council voted

To revise the [ASHP Statement on the Roles and Responsibilities of the Pharmacy Executive](#).

As the Council discussed a number of topics it identified skills that are not currently identified in the *ASHP Statement on the Roles and Responsibilities of the Pharmacy Executive*. These included responsibilities for business planning, managing merger and integration of new pharmacy business units, role in integrating pharmacy strategic and tactical planning with the business plans of the enterprise, knowledge of corporate decision- and policymaking, alignment of business units across the continuum of care, contracting, and revenue cycle management and compliance. The Council believed that the statement should be revised to incorporate these skills, as they will increasingly be required in large systems and integrated delivery networks.

Principles of Managed Care

The Council voted

To compile further background information and review [ASHP policy 0709, Principles of Managed Care](#), at a future meeting of the Council.

The Council reviewed policy 0709 as a part of sunset review of policies and believed the policy should be revised but wanted to gather more information prior to undertaking a revision. The Council voted to place the topic on the agenda for next year's Council and asked staff to gather further background relating to this policy.

Product Reimbursement and Pharmacist Compensation

The Council voted

To compile further background information and review [ASHP policy 0207, Product Reimbursement and Pharmacist Compensation](#), at a future meeting of the Council.

The Council reviewed policy 0207 as a part of sunset review of policies and believed the policy should be revised but wanted to gather more information prior to undertaking a revision. The Council voted to place the topic on the agenda for next year's Council and asked staff to gather further background relating to this policy.

Development of Ambulatory Pharmacy Programs in Health Systems

The Council discussed the role of the pharmacy enterprise in caring for patients in ambulatory care settings. As CMS implements the Affordable Health Care Act and various components included under the law, hospitals and health systems are becoming increasingly accountable for health care quality. With this increasing accountability, hospitals and health systems are increasingly assuming responsibility for the outcomes of ambulatory patients. The development of [accountable care organizations](#) (ACOs) and medical homes (MHs) is also driving more interest in ambulatory care among health systems. This will create opportunities for expansion of ambulatory pharmacy services to ensure the best possible outcomes for their patients. Ambulatory patients can receive pharmaceutical services in a number of health-system settings, including freestanding pharmacies, ambulatory care clinics, hospital outpatient departments, assisted living centers, infusion centers, and physician offices. Hospital and health-system pharmacy leaders should assertively plan for the expansion of pharmacy services that provide medications to ensure continuity of care, improve medication adherence, and avoid medication misadventures, thereby minimizing hospital readmissions.

The Council also noted that these changes are also affecting other segments of pharmacy practice. Hospital pharmacy departments should also be aware of the impact of the new 340B Drug Pricing Program rules that allow a single hospital site to contract with multiple contract pharmacies to dispense 340B drugs. Chain drug stores are approaching hospitals and health systems to contract with the hospitals to dispense 340B drugs. Some health systems have entered these contracts without the input or involvement of the pharmacy department. While these contract pharmacy arrangements may provide increased access to 340B drugs for patients, they also allow both pharmacy market capture and 340B savings capture by the chain pharmacies. The impact of these contract pharmacy arrangements on both the 340B Drug Pricing Program as well as outpatient pharmacy services provided by hospitals and health systems should be examined.

The Council believed that ASHP should develop education, tools, and resources to assist members in responding to this changing environment. While the Council believed that PPMI provides a road map, there is a need to more clearly link PPMI to an ambulatory care strategy and define clearly the roles of pharmacists in ambulatory care. Changing economic models for health systems will result in an increased focus on ambulatory care and pharmacy will need to align both a practice model and business model that effectively deploys pharmacists to improve outcomes and quality, reduce costs, and reduce readmissions of ambulatory patients.

Contemporary Roles of Pharmacy Technicians in the Pharmacy Enterprise

The Council discussed the contemporary roles of pharmacy technicians and reviewed results of the PPMI Summit. The Council supported the consensus of the Summit and agreed that pharmacy technicians should be licensed. The Council reviewed [ASHP policy 0702, Pharmacy Technician Training](#), and [policy 8610, Pharmacy Technicians](#), and suggested that these policies should be strengthened. The Council noted that tech-check-tech is already permitted in a number of states, and that technicians working for the Department of Defense function very differently than those in the civilian sector and bear primary responsibility for drug distribution. The Council believed that economic pressures on health care will require pharmacy to adapt and utilize technicians to a much greater extent in order to achieve the vision of the PPMI summit.

The Council believed that ASHP should focus more effort on developing technician education. There are currently too few accredited training programs. ASHP should encourage the development of more accredited training. There is also a need for education and training of technicians beyond the basic requirements for accredited training. ASHP should develop resources to assist hospitals and health systems to train technicians in more advanced support roles such as managing investigational drugs, managing patient assistance programs, chemotherapy preparation, and others.

Factors Influencing Medication Complexity Index

An outgrowth of the PPMI Summit was an effort to develop a medication complexity index. The Council was asked to review available literature from pharmacy, nursing, and other disciplines with the goal of recommending factors the expert panel should consider. An expert panel, convened by ASHP and the ASHP Foundation, has been formed and charged with development of a Patient Medication Complexity Index that can be used by hospitals and health systems that are committed to advancing their pharmacy practice models. This complexity index will be a tool that supports allocation and/or reallocation of pharmacist-provided drug therapy management services to individual patients and populations of patients in both the inpatient and health system-based outpatient settings.

Nursing has utilized patient acuity modeling to determine staffing for some time, and commercial products are available to assist in the assignment of nursing resources. These models have allowed nursing to adjust scheduling continuously based upon volume and acuity. Some hospitals have begun to utilize such solutions in other departments. The Council noted that the complexity of medication therapy is affected by numerous factors, including the therapeutics of the drug therapy, the number of drugs utilized, the number of concomitant

disease states, specific pharmacodynamic variables related to drug metabolism and elimination, the mode of drug delivery, the rate of disease progression, and frequency of drug therapy adjustments for certain care units or patient populations, among others.

The Council believed that ASHP and pharmacy directors need to envision a tool that could be utilized more prospectively to assign or reallocate pharmacists based on patient needs and not simply as a tool that could be used to determine the number of pharmacists needed and justify new positions. Such a tool could allow managers to focus pharmacists' time where pharmacy can most provide value. The Council noted that pharmacy has traditionally thought of assigning a full-time equivalent (FTE) to a unit, but should be thinking of deploying pharmacists as both fixed and variable resources. Pharmacists could be deployed to high-risk patients across the enterprise rather than assigned to a specific patient-care unit. This concept could be expanded even further via telepharmacy solutions to allow pharmacy specialists to serve complex patients across an entire system or network. Individual pharmacists could also be shifted from one patient-care unit to another based upon the complexity and patient needs.

The Council noted that such a system would need to be simple, highly automated, and integrated with the health system's health IT infrastructure. It will be important to plan for a tool that facilitates the deployment of pharmacists for both acute care as well as ambulatory patients. The Council also noted that the use of such a tool would likely be quite different in a very small facility compared to a large tertiary referral center. The Council believed that the effective development of such a tool could support the development of more effective benchmarking.

Interface of Health Care Reform and Practice Models

The Council discussed the impact of health care reform efforts and economic pressures on successful implementation of the PPMI. There is great uncertainty in many business sectors right now and health care is among them. Hospitals and health systems are evaluating the impact of health care reform and changing reimbursement models on their business. Some hospital administrators are questioning the future of accountable care organizations, while others are embracing the concept. The pace of consolidations and mergers has continued to increase and most urban markets now have no more than three health systems. Health systems are developing more corporate structures and cultures. Many health systems are currently downsizing staffing in anticipation of lower reimbursements.

Regardless of the current uncertainty it appears likely that hospital and health care reimbursements will change and that while there may be further change over time some trends will continue. There will likely be continuing pressure to reduce the cost of health care, and health systems are likely to face increasing pressure to reduce costs, improve quality, improve patient satisfaction, and reduce readmissions. The Council believed that it will be critical for pharmacy leaders to understand how these changes are affecting the economic outcomes of the health care enterprise and develop new business plans for the pharmacy enterprise that clearly define pharmacy's value in terms of revenue and in terms of achieving value-based purchasing objectives that drive revenues. Further, pharmacy will need to define and measure its impact on patient care and on organizational objectives. There will be a need to reallocate resources including expanded use of technicians and technology, reallocation to ambulatory

care and managing transitions of care, and changes to models for training students and residents.

The Council also discussed [ASHP policy 0227, Pharmacist's Responsibility for Patient Safety](#). The Council believed that this policy did a good job of defining the pharmacist's responsibilities but should be strengthened to include responsibilities of the pharmacy department. The policy should also encourage the development and implementation of training pharmacists in the application of tools and techniques such as root cause analysis. The Council recommended that the Council on Pharmacy Practice review the policy next year for possible revision.

The Council encouraged ASHP to develop education and resources to assist pharmacists in making these transitions. Areas of need include patient adherence, customer service and patient satisfaction, business planning, managing change, efficiency and process management, and strategies to link PPMI to business plans.

Workload and Productivity Measures

Based on a recommendation from the House of Delegates, the Council discussed the need for ASHP-endorsed workload and productivity measures. The Council has discussed concerns with workload and productivity measurement at several past meetings and acknowledged that ASHP and the SPPM have developed useful publications and educational offerings to assist members, but also agreed that there is a need for ASHP to take more formal leadership in developing uniform measures. The Council noted that administrators will not accept the excuse that pharmacy is different and will increasingly require pharmacy directors to compare their performance with that of other organizations. The Council acknowledged that this will not be an easy undertaking, but also believed strongly that there is a need to develop measures even if they are not perfect. Council members noted that administrators want simple and easy-to-understand measures. ASHP should avoid the approach of trying to achieve perfection and should focus on incremental improvement. The Council believed the use of a balanced scorecard approach could be useful and that the development of a medication acuity index may also be part of the solution. The Council also suggested that ASHP engage administrator organizations and consider a partnership with groups such as ACHE.



SEIZE THE INITIATIVE

ASHP House of Delegates 2012
June 10 and 12, 2012

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.

Larry C. Clark, *Board Liaison*

Council Members

- Brian D. Hodgkins, *Chair* (California)
- Christopher Betz, *Vice Chair* (Kentucky)
- Donna J. Field (Washington)
- Ryan A. Forrey (Ohio)
- Kristine P. Gullickson (Minnesota)
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- Melinda C. Stanton, *Student* (Ohio)
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(Click on title to view section)

Policy Recommendations



A. Pharmacist Prescribing in Interdisciplinary Patient Care

- 1 To define pharmacist prescribing as follows: the selection, initiation, monitoring, and
- 2 adjustment of medication therapy pursuant to diagnosis of a medical disease or
- 3 condition; further,
- 4 To advocate that health care organizations establish credentialing and privileging
- 5 processes that delineate the scope of pharmacist prescribing within the hospital or
- 6 health system and to ensure that pharmacists who prescribe are competent and
- 7 qualified to do so.

Rationale

The [Pharmacy Practice Model Initiative](#) (PPMI) Summit recommended that “[t]hrough credentialing and privileging processes, pharmacists should include in their scope of practice prescribing as part of the collaborative practice team.” (Recommendation B14) With the demand for health care growing as the nation ages and increasing concern about the shortage of primary care providers, expanding the pharmacist’s role will contribute to the overall capacity of the health care workforce to meet patients’ primary health care needs.

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

In the proposed definition, pharmacist prescribing differs from that by other authorized prescribers and from medication therapy management (MTM) and CDTM in three significant aspects. First, prescribing by pharmacists requires active participation in the patient’s health care team or active engagement and coordination with other individual practitioners responsible for the patient’s care. Second, pharmacist prescribing must take place in concert with assessment, diagnosis, and other clinical findings contributed by the patient’s other care providers, and changes in the patient’s medication therapy must be communicated to these individuals in a readily available and timely manner. Third, pharmacists who prescribe are accountable to patients and to the health care team for exercising professional judgment in pharmacotherapy and medication-use decision-making according to their defined scope of

services, as well as for the outcomes of those services. While many pharmacists may currently order medications under protocols for MTM or CDTM, prescribing entails a higher degree of autonomy and is a role for advanced practitioners with demonstrated competency and expertise.

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

The [American Medical Association](#) and the [American Academy of Family Physicians](#) have publicly and staunchly opposed any expansion of pharmacist scope of practice perceived to encroach on the practice of medicine. Pharmacist prescribing is implicit to interdisciplinary care delivery, however. Independent drug therapy decision-making by pharmacists in hospitals is already common. It is often accepted and even expected by physicians. Physicians participating in multidisciplinary teams with pharmacists come to rely on their knowledge and see an opportunity to free themselves from tasks that can be done by another professional with demonstrated competency and expertise. Pharmacists in specialty practices such as anticoagulation management, solid organ transplant, and nutrition support have long functioned in roles in which near-independent authority to manage drug therapy has resulted in improved outcomes. In settings such as the Indian Health Service and Veterans Affairs health systems, where access to a primary care provider is limited, care provided by pharmacists with prescribing authority has demonstrated the benefits of this model.

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

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

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

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

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

Background

The Council voted and the Board agreed to establish a definition of pharmacist prescribing that can be used to promote common understanding of this term in the health care community. Acknowledging inevitable opposition by other licensed independent prescribers, the Council recommended a number of tactics ASHP should consider when implementing the policy:

- Establish a clear definition with supporting rationale.
- Explore and resolve concerns of other disciplines about encroachment into the practice of medicine.
- Identify the potential for pharmacists to extend the capacity of the primary care provider workforce by relieving primary care providers of unnecessary tasks, reducing medication-related adverse events, and improving therapeutic outcomes.
- Encourage and support expanded state scope of practice acts.
- Develop messaging to address financial implications for physicians if they are concerned about reimbursement restructuring.
- Emphasize the collaborative nature of pharmacist prescribing and its benefits to patients, prescribers, and other health care workers using data on the dwindling health care workforce, particularly primary health care providers, and the anticipated increase of patients due to health care reform and the aging baby boomer population.
- Assess, analyze, and develop strategies to resolve ethical and legal issues.
- Educate pharmacists on the implications of an advanced practice that includes prescribing.

In light of regulatory, reimbursement, and other changes that must first take place, the Council predicted that implementation will occur in phases and the pharmacist's prescribing role will continuously evolve until state practice acts are changed, liability issues are defined, and ethical concerns are resolved. The Council acknowledged a number of regulatory and scope of practice

issues that may present a barrier to implementing a pharmacist prescribing policy. While few states have scope of practice acts that allow pharmacists to independently prescribe, a number of state boards have initiated discussions of this topic, and at least one state, Washington, is currently developing regulations for pharmacist prescribing within a collaborative practice model. Because these topics fall under the purview of the Council on Public Policy, the Council focused instead on the importance of licensing, privileging, and credentialing procedures by hospitals for pharmacists who prescribe.



B. Pharmacist's Role in Accountable Care Organizations

- 1 To recognize that pharmacist participation in collaborative health care teams
- 2 improves outcomes from medication use and lowers costs; further,

- 3 To advocate to health policymakers, payers, and other stakeholders for the inclusion
- 4 of pharmacists as health care providers within accountable care organizations (ACOs)
- 5 and other models of integrated health care delivery; further,

- 6 To advocate that pharmacist-provided care (including care coordination services) be
- 7 appropriately recognized in reimbursement models for ACOs; further,

- 8 To advocate that pharmacists be included as health care providers in demonstration
- 9 projects for ACOs; further,

- 10 To encourage comparative effectiveness research and measurement of key outcomes
- 11 (e.g., clinical, economic, quality, access) for pharmacist services in ACOs; further,

- 12 To encourage pharmacy leaders to develop strategic plans for positioning pharmacists
- 13 in key roles within ACOs.

Rationale

The Affordable Care Act of 2009 encourages the formation of [accountable care organizations](#) (ACOs). Similar in concept to health maintenance organizations, these entities consist of alliances between physicians, other health care providers, and hospitals that provide comprehensive and coordinated health care to a population of patients. ACOs emphasize primary and preventive care, are provider-led, and receive reimbursement linked to increasing health care quality and lowering per capita costs. The ACO model is based on the premise that care coordinated in this manner and incentivized by a shared-risk reimbursement model will improve health care quality and slow the growth of health care spending. One significant deterrent to pharmacist participation in the fee-for-service care model, lack of provider status, is less of a barrier in the ACO model because reimbursement is tied to quality and reduced costs rather than specific services.

Integrated systems present an important opportunity for pharmacists to demonstrate their value to the quality of care. Pharmacists could contribute to the success of ACOs by providing the following patient care services:

- Developing, implementing, and monitoring patient-specific, evidence-based drug therapy as an active participant in team-based care.
- Improving transitions in care with coordinated MTM services for patients in the hospital as well as post-discharge in ambulatory clinics and physician practices.
- Monitoring the therapy of patients with multiple chronic conditions or complex medication regimens.
- Preventing and managing adverse drug events.

Although a number of ACOs have already evolved from existing disease management and medical home programs, not much is known about the elements of success for ACOs, and implementation is likely to be challenging. To establish these elements of success, pharmacists will need to be included in ACO demonstration projects and pharmacist services will need to be the subject of research on ACO effectiveness.

As pharmacists assume the expanded roles outlined in the PPMI recommendations, pharmacy leaders should use their expertise to explore innovative strategies to meet the broader goals of ACOs. This payment model is an opportunity to demonstrate how pharmacists can help these organizations reach clinical and financial performance targets set by the Centers for Medicare & Medicaid Services (CMS), i.e., improved patient results and lower health care costs. Pharmacy managers and other pharmacy leaders should prepare now to participate in emerging ACOs by developing strategic plans for positioning pharmacists in roles where their expertise can be best applied to these goals.

Background

Although a number of ACOs have already evolved from existing disease management and medical home programs, the Council noted that implementation is likely to be challenging and considered whether policy development should be deferred until more is known about the elements of success for ACOs. [Final regulations for ACOs](#) were not released until October 2011, after the Council's meeting, but the Council concluded that ASHP policy is needed now to establish the role of pharmacists in ACOs and demonstrate ways pharmacists can contribute to quality of care while lowering costs.



C. Pharmacist's Role in Team-Based Care

- 1 To recognize that pharmacist participation in interdisciplinary health care teams as
- 2 the medication-use expert increases the capacity and efficiency of teams for
- 3 delivering high-quality care; further,

- 4 To assert that pharmacists are responsible for coordinating the care they provide with
- 5 that provided by other members of the health care team and are accountable to the
- 6 patient and to the health care team for the outcomes of that care; further,

- 7 To urge pharmacists on health care teams to collaborate with other team members in
- 8 establishing quality measures for care provided by those teams.

Rationale

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

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

Background

ASHP support for pharmacist participation in interdisciplinary care teams is longstanding. ASHP policy positions, statements, and guidelines support pharmacist participation on the interdisciplinary primary care team, on teams in hospice, and in other care settings as a means of ensuring safe and effective use of medications. In addition, ASHP participates in the Hospital Care Collaborative, an ongoing initiative in collaboration with the Society of Hospital Medicine and others that is aimed at developing and promoting successful models where care is delivered by an interdisciplinary team.

Council members suggested that additional detailed practice guidance is required to unify the profession's approach to team-based care. They recommended development of an ASHP statement or guidelines that address such topics as how teams operate in various care settings, how communication determines team success, the use of national guidelines and core

measures, how to adapt the team or its services to meet patient needs, and using measures of team performance for continuous improvement. The Council emphasized the importance of these data if pharmacists are to continue to be relevant in light of a future health care delivery system that emphasizes coordinated care that is accessible, effective, less expensive, and safer.



D. ASHP Statement on the Pharmacist's Role in Medication Reconciliation

- 1 To approve the *ASHP Statement on the Pharmacist's Role in Medication Reconciliation* ([Appendix](#)).

Background

In 2010, the Council recommended revising ASHP policy 0620, Pharmacists' Role in Medication Reconciliation. After debating and approving the revised policy ([ASHP policy 1117, Pharmacists' Role in Medication Reconciliation](#)), several House delegates recommended development of a statement to more thoroughly delineate ASHP policy on the roles pharmacists should play in medication reconciliation. A statement was subsequently drafted, and the Council reviewed the draft at its September 2011 meeting. The statement was revised to reflect the Council discussion, and the resulting draft was sent for peer review in December 2011. The draft was revised in response to the comments of more than 25 ASHP members as well as representatives of the Academy of Managed Care Pharmacy, the American College of Physicians, and the Canadian Society for Hospital Pharmacists.



E. New and Emerging Medication Ordering and Distribution Systems

- 1 To discontinue ASHP policy 0522, which reads:
 - 2 To support the use of new and emerging medication ordering and distribution
 - 3 systems (e.g., via the World Wide Web) when such systems (1) enable
 - 4 pharmacists to provide patient care services, (2) ensure that patients will not
 - 5 receive improperly labeled and packaged, deteriorated, outdated, counterfeit,
 - 6 or non-FDA-approved drug products, (3) provide appropriate relationships
 - 7 among an authorized prescriber, pharmacist, and patient, (4) enhance the
 - 8 continuity of patient care, (5) support the pharmacist's role as a patient care
 - 9 advocate, and (6) provide for data security and confidentiality.

Background

As part of sunset review, the Council reviewed policy 0522 and noted that Plank 3 of the [ASHP Leadership Agenda](#), Pharmacist Leadership in Health Information Technology, will likely

accomplish much of the intent of this policy. The Council also noted that automated medication distribution systems are adequately addressed in a number of existing ASHP technology policies.



F. Role of Pharmacists in Sports Pharmacy and Doping Control

- 1 To discontinue ASHP policy 0710, which reads:
 - 2 To encourage pharmacists to engage in community outreach efforts to provide
 - 3 education to athletes on the risks associated with the use of performance-
 - 4 enhancing drugs; further,
 - 5 To encourage pharmacists to advise athletic authorities and athletes on
 - 6 medications that are prohibited in competition; further,
 - 7 To advocate for the role of the pharmacist in all aspects of sports pharmacy
 - 8 and doping control.

Background

As part of sunset review, the Council reviewed policy 0710 and concluded that the policy is no longer needed due to stricter regulations and testing for drug abuse in sports.



G. Pharmacist's Responsibility for Patient Safety

- 1 To discontinue ASHP policy 0227, which reads:
 - 2 To affirm that individual pharmacists have a professional responsibility to
 - 3 ensure patient safety through the use of proven interventions and best
 - 4 practices; further,
 - 5 To affirm that employee performance measurement and evaluation systems
 - 6 should incorporate measures that support and encourage a focus on patient
 - 7 safety by pharmacists.

Background

As part of sunset review, the Council reviewed policy 0227 and determined that the concepts in this policy are adequately addressed by ASHP policy 1114, Pharmacist Accountability for Patient Outcomes, which reads:

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

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

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

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

Board Actions

Sunset Review of Professional Policies

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

- [Electronic Health and Business Technology and Services](#) (0712)
- [Appropriate Dosing of Medications in Patient Populations with Unique Needs](#) (0228)
- [Pharmacist's Role in Drug Procurement, Distribution, Surveillance, and Control](#) (0232)
- [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 Statement on the Role of Health-System Pharmacists in Public Health](#)
- [ASHP Statement on Racial and Ethnic Disparities in Health Care](#)
- [ASHP Guidelines on Pharmacist-Conducted Patient Education and Counseling](#)
- [Principles of a Sound Drug Formulary System](#) (Endorsed)

Other Council Activity

Pediatric Dosage Forms

The Council voted to defer sunset review of [ASHP policy 9707, Pediatric Dosage Forms of Drug Products](#). The Council requested a report regarding implementation of the policy in order to determine whether the intent has been fully met and will vote by mail ballot.

Ethical Considerations for Patient Prioritization During Drug Shortages

The Council determined that the current critical status of drug shortages requires ethical guidance for pharmacist decision-making regarding patient care when critical medications are scarce or unavailable. Drug shortages have increased at an alarming rate over the last five years and show no sign of declining in the foreseeable future.

Pharmacists play an integral role in communicating drug supply status to the clinical staff and medication-use policy committees in their organizations. Pharmacists also provide expertise in developing prioritization criteria to conserve scarce drug supplies, including recommendations for alternative agents and dose modification.

A number of unresolved ethical issues were raised by the Council, and members recommended that ASHP solicit a bioethicist's expert opinion regarding these issues and publish a comprehensive review of ethical considerations for managing drug shortages in *AJHP*.

ASHP Statement on Professionalism

The Council recommended revising the [ASHP Statement on Professionalism](#) in order to incorporate recommendations from the PPMI Summit and [ASHP policy 1114, Pharmacist Accountability for Patient Outcomes](#).

Shared Accountability Between Pharmacists and Technicians

The Council discussed PPMI Summit recommendations that identify new and expanded roles for technicians in order to provide the practitioner's perspective to the Council on Public Policy's consideration of professional policy on this issue. The Council considered the implications of an expanded technician role that includes greater responsibility, critical thinking, and independent decision-making with regard to operational matters. Council members cited examples of complex technician responsibilities that might significantly advance the practice of pharmacy, such as technical workforce supervision, technology management, and participation in medication reconciliation. Council members offered the following perspectives to the Council on Public Policy.

- Highly skilled, competent technicians are essential if the profession of pharmacy is to advance.
- ASHP should set high standards for technician competence and accountability for the quality of their work.
- Technicians will perform critical, complex, highly technical job responsibilities.

- Technicians should have decision-making authority consistent with these responsibilities.
- Technicians, like any other health care worker, have a fundamental accountability to the patient for acting in a safe and responsible manner in performance of their duties.

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

Professional Judgment and Medication Use

The Council reviewed regulatory and accreditation standards requirements that limit the information that can be used to determine storage and stability of medications to approved product labeling (i.e., the package insert).

The Council agreed that, while product labeling is an important source of stability and storage information, it is the pharmacist's responsibility and within pharmacy scope of practice to use professional judgment to determine how drugs may appropriately be packaged, stored, administered, and recommended for particular clinical conditions.

Prohibiting use of stability data from non-FDA-approved sources, such as official compendia or other authoritative sources of drug information, has the potential to increase waste and worsen drug shortages. As the [ASHP Statement on the Pharmacist's Responsibility for Distribution and Control of Drug Products](#) is currently in revision, the Council forwarded a suggested revision recommending that organizational policies on storage and stability be supported by information in nationally recognized compendia or other authoritative references, or confirmation by the manufacturer that the use is appropriate, or scientific studies published in the biomedical literature.

ASHP Guidelines for Pharmacists on the Activities of Vendors' Representatives in Organized Healthcare Systems

Council members reviewed the draft ASHP Guidelines on the Pharmacist's Relationship with Industry, which will supersede these guidelines when finalized. Council members offered a number of additional revisions for consideration:

- Require tighter restrictions on vendor activity than those in the draft guidelines. Several Council members' institutions allow vendors to make appointments only with the Director of Pharmacy during a specified time routinely set aside for that purpose. Others meet with vendor representatives offsite due to accreditation standards requiring that vendors meet immunization and safety training requirements.
- Council members advised that practice managers should develop policies limiting the activities of physicians' assistants and nurse practitioners employed as representatives by certain companies. Some Council members have noted that these individuals divert hospital business to their specialty pharmacies while detailing their products and services.

Council members also suggested that sample vendor policies would be a useful practice manager resource.

Practice Implications for Remote Product Verification

The Council reviewed both [ASHP policy 0716, Regulation of Telepharmacy Services](#), and the current [ASHP Guidelines on Remote Medication Order Processing](#). The Council recommended that the Section of Pharmacy Informatics and Technology collaborate with the Council on Public Policy to consider revising these documents to include emerging technology for remote order verification and to ensure that adequate downtime procedures are developed. While the current guidance is comprehensive, innovation in this field has advanced rapidly and ASHP documents no longer reflect current practice.

The Council offered a number of proposed revisions:

- An amendment to ASHP policy 0716 that addresses remote product verification.
- Clarification of the phrases “remote double-checking of the completed medication order before dispensing” and “actual dispensing” in order to clearly convey that a final check required to verify that a product is dispensed as ordered.
- Consider the addition of more detailed recommendations in the guidelines for implementation of downtime procedures in remote facilities.
- Affirm that pharmacists must have access to all patient clinical information, rather than minimum elements.
- Consider reviewing and revising ASHP policy and guidance documents on hazardous medications to include implications for remote order and product verification. A significant proportion of oncology medications are prepared in clinics and community-based practices without oversight of a pharmacist.

Board Certification for Pharmacists

The Council reviewed the new business item and background as requested by the ASHP Section of Clinical Specialists and Scientists (SCSS) and submitted comments for readying the policy for the next step in the policy process. Council members provided a number of comments supporting the policy as well as potential obstacles or objections the policy might encounter in the approval process. The Council Secretary forwarded these comments to SCSS for their consideration.

Technician Licensure

As requested, the Council reviewed background and recommendations from the PPMI Summit in order to advise ASHP regarding its initiative to seek technician licensure rather than registration. Much of the Council’s discussion took place in conjunction with consideration of recommending a new policy for technician accountability.

In general, the Council believed the public would be well served by licensure of technicians, if licensure is clearly defined regarding scope of practice and application requirements. Council members provided examples illustrating that the differences among licensing, registration, and certification are not obvious or well understood. One state board,

Louisiana, already licenses technicians and requires PTCB certification and training in a Board-approved training program. Several Council members stated the requirements were the same in their states for registration.

Council members stated that licensure should require more than competency. It is a contract with the public that the licensed individual has a specialized skill and is responsible for using good judgment in performing his or her job, not simply a tracking and disciplinary procedure. The Council's recommendations were forwarded to the Council on Education and Workforce Development and the Council on Public Policy for incorporation into proposed policies on technician competency and licensing by state regulatory boards.

The Council agreed that licensure, subsequent to completion of an ASHP-accredited training program and PTCB certification, is required to develop the skilled technician workforce needed to support expanded roles for pharmacists. They recommended that all technicians become licensed but advised that one size might not fit all. Evolving technician roles might include independent decision-making responsibility for operational issues, informatics, and supervision.

Review of Documents in Development

The Council reviewed the document development plan for the next three-year period and forwarded recommendations continuation, discontinuation, or suspension to ASHP.

Appendix



ASHP Statement on the Pharmacist's Role in Medication Reconciliation

Position

1 The American Society of Health System Pharmacists (ASHP) believes that an effective
2 process for medication reconciliation reduces medication errors and supports safe
3 medication use by patients. ASHP encourages hospitals and health systems, including
4 community-based providers and managed care systems, to collaborate in organized,
5 multidisciplinary medication reconciliation programs to promote continuity of patient care.
6 ASHP further believes that pharmacists, because of their distinct knowledge, skills, and
7 abilities, are uniquely qualified to lead interdisciplinary efforts to establish and maintain an
8 effective medication reconciliation process in hospitals and across health systems.
9 Pharmacists should lead or assume key roles in the following essential components of
10 medication reconciliation: developing policies and procedures, implementing and
11 continuously improving medication reconciliation processes, training and assuring the
12 continuing competency of those involved in medication reconciliation, providing operational
13 and therapeutic expertise in the development of information systems that support
14 medication reconciliation, and advocating for medication reconciliation programs in the
15 community. Pursuant to their leadership role, pharmacists share accountability with other
16 hospital and health-system leaders for the ongoing success of medication reconciliation
17 processes across the continuum of care.

Background

18 The term “medication reconciliation” is defined by The Joint Commission (TJC) as “the
19 process of comparing the medications a patient is taking (and should be taking) with newly
20 ordered medications” in order to resolve discrepancies or potential problems.¹ The goals of
21 medication reconciliation are to obtain and maintain accurate and complete medication
22 information for a patient and use the information within and across the continuum of care
23 to ensure safe and effective medication use. Although it is sometimes associated with
24 survey and accreditation activities, medication reconciliation is an important component of
25 patient safety and has demonstrated effectiveness in preventing adverse drug events. When
26 organizations do not consistently and reliably reconcile patient medications across the
27 continuum of care, medication errors and adverse drug events occur: approximately half of
28 all hospital-related medication errors and 20% of all adverse drug events have been
29 attributed to poor communication at the transitions and interfaces of care.²⁻³

30 In 1999, the Institute of Medicine (IOM) report *To Err Is Human: Building a Safer Health*
31 *System*⁴ identified medication errors as the most common type of health-system error,
32 contributing to several thousand deaths each year. The fiscal impact of these errors is also
33 significant. With reported costs of \$2595–4685 per adverse drug event, drug-related
34 morbidity and mortality was estimated to be over \$177 billion in 2000 alone.⁵

35 Reports and studies such as these had a profound impact on the medical community,
36 and the call for action was immediate. Organizations such as the Institute for Healthcare
37 Improvement (IHI), the Agency for Healthcare Research and Quality (AHRQ), and TJC

38 launched initiatives for performance improvement and established higher expectations
39 through new regulatory standards for improved communication between providers and
40 patients and across health care systems.

41 In 2005, TJC made medication reconciliation a focus of one of its National Patient
42 Safety Goals. The initial goal included a number of detailed and specific requirements, which
43 made implementation challenging and resulted in numerous findings of noncompliance
44 during survey. In response, TJC affirmed the importance of the goal but suspended it in
45 2009 and 2010 for extensive revision. After a comprehensive literature review and analysis
46 of data collected by surveyor teams, a modified goal was released in 2011, and scoring of
47 the goal began in July 2011.⁶ The revised goal sets an expectation for maintaining accurate
48 medication information at critical risk points in the medication-use process while allowing
49 organizations latitude to define processes and encouraging performance improvement.

50 The purpose of this statement is to describe pharmacists' responsibilities and
51 accountabilities in medication reconciliation practices.

Pharmacists' Responsibilities

52 When performed by pharmacists, medication reconciliation can reduce the frequency and
53 severity of hospital medication errors that could potentially result in patient harm.⁷

54 Pharmacists have demonstrated high rates of patient interventions; interventions per
55 patient; and documentation of medications, medication interactions, drug-related
56 admissions, and previous drug failures.⁸

57 ASHP and the American Pharmacists Association (APhA) began a collaborative effort in
58 2007 and 2008 to create a shared vision for the role of the pharmacist in medication
59 reconciliation processes.⁹ That vision recognizes that pharmacists should take a leadership
60 role in improving medication reconciliation, acting as both advocates and medication
61 experts, to provide information to and educate patients and health care providers.
62 Specifically, pharmacists' responsibilities were described as including but not being limited
63 to

- 64 • providing leadership in designing and managing patient-centered medication
65 reconciliation systems,
- 66 • educating patients and health care professionals about the benefits and limitations
67 of the medication reconciliation process, and
- 68 • serving as patient advocates throughout transitions of care.

69 Using this vision as a guide, ASHP has developed the following recommendations for
70 pharmacists' functions in medication reconciliation activities.

Pharmacists' Functions

71 Although medication reconciliation is required at key transitions of care, activities
72 associated with medication reconciliation should be considered part of ongoing care
73 provided to a patient. Beyond active participation in medication reconciliation activities,
74 pharmacists have five fundamental functions in medication reconciliation: developing
75 policies and procedures regarding medication reconciliation processes, implementing and
76 continuously improving those processes, training and assuring the continuing competency
77 of those involved in medication reconciliation, providing operational and therapeutic
78 expertise in the development of information systems that support medication
79 reconciliation, and advocating for medication reconciliation programs in the community.

80 The extent of pharmacist involvement in these functions will depend on the resources
81 available.

82 **Policy and procedure development.** Pharmacists should provide leadership and
83 participate in establishing policies and procedures that encourage (a) provision of patient-
84 care services that include medication reconciliation processes, (b) implementation and
85 operation of an evidence-based medication reconciliation system that optimizes available
86 resources, (c) education of organization staff on the importance of medication reconciliation
87 as a patient safety initiative, and (d) promotion of medication reconciliation as a focus of
88 performance improvement activities.

89 **Implementation and performance improvement.** Pharmacists should lead or
90 participate in organizational implementation of and performance improvement efforts
91 regarding medication reconciliation activities. These activities may include but are not
92 limited to: (a) establishing a medication reconciliation implementation task force or
93 redesign team; (b) creating a vision and expectations for medication reconciliation activities;
94 (c) securing executive-level commitment to or sponsorship of medication reconciliation
95 resource needs; (d) identifying barriers that are preventing, or potential barriers that may
96 prevent, safe and effective medication reconciliation procedures within their practice
97 model, as well as possible solutions; (e) guiding workflow development that integrates
98 operational and clinical needs; (f) establishing roles and responsibilities of health care
99 providers in medication reconciliation processes, including pharmacy technicians, pharmacy
100 students, and other medical support personnel; (g) ensuring that competency-based
101 training for all personnel involved in medication reconciliation procedures is established; (h)
102 creating or assisting in the development of standardized documentation templates for
103 medication lists and reconciliation; (i) ensuring that established procedures meet regulatory
104 requirements and organizational policy; and (j) developing a method for ongoing medication
105 reconciliation system evaluation.

106 **Training and competency assurance.** Pharmacists should lead or participate in (a)
107 identifying all health care providers and support staff involved in medication reconciliation
108 activities; (b) creating competency training and skills assessment that are specific to each
109 staff member's roles and responsibilities in medication reconciliation (e.g., conducting a
110 medication interview, taking a medication history, performing medication reconciliation);
111 (c) providing education and performing assessments to ensure the competency of those
112 who document and perform medication reconciliation activities; and (d) providing didactic
113 or simulated training for medication history and reconciliation procedures.

114 **Information systems development.** As more organizations adopt computerized
115 provider order entry, electronic medical records, and other information systems,
116 pharmacists should ensure that the systems support medication reconciliation throughout
117 the continuum of care. Consideration should be given to establishing methods for data
118 extraction from the medical record that allow for internal and external reporting of
119 measures related to medication reconciliation.

120 **Advocacy.** Pharmacists should provide information about medication reconciliation to
121 health care providers, patients, and the community, and they should evaluate the
122 effectiveness of these advocacy efforts on the medication reconciliation process. Activities
123 may include clinical grand rounds, professional conferences, patient counseling, or mass
124 communications such as newsletters or public service announcements. These efforts should
125 (a) demonstrate the effectiveness of sound medication reconciliation processes in

126 improving patient safety and reducing health care costs; (b) emphasize the importance of
127 timely and accurate communication of medication information between patients and their
128 health care providers; (c) clarify and describe the important role of technology and
129 electronic medical records that support medication reconciliation documentation and
130 reconciliation; (d) provide strategies for preventing medication adverse events related to
131 overuse, misuse, omission, duplication, or other discrepancies found during medication
132 reconciliation processes; (e) highlight the importance of completing a full and accurate
133 medication history, including supplement use, prior to prescribing or administering a new
134 medication; and (f) describe opportunities for pharmacist extenders, such as pharmacy
135 technicians and students, to participate in medication reconciliation activities.

136 **Resource constraints.** Although the literature demonstrates the important role of
137 pharmacists in successful medication reconciliation processes across the continuum of care,
138 significant resources are needed to perform medication reconciliation skillfully and
139 efficiently, which suggests opportunities for expanding the roles of pharmacy residents,
140 students, and technicians. When properly trained, these individuals can participate in the
141 documentation of medication histories, which should then be reviewed by the pharmacist
142 for accuracy prior to medication reconciliation, as described in the ASHP Pharmacy Practice
143 Model Initiative Summit Recommendations.¹⁰ In one study, potential errors due to
144 incomplete or incorrect information, illegible orders, and serious drug interactions were
145 reduced by 82% by having pharmacy technicians obtain medication histories.¹¹

146 When confronted with limited resources, pharmacists should at a minimum participate
147 in and guide interdisciplinary efforts to develop and define policies and procedures for their
148 organizations, standardize workflows for electronic documentation, promote safe practices
149 to the community, and, most importantly, engage health care leadership in efforts to ensure
150 medication reconciliation processes are successful.

Conclusion

151 An effective process for medication reconciliation reduces medication errors and supports
152 safe medication use. Pharmacists are uniquely qualified to lead interdisciplinary efforts to
153 establish and maintain an effective medication reconciliation process in hospitals and across
154 health systems and should lead or assume key roles in the essential components of
155 medication reconciliation. Because of their crucial role, pharmacists share accountability
156 with other hospital and health-system leaders for the ongoing success of medication
157 reconciliation processes across the continuum of care.

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SEIZE THE INITIATIVE

ASHP House of Delegates 2012
June 10 and 12, 2012

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.

Christene M. Jolowsky, *Board Liaison*

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Policy Recommendations



A. Licensure of Pharmacy Technicians

1 To advocate that pharmacy move toward the following model with respect to
2 technicians as the optimal approach to protecting public health and safety: (1)
3 development and adoption of uniform state laws and regulations regarding licensure
4 of pharmacy technicians, (2) mandatory completion of an ASHP-accredited program
5 of education and training as a prerequisite to pharmacy technician certification, (3)
6 mandatory certification by the Pharmacy Technician Certification Board as a
7 prerequisite to licensure by the state board of pharmacy, and (4) licensure of
8 pharmacy technicians by state boards of pharmacy granting the technician permission
9 to engage in the full scope of responsibilities authorized by the state; further,

10 To advocate licensure of pharmacy technicians by state boards of pharmacy; further,

11 To advocate, with respect to certification, as an interim measure until the optimal
12 model is fully implemented, that individuals be required either (1) to have completed
13 an ASHP-accredited program of education and training or (2) to have at least one year
14 of full-time equivalent experience as pharmacy technicians before they are eligible to
15 become certified; further,

16 To advocate that licensed pharmacists and technicians be held jointly accountable for
17 the quality of pharmacy services provided and the actions of licensed pharmacy
18 technicians under their charge.

19 (Note: Licensure is the process by which an agency of government grants permission
20 to an individual to engage in a given occupation upon finding that the applicant has
21 attained the minimal degree of competency necessary to ensure that the public
22 health, safety, and welfare will be reasonably well protected. Certification is the
23 process by which a nongovernmental agency or association grants recognition to an
24 individual who has met certain predetermined qualifications specified by that agency
25 or association.)

(Note: This policy would supersede ASHP policy 0815.)

Rationale

ASHP policy 0815 was revised to advocate for licensure of pharmacy technicians in response to Recommendation D8 by the [Pharmacy Practice Model Initiative](#) (PPMI) Summit and subsequent discussion by the ASHP Board of Directors. Optimal use of pharmacy technicians will enable pharmacists to devote more time to drug therapy management. Uniformity among state laws is

essential to achieve the preferred vision for practice. Moreover, requiring licensure rather than registration will enable state boards to require competency, impose disciplinary sanctions, and hold technicians accountable for their actions.

The process proposed for pharmacy technicians to achieve licensure follows the same steps outlined in policy 0815: education and training, followed by examination and certification, as prerequisites to licensure. The movement to technician licensure was essential to assure the public that the medication-use system includes individuals competent to assist pharmacists to provide and manage their medication regimens. Licensure will provide state boards with the tools necessary to provide that assurance to the public.

Background

The Council recommended and the Board voted to revise ASHP policy 0815, Uniform State Laws and Regulations Regarding Pharmacy Technicians, as follows (underline indicates new text; ~~strikethrough~~ indicates deletions):

To advocate that pharmacy move toward the following model with respect to technicians as the optimal approach to protecting public health and safety: (1) development and adoption of uniform state laws and regulations regarding licensure of pharmacy technicians, (2) mandatory completion of an ASHP-accredited program of education and training as a prerequisite to pharmacy technician certification, ~~and~~ (3) mandatory certification by the Pharmacy Technician Certification Board as a prerequisite to licensure by the state board of pharmacy, and (4) licensure of pharmacy technicians by state boards of pharmacy granting the technician permission to engage in the full scope of responsibilities authorized by the state; further,

To advocate licensure ~~registration~~ of pharmacy technicians by state boards of pharmacy; further,

To advocate, with respect to certification, as an interim measure until the optimal model is fully implemented, that individuals be required either (1) to have completed an ASHP- accredited program of education and training or (2) to have at least one year of full-time equivalent experience as pharmacy technicians before they are eligible to become certified; further,

To advocate that licensed pharmacists and technicians be held jointly accountable for the quality of pharmacy services provided and the actions of licensed pharmacy technicians under their charge.

(Note: Licensure is the process by which an agency of government grants permission to an individual to engage in a given occupation upon finding that the applicant has attained the minimal degree of competency necessary to ensure that the public health, safety, and welfare will be reasonably well protected. Certification is the process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association. ~~Registration is the process of making a list or being enrolled in an existing list;~~

~~registration should be used to help safeguard the public through interstate and intrastate tracking of the technician work force and preventing individuals with documented problems from serving as pharmacy technicians.)~~

This policy recommendation resulted from Recommendation D8 of the PPMI Summit, which calls for licensure by state boards of pharmacy that would support optimal models and the desired future state of pharmacy practice in hospitals and health systems. The Council and Board recognized that this policy and the advocacy required to achieve these changes in all 50 states would require a long-term effort. However, it was agreed that it is essential to begin the process by revising the policy to prepare the pharmacy workforce to meet the current challenges of our preferred practice vision.



B. Opposition to Creation of New Categories of Licensed Personnel

- 1 To discontinue ASHP policy 0521, which reads:
- 2 To reaffirm the following statement in the White Paper on Pharmacy Technicians
- 3 (April 1996) endorsed by ASHP and the American Pharmacists Association:
- 4 "Although there is a compelling need for pharmacists to expand the
- 5 purview of their professional practice, there is also a need for pharmacists
- 6 to maintain control over all aspects of drug product handling in the patient
- 7 care arena, including dispensing and compounding. No other discipline is as
- 8 well qualified to ensure public safety in this important aspect of health
- 9 care."
- 10 Further,
- 11 To oppose the creation of new categories of licensed pharmacy personnel;
- 12 further,
- 13 To advocate that all professional pharmacy functions be performed under the
- 14 supervision of a licensed pharmacist to avoid confusion regarding the roles of
- 15 pharmacy personnel within health systems.

Background

In light of the revision to policy 0815 (discussed above), the Council recommended and the Board voted to discontinue policy 0521. Policy 0521 and related language in the White Paper on Pharmacy Technicians were intended to prevent reemergence of licensed categories in state practice acts such as pharmacist assistant or assistant pharmacist. Those efforts have been dormant, and the Council and Board feel the policy is no longer relevant. Moreover, the Council's previous discussion in revising policy 0815 emphasized the need to respond to the

recommendations of the PPMI and subsequent discussion by the Board of Directors. The Council and Board observed that if policy 0521 is not discontinued, advocacy of pharmacy technician licensure could not be supported.



C. Pharmacy Technicians

- 1 To discontinue ASHP policy 8610, which reads:
 - 2 To work toward the removal of legislative and regulatory barriers preventing
 - 3 pharmacists from delegating certain technical activities to other trained
 - 4 personnel.

Background

In light of revisions to policy 0815 (discussed above), the Council recommended and the Board voted to discontinue policy 8610. Policy 8610 was adopted by the House of Delegates over 25 years ago and was intended to allow pharmacists the ability to safely and efficiently utilize the skills of technicians and other personnel. State practice acts and technician regulation have evolved considerably since then. Moreover, the Council and Board believe the policy recommendation above concerning licensure of technicians would more comprehensively describe ASHP's current policy and include the intent of policy 8610.



D. Collaborative Drug Therapy Management

- 1 To pursue the development of federal and state legislative and regulatory provisions
- 2 that authorize collaborative drug therapy management by pharmacists; further,
 - 3 To advocate expansion of federal and state legislative and regulatory provisions that
 - 4 optimize pharmacists' ability to provide the full range of professional services within
 - 5 their scope of expertise; further,
 - 6 To acknowledge that as part of these advanced collaborative practices, pharmacists,
 - 7 as active members in team-based care, must be responsible and accountable for
 - 8 medication-related outcomes; further,
 - 9 To support affiliated state societies in the pursuit of state-level collaborative drug
 - 10 therapy management authority for pharmacists.

(Note: This policy would supersede ASHP policy 9812.)

Rationale

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

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

Background

The Council recommended and the Board with amendment voted to revise ASHP policy 9812, Collaborative Drug Therapy Management, as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

To pursue the development of federal and state legislative and regulatory provisions that authorize collaborative drug therapy management by ~~the pharmacists as a component of medication therapy management pharmaceutical care~~; further,

To advocate expansion of federal and state legislative and regulatory provisions that optimize pharmacists' ability to provide the full range of professional services within their scope of expertise; further,

To acknowledge that as part of these advanced collaborative practices, pharmacists, as active members in team-based care, must be responsible and accountable for medication-related outcomes; further,

To ~~actively~~ support affiliated state societies in the pursuit of state-level collaborative drug therapy management authority for pharmacists.

The Council's discussion of this issue and decision to revise policy 9812 was in response to the growing interest among all health professions to practice to the fullest extent of their scope of practice in order to provide the best possible care to patients as part of an interdisciplinary team. In addition, a recommendation by the PPMI Summit stated, "[t]hrough credentialing and privileging processes, pharmacists should include in their scope of practice prescribing as part of the collaborative practice team." These two factors prompted a review by the Council and its decision to strengthen the policy by adding the two additional clauses. The Council also noted the relationship to [ASHP policies 9801](#), which defines CDTM, and [0905](#), which discusses the importance of credentialing and privileging for providing CDTM, as well as compensation for these services. Council members also observed the need to engage payers in discussing effective payment models in alignment with accountability for medication-related outcomes.



E. Approval of Biosimilar Medications

- 1 To encourage the development of safe and effective biosimilar medications in order
- 2 to make such medications more affordable and accessible; further,

- 3 To encourage research on the safety, effectiveness, and interchangeability of
- 4 biosimilar medications; further,

- 5 To support legislation and regulation to allow Food and Drug Administration (FDA)
- 6 approval of biosimilar medications; further,

- 7 To support legislation and regulation to allow FDA approval of biosimilar medications
- 8 that are also determined by the FDA to be interchangeable and therefore may be
- 9 substituted for the reference product without the intervention of the prescriber;
- 10 further,

- 11 To require postmarketing surveillance for all biosimilar medications to ensure their
- 12 continued safety, effectiveness, purity, quality, identity, and strength; further,

- 13 To advocate for adequate reimbursement for biosimilar medications that are deemed
- 14 interchangeable; further,

- 15 To promote and develop ASHP-directed education of pharmacists about biosimilar
- 16 medications and their appropriate use within hospitals and health systems; further,

- 17 To advocate and encourage pharmacist evaluation and the application of the
- 18 formulary system before biosimilar medications are used in hospitals and health
- 19 systems.

(Note: This policy would supersede ASHP policy 0906.)

Rationale

A provision in the Patient Protection and Affordable Care Act created a new pathway for the FDA to approve biosimilar products. The FDA is developing its implementing regulations in order to consider applications from manufacturers. Policy 0906 was revised to reflect use of the terms “biosimilar” and “interchangeable” in the Affordable Care Act and its subtitles. In addition, a clause was added to advocate that FDA determine interchangeability with a reference product, thereby allowing for the substitution of a biosimilar product through a hospital or health system’s formulary process and pharmacy and therapeutics committee (or similar entity). In light of these developments, there is a need for ASHP-developed education about biosimilars, with a particular emphasis on the role of formulary systems in determining the appropriate use of these medications.

Background

The Council recommended and the Board voted to revise ASHP policy 0906, Approval of Follow-on Biological Medications, as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

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

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

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

To support legislation and regulation to allow FDA approval of biosimilar medications that are also determined by the FDA to be interchangeable and therefore may be substituted for the reference product without the intervention of the prescriber; further,

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

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

To promote and develop ASHP-directed education of pharmacists about biosimilar ~~follow-on biological~~ medications and their appropriate use within hospitals and health systems; further,

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

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



F. Stable Funding for HRSA Office of Pharmacy Affairs

- 1 To advocate for a sustainable level of funding, including appropriations, sufficient to
- 2 support the public health mission of the Health Resources and Services
- 3 Administration (HRSA) Office of Pharmacy Affairs; further,

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

- 7 To encourage research on the potential impact of any proposed fees or alternative
- 8 funding sources for the Office of Pharmacy Affairs.

(Note: This policy would supersede ASHP policy 0911.)

Rationale

The Office of Pharmacy Affairs (OPA) currently relies on general funding from its parent agency, HRSA, and not a line-item annual appropriation to administer the 340B Drug Discount Program. The OPA and HRSA have sought funding to establish a cost recovery (user fee) program to administer the program. The initial fee would be 0.1 percent of the total 340B drug purchases paid by participating covered entities. HRSA and OPA contend that the cost recovery fee will create a sustainable funding source to meet the demands of the existing and projected growth of the 340B program, the changing marketplace, and new statutory program requirements. There is a need for stable and sustainable funding for the OPA. A variety of funding sources should be considered, perhaps involving entities that do not participate in the 340B program. Any user fee program should include an annual review of the percentage used to determine the annual fee charged to participating entities. In addition, OPA should not be solely dependent on user fees for its program administration; some level of congressional appropriations would serve as an important safeguard against such a dependency.

Background

The Council recommended and the Board voted to revise ASHP policy 0911, Stable Funding for Office of Pharmacy Affairs, as follows (underscore indicates new text; ~~strike through~~ indicates deletions):

To advocate for a sustainable level of adequate funding, including appropriations, sufficient to support the public health mission of ~~for~~ the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs ~~to support its public health mission;~~ further,

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

To encourage research on the potential impact of any proposed fees or alternative funding sources for the Office of Pharmacy Affairs.



G. Standardized Immunization Authority to Improve Public Health

- 1 To advocate that, to improve public health and patient access to immunizations,
- 2 states grant pharmacists the authority to initiate and administer all adult and child
- 3 immunizations through a universal protocol developed by state health authorities;
- 4 further,
- 5 To advocate that only pharmacists who have completed a training and certification
- 6 program acceptable to state boards of pharmacy and meeting the standards established
- 7 by the Centers for Disease Control and Prevention may provide such immunizations;
- 8 further,
- 9 To advocate that state health authorities establish a centralized database for
- 10 documenting administration of immunizations that is accessible to all health care
- 11 providers.

Rationale

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

Although all states permit pharmacist administration of some vaccines, state laws differ in the range of vaccines pharmacists may administer and the patient populations they are permitted to vaccinate. A universal administration protocol developed by state health departments would, in contrast, encourage standardization of pharmacy immunization practice within and among states. In addition, under such a protocol, it would not be necessary for pharmacist-provided immunizations to be conducted within a collaborative drug therapy management agreement.

Only pharmacists who undergo appropriate training and certification should be authorized by state boards to provide immunizations. To ensure their consistency and quality, those training and certification programs should meet Centers for Disease Control and Prevention (CDC) standards. Finally, to aid in sharing important patient immunization information, a central database of patient immunizations should be established with access by primary care providers and other authorized practitioners.

Background

The Council recommended and the Board with amendment voted to approve this new policy in response to a delegate recommendation seeking ASHP advocacy for standardization of pharmacist authority to administer vaccinations.



H. Automated Systems

- 1 To discontinue ASHP policy 9205, which reads:
- 2 To support the use of current and emerging technology in the advancement
- 3 of pharmaceutical care; further,
- 4 To encourage a review and evaluation of the state and federal legal and
- 5 regulatory status of new technologies as they apply to pharmacy practice.

Background

As part of its sunset review, the Council reviewed policy 9205. The Council and Board concluded that other ASHP policies addressed the intent of the policy. The Council and Board also noted

that since the policy was adopted in 1992, ASHP has established the Section of Pharmacy Informatics and Technology, which has developed substantial guidance for members on this topic. The Council recommended and the Board voted to discontinue the policy.



I. Medical Devices

- 1 To discontinue ASHP policy 9106, which reads:
- 2 To support public and private initiatives to clarify and define the relationship
- 3 among drugs, devices, and new technologies in order to promote safety and
- 4 effectiveness as well as better delivery of patient care.

Background

As part of its sunset review, the Council reviewed policy 9106. The Council and the Board agreed that other ASHP policies better address the intent of the policy, which was developed as Congress was developing legislation to better define a medical device and provide for problem-reporting to the FDA. The Council recommended and the Board voted to discontinue the policy.

Board Actions

Sunset Review of Professional Policies

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

- [Restricted Drug Distribution](#) (0714)
- [Patient Access to Orphan Drug Products](#) (0715)
- [Regulation of Telepharmacy Services](#) (0716)
- [FDA Authority to Prohibit Reuse of Brand Names](#) (0719)
- [Standardizing Prefixes and Suffixes in Drug Product Names](#) (0720)
- [Pharmacist Recruitment and Retention](#) (0218)
- [Intermediate Category of Drugs](#) (0220)
- [Greater Access to Less Expensive Generic Drugs](#) (0222)
- [Drug Samples](#) (9702)
- [Manufacturer-Sponsored Patient Assistance Programs](#) (9703)
- [Drug Testing](#) (9103)
- [Employee Testing](#) (9108)
- [Codes on Solid Dosage Forms of Prescription Drug Products](#) (8709)
- [Size, Color, and Shape of Drug Products](#) (8310)

Other Council Activity

Statement on Pharmacy Technician Workforce

In the Council's discussion that led to revision of ASHP policy 0815 and discontinuation of policies 0521 and 8610, it became clear that an ASHP statement that describes the desired scope of practice for a licensed pharmacy technician was necessary. The Council believed that merely inserting "licensure" for "registration" in existing policy was only one component of the policy actions needed to move toward licensure. In addition, the Council's discussion emanated from the recommendations of the PPMI and discussion by the Board of Directors.

Thus, the Council voted to draft an ASHP statement on the pharmacy technician workforce that addresses technician scope of practice and describes whether there are (1) functions for which a licensed pharmacy technician is fully responsible and accountable, and (2) functions for which there is shared responsibility and accountability between the licensed pharmacy technician and the pharmacists.

The Council felt that a statement that describes a licensed pharmacy technician's scope of practice could further explain the duties and functions as well as delineate those that would involve shared responsibility and accountability. Additional areas contained in a statement would include the need for education and training, examination and certification, disciplinary sanctions, and the functions authorized to be performed independently, without the supervision of a pharmacist, and those requiring pharmacist supervision.

The Council noted that the statement could also address the ability of health systems to require specific credentials in order for pharmacy technicians to practice in their organization. Council members also suggested that expansion and inclusion of more community-based questions in the Pharmacy Technician Certification Board examination would position it as a generalist exam. The Council also noted that the specific recommendations from the PPMI Summit as well as from states that currently license pharmacy technicians would aid in developing the statement.

Board Certification of Pharmacists

The Council discussed the new business item proposed by the Section of Clinical Specialists and Scientists concerning certification and the role of the Board of Pharmacy Specialties. The Council understood the rationale for the proposal by the Section and offered some commentary. Specifically, it suggested addressing certification where a subspecialty may be formally recognized by the profession. The Council agreed that credential and exam requirements need to be streamlined, with uniform eligibility criteria between the various subspecialty (i.e., non-Pharmacotherapy) exams. Finally, Council members suggested that the policy include a statement that any future eligibility include residency training.

Prescription Drug User Fee Act Reauthorization

The Council reviewed the process and timeline for reauthorization of the Prescription Drug User Fee Act (PDUFA), which is contained in the Food, Drug and Cosmetic (FD&C) Act. PDUFA expires every five years, and it must be renewed by Congress by September 30, 2012. It allows for the

collection of user fees from manufacturers in exchange for the FDA meeting certain performance goals as part of the drug approval process. The Council reviewed current ASHP policies and noted the opportunity to make changes to the FD&C Act during the reauthorization process. The Council noted existing ASHP policy as part of ASHP's advocacy as the FDA finalizes its recommendations to Congress and during the legislative process. Specifically identified were policies relating to product recalls, transparency of information about clinical trial design, and FDA's evaluation using evidence-based medicine. Also identified were risk/benefit communication and the use of risk evaluation and mitigation strategies (REMS), particularly those REMS requiring additional elements to assure safe use. Additional issues discussed included FDA governance, direct-to-consumer/purchaser/prescriber communications, and information technology issues associated with National Drug Code numbering.

Standardized Pharmacist Licensure Reciprocity

In response to a delegate recommendation, the Council discussed the notion of streamlining licensure reciprocity to allow for a pharmacist to reciprocate either their original state license or from their current state license (if not the original state). The Council noted the benefit and intent of the recommendation as part of discussions with the National Association of State Boards of Pharmacy (NABP). The Council also reviewed [ASHP policy 0612, Streamlined Licensure Reciprocity](#), and felt it was useful and broad enough to aid in any discussions with NABP.

ASHP Statement on Confidentiality of Patient Health Care Information

In response to a delegate recommendation, the Council discussed the [ASHP Statement on Confidentiality of Patient Health Care Information](#). The Council noted that provisions in the Health Information Technology for Economic and Clinical Health (HITECH) Act and subsequent regulations may suggest a need for changes to the ASHP statement. However, the Council felt that over the course of the following year, the regulatory picture may become clearer. At that point, the Council will revisit the recommendation to update the statement.



SEIZE THE INITIATIVE

**ASHP House of Delegates 2012
June 10 and 12, 2012**

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.

Michael D. Sanborn, *Board Liaison*

Council Members

Jill S. Bates, *Chair* (North Carolina)
 Catherine D. Johnson, *Vice Chair* (Wisconsin)
 Linda W. Banares, *New Practitioner* (California)
 Curtis D. Collins (Michigan)
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Policy Recommendations



A. Criteria for Medication Use in Geriatric Patients

- 1 To support medication therapy management, including assessment of physiologic and
- 2 pharmacokinetic factors, as a central component of providing safe and effective drug
- 3 therapy to geriatric patients; further,

- 4 To oppose use of the Beers criteria by the Centers for Medicare & Medicaid Services
- 5 and other accreditation and quality improvement entities as an indicator to assess the
- 6 appropriateness of prescribing for geriatric patients based on known limitations in the
- 7 development of that tool and evidence suggesting a lack of association between use
- 8 of medications listed in the Beers criteria and subsequent adverse drug events;
- 9 further,

- 10 To advocate for the development, refinement, and validation of new criteria that
- 11 consider drug-, disease-, and patient-specific factors and demonstrate the ability to
- 12 decrease the occurrence of adverse drug events in geriatric patients; further,

- 13 To support research to assess the clinical application of existing and proposed criteria,
- 14 including assessment of their correlation to patient outcomes and strategies for
- 15 implementation; further,

- 16 To encourage inclusion of validated criteria in clinical decision support systems and
- 17 other information technologies to facilitate prescribing for geriatric patients; further,

- 18 To acknowledge that such criteria are intended as a guide and should not replace the
- 19 clinical judgment of pharmacists and other clinicians.

Rationale

Criteria have been developed to identify high-risk drugs that should be avoided in geriatric patients (i.e., those 65 years of age or older) based on the potential for these therapies to cause adverse drug events that can result in falls, hospitalizations, and other incidents that lead to significant morbidity and mortality in this patient population. Those criteria include the 2002 iteration of the [Beers criteria](#) (published in 2003) and the [Screening Tool of Older Persons' Potentially Inappropriate Prescriptions](#), or STOPP. Although ASHP supports the intent of these criteria to prevent patient harm, safe and effective use of medications in geriatric patients requires the more thorough assessment associated with pharmacist-provided medication therapy management. ASHP opposes adoption of the Beers criteria by the Centers for Medicare & Medicaid Services (CMS) other accreditation and quality improvement organizations as a tool

to assess prescribing in the long-term care and other settings, noting concerns about the development and validation of that tool. More importantly, studies evaluating the clinical application of Beers criteria have not demonstrated a reduction in adverse events when that tool is used. In that regard, STOPP, which is based on organ systems and accounts for patients' concomitant disease, is considered more useful. Studies evaluating STOPP, though small in number, project a favorable impact on patient outcomes. ASHP encourages additional work to develop, refine, and validate this and similar evidence-based criteria. Further, there is a need for practice-based research to evaluate the application of such criteria and inclusion of validated criteria in clinical decision support systems and other information technologies is necessary to facilitate the use of these criteria in clinical practice. Finally, these tools are intended to serve as a guide or screening tool and should not replace the clinical judgment of pharmacists and other clinicians.

Background

The Council revisited the use of prescribing criteria intended to ensure safe drug therapy in geriatric patients by avoiding therapies that may be associated with an increased risk of adverse drug events in that patient population. This topic was first addressed by the Council in 2007 when the 2002 iteration of the Beers criteria and Assessing Care of Vulnerable Elders (ACOVE) criteria were reviewed. At that time, the Council stated that there was no ideal system for measuring appropriate prescribing in geriatric patients and noted that additional research was needed to validate the ability of these criteria to improve patient outcomes. This year, the Council compared those previously reviewed criteria to STOPP, a new tool that was evaluated in a study published in the *Archives of Internal Medicine* in June 2011. In that and other evaluations, researchers concluded that use of STOPP would prevent adverse drug events in geriatric patients. Other available criteria or tools include a drug burden index, which assesses the impact of drug therapy on physical and cognitive function based on pharmacologic principles, and the medication appropriateness index, which assesses the overall quality of prescribing. While supporting the intent of prescribing criteria, the Council and Board strongly advocated for pharmacist-provided medication therapy management (MTM) as a primary mechanism to ensure safe drug therapy in this patient population. MTM, which utilizes the drug therapy expertise of a pharmacist, was considered superior to explicit criteria, such as the Beers criteria, that are easy to implement but limited by their checklist or "black and white" nature. It was noted that pharmacist review should include an assessment of pharmacokinetic and pharmacodynamic factors, as well other drug-, disease-, and patient-specific factors. The Council strongly believed that prescribing criteria should be used to augment or facilitate, not replace, the pharmacist's clinical judgment. The Board agreed.

The Council noted that CMS included the Beers criteria in its interpretive guidelines for evaluating medication use in the long-term-care setting. The Council and Board opposed this use by CMS and other organizations based on concerns about the processes used to develop and validate the Beers criteria, as well as a lack of evidence demonstrating its ability to prevent adverse drug events when applied in the clinical setting. The Council described the Beers criteria as a checklist of drugs that largely fails to address other factors, including patient-specific factors, that affect the safety of drug therapy, and the Board concurred. Several drugs on the list, including propoxyphene, are no longer available. In addition, it was suggested that

other therapies defined by Beers criteria should not be on the list because use of those therapies may be appropriate in some geriatric patients. Council members also noted that the current iteration of the Beers criteria fails to address many therapies used in the inpatient setting. [Note: The American Geriatric Society is currently updating the 2002 iteration of the Beers criteria, which were published in the *Archives of Internal Medicine* in December 2003. It is anticipated that the update will address some concerns (e.g., removal of drugs no longer available) but not all of the shortcomings (e.g., lack of validation) described by the Council.]

The Council and Board were encouraged by early evaluations of the STOPP criteria that demonstrated a favorable effect on patient outcomes, including the potential to prevent adverse drug event (ADE)-related hospitalizations. It was noted that STOPP incorporated a stronger focus on organ function and other factors that can affect the safe use of drugs in geriatric patients. Additional advantages of STOPP are that it has been evaluated prospectively in the inpatient setting in a study comparing its use to usual care. The Council acknowledged that the extent of data from current trials evaluating STOPP was limited and encouraged additional studies to validate the tool. The Board agreed with this assessment and recommendation. In addition, the need to adapt STOPP to reflect medications available in the United States was noted.

The Council also discussed the practical application of prescribing criteria, including their ease of use. It was noted that the Beers criteria is easy to implement, which may lead to increased use, despite its limitations. High workload and lack of access to information via clinical decision support systems and other information technologies were noted as barriers to using existing or future criteria. In addition to outcomes research, the Council and Board encouraged research to determine best strategies for implementing prescribing criteria to guide drug selection for geriatric patients. The Council believed that such research could demonstrate a positive return on investment to support salaries for the increased staff needed to complete this assessment when compared to the costs of adverse drug events that would be averted. Further, the Council encouraged inclusion of validated criteria within information technology systems to facilitate their use. The need for increased pharmacist knowledge about the complexity of drug therapy in the geriatric patients was also noted.



B. Medication Adherence

- 1 To recognize that improving medication adherence should be a key component of
2 strategies to improve the quality and safety of patient care only when adherence
3 improvement efforts include the following as required elements: (1) assessing the
4 appropriateness of therapy, (2) providing patient education, and (3) ensuring patient
5 comprehension of information necessary to support safe and appropriate use of
6 prescribed therapies; further,
- 7 To advocate that pharmacists, because of their distinct knowledge, skills, and abilities,
8 should take a leadership role in multidisciplinary efforts to develop, implement,
9 monitor, and maintain effective strategies for improving medication adherence;
10 further,
- 11 To recognize that clinicians, patients, and caregivers share accountability for the
12 outcomes of medication therapies, and that the central role patients and their
13 caregivers have in disease management includes responsibility for following
14 instructions for safe and effective medication use; further,
- 15 To encourage development, evaluation, and dissemination of models that improve
16 adherence, including those that combine existing strategies that have demonstrated
17 effectiveness; further,
- 18 To support the development of mechanisms to document medication adherence
19 interventions, including information technology solutions; further,
- 20 To advocate for payment models that facilitate an expanded role for pharmacists in
21 medication adherence efforts.

Rationale

The need to improve medication adherence as a cornerstone of efforts to improve patient care outcomes is widely recognized. A [2010 New England Journal of Medicine editorial](#) issued a call to action to improve adherence based on estimates that 50 percent of all patients are non-adherent, resulting in an estimated \$100 billion spent annually on avoidable hospitalizations. ASHP supports programs to improve adherence, but such efforts are not useful, and are perhaps harmful, if they fail to (1) assess the appropriateness of therapy, (2) provide patient education, and (3) ensure patient comprehension of information necessary to support safe and appropriate use of prescribed therapies. Pharmacists are the ideal clinician to lead multidisciplinary efforts to improve medication adherence based on their distinct knowledge, skills, and abilities related to drug therapy management. Other members of the

multidisciplinary team could include physicians, nurses, health psychologists, and social workers. Patients and their caregivers must share accountability with clinicians for medication outcomes, including the responsibility for following instructions for safe and effective medication use. Otherwise, the results from efforts of pharmacists and other clinicians would be negligible. Some interventions to improve medication adherence have shown favorable results, but the greatest success is achieved by models that incorporate multiple strategies reinforced over time. Therefore, the development, evaluation, and dissemination of models that use multimodal approaches are encouraged. The development of information technology solutions and other mechanisms to document interventions intended to improve medication adherence are also recommended. Further, payment models that support an expanded role for pharmacists in medication adherence efforts should be pursued.

Background

The Council discussed the increased prominence of medication adherence in efforts to improve the quality and safety of health care. A recent *New England Journal of Medicine* editorial issued a call to action to improve adherence as a cornerstone of health care reform, noting that 50 percent of all patients are non-adherent, resulting in an estimated \$100 billion spent annually on avoidable hospitalizations. Quality improvement organizations, including the National Quality Forum, have provided quality measures for medication management that focus on measuring medication adherence. The Council appreciated the intent of these efforts, but believed that traditional efforts to improve medication adherence focus too heavily on whether the patient is taking a medication and fail to assess the appropriateness of prescribed therapies, provide patient education on the appropriate use of prescribed therapies, and ensure patient comprehension of that information. The Council believed these elements were essential to adherence improvement efforts and the Board concurred with this assessment. The Council also discussed best practices and the role of pharmacists in this work. Pharmacists were considered the ideal clinician to lead medication adherence efforts based on their drug therapy expertise. However, the Council and Board strongly encouraged a multidisciplinary approach that maximizes the unique skills of all team members, which could include physicians, nurses, health psychologists, and social workers. For example, it was noted that pharmacists have limited training in behavioral interventions—an area where the expertise of health psychologists would be beneficial. Pharmacy residents and students were also identified as key team members that could augment existing staff resources. The Council strongly believed that patients and their caregivers must share accountability with clinicians for medication outcomes, including the responsibility for following instructions for safe and effective medication use, and the Board agreed. It was suggested that pharmacy benefit managers and other insurers should also share responsibility in improving adherence. It was noted that there are sometimes dueling priorities between the cost containment aspect of formulary management and the ability to simplify drug regimens, which has been shown to improve adherence. For example, formulary restrictions in the inpatient setting may require that hospitalized patients be switched from once daily formulations to formulations that require multiple doses per day.

The Council and Board noted that efforts to improve adherence are especially important at transitions of care, where improvements can minimize the risk of rehospitalizations and other adverse drug events. Successful interventions include simplifying medication regimens, as

well as more innovative models that incorporate reminder calls and visits or medication event monitoring systems (i.e., electronic caps that monitor patient access to prescription vials). The Council stated that no strategy is perfect and that those with increased effectiveness are often associated with increased cost or burden to implement. Approaches that incorporate a number of strategies implemented on an ongoing or repeated basis frequently achieved better results. Therefore, the Council and Board encouraged development, evaluation, and dissemination of models that combine the most effective strategies.

The Council also considered existing approaches to measuring medication adherence, including medication possession ratios, patient report questionnaires, and medication event monitoring systems. The Council noted that most approaches had value, but believed that variability in the selection of measures inhibits the ability to evaluate and compare interventions. The Council did not recommend additional research to determine the ideal measure, but rather encouraged selection and more consistent use of a measure from among those that already exist. The Council recommended educational programming or an article in the *American Journal of Health-System Pharmacy (AJHP)* that would provide an overview of existing measures and the pros and cons of their use. The Board supported the need for education on this topic. Development and dissemination of best practices to improve medication adherence was also encouraged.



C. Globalization of Clinical Trials

- 1 To encourage the Food and Drug Administration (FDA) to use its existing authority to
- 2 increase monitoring and inspection of foreign clinical trials to ensure the integrity and
- 3 quality of those studies; further,

- 4 To advocate that the FDA expand its oversight of clinical trials conducted abroad by
- 5 continuing to pursue innovative strategies, such as increased collaboration with
- 6 foreign regulatory agencies and changes in domestic regulatory processes that
- 7 support timely submission of foreign clinical trial information; further,

- 8 To encourage the FDA to establish a standardized electronic format and reporting
- 9 standards that would be required for submission of data from foreign clinical trials;
- 10 further,

- 11 To support the ethical treatment of patients in foreign clinical trials in accordance
- 12 with international standards designed to protect human subjects; further,

- 13 To encourage public and private research to study the impact of the globalization of
- 14 clinical trials on patient care.

Rationale

More than 80% of marketing applications for drugs approved in fiscal year 2008 were supported by data from foreign clinical trials, and more than 50% were based on data from trials that were conducted entirely outside of the United States. This trend toward the globalization of clinical trials is expected to continue because of potential benefits to drug manufacturers (e.g., decreased costs, availability of treatment-naive patients). ASHP is concerned that limited experience with clinical trials in some countries could affect data integrity and questioned whether results from foreign clinical trials could always be generalized to patients in the United States because of differences in genetics and cultural factors (e.g., diet, use of supplements). Existing FDA authority allows for oversight of foreign clinical trials, including a requirement for mandatory reporting. However, according to the 2010 Office of Inspector General (OIG) report, [Challenges to FDA's Ability to Monitor and Inspect Foreign Clinical Trials](#), only 0.7 percent of foreign trial investigators were inspected in FY 2008 (compared to 1.9% of investigators in the United States). The FDA should increase oversight of foreign clinical trials given the potential for inconsistencies in protocol implementation and concerns about the availability and integrity of data noted in the OIG report. Development of innovative approaches to expand oversight given limited FDA resources is also encouraged. ASHP supports a recent [FDA agreement with the European Medicines Agency](#) to share information from inspections conducted by that agency and encourages the FDA to establish this type of agreement with other countries, including those whose experience with clinical trials is limited. The FDA should also explore regulatory changes that would support more timely submission of foreign clinical trial information. This recommendation is based on concern that some aspects of current regulations may encourage drug manufacturers to favor foreign clinical trials. For example, submission of an investigational new drug (IND) application triggers FDA oversight, including required submission of clinical trial protocols. Timely submission of an IND is necessary for studies conducted within the United States because it provides an exemption from interstate commerce laws, which is needed to conduct clinical trials. However, interstate commerce laws do not apply abroad. Therefore, there is no requirement or incentive for manufacturers to submit study protocols for foreign trials if they are conducted prior to the IND submission. However, results from those trials are sometimes used to support marketing applications for drug approval. While the FDA can review protocol and data from these studies retrospectively, data omissions and other factors limit the effectiveness of this approach. Earlier submission of this information would enhance the effectiveness of FDA's oversight. Standardization and electronic submission of data from foreign clinical trials should also be encouraged, given the OIG finding that data from these trials was sometimes not available to FDA reviewers. Ethical concerns associated with foreign clinical trials, including documented lapses in informed consent, support the need for improved adherence to ethical standards for conducting clinical research, such as those described in the [International Conference on Harmonisation Tripartite Guideline for Good Clinical Practice](#) and other international guidelines. Finally, the FDA and private entities are encouraged to study the potential patient care impact of the globalization of clinical trials to determine whether there is an impact even when studies are conducted appropriately.

Background

The Council considered the trend of globalization of clinical trials in which studies to support drug approval by the FDA are increasingly being conducted abroad in countries such as China, Asia, Eastern Europe, and Latin America. Benefits of this approach include the availability of treatment-naïve patients and reduced costs. However, questions have been raised about whether there is sufficient FDA oversight of foreign clinical trials, especially in countries with limited experience in conducting this work. In addition, there is concern as to whether the selected patient populations accurately reflect the characteristics of patients in the United States who will be treated with these FDA-approved drugs. The Council's discussion focused on the 2010 Office of Inspector General (OIG) report, *Challenges to the FDA's Ability to Monitor and Inspect Foreign Clinical Trials*, which defined limitations in the FDA's current processes and offered recommendations for improvement. The Council and Board were very supportive of the OIG recommendations, but wished to place additional emphasis on exploring regulatory changes that could improve FDA oversight.

Overall, the Council was supportive of current FDA regulatory requirements that ensure the effectiveness and safety of drug products. However, the Council considered if manufacturers may favor conducting early clinical trials abroad, which can extend patent life by delaying the IND submission. Submission of an IND triggers FDA oversight, including required submission of clinical trial protocols. An IND is necessary for studies conducted within the United States because it provides an exemption from interstate commerce laws. However, interstate commerce laws do not apply abroad. Therefore, there is no requirement or incentive for manufacturers to submit study protocols for foreign trials if they are conducted prior to the IND submission. The Council and Board encouraged the FDA to explore incentives or other strategies to support earlier IND submissions, and in turn, improve availability of information from foreign clinical trials. Other OIG recommendations supported by the Council and Board included the need for a standardized and electronic format for submitting foreign clinical trial data to ensure that it is consistently available and development of innovative strategies to expand FDA oversight, including collaborative agreements with foreign governments to share data from inspections conducted by those entities.

The Council believed that drug manufacturers were ultimately responsible for ensuring the integrity of these trials and noted that no amount of FDA oversight would fully eliminate concerns about study design and implementation. The Board agreed with this assessment. A review of www.clinicaltrials.gov during the Council meeting found 133,000 active trials in 176 countries. Given those numbers, the extent of oversight needed to prevent or eliminate lapses in protocol or misconduct is unattainable. The Council did debate if increased oversight was necessary given that there is limited evidence demonstrating an impact on patient care from the globalization of clinical trials. Some Council members believed that increased oversight was unwarranted, but most agreed that greater enforcement of existing regulations was necessary, even in the absence of evidence of harm. In addition, several examples were provided to illustrate that results from foreign clinical trials are not always directly applicable in the United States. For example, studies to support a new erythromycin-like therapy did not evaluate the drug's activity against a strain of *C. difficile* that is common in the United States. Cultural differences, such as the increased use of dietary supplements or differences in diet, can also impact patient response to therapy and the occurrence of drug interactions. The Council and

Board believed that increased transparency about foreign clinical trials was needed to allow clinicians to better assess how the results should be applied to patients in the United States. In addition, the Council encouraged the FDA and private entities to support evaluations, including postmarketing studies, to assess what, if any, influence these studies had on patient care in this country. The Board supported this recommendation. ASHP was encouraged to provide education to members about the globalization of clinical trials and subsequent application to patient care. Such education could be provided through journal articles, live or web-based education, or in conjunction with partners such as International Pharmaceutical Federation (FIP).

The Council also discussed ethical concerns related to the globalization of clinical trials. A review of published studies conducted in China found that only 18% of reports discussed or provided sufficient information on informed consent processes. The Council believed that peer-reviewed publications should play an enhanced role in ensuring that this information is available. The Council noted that patients often receive financial support for participating in foreign clinical trials. While this support may be nominal by United States standards, it can represent an annual salary in some countries. In addition, in some under developed countries, patients may only gain access to treatment by participating in study protocols. The Council believed that these scenarios place study participants at risk for unethical behavior by study investigators and may influence patient behavior (e.g., lack of adherence), and the Board agreed. Therefore, the Council and Board advocated for improved adherence to ethical standards for conducting clinical research, such as those described in the International Conference on Harmonization Tripartite Guideline for Good Clinical Practice and other international guidelines.



D. Tobacco and Tobacco Products

- 1 To discourage the use and distribution of tobacco and tobacco products in and by
- 2 pharmacies; further,
- 3 To advocate for tobacco-free environments in hospitals and health systems; further,
- 4 To seek, within the bounds of public law and policy, to eliminate the use and
- 5 distribution of tobacco and tobacco products in meeting rooms and corridors at
- 6 ASHP-sponsored events; further,
- 7 To promote the role of pharmacists in tobacco-cessation counseling and medication
- 8 therapy management; further,
- 9 To join with other interested organizations in statements and expressions of
- 10 opposition to the use of tobacco and tobacco products.

(Note: This proposed policy would supersede ASHP policy 0713.)

Rationale

ASHP policy 0713, Tobacco and Tobacco Products, was revised to more clearly define the expanded role of pharmacists in recommending and managing drug therapy to support tobacco cessation, as described in the [ASHP Therapeutic Position Statement on Cessation of Tobacco Use](#). Newer therapies, including varenicline, are associated with more and evolving safety risks when compared to nicotine replacement therapies. Given the complexity of drug therapy, pharmacists should play a central role in ensuring the safe and appropriate use of these therapies. The revisions to this policy better reflect the important role of pharmacists in medication therapy management.

Background

The Council recommended and the Board voted to revise ASHP policy 0713, Tobacco and Tobacco Products, as follows (underline indicates new text):

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 and medication therapy management; further,

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

The Council and Board believed that this change would better reflect the role of pharmacists in recommending and managing drug therapy to support tobacco cessation. This role has increased dramatically since this policy was introduced. It was noted that newer therapies, including varenicline, are associated with more and evolving safety risks when compared to nicotine replacement therapies. The Council believed and the Board agreed that the increased risks associated with these therapies necessitate greater engagement by pharmacists beyond merely counseling on the benefits of smoking cessation. The Council and Board noted the establishment of FDA oversight of tobacco products as drugs via passage of the Family Smoking Prevention and Tobacco Control Act of 2009. This development, which occurred since this policy was last reviewed in 2007, was viewed favorably.

The Council also discussed the recent introduction of electronic cigarettes, with a focus on the safety risks associated with their use because of harmful chemicals, such as propylene glycol, that have been found in solutions marketed for use with these devices. The Council considered whether additional changes were needed to the policy language to address delivery of the drug via this device. However, a review of recent FDA correspondence indicated that the agency intends to regulate electronic cigarettes as tobacco products, noting that these products

are subject to regulation unless they are marketed as a combination drug/device for therapeutic purposes. Given this intent, the Council believed that the existing verbiage of tobacco products sufficiently addressed this and future devices used to administer the drug. The Board agreed with this assessment. The Council noted that the *ASHP Therapeutic Position Statement on the Cessation of Tobacco Use* would be addressed as part of sunset review in 2012. If continued at that time, the Council suggested that revisions be made to address electronic cigarettes. Education about these drug delivery devices was also recommended via *AJHP*, educational programming, or other communication vehicles.



E. Removal of Propoxyphene from the Market

- 1 To discontinue ASHP policy 0723, which reads:
 - 2 To advocate that the Food and Drug Administration remove propoxyphene
 - 3 from the market because of its poor efficacy and poor safety profile and
 - 4 because more effective and safer alternatives are available to treat mild to
 - 5 moderate pain.

Background

The Council discussed ASHP policy 0723, Removal of Propoxyphene from the Market, as part of sunset review. The Council stated that this policy was no longer needed as a result of the product withdrawal, and recommended that the policy be discontinued. The Board concurred. Activities that led to the withdrawal of propoxyphene from the market in November 2010 were described and the leadership of ASHP in advocating for this action was applauded. The Council played a pivotal role in that work by proposing policy 0723 and developing a guidance document that outlined the evidence demonstrating the poor efficacy and safety profile of the drug and provided recommendations for therapeutic alternatives for the treatment of mild to moderate pain. This guidance was nearing publication when the drug was withdrawn. Therefore, it was not published because it was no longer needed as a result of this action. However, the guidance served as the basis of ASHP advocacy to FDA on this issue. It was noted that propoxyphene and propoxyphene-containing products had previously been the 38th most commonly prescribed drug products in the United States, with a total of 17.5 million prescriptions issued in 2009. Despite this broad use, patient care issues associated with discontinuation of these products were minimized. The success of this transition may, in part, be attributed to drug therapy management provided by pharmacists.

Board Actions

Endorsement of CPIC Guidelines for Cytochrome P450-2C19 (CYP2C19) Genotype and Clopidogrel Therapy

The Council recommended and the Board voted

To endorse the *Clinical Pharmacogenetics Implementation Consortium Guidelines for Cytochrome P450-2C19 (CYP2C19) Genotype and Clopidogrel Therapy*.

The Council reviewed the [Clinical Pharmacogenetics Implementation Consortium Guidelines for Cytochrome P450-2C19 \(CYP2C19\) Genotype and Clopidogrel Therapy](#), which provides guidance on using pharmacogenomic testing to evaluate for variations in cytochrome P450-2C19 (CYP2C19), a liver enzyme that can affect the metabolism of clopidogrel and other drug therapies. The Clinical Pharmacogenetics Implementation Consortium, or CPIC, was formed by the National Institutes of Health's Pharmacogenomics Research Network and the Pharmacogenomics Knowledge Base. The Council recommended and the Board voted to endorse this guidance, noting that it addresses an important need for information on the clinical application of pharmacogenomic testing by providing specific recommendations for interpreting the pharmacogenomic test for CYP2C19 in patients who require antiplatelet therapy. This need for practical guidance was identified in previous Council discussions on pharmacogenomics. The Council and Board appreciated that the guideline did not recommend whether the test should or shouldn't be used, but rather focused on how to interpret the test if it is done. This approach was preferred given ongoing debate about use of the test and barriers to use that include limited access outside of academic medical centers and the extended time frame required to receive results in those settings. The Council stated that lack of evidence demonstrating the cost-effectiveness of the test has also limited its use predominately to high-risk patients (e.g., those who have experienced multiple coronary events) and noted that additional evidence on cost-effectiveness was needed before the test would be used more broadly. The Board agreed with this assessment. In addition to endorsement, ASHP was encouraged to make members aware of the guideline via educational programming or an *AJHP* article that might address the use of this and other pharmacogenomic tests. The Council also provided feedback on the guideline format and content, which will be provided to CPIC to support the development of future guidelines.

ASHP Therapeutic Position Statement on the Treatment of Hypertension

The Council recommended and the Board voted

To discontinue the *ASHP Therapeutic Position Statement on the Treatment of Hypertension*.

The Council reviewed the *ASHP Therapeutic Position Statement on the Treatment of Hypertension* as part of sunset review. This therapeutic position statement (TPS), which was published in 2006, addresses the assertive use of antihypertensive therapies to achieve target blood pressure control in patients with hypertension. The Council stated that inadequate blood

pressure control remains a significant issue. It was noted that Healthy People 2010 called for and achieved blood pressure control in 50 percent of patients with hypertension. While this achievement is commendable, the blood pressure of half of the affected population is still uncontrolled. The Council noted that the TPS—which is based on recommendations in the *Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure* and guidelines provided by the National Kidney Disease Education Program and the American Diabetes Association—is outdated, and the Board concurred. However, revision was not recommended until the [*Eighth Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure*](#) (JNC 8) is released. A draft of that guideline is expected to be available for public comment in late 2011, followed by publication in 2012. The Council recommended and the Board agreed that the current TPS be discontinued for reasons of currency, but advised ASHP to revisit the ongoing need for this guidance following publication of JNC 8. Decision points at that time should include whether ASHP guidance would augment, and not duplicate, guidelines from JNC and other organizations.

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.)

- [Institutional Review Boards and Investigational Use of Drugs](#) (0711)
- [Clinical Investigations of Drugs Used in Elderly and Pediatric Patients](#) (0229)

Other Council Activity

Application of Emerging Drug Safety Information to Clinical Practice

The Council discussed the increasing number of safety issues that arise with drug products following drug approval by the FDA. The extent of new safety information found in the medical literature and in safety warnings issued by MedWatch is useful, but these messages often raise questions without providing clear answers on how the information should be applied to individual patient care. This is especially true of MedWatch notices that are issued in response to early signals of serious risk identified in the Adverse Drug Event Reporting System (AERS) database. As described by the FDA, these messages indicate a potential safety issue, but one that has not been definitively identified as caused by the drug and therefore the subject of ongoing review by the FDA.

The Council stated that there are significant challenges in applying emerging safety information to clinical practice, including assessing the clinical significance of the safety concern, evaluating the correlation between the drug and the safety risk, and determining and implementing proposed actions. The Council estimated that each MedWatch notice requires between 2 and 10 hours to assess and implement depending on the type and severity of the safety concern. Evolving safety messages based on early safety signals are especially problematic in terms of deciding whether, when, and what changes are needed related to use of the drug within the facility. These decision points often lead to inconsistencies in how

messages are applied at different facilities within one health system and among different health systems. To address these challenges, the Council recommended that ASHP develop a guidance document that would describe the recommended steps that health systems should follow when managing these safety messages. The goal of the guidance would be to increase standardization and ensure the safety of drug use. The Council also encouraged drug information providers, software vendors, and group purchasing organizations to provide information and resources to assist in this process whenever possible. ASHP was encouraged to make members aware of a publicly accessible web site offered by the University of Utah Drug Information Service (<http://healthcare.utah.edu/pharmacy/alerts/>) that provides guidance on the implementation of specific MedWatch notices.

The Council believed that existing work in this area by the FDA was very good, but offered several suggestions to enhance the usefulness of MedWatch messages. These suggestions, which include providing information about the specific studies that generated the warning and data on the number of safety reports compared to the extent of drug use in the overall population, will be shared with FDA staff. Development of a rating scale to identify warnings of highest importance was also suggested. While the intent of MedWatch notices is to prevent harm, the Council believed that these messages frequently generate undue fear in patients when they are taken out of context or over-emphasized by traditional or social media sources. Simultaneous and broad dissemination to all audiences often precipitates immediate phone calls to pharmacists and other clinicians before information resources are available to address patient concerns. It was noted that ASHP's *American Hospital Formulary Service (AHFS)*, which serves as the drug information source for LexiComp and other databases used in the inpatient and outpatient settings, includes this information within 24 hours of receiving the MedWatch notice. The Council encouraged FDA to provide this information to *AHFS* and other drug information providers just prior to public release under an embargo agreement that would facilitate more rapid dissemination of the information and ensure that it is available when it is most needed at the point of patient care (i.e., within the first several days of the announcement).

ASHP Therapeutic Position Statement on the Use of Second-Generation Antipsychotic Medications in the Treatment of Adults with Psychotic Disorders

The Council reviewed the [ASHP Therapeutic Position Statement on the Use of Second-Generation Antipsychotic Medications in the Treatment of Adults with Psychotic Disorders](#) as part of sunset review. This TPS, which was published in 2007, addresses the appropriate use of second generation antipsychotics as first-line treatment for psychotic disorders. Discussion focused on new effectiveness data as well as strategies to prevent side effects associated with these therapies, including metabolic syndrome and sudden cardiac death. The Council noted that management of these therapies is complex and requires attention to differing cognitive effects, dosing, and monitoring for side effects and effectiveness as compared to first-generation antipsychotics. The Council strongly believed that pharmacists can and should play a central role in managing these therapies. Therefore, the Council stated that this guidance was still relevant and voted to revise it. Suggested revisions include updating the guidance to include more recent data on effectiveness and strategies for proactive monitoring of patients

with cardiovascular risks to prevent side effects. A brief discussion of pharmacy resources necessary to manage these therapies was recommended. It was also suggested that the guideline be expanded to evaluate the evidence for use of second-generation antipsychotics to treat other conditions, including depression, post-traumatic stress disorder, insomnia, and agitation or delirium in the emergency room or intensive care setting.

Evaluation of Proposed Models for Print Direct-to-Consumer Advertising

The Council reviewed a recent FDA-conducted study of proposed models for print direct-to-consumer (DTC) advertising. New formats have been proposed to improve the required brief summary, which is intended to provide information on a drug's side effects, contraindications, and effectiveness. FDA regulations state that print advertising must provide a brief summary of side effects, contraindications and effectiveness information from the approved product labeling. Current approaches for including this information include reprinting relevant sections of the prescribing information (PI) or reprinting the entire PI. The Council stated that neither approach supports informed decision-making by patients. There was strong agreement that these advertisements cannot stand alone and need to be supplemented by discussions between the patient and their clinicians.

The Council reviewed the proposed print models in the context of existing [ASHP policy 1119, Direct-to-Consumer Advertising of Prescription and Nonprescription Medications](#), which opposes DTC advertising unless it meets certain requirements. Four models were evaluated using a hypothetical drug for weight loss. Models included the traditional format, an abbreviated version that highlighted required information, a question and answer format, and a drug facts box intended to mirror the format used for nonprescription products. The study, which surveyed 300 volunteers recruited in a shopping mall, found that participants favored the drug facts box. The question and answer format was the second most preferred format.

The Council appreciated the familiarity and brevity of the drug facts box, but questioned if all relevant information could be provided in this abbreviated format. There was also some concern that this format would cause patients to be confused about whether a product was available as a nonprescription product or by prescription only. A perceived benefit of the question and answer format was delivery of information in a format that is actionable. An approach that would combine the drug facts box and question and answer format was recommended by some Council members. The Council appreciated FDA's efforts to improve print DTC advertising, but recommended that the Agency conduct additional studies of these formats using information from an FDA-approved product instead of a hypothetical drug product. The Council also questioned whether recruitment of patients at a shopping mall might bias selection to individuals of higher socioeconomic status. Studies to evaluate the advertisements' affect on actual drug use and patient outcomes, in addition to format preference and comprehension, would also be beneficial. The Council believed that any of the proposed formats was an improvement compared to the existing approach. Therefore, the Council was not opposed to implementation of a proposed model while additional research is conducted.

Safety and Effectiveness of Proposed Nonprescription Status for Oral Contraceptives

The Council considered the implications on safety and effectiveness if oral contraceptives were made available as nonprescription therapies. With the intent of reducing unwanted pregnancies, the Reproductive Health Technologies Project Working Group on Oral Contraceptives (a private women's health clinical and research group) and others have called for broader access to these therapies via a nonprescription progestin-only formulation. It was noted that in early 2011, [Changing Oral Contraceptives to Over-the-Counter Status: An Opinion Statement of the Women's Health Practice and Research Network of the American College of Clinical Pharmacy](#) was published in *Pharmacotherapy*. That statement supports nonprescription status of progestin-only and estrogen-progestin combination oral contraceptive products if certain conditions are met, including availability only through licensed pharmacies while a pharmacist is available for consultation and Medicaid coverage. The statement had not been considered for endorsement by the American College of Clinical Pharmacy Board of Directors at the time of the Council's discussion.

The Council discussed progestin-only and combination oral contraceptive products in the context of FDA's criteria for nonprescription status—which include that the benefit of use must outweigh the risk, ability of patients to self diagnose, provision of adequate labeling, and no need for guidance from a health care professional to ensure proper use. The Council could not reach consensus on whether all of these conditions were met. The debate focused on an assessment of the risk versus benefit of making these products available without a prescription. The Council did agree that there was a significant difference in safety and effectiveness profiles when comparing progestin-only and combination oral contraceptive products. It was noted that combination products are effective and easy to use, but are associated with more adverse events. Progestin-only products are generally safer for most patients, but are contraindicated for some, including those with liver disease or breast carcinoma. Progestin-only products can also be less effective if patients do not closely adhere to directions for use (e.g., consistent timing of administration). It was noted that progestin-only products are not considered first-line therapy and the need for screening and follow-up by a health care professional would likely tip the balance toward these products being inappropriate for nonprescription status. Related to self-diagnosis, the Council stated that smoking history, high blood pressure, and cardiovascular disease are important screenings for both product types. A majority of Council members were encouraged by studies showing that most patients were able to appropriately self-screen for contraindications to oral contraceptives. However, other Council members expressed concern that almost 7 percent of patients did not correctly self-screen for contraindications in one study. The Council also considered arguments against nonprescription status that assert that this access would dissuade women from having routine gynecological exams. These appointments often serve as a gatekeeper for prescriptions for oral contraceptives. The Council rejected this argument, noting that oral contraceptives should not be used to mandate health care visits. It was noted that oral contraceptives are effective if used appropriately and that laboratory monitoring is not needed for these products, with the exception of those that contain drospirenone, which can alter potassium levels. These factors could support

nonprescription status, but Council members remained concerned about whether the benefits outweighed the potential risks.

The Council believed that pharmacists could play a role in screening and monitoring related to the use of these therapies, but expressed concern about workload and lack of reimbursement for these services. The Council also raised several practical concerns about nonprescription status for oral contraceptive products. Documentation of the use of oral contraceptives in the patient's medication profile was considered necessary to ensure proper screening for interactions with antibiotics and other drugs. It was noted that this documentation is more challenging for nonprescription products, which patients may obtain from multiple pharmacies. Liability for pregnancies resulting from inappropriate use of a nonprescription or intermediate category product was another concern. The Council also debated whether current access to these therapies is truly insufficient, noting that oral contraceptives are widely available through Planned Parenthood and other free clinics. There was concern that nonprescription status would actually increase patient costs as was seen when nonsedating antihistamines gained nonprescription status.

The Council did not reach consensus on whether oral contraceptives were safe and effective for nonprescription use. Therefore, it was requested that ASHP continue to monitor developments, including tracking the stances of other health care professional associations. The Council wished to revisit this topic when more information becomes available.

Factors Affecting a Medication Complexity Index

The Council provided guidance in advance of an expert panel that will be convened by ASHP and the ASHP Research and Education Foundation to develop a medication complexity index. The need for this index is based on a recommendation from the Pharmacy Practice Model Initiative Summit that "all patients should have a right to receive the care of a pharmacist." Summit participants recognized that limited pharmacist resources need to be allocated based on the complexity of patient needs and health system characteristics. Therefore, development of a medication complexity index that could be used to prioritize patients that should receive pharmacist-provided drug therapy management was requested. The Council discussion focused on clinical and practice factors that should be considered in developing that index.

The Council noted that nursing has developed indices that have been shown to improve patient outcomes and reduce health care costs. These models are usually based on patient acuity and include factors such as the type of medical procedure performed, use of "complicated" intravenous drugs, and the overall number of medications. These and other indices, such as the case mix index that focuses on costs associated with Diagnosis Related Groups, are generally not appropriate to allocate pharmacy services because these methods do not correlate well with the complexity of drug therapy. For example, a post-operative patient may require intense nursing care but only receive two or three medications that require limited intervention by a pharmacist. On the other hand, a patient admitted for exacerbation of congestive heart failure may not be targeted using nursing indices, but would benefit from pharmacist-provided medication therapy management to improve chronic disease management.

The Council believed that the type and number of medications is an important factor for development of the index. Medications targeted for intervention might include those that require titration, self-administration, or self monitoring. While a medication focus may be a likely starting point, the Council strongly encouraged the expert panel to consider quality measures and reimbursement policies, including those related to readmissions and health-care acquired conditions, when developing the index. The Council discussed the distinction between an index based on medication complexity and one based on patient complexity, which would assess need based on drug therapy and other factors that determine if patient outcomes are amenable to pharmacist interventions. These factors include, but are not limited to, disease severity, disease control, and the number and type of concomitant conditions. The Council highlighted that medication use can also be influenced by non-disease- and non-drug factors, such as health literacy, socioeconomic status, and availability of a family or other support structure.

Desirable characteristics of a medication complexity index include a tool that is simple, but also adaptable and applicable across various health care settings. While the tool should be predominantly based on objective data, the Council advised that its use should allow for subjective interpretation. Ease of use and time to implement are key factors to aid adoption. The Council suggested a format similar to the point system established in the CHEST guidelines. The Council also discussed timing for use of the tool. At admission was considered an ideal time, but transitions of care are also critical. The Council considered whether the index would be applied differently in patients in critical condition versus those preparing for hospital discharge and questioned whether one index would meet both needs.

Board Certification for Pharmacists

The Council discussed the new business item, “Board Certification for Pharmacists,” that was submitted by the Section of Clinical Specialists and Scientists during the 2011 ASHP House of Delegates. The New Business Item was referred by the House, approved by the ASHP Board of Directors in January, and is being considered by the House. The Council was asked to review and comment on the clinical and practice impact of the New Business Item, with the intent of informing those discussions. The Council was largely supportive of the New Business Item, which states that all pharmacists who practice in specialty areas should be certified, if such certification exists. Overall, this was viewed favorably as a future vision for pharmacy practice. The Council’s discussion focused on the time line and process for expanding certification, including how it would implemented at the practice level (e.g., hiring requirements, continuing professional development).

The Council strongly supported the need to establish a baseline credential that would be applicable across patient populations and settings. This was considered important to minimize calls for sub-specialties that may not have adequate demand or resources to justify a stand-alone credential. In terms of determining and prioritizing future specialties, in addition to the factors described in the policy, the Council believed it was important to consider the number of available residencies as this would indicate a pipeline of expertise to both develop and take the exam. The need for a specialty credential in pharmacy management was noted, whether this was provided via BPS or an organization such as the American College of Healthcare Executives.

In general, the Council supported standardization of eligibility requirements, but questioned whether there might be some specialties for which minor variation was desirable based on patient care needs. In addition, some Council members expressed concern that the proposed standardization of eligibility requirements included completion of postgraduate year 2 residency program. This concern was based on the limited number of residencies in some specialty areas. The Council was reminded that the proposed policy was intended as a future vision for pharmacy practice and that an increase in the number of specialized residencies was projected.



SEIZE THE INITIATIVE

ASHP House of Delegates 2012
June 10 and 12, 2012

Policy Recommendation from the Section of Clinical Specialists and Scientists



Board Certification for Pharmacists

- 1 To support the principle that pharmacists who practice where a pharmacy specialty
- 2 has been formally recognized by the profession should become board certified in the
- 3 appropriate specialty area; further,

- 4 To recognize the Board of Pharmacy Specialties (BPS) as an appropriate organization
- 5 through which specialties are formally recognized and specialty pharmacy
- 6 certification should occur; further,

- 7 To advocate prioritization for recognition of new specialties in those areas where
- 8 sufficient numbers of postgraduate year two residency training programs are
- 9 established and where adequate numbers of pharmacists are completing accredited
- 10 training programs to prepare them to practice in the specialty area; further,

- 11 To advocate for standardization of credentialing eligibility and recertification
- 12 requirements to include consistent requirements for advanced postgraduate
- 13 residency training; further,

- 14 To promote a future vision encouraging accredited training as an eventual
- 15 prerequisite for board certification; further,

- 16 To encourage BPS to be sensitive to the needs of current practitioners as
- 17 prerequisites evolve; further,

- 18 To actively encourage and support the development of effective training and
- 19 recertification programs that prepare specialists for certification examination and
- 20 ensure the maintenance of core competencies in their area of specialization.

Rationale

As medication therapies become more complex, the need for specialized expertise increases. Some areas of health care practice evolve to the point where certification, based on formal accredited training and psychometrically valid examination, is needed to assure the public and other health care professionals of a level of competence, quality, and consistency among specialists practicing in that field. Certification, as defined by Council on Credentialing in Pharmacy, is the process by which a nongovernmental agency or an association grants recognition to an individual who has met certain predetermined qualifications specified by that organization. Formal recognition of pharmacy specialties demonstrates the unique knowledge, skills, and abilities of pharmacists in well-defined areas of practice and provides the assurance the public and other health care professionals need.

ASHP has long recognized the value of specialty certification. ASHP has been involved in four of the six petitions to the Board of Pharmacy Specialties (BPS) requesting recognition of new pharmacy specialties. ASHP was the sole petitioning organization for two specialties, and has worked jointly with other organizations in developing two other specialties. The *ASHP Long Range Vision for Pharmacy Work Force in Hospitals and Health Systems* states that pharmacists who provide services in an area where specialty certification exists should be certified in that specialty, and the *ASHP Supplemental Standards for Postgraduate Training* require such certification of residency program directors only. More recently, the Pharmacy Practice Model Initiative (PPMI) recommended that pharmacists who provide drug therapy management should be certified through the most appropriate BPS board-certification process if such a specialty has been established (Recommendation B10).

BPS is currently the only pharmacist-certifying organization accredited by the National Commission for Certifying Agencies (NCCA). NCCA accreditation ensures very high quality standards in the professional certification industry. Although other organizations have developed an array of credentials of differing value, those credentials do not necessarily represent the recognition of a unique area of specialization and the development of processes recognized by the profession to ensure the quality of specialty practice. It is also important to distinguish the recognition of specialties within the practice of pharmacy from other multidisciplinary certifications. Although some similarities exist in the nature of such programs, they also do not represent the recognition of a unique area of specialization and the development of processes recognized by the pharmacy profession to ensure the quality of specialty practice.

The profession should be more strategic in its efforts to grow and mature new specialties. To date, the pharmacy profession has relied upon an episodic petitioning process to identify and recognize new specialties. A methodical specialty development process would prioritize recognition of areas of practice for which a sufficient number of high-quality training programs exist and would promote development of training programs in emerging areas of pharmacy specialization in advance of specialty recognition.

Eligibility requirements for Board certification vary widely among currently recognized specialties. Although it may not currently be possible to require residency training as a prerequisite for all BPS specialty certification applicants, over time postgraduate year two residency training should become the preferred prerequisite to establish consistent requirements across specialties and provide a stronger linkage between training and

certification. ASHP policy currently supports the principle that accredited training is an important future prerequisite for pharmacy technicians prior to certification by the Pharmacy Technician Certification Board. This same principle that accredited training should precede certification should also apply to specialists in our profession. It will be important for BPS to plan for this future vision and evolve requirements in a manner that is sensitive to the needs of existing practitioners.

Background

In 2011, the House of Delegates approved a new business item from the Section of Clinical Specialists and Scientists concerning BPS certification. Following the House session, the Section solicited feedback from members and ASHP councils to draft final policy recommendation language, which was amended and approved by the Board at its January meeting.



SEIZE THE INITIATIVE

ASHP House of Delegates 2012
June 10 and 12, 2012



ASHP Statement on Use of Social Media by Pharmacy Professionals

Position

- 1 The American Society of Health-System Pharmacists (ASHP) encourages pharmacy
2 professionals working in hospitals and health systems to use social media in a professional,
3 responsible, and respectful manner to complement and enhance their relationships with
4 patients, caregivers, other members of the health care team, and the public. To achieve that
5 goal, pharmacy professionals should
- 6 • thoroughly consider the purposes and potential outcomes of participation in social
7 media and develop the strategies and skills required to effectively utilize social
8 media to meet their goals, and
 - 9 • exercise professional judgment and adhere to professional standards and legal
10 requirements in both private and public social media communications, especially
11 legal and ethical obligations to protect the privacy of personal health information.

Background

12 The term “social media” may be defined as online tools that allow interaction among
13 individuals. Examples include professional networks such as ASHP Connect, career-building
14 networks such as LinkedIn, and sites such as Facebook and Twitter that are primarily social
15 but which may serve multiple purposes.¹⁻³ Informational sites regarding medical information
16 that allow for commentary from users and medical professionals (e.g., PharmQD, The
17 Pharmacist Society, Sermo) should also be considered collaborative social media.

18 Social media have transformed the way people communicate by reducing barriers to
19 the exchange of information, increasing both the amount of communication and the
20 number of people who can participate. Health care organizations (e.g., hospitals, health
21 systems, professional societies, pharmaceutical companies, patient advocacy groups, and
22 pharmacy benefit companies) have chosen to use social media for both communication and
23 marketing.

24 Like other health care professionals, pharmacy professionals have adapted to
25 advancing technology and are using social media to communicate with patients, caregivers,
26 other health care professionals, and the public. Pharmacy professionals (including pharmacy
27 students, as professionals in training) should continue to incorporate these new tools into
28 the armamentarium of pharmacy practice and apply them with professional judgment to
29 pursue the goal of helping people make the best use of medications. Social media provide
30 pharmacy professionals with opportunities to educate patients and practitioners, seek
31 advice from and provide advice to colleagues, optimize the medication use of individual
32 patients and populations, promote the role of pharmacists in caring for patients, and
33 engage in debate about issues in health care practice and policy, among other things.¹⁻⁵

Participation in Social Media

34 Hospitals or health systems that choose to use social media or permit practice-related social
35 media use by staff should have in place policies and procedures that

- 36 • balance the benefits social media provide with the obligations and liabilities they
37 may create, and
- 38 • encourage the development and application of best practices by users of social
39 media.

40 The details of such policies, procedures, and best practices are beyond the scope of this
41 statement, which has as its purpose to briefly outline some of the considerations that
42 should guide pharmacy professionals' participation in social media.

43 Pharmacy professionals should carefully consider the purposes and potential outcomes
44 of their participation in social media and develop the strategies and skills required to
45 achieve their goals. They need to be aware of and employ best practices when using social
46 media, because health care practitioners, including pharmacy professionals, are held to a
47 higher standard of professionalism within and outside the workplace than members of the
48 public.⁶ Pharmacy professionals who participate in social media should strive for a high
49 degree of professionalism in their communications and ensure that patient privacy is not
50 compromised.

Professionalism

51 ASHP has long advocated for the adoption of high professional aspirations for pharmacy
52 practice. Pharmacists' responsibilities as professionals include "advancing the well-being
53 and dignity of their patients, acting with integrity and conscience, [and] collaborating
54 respectfully with health care colleagues."⁷ The following recommendations for the use of
55 social media represent high professional aspirations, and pharmacy professionals are
56 encouraged to exercise their professional judgment in incorporating them into their
57 practices.

58 **Advancing the well-being and dignity of patients.** The following recommendations can
59 help pharmacy professionals who choose to participate in social media advance the well-
60 being and dignity of patients.

- 61 1. Medical advice offered through social media should be provided in accordance with
62 the professional standards of pharmacy practice. For example, pharmacy professionals
63 should provide medical advice only with a complete understanding of the patient's
64 medical conditions and only if they accept the associated liabilities, especially those
65 regarding privacy and the requirements of pharmacy practice. Pharmacy professionals
66 should be aware that providing medical advice may create a pharmacist-patient
67 relationship, with all its attendant obligations and liabilities. All online relationships
68 should conform to the ethical boundaries of an appropriate patient-pharmacist
69 relationship.⁸
- 70 2. Pharmacy professionals should be cognizant of both the benefits and limitations of
71 online communication. Social media may serve especially well as a point of initial
72 contact or as a convenient way to maintain contact between patients and care
73 providers, but professionals must recognize when a patient's health care needs would
74 be better met through other means (e.g., phone consultation or an office visit).
- 75 3. Pharmacy professionals should view social media as a means to not only provide timely
76 and accurate drug information but also to rebut inaccurate, misleading, or outdated

77 information. While the purpose of specific social media content may not always be
78 apparent, pharmacy professionals also need to be aware of and alert to the use of
79 social media for marketing and sales purposes.

80 4. Complaining about or disparaging patients, even in general terms, does not advance
81 the dignity of patients or the profession. Communications that contain patients'
82 identifying information would violate privacy requirements, which are discussed in
83 more detail below. Pharmacy professionals should keep in mind that simply avoiding
84 the name of a patient may not be sufficient to avoid patient identification.

85 **Acting with integrity and conscience.** The following recommendations are intended to
86 assist pharmacy professionals to act with integrity and conscience in their use of social
87 media.

- 88 1. Pharmacy professionals should carefully distinguish between personal and
89 professional information within social media and make conscientious decisions
90 regarding who will have access to personal or professional information. Although some
91 organizations recommend use of a strictly personal and a separate, strictly practice-
92 related page,⁹ professionals will quickly recognize the difficulty of making such
93 distinctions. The higher standards of conduct expected of professionals, even in
94 personal behavior, apply as well to their participation in social media.^{6, 10}
- 95 2. Pharmacy professionals must be conscious that content posted to social media may
96 have consequences on reputations or careers for years to come, reflect poorly upon
97 the pharmacy profession, or undermine patient confidence in the care provided.
98 Postings on social media should be subject to the same professional standards and
99 ethical considerations as other personal or public interactions.
- 100 3. The apparent anonymity provided by social media does not release pharmacy
101 professionals from their ethical obligation to disclose potential conflicts of interest,
102 especially when representing themselves as professionals. Some circumstances may
103 require personal identification or disclosure of potential competing interests.⁹
- 104 4. Although all pharmacists should use social media in ways that set positive examples
105 for pharmacy students and residents, preceptors and mentors have a special
106 responsibility to model appropriate practices.^{7, 11}

107 **Collaborating respectfully with health care colleagues.** Although social media can and
108 should be used to promote healthy debate about health care and pharmacy practice, such
109 debate should be conducted in a respectful manner. Reasoned debate sometimes requires
110 constructive criticism, but pharmacy professionals should not use social media to make ad
111 hominem comments or needlessly denigrate specific care providers, institutions, or
112 professions.

Patient Privacy

113 Health care professionals have long confronted the challenge of “communicat[ing] freely
114 with each other while maintaining patient confidentiality and privacy.”¹² Social media, by
115 their very nature, present new issues of privacy and confidentiality by extending the reach
116 of communications. The following recommendations may help pharmacy professionals
117 protect patient privacy and confidentiality as they navigate this new terrain.

- 118 1. Pharmacy professionals should continue to adhere to all laws, regulations, standards,
119 and other mandates intended to protect patient privacy and confidentiality in all
120 environments, including social media.⁸

- 121 2. Pharmacy professionals should exercise professional judgment and employ established
 122 best practices to ensure compliance with privacy requirements when communicating
 123 with patients or about specific patient cases on social media.^{9, 13, 14}
 124 3. Pharmacy professionals should select privacy settings in social media accounts that
 125 provide the greatest degree of protection for personal information, keeping in mind
 126 that privacy settings are not perfect and that information posted online is likely
 127 permanent. Continuous self-monitoring of privacy settings is necessary, as social
 128 media sites change privacy policies.¹⁰

Conclusion

129 Social media are emerging as important modes of communication and are increasingly
 130 being used for personal, professional, and business communication, as well as for patient
 131 care. As medical professionals held to high standards of personal, professional, ethical, and
 132 moral conduct, pharmacy professionals have a responsibility to use social media
 133 appropriately.

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Background

In 2010, the Council on Pharmacy Practice noted the growing use of social media by pharmacy professionals and discussed its benefits and risks. The Council recommended that the Pharmacy Student Forum consider developing guidance on the topic. The Executive Committee of the Pharmacy Student Forum began work on an ASHP statement in 2011, and with the assistance of members of the Section of Pharmacy Informatics and Technology, a draft was completed by November 2011. The draft was revised in response to comments from more than 25 ASHP members and subsequently approved by the executive committees of the Pharmacy Student Forum and the Section of Pharmacy Informatics and Technology and by the Board of Directors.



Reports on Sections and Forums

ASHP sections consist of members within five well-defined areas of health-system pharmacy who collaborate to advance professional practice in their respective areas.

ASHP members may enroll in as many sections as they wish; practitioner members are asked to select one section as their primary “home,” which allows them to vote for the chair and members of the executive committee of that section.

The ASHP Pharmacy Student Forum consists of all student members. The New Practitioners Forum consists of all practitioner members who are within five years of graduation from a school or college of pharmacy.

Each section and forum is led by an Executive Committee elected (sections) or appointed (forums) from the ASHP membership. Each Executive Committee met face to face June 10 and December 3 or 4, 2011, to review the past year’s activities and plan for the coming year. The committees also met by telephone periodically during the year to assess progress on initiatives and discuss new trends or events that warranted section or forum activity. Each section and forum has its own mission, vision, goals, and objectives.

Pharmacy Student Forum.....	2
New Practitioners Forum.....	9
Section of Ambulatory Care Practitioners.....	16
Section of Clinical Specialists and Scientists.....	21
Section of Inpatient Care Practitioners.....	27
Section of Pharmacy Informatics and Technology.....	34
Section of Pharmacy Practice Managers.....	41



SEIZE THE INITIATIVE

ASHP House of Delegates 2012
June 10 and 12, 2012

Report on the Pharmacy Student Forum

The Pharmacy Student Forum serves to prepare the next generation of health-system pharmacists to be leaders in their schools and communities and to advance the future of the pharmacy profession. The Forum volunteer leadership is composed of five student members of the ASHP Pharmacy Student Forum Executive Committee who were appointed by the ASHP President in 2010. Each Executive Committee member serves as a liaison to one of the five Forum advisory groups: Leadership Development, Education and Programming, Student Society Development, Policy and Legislative Advocacy, and Community and eCommunications. The Executive Committee is responsible for advising the ASHP Board of Directors and staff on the overall direction of the Forum, including member benefits and services. The Chair of the Executive Committee serves as the voting student representative to the ASHP House of Delegates. The Executive Committee also assists in building relationships between ASHP and schools of pharmacy by serving as liaisons, providing information to student society leaders, and helping to strengthen the student society of health-system pharmacy (SSHP) activities and programs on each campus.

Executive Committee

Stacy B. Livingston, *Chair* (Iowa)
Ashley M. Overy, *Vice Chair* (Ohio)
Sarah A. Johannes (North Carolina)
Jesni A. Mathew (Florida)
Diana Park (Arkansas)
Christene M. Jolowsky, *Board Liaison*
Diana L. Dabdub, *Secretary*

Strategic Goals. The 2011–2012 Executive Committee established a strategic plan with five core goals to direct Forum operations:

1. Cultivate a community of pharmacy students who are actively engaged and participating in ASHP as their primary professional home.
2. Grow the number of SSHPs and improve the effectiveness of these campus-based organizations in achieving the goals and requirements of ASHP recognition.
3. Expand the engagement of students and faculty in important professional issues and the ASHP programs and initiatives that address these issues.
4. Encourage and support the development of leadership skills across the continuum of students' education.
5. Assist students in career planning and their successful transition from student to new practitioner.

2011–2012 Forum Highlights. The past year was successful for the Pharmacy Student Forum, marked by continued growth in membership, student involvement, and the ASHP-SSHP Recognition Program. Forum membership exceeds 16,000 students, from schools of pharmacy across the nation. The consistent growth trend in the Forum is attributed to the growing number and expansion of pharmacy programs, the structure and strength of the ASHP-SSHP Recognition Program, as well as the wealth of valuable member benefits that help students achieve their professional goals.

The Forum continually strives to meet the needs and exceed expectations of student members. This goal was accomplished through increasing awareness of career opportunities within health-system practice; providing information regarding residencies and other postgraduate education programs; and encouraging professional development by fostering student leadership development and involvement in ASHP, state, and local health-system pharmacy organizations.

The Forum Executive Committee and advisory groups focused efforts on the strategic goals established at the start of the year and made significant progress. Some highlights include the collaboration with the Section of Pharmacy Informatics and Technology on the *ASHP Statement on Pharmacy Professionals' Use of Social Media*, and heightened training and investment in SSHP leaders to strengthen campus-level membership.

ASHP-SSHP Recognition Program. In 2007, the Forum devoted resources to advance the development of strong SSHPs. As a result of these efforts, the ASHP-SSHP Recognition Program was developed. SSHPs nationwide have the opportunity to earn this official annual recognition from ASHP based on programming and activities completed each year. Criteria for recognition encourage SSHP activities that promote membership in local, state, and national health-system organizations; stimulate interest in health-system pharmacy careers; and encourage career development and professionalism among students aspiring to careers in health-system pharmacy. In 2011, 101 SSHPs met the criteria for recognition and received benefits, including a complimentary student registration to the Midyear and Summer meetings, awards for incoming and outgoing officers, a custom SSHP logo, and a certificate of recognition.

Outreach, Connection, and Engagement. The Pharmacy Student Forum strives to engage students who have an interest in hospital and health-system careers. Our aim is to reach every school of pharmacy every year to inform students about member benefits, including leadership training and opportunities, educational programming, professional development resources, and career preparation tools. Our outreach efforts are multifaceted, consisting of campus visits by ASHP staff and volunteer leaders and virtual visits using web-based conferencing technology.

With the growing number of members and activity in the Forum, creating a sense of community and connection is critical to foster engagement with the organization. The Forum facilitates connections with and between students by leveraging a wide variety of communication vehicles, such as the student pages of the ASHP website, the twice-monthly NewsLink email service to provide deadline reminders and updates, and our newest resource, ASHP Connect. This tool provides students with a multitude of ways to directly connect with ASHP and with each other through the Discussion Board, Facebook Fan Page, LinkedIn, Twitter, YouTube, and more.

Meetings and Programming. ASHP offers programming designed specifically for student members at both the Midyear Clinical Meeting (MCM) and Summer Meeting (SM). The 46th annual ASHP MCM in New Orleans, Louisiana attracted more than 5000 pharmacy students. This meeting offered a wealth of options for students, including the Residency Showcase, Personnel Placement Service, and research posters. In addition, students took advantage of a full day of educational programming tailored for their unique needs, with topics including residency preparation, resume writing and interviewing, and financial management. A highlight of the week was the Clinical Skills Competition, where a record number of schools from across the nation participated. A special awards ceremony was held in conjunction with the Student Society Showcase to recognize the outstanding contribution and leadership of several ASHP and SSHP student members.

The Meet and Greet with Pharmacy Leaders session at the 2011 SM was a success and allowed students to speak with key leaders in pharmacy. Additionally, the ASHP policy process educational session, geared initially for students, was continued and opened to all SM attendees. Students were also encouraged to get involved in ASHP policy by attending key House of Delegates events.

Clinical Skills Competition. The 16th Annual ASHP Clinical Skills Competition, supported by the ASHP Research and Education Foundation, was held at the 2011 MCM. Teams from 115 schools of pharmacy throughout the nation competed. This two-day competition offered students the opportunity to analyze patient cases; demonstrate their skills in assessing a patient's medical history; identify drug therapy problems and treatment goals; and recommend a pharmacist's care plan, including monitoring desired patient outcomes. The national title was awarded to Linda Lei and Stephanie Friedman from the University of Washington School of Pharmacy.

ASHP Student Leadership Award Program. The ASHP Student Leadership Award program prominently recognizes and celebrates the contributions of students who represent the very best attributes and accomplishments of ASHP student members. The highly competitive program consists of up to 12 annual awards to four student members in each professional year

of pharmacy school, beginning with the second professional year. Award recipients receive a plaque, an ASHP drug information reference library, and a cash award provided by the ASHP Research and Education Foundation and funded through the Walter Jones Memorial Student Financial Aid Fund. The objective of the program is to encourage personal and professional development through a formal program providing well-deserved recognition to student leader role models who have demonstrated an interest in health-system practice and displayed exemplary student involvement in professional organizations.

2011 ASHP Student Leadership Award recipients were as follows:

Class of 2011: Alexander Flannery, University of Kentucky; Tiffany Pon, Purdue University; Jennifer Cerdena, University of Utah

Class of 2012: Charles Makowski, Wayne State University; Karen Craddick, University of Washington; Dazhi Liu, The University of Iowa; Heather Woodward, University of Colorado

Class of 2013: Meenakshi Girish Shelat, University of Michigan; Nola Fry, Texas A&M; Christopher Lai Hipp, University of Hawaii

Experiential Education Program. ASHP offers an elective Advanced Pharmacy Practice Experience (APPE) in national association management. The purpose of the program is to provide students with an understanding of the importance of pharmacy associations to the profession and the value of participation in local, state, and national pharmacy organizations. The rotation also provides an opportunity for pharmacy students with an interest in association management to experience a professional association's practices and procedures in furthering its mission, vision, and goals. The program also identifies potential leaders in the pharmacy profession. In the 2011–2012 academic year, the following students were selected to participate in this program:

- Keli Edwards, Howard University
- Stacy Livingston, University of Iowa
- Ashley Overy, Ohio Northern University
- Elizabeth Oladele, Duquesne University
- Veldana Nuhi, University of Florida
- Amanda Johnson, University of Pittsburgh
- Jennifer Smith, University of Pittsburgh
- James Lott, Chicago State University
- Arpit Mehta, Lake Erie College of Osteopathic Medicine School
- Olabode Ogundare, University of Maryland

Summer Internship Program. ASHP offers a 10-week training program in national association management. The interns, students early in their pharmacy education, are introduced to the role of pharmacy associations to the profession while being exposed to ASHP's practices and procedures in furthering its mission, vision, and goals. In 2011, one intern joined ASHP in the

Office of Member Relations, Jacalyn Jones, of Northeast Ohio Medical University. Her focus area was Pharmacy Technician Initiative and Pharmacy Practice Model Initiative (PPMI).

Student Society Development Grant Program. ASHP offers grants to aid in the development of SSHPs. The grants are intended for use by the ASHP state affiliate and college of pharmacy partners to establish a new SSHP, or to strengthen an existing SSHP, ultimately aiding the SSHP to achieve official ASHP Recognition. In 2011, grants were awarded to the following pharmacy programs:

- Albany College of Pharmacy and Health Science
- Concordia University of Wisconsin School of Pharmacy
- Husson University School of Pharmacy
- Jefferson School of Pharmacy, Thomas Jefferson University
- Presbyterian College School of Pharmacy
- Regis University School of Pharmacy
- University of Nebraska College of Pharmacy
- Roosevelt University College of Pharmacy

Student Research Award. Through the ASHP Research and Education Foundation's annual Literature Awards Program, a Student Research Award is presented to a pharmacy student for a published or unpublished paper or report of a completed research project related to pharmacy practice in a health system. The Foundation provides a plaque and an honorarium to the award recipient, as well as an expense allowance to attend the MCM to receive the award. The 2011 recipient was Michael Spinner from the St. Louis College of Pharmacy as the leading author of a paper published in *Transplantation*, titled "Impact of Prophylactic Versus Preemptive Valganciclovir on Long-term Renal Allograft Outcomes."

Advisory Group Appointments. The five advisory groups of the Forum serve to offer feedback to ASHP on areas of specific interest to pharmacy students, while expanding the opportunity for student leadership at the national level. For the 2011–2012 academic year, 55 students from the first through fourth professional years were appointed to these advisory groups. The groups completed their work via electronic communications, conference calls, and one in-person meeting preceding the MCM in December.

Community and eCommunications Advisory Group. The advisory group has focused efforts on continuing to leverage ASHP Connect to engage and increase student member participation. The group will be providing suggestions for resources for SSHPs to participate in ASHP Connect. Suggestions for improving the Pharmacy Student Forum website were recommended to ASHP. The group will continue to work on developing a document, for students, to explain the Residency Stakeholders conference and the steps ASHP is taking to address residency program expansion. The advisory group collaborated with the Section of Pharmacy Informatics and Technology on the *ASHP Statement on the Use of Social Media by Pharmacy Professionals*.

Education and Programming Advisory Group. The advisory group provided detailed guidance in the preparation of programming and collateral materials for the MCM. The group provided recommendations on ways to increase students' awareness of PPMI during the MCM. The advisory group recommended the Forum develop a survey to obtain a baseline measure PPMI awareness at the student level. The survey focus is to identify what is known about PPMI and resources needed to increase awareness about PPMI. Recommended actions to improve the student experience at the SM were also provided.

Leadership Development Advisory Group. The advisory group made significant progress to expand leadership development resources available to ASHP student members. The advisory group conducted a series of journal club activities via the ASHP Connect Discussion Board centered on leadership topics. A recommendation was developed for the creation of a student leader spotlight to highlight outstanding student leaders. A best practices document outlining characteristics of pharmacy internships based on student experience is in development. The group developed a survey regarding mentoring to gather information about how students form mentoring relations and to identify ideas for resources that may aid students in developing mentoring relationships.

Policy and Legislative Advocacy Advisory Group. The advisory group made significant strides to engage student members in ASHP policy and advocacy efforts. They provided a recommendation to improve the content and increase the utilization of the web-based Advocacy Toolkit. Included in the recommendation were new resources to assist SSHPs in planning and implementing advocacy-related initiatives that address the SSHP recognition requirement for a professional development project. The advisory group also created summaries of the five PPMI webinars and will be exploring ways to best distribute this information to students.

Student Society Development Advisory Group. The advisory group has made efforts to further strengthen the relationship between ASHP, ASHP state affiliates and the ASHP student liaisons on each campus. This group developed a collaboration document that outlines ideas on how SSHPs can work more closely with their affiliates. To help SSHPs, the group will continue work on developing an SSHP Speakers Resource document that will offer suggestions for speakers. To highlight outstanding SSHP professional development projects, the group developed a recommendation for implementing a SSHP professional development project award at the Student Society Showcase during the MCM.

Community and eCommunications Advisory Group

Veldana Nuhi, Chair, University of Florida-Jacksonville; Arpit Mehta, Lake Erie College of Osteopathic Medicine School; Dazhi Liu, University of Iowa; Elizabeth Dow, University of Minnesota; Kelli Shae'Michael, Campbell University; Kenneth W. Worsham II, Hampton University; Lisa Scherkenbach, University of Minnesota; Matthew Allsbrook, University of Michigan; Ryan Birk, Southern Illinois University-Edwardsville; Ryan Markham, University of

Georgia; Yao Hua Lin, University of Houston; Ashley Overy, Executive Committee Liaison, Ohio Northern University

Education and Programming Advisory Group

Christine Vi Dang, Chair, University of Colorado; Caroline M. Small, University of New Mexico; Samar Chakar, University of New England; Lea Elyse Mollon, University of Arizona; Steve Erickson, University of Washington; Catherine Floroff, Virginia Commonwealth University-Richmond; Melissa Buchanan, Campbell University; Linda Lee, Harding University; Leah Quealy, University of Southern Nevada-South Jordan; Viet Nguyen, University of Texas-Austin; Bushra Muraywid, University of Missouri-Columbia Campus; Stacy Livingston, Executive Committee Liaison, University of Iowa

Leadership Development Advisory Group

Sherry Kwon, Chair, University of California – San Francisco; Thomas Achey, Auburn University; Aimee Mishler, Ferris State University – Grand Rapids; Todd Knepper, University of North Carolina – Chapel Hill; Calvin Ice, Ohio Northern University; Elaine Nguyen, University of Iowa; Meenakshi Shelat, University of Michigan; Phuoc Anh Nguyen, University of Texas – Austin; Janessa Smith, University of Maryland – Baltimore; Andrea Faison, University of North Carolina – Chapel Hill; Christine Wicke, University of Texas – Austin; Sarah Johannes, Executive Committee Liaison, University of North Carolina

Policy and Legislative Advocacy Advisory Group

Ryan Fischer, Chair, Ohio Northern University; Krystal Canally, The Ohio State University; Shyla Rider, The Ohio State University; Jamie Elsner, University of Maryland-Baltimore; Mark Stone, University of Florida-Jacksonville; Janet Lee, University of Maryland-Baltimore; Grayson Peek, University of Tennessee-Knoxville; Matthew Guindon, University of Washington; Kelsey Laks, Lake Erie College of Osteopathic Medicine; Kristina Schieffert, Temple University; Marc Crane, Temple University; Jesni Mathew, Executive Committee Liaison, University of Florida

Student Society Development Advisory Group

Saranyu Ravi, Chair Thomas Jefferson University; Hannah Suh, Harding University; Sarah Mahon, Thomas Jefferson University; Mary Beatham, Husson University; Halena Leah Sautman, Palm Beach Atlantic University; Kristin Wong, Touro University-California; Andrea Passarelli, University of Maryland-Baltimore; Houda Aboujamous, Mercer University; Jessica Ho, South Carolina College- MUSC Charleston; Meredith Holmes, University of Colorado; Nola Fry, Texas A&M Health Science Center; Diana Park, Executive Committee Liaison, Harding University



SEIZE THE INITIATIVE

ASHP House of Delegates 2012
June 10 and 12, 2012

Report on the New Practitioners Forum

The New Practitioners Forum is led by a five-member Executive Committee appointed each year by the ASHP President-elect and approved by the Board of Directors. The Executive Committee is responsible for advising the Board and ASHP staff on the overall direction of the Forum, including member services, programs, and resources. The Executive Committee Chair participates in ASHP's strategic planning process and serves as a voting new practitioner member in the ASHP House of Delegates. Each Executive Committee member serves as a liaison to one of the Forum's six advisory groups.

Recognizing that recent pharmacy graduates have unique and diverse professional needs, the ASHP New Practitioners Forum seeks to provide a community and collective voice for new practitioners as they transition into hospital and health system pharmacy practice. Through innovative programming, educational resources, advocacy tools, networking events, and leadership opportunities, the Forum supports the integration of new practitioners into ASHP and empowers members to lead the future of pharmacy practice.

The ASHP New Practitioners Forum seeks to be the preferred organizational home for new practitioners practicing in hospitals and health systems. Through our dynamic programs and services, our knowledgeable and respected members will collaboratively develop, promote, and lead best practices supporting innovative practice models that provide optimal care to patients.

Executive Committee

Jeffrey D. Little, *Chair* (Kansas)

Katherine A. Palmer, *Vice Chair* (California)

Nicholas T. Bennett (Missouri)

Karen Berger (New York)

Kayla M. Hansen (North Carolina)

Larry C. Clark, *Board Liaison*

Jill L. Haug, *Secretary*

Strategic Goals. The Executive Committee established five strategic goals, with accompanying objectives, to direct the Forum's operations:

- 1. *Serve the unique and evolving educational and informational needs of new practitioner members.*** Objectives: (1) Conduct continual assessment and analysis of evolving needs and the effectiveness of Forum programs to meet these needs. (2) Provide programs and publications that meet the educational and informational needs of new practitioner members. (3) Utilize social media to effectively communicate with new practitioner members.
- 2. *Support the development of leadership skills and professionalism in new practitioner members.*** Objectives: (1) Promote leadership and engagement opportunities for new practitioner members within the Forum and ASHP. (2) Provide programs and resources that promote leadership skill development and foster professionalism in new practitioner members.
- 3. *Promote membership and active involvement in the ASHP New Practitioners Forum.*** Objectives: (1) Recruit, retain and promote active involvement in the Forum. (2) Enhance visibility and awareness of Forum membership benefits. (3) Expand collaboration between Forum members and others in ASHP, including section and Student Forum members. (4) Promote initiatives and accomplishments of Forum members.
- 4. *Facilitate greater understanding and participation in professional policy development and advocacy by new practitioner members.*** Objectives: (1) Generate awareness and encourage participation of new practitioner members in professional policy development. (2) Create awareness and support involvement of new practitioner members in advocacy.
- 5. *Support new practitioner engagement in practice advancement initiatives.*** Objectives: (1) Create awareness and support for the Pharmacy Practice Model Initiative (PPMI). (2) Support and promote initiatives focused on increasing residency capacity. (3) Develop and promote programs that support Forum members preparing for board certification.

2011–2012 Forum Highlights. Landmark achievements consistent with these goals and objectives in 2011 –2012 included (1) fully implementing and expanding the multifaceted *Great eXpectations eXperience* program by hosting the sixth *Great eXpectations Live* program for the third consecutive year at the Midyear Clinical Meeting, holding the second *Great eXpectations eConference* in May, and expanding the web-based, on-demand *Great eXpectations Video* program; (2) awarding the fifth New Practitioners Forum Distinguished Service award; (3) actively engaging Forum members in activities related to the Pharmacy Practice Model Initiative (PPMI) and residency capacity expansion efforts; (4) increasing awareness of member-generated web-based video career profiles to spotlight the professional accomplishments of new practitioner members; and (5) establishing a Forum working group focused on developing

resources that support members pursuing board certification. These activities demonstrate the commitment of ASHP and the Forum to meeting the unique needs of over 5000 new practitioner members. The continual creation and provision of career development tools, leadership opportunities, practice resources and identification of opportunities for collaboration with the ASHP practice sections also show support for this membership group. By meeting new practitioner needs, ASHP hopes to foster professional development in new practitioners that extends into greater involvement in ASHP and state and local health-system pharmacy organizations.

Distinguished Service Award. The Forum selected Michael DeCoske as the winner of the New Practitioners Forum Distinguished Service Award. Established in 2007, the ASHP New Practitioners Forum Distinguished Service Award recognizes a member of the Forum whose volunteer activities have supported the Forum's mission and helped advance the profession. The award was presented at the 2011 Midyear Clinical Meeting.

Advisory Groups. The Chair of the New Practitioners Forum Executive Committee appoints Forum members to advisory groups in June, placing over 60 new practitioners in leadership positions. The advisory groups are charged with providing feedback, guidance, and assistance in achieving the Forum's strategic goals. A returning advisory group member is appointed annually to the chair position and executive committee members serve as liaisons to each advisory group.

Communications and Technology Advisory Group. This group is charged with enhancing the Forum's image and outreach using various electronic communication tools. Priorities this year included ongoing promotion and assessment of the Forum's new web-based video profiles program to spotlight new practitioners in various practice initiatives, providing ongoing review and feedback regarding the Forum's engagement in social media, posting regularly to ASHP Connect to initiate ongoing interest and discussion with members, writing an article on e-professionalism, and exploring other technological tools to improve outreach and meet the needs of new practitioner members.

Membership and Outreach Advisory Group. This group is charged with advancing the objectives set forth in strategic goal 3 and focused on projects that might expand collaboration between Forum members and the broader ASHP membership. Priorities this year included researching and compiling a resource highlighting the best practices of those state affiliates successful in engaging new practitioners on the state and local level, highlighting new practitioners within the ASHP Connect community, and exploring ways to improve communication between members and fostering the development of mentoring relationships.

Public Affairs and Advocacy Advisory Group. This group is charged with advancing the objectives set forth in goals 4 and 5. Priorities this year included promoting new practitioner involvement in advocacy efforts related to the PPMI and residency capacity expansion and exploring innovative ways to disseminate information about advocacy efforts to new practitioners utilizing social media.

Leadership and Career Development Advisory Group. This group is charged with advancing the objectives set forth in goal 2. Priorities this year included developing a webinar on advanced practice management degrees, enhancing and promoting the Forum's web-based

leadership journal club, and exploring unique ways to identify and showcase resident projects that align with PPMI.

Professional Practice Advisory Group. This group is charged with advancing the objectives set forth in goal 1, specific to professional practice issues, and goal 5. Priorities this year included developing a clinical pearls session for the Pharmacy Student Forum programming at the 2011 Midyear Clinical Meeting, developing clinical specialty resources for all practitioners, conducting a gap analysis and associated recommendations for available ASHP practice resources, and developing an interactive process for pharmacists to discuss current landmark trials.

Science and Research Advisory Group. This group is charged with advancing the objectives set forth in goal 1, specific to science and research issues. Priorities this year included creating and distributing an annotated bibliography regarding evidence on the positive impact pharmacy residencies have on the health care system and stimulating awareness and deeper understanding within new practitioners of current clinical practices through postings and discussions on ASHP Connect regarding identified landmark trials.

Meetings and Programming. For the third consecutive year, *Great eXpectations Live* was held at the Midyear Clinical Meeting and was enormously successful. High-tech, interactive, fresh, and fun, the *Great X* program allows new practitioners the opportunity to learn, network, and move forward in their careers. This live event offered skill-building sessions in three learning tracks: Fine Tuning Your Clinical Skills, Mentoring and Leadership, and Advancing Your Career. Attendees also had many opportunities to mix and mingle with fellow new practitioners from across the country.

ASHP hosted the *Great eXpectations eConference* on April 1, 2011, the first virtual conference offered in the pharmacy association world. This successful program provided new practitioners the opportunity to network and access timely continuing education sessions without having to travel and was accessible via recordings for one year after the event. The second *Great X eConference* will be held May 16–18, 2012.

Completing the *Great eXpectations eXperience* portfolio, *Great eXpectations Video* was launched in 2011 with an initial offering of two continuing education video programs focusing on effectively presenting a professional poster and influencing change as a member of the healthcare team. Additional videos are currently being produced and will be available in the July 2012. These continuing education videos are available on-demand on the New Practitioners Forum website.

The 2011 Midyear Clinical Meeting offered a variety of programs and opportunities for new practitioners. New practitioners participated in the residency showcase and personnel placement service. The all-day *Great eXpectations Live* program provided 15 hours of continuing education targeted at new practitioners. The New Practitioner Lounge was available throughout the meeting, giving new practitioners a place to meet with peers in an informal setting and discover more about the New Practitioners Forum either by reviewing information placed in the lounge or by meeting with other members actively engaged with the Forum. Executive Committee members also represented the Forum in the ASHP Experience Membership booth.

The Forum added four webinars to its online library this year, a three-part series on e-professionalism and a webinar on advanced leadership degrees. Forum webinars are recorded educational sessions on relevant practice topics, available for new practitioners to view at their convenience.

Communications. The Forum relies on ASHP Connect for new practitioner members to communicate on practice and career development issues. ASHP Connect provides members the convenience of only participating in discussions of interest and in ways they prefer to communicate.

All Forum members receive the ASHP New Practitioners Forum NewsLink once a month. This service provides information relevant to recent graduates, communicates deadlines, and helps recruit members for greater involvement in the Forum. The NewsLink has enabled the Forum to recruit new practitioner authors, advisory group members, and volunteers for various outreach efforts and identify new practitioners to highlight on the webpage. In addition, Forum members receive an electronic Message from the New Practitioners Forum Executive Committee once a month that highlights key program and initiatives as well as provides an ongoing update of what the Executive Committee and Forum Advisory Groups are doing on behalf of members.

The Forum launched a new electronic communication initiative this year with its Residency Program Director e-newsletter. Recognizing that many program directors might not be aware of the valuable resources and opportunities available to their residents, the Forum has developed this concise communication to highlight key programs for residents and upcoming deadlines.

The Forum has its own area on the ASHP website where new practitioners can find information pertinent to their needs, such as updates on Forum activities, career development resources, leadership opportunities, and a personal message from the Forum Executive Committee. Efforts have focused on making the site a clearinghouse for career development, advocacy, clinical, precepting, and administrative and management resources to meet new practitioners' varying informational needs. This section of the website also highlights each member of the Executive Committee and allows Forum members to communicate directly with these leaders.

New Practitioners Forum Column. Members of the Forum are contributing authors for the New Practitioners Forum column in the *American Journal of Health-System Pharmacy*. The topics, pertinent to the needs of practitioners just starting their careers, have included a variety of career and professional development topics, such as residency training, legislative advocacy, and developing clinical practices. The column offers new graduates the chance to learn about writing for a professional journal and increases their awareness of opportunities for new practitioners in ASHP.

Outreach. Forum members desire to mentor students and share experiences with peers. To this end, Forum leaders volunteer to participate in various student outreach initiatives throughout the year to promote ASHP membership, provide information on pursuing residencies, promote the value of involvement in professional organizations, and explain how

to become more engaged in professional endeavors on the local, state, and national level. Forum leaders also represented the Forum at seven of the regional residency conferences during the spring, promoting the Forum and encouraging peers to become involved in the many opportunities ASHP offers exclusively for new practitioners.

For the fourth year, the New Practitioners Forum Executive Committee charged all advisory groups to participate in a Targeted Recruitment Initiative. This initiative focuses on identifying peers who are either currently members of ASHP but not involved or who are not members of ASHP and recommending them for an involvement opportunity in the Forum. Through this endeavor, over 70 new practitioners were recommended for advisory group positions, educational program coordination, executive committee consideration, or policy committee appointments. Each nominee was sent a personalized message encouraging them to consider greater involvement in these activities at the recommendation of their peer.

Section Collaboration. Forum members share common professional and career development needs, but their varied practice needs are addressed through involvement in the ASHP pharmacy practice sections. Many new practitioners hold positions on section committees and advisory groups.

ASHP Resident Visit Program. For many years ASHP has invited residents in accredited programs to visit ASHP headquarters. These all-day visits give residents an inside glimpse of ASHP operations and an opportunity to learn about the many ways to get involved in ASHP and the resources available to them as new practitioner members. Three visits were held this year, with over 100 residents participating. ASHP has redesigned this program in recent years. Now, participants not only learn but actively participate and provide feedback to ASHP on issues of importance.

Recognizing that not all residency programs can send their residents to ASHP headquarters for this visit experience, the Forum has developed a web-based virtual resident visit program that provides a series of webinars reflective of the information presented during the live resident visits. This new resource has been and will continue to be heavily promoted to all ASHP-accredited residency program directors.

Advisory Group on Communications and Technology

Christina Martin, Chair (Kansas); Kayla Hansen, Executive Committee Liaison (North Carolina); Adam Harris (Arkansas); Barry McClain (Wisconsin); Charles Darling (South Carolina); Isha John (Maryland); Lindsey Childs (Texas); Matthew Jenkins (Florida); Rachel Root (Oregon); Samm Anderegg (Missouri); Sara Parli (Kentucky); Susan Flaker (Missouri)

Advisory Group on Leadership and Career Development

Katherine Miller, Chair (Minnesota); Katherine Palmer, Executive Committee Liaison (California); Angela Bingham (North Carolina); Joe Maki (North Carolina); Kisha Gant (Mississippi); Neha Mangini (New Jersey); Nicole Panosh (Oregon); Pamela Gobina (Texas); Rachael Joy Ng (Ohio); Stacy Elder (Maryland); Stephen Davis (Texas); Lindsey Poppe (North Carolina)

Advisory Group on Membership and Outreach

Becky Natali, Chair (California); Katherine Palmer, Executive Committee Liaison (California); Andrea Bishop (Washington); Ashley Feldt (Wisconsin); Audrey Kennedy (Kansas); Elizabeth Perry (Louisiana); Elva A. Van Devender (Oregon); Jason Babby (New York); Jessica Winter (Ohio); Kristen Hillebrand (Ohio); Melissa M. Chesson (Georgia); W. Russell Laundon (North Carolina)

Advisory Group on Professional Practice

Jason Chou, Chair (North Carolina); Jeff Little, Executive Committee Liaison (Kansas); Adam Pate (Louisiana); Amy Baker (Hawaii); Daniel Rackham (Oregon); Elizabeth Markway (Kentucky); Emily Pherson (Maryland); Erica Maceira (New York); Jessica Larva (Indiana); Katrina Derry (Iowa); Sarah Phanco (North Carolina); Tara Gleason (Illinois)

Advisory Group on Public Affairs and Advocacy

Meghan Davlin, Chair (Maryland); Nicholas Bennett, Executive Committee Liaison (Kansas); Andrea Eberly (Washington); Elaine Mebel (Pennsylvania); James Lee (Iowa); Keli Edwards (District of Columbia); Kristin Banek Murphy (Maryland); Lindsey Elmore (Alabama); Matt Sapko (Ohio); Melissa Ortega (Wisconsin); Starr-Mar'ee Bedy (Ohio); Zachary J. Pollock (Minnesota)

Advisory Group on Science and Research

Eric Wombwell, Chair (Missouri); Karen Berger, Executive Committee Liaison (New York); Adriane Irwin (New Mexico); Alexander Flannery (South Carolina); Brandon Shank (Maryland); Daniel Crona (North Carolina); Josh Swan (Texas); Mary Giouroukakis (Utah); Michael Gillette (Florida); Monica Munoz (Florida); Ryan Fleming (Wisconsin); John Hammer (Michigan)



SEIZE THE INITIATIVE

**ASHP House of Delegates 2012
June 10 and 12, 2012**

Report on the Section of Ambulatory Care Practitioners

The mission of the ASHP Section of Ambulatory Care Practitioners is to improve patient care and patient health outcomes by advancing and supporting the professional practice of pharmacists who are medication-use specialists, patient care providers, and operational specialists in ambulatory care settings. The ASHP Section of Ambulatory Care Practitioners dedicates itself to achieving a vision of pharmacy practice where pharmacists are the medication-use specialists accountable for optimization of medication-related outcomes in the ambulatory care setting and engage relevant stakeholders across the continuum of care to improve both the individual and overall process of medication use.

The Section's goals are to (1) maximize communications, interactions, and networking with and among Section members; (2) foster a sense of professional community in ambulatory care practitioners based on their common mission of improving patient care and patient health outcomes through improvements in continuity of care and transitions in care; (3) support members with services, resources, education, and information to help them establish and advance patient-focused practices in ambulatory care settings; (4) ensure that ambulatory care pharmacists are leaders in and advocates for the safe and effective use of medication and are recognized as the experts in facilitating positive patient care outcomes; and (5) foster optimal models for interdisciplinary, patient-centered care that includes the pharmacist as the expert on medication therapy management in ambulatory care settings.

Executive Committee

Pamela L. Stamm, Chair (Alabama)
Steven M. Riddle, Chair-elect (Washington)
Roger S. Klotz, Immediate Past Chair (California)
Seena L. Haines, Director-at-Large (Florida)
Cathy Johnson, Director-at-Large (Ohio)
Gloria P. Sachdev, Director-at-Large-elect (Indiana)
Gerald E. Meyer, Board Liaison (Pennsylvania)
Justine K. Coffey, Secretary

2011–2012 Section Highlights. In 2011, the Section focused on building ambulatory services and addressing and overcoming barriers as ambulatory care pharmacists participate in accountable care organizations (ACOs) and patient-centered medical homes. The Executive Committee approved a newly updated Strategic Plan to accomplish its goals.

As of December 2011, there were 9969 members in the Section, with 2415 choosing the Section as their primary section. Overall, the Section membership is up almost 12% since December 2010, and the Section's membership numbers continue to grow. Section members elected Mr. Riddle as Chair and Dr. Sachdev as Director-at-Large, and both individuals will be installed at the June 2012 ASHP Summer Meeting.

The Section selected Richard Stambaugh as the winner of the Section of Ambulatory Care Practitioners' Distinguished Service Award. Established in 2007, the ASHP Pharmacy Practice Sections' Distinguished Service Award recognizes a member of each section whose volunteer activities have supported the section's mission and helped advance the profession. The award was presented at the 2011 Midyear Clinical Meeting (MCM).

In addition to the activities outlined below, the Section has been extremely active in meeting its goals. Dr. Haines has taken the lead on updating the ASHP ambulatory care practice guidelines to reflect recommendations of the Pharmacy Practice Model Initiative (PPMI), and she is coordinating a working group to develop ambulatory care pharmacy competencies. Additionally, Dr. Haines developed and facilitated a networking session at the 2011 MCM, hosted by the Section's Executive Committee, titled "Postgraduate Opportunities and Resources in Ambulatory Care Environments."

Each Section advisory group has been tasked with, and is successfully completing, Tips of the Month and news items that are included in the Section's Newslink. They have drafted, or are in the process of drafting, Member Spotlights, and are continuing to post discussions to the Section's community on ASHP Connect. All Section advisory groups are ensuring PPMI goals are considered and incorporated into projects and deliverables. The Section also provided a major update to the Risk Evaluation and Mitigation Strategies (REMS) Resource Page on the ASHP website.

Educational and Networking Opportunities. The Section's Educational Steering Committee is charged with developing programming that will be of interest to ambulatory care practitioners. The Committee is also charged with identifying programming priorities. The 2010–2011 Committee planned over 17 hours of 2011 ASHP MCM educational programming specifically for ambulatory care practitioners. Topics included pain management and a six-hour Learning Community on building ambulatory pharmacy services.

The Section also planned five networking sessions at the 2011 MCM, two in partnership with the Section of Clinical Specialists and Scientists. Topics covered at the networking sessions included home infusion, pharmacotherapy in the new ambulatory care environment, pain management, postgraduate opportunities and resources in ambulatory care environments, and overcoming barriers as ambulatory care pharmacists enter ACOs and patient-centered medical homes.

The Section's electronic NewsLink is distributed once a month to over 8,000 ASHP members, providing news and current information on medical research, regulatory and health policy issues, health care, and reimbursement issues. The Section Chair's Message is also

distributed once a month to NewsLink subscribers and provides news on Section and ASHP programs and initiatives. The Section's electronic discussion group on ASHP Connect provides a forum for Section members to exchange information and ideas on a wide variety of topics related to ambulatory care.

The Section provided four Webinars in 2011, two developed by the Home Infusion Section Advisory Group, one by the Clinical Practice Advancement Section Advisory Group, and one by the Clinical Business Development Section Advisory Group.

Ambulatory Care Specialty Credential. In 2011, 511 candidates passed the Board of Pharmacy Specialties' (BPS) first Ambulatory Care Pharmacy exam, and are now BPS Board Certified Ambulatory Care Pharmacists (BCACP).

ASHP, along with the American College of Clinical Pharmacy and the American Pharmacists Association (APhA), supported the process for establishing an ambulatory care specialty credential. With the specialty now approved, BPS announced a collaboration between ASHP and APhA as approved providers of continuing professional development programs for the BCACP. A number of Section leaders served as faculty for the first ASHP Ambulatory Care Pharmacy Review Course held at the 2010 MCM, and will continue to serve as faculty for the review course and recertification educational programming.

Advocacy. Many Section members represent ASHP on various coalitions and committees, including The National Quality Forum, The Pharmacy Services Technical Advisory Coalition workgroups, The Joint Commission Professional and Technical Advisory Committees on Ambulatory Care and Home Care, and the National Asthma Education and Prevention Program. Section members on these committees provide the health-system pharmacist's perspective in discussions that have an impact on patient care nationwide. Section members continue to support ASHP's efforts in fostering optimal models for interdisciplinary, patient-centered care that includes the pharmacist as the expert on medication therapy management in ambulatory care settings.

Additionally, the Pain Management and Palliative Care Section Advisory Group has been extremely active in responding to requests for feedback from ASHP's Government Affairs Division relating to comments from the Society to government agencies.

Advisory Group on Clinical Business Development. This Section advisory group was established in 2009 to address the growing number of issues challenging pharmacists in their ability to be reimbursed for clinic-based patient-care services. This advisory group is focusing on the business and advocacy elements necessary to support and expand ambulatory clinic models.

This group is developing a database of individuals who responded to the 2010 Ambulatory Care Practice Model Survey. In addition, the group finalized and published on the Section's website an FAQ for hospital-based clinics that pharmacists can use to determine best reimbursement models and how to comply with Centers for Medicare & Medicaid Services (CMS) requirements.

The group collaborated with the Clinical Practice Advancement Section Advisory Group on a full-day Learning Community that was held at 2011 MCM, and also hosted a networking

session at 2011 MCM, titled “Overcoming Barriers as Ambulatory Care Pharmacists Enter Accountable Care Organizations and Patient Centered Medical Homes.”

Advisory Group on Clinical Practice Advancement. The charge of the Section Advisory Group on Clinical Practice Advancement (formerly Cognitive Reimbursement Resources) is to develop resources to promote clinical practice advancement and reimbursement in the ambulatory setting and across the continuum of care. This advisory group developed and conducted a webinar on the Accountable Care Act and ACOs, collaborated with the Clinical Business Development Section Advisory Group on a full-day Learning Community held at the 2011 MCM, and partnered with the Section of Clinical Specialists and Scientists on a 2011 MCM networking session titled “Pharmacotherapy in the New Ambulatory Care Environment.”

Advisory Group on Home Infusion. This Section advisory group has updated the ASHP Guidelines on Home Infusion Pharmacy Services. The Guidelines are currently in draft form, with expected completion and approval in 2012. Additionally, the advisory group developed and conducted two live webinars. The first webinar was titled “Tips for Precepting Pharmacy Students,” and the second was titled “Development and Management of PGY1 Residencies in Unique Practice Settings.” The section advisory group also developed a networking session on home infusion for 2011 MCM.

Advisory Group on Pain Management and Palliative Care. This advisory group was successful in having a number of educational proposals accepted by ASHP for the 2011 MCM, including advanced pain management, street-level perspectives on prescription drug abuse, and controversies in chronic pain management with opioids. The group also partnered with the Section of Clinical Specialists and Scientists on a pain management networking session for 2011 MCM, and is considering ways to develop and expand specialty residencies in pain and palliative care.

Advisory Group on Membership and Marketing. The Section established the Membership and Marketing Committee in 2009 to facilitate and lead the efforts of the Section in raising awareness of the Section’s work, provide opportunities for ASHP members to participate, and grow the Section’s membership. The Committee was converted to a Section advisory group in 2011. This group drafted a “Meet the Authors” spotlight to promote “Building A Successful Ambulatory Care Practice: A Complete Guide for Pharmacists,” by Mary Ann Kliethermes and Tim Brown. This spotlight was posted to the Section’s webpage. The advisory group also developed and recorded a webinar about the Section, currently located on the Section’s webpage, titled “Why You Should Call Us Home.”

Advisory Group on Clinical Business Development

Gloria Sachdev, Chair (Indiana); Kimberly Braxton Lloyd, Vice Chair (Alabama); Jeffrey M. Brewer, (New York); Amy Brooks (Missouri); Stephanie Burns (Oklahoma); Susan Conway (Oklahoma); Kathy Donley (Ohio); Mary Ann Kliethermes (Illinois); Santhi Masilamani (Texas);

Ashley Parrott (Ohio); Renu Singh (California); Jennifer Taylor (Washington); Steven M. Riddle, Executive Committee Liaison (Washington)

Advisory Group on Clinical Practice Advancement

Sandra Leal, Chair (Arizona); Richard L. Stambaugh, Vice Chair (Minnesota); Becky L. Armor (Oklahoma), Laura Britton (Utah); Kristy Butler (Oregon); Sarah Deines (Oregon); Monica Green (Texas); Huzefa Master (Illinois); Betsy Bryant-Shilliday (North Carolina); Mollie Ashe Scott (North Carolina); Amy L. Stump, (Indiana); Laura Traynor (Wisconsin); Seena Haines, Executive Committee Liaison (Florida)

Advisory Group on Home Infusion

Barbara Petroff, Chair (Michigan); Anna Nowobilski-Vasilios, Vice Chair (Illinois); Donald J. Filibeck, (Ohio); Kurt Harlan (California); Steven M. Pate (Tennessee); Douglas Powers (Tennessee); Carol J. Rollins (Arizona); Melisa Tong (California); Yolanda Williams (Tennessee); Cathy Johnson, Executive Committee Liaison (Ohio)

Advisory Group on Pain Management and Palliative Care

Christopher Herndon, Chair (Illinois); Ernest Dole, Vice Chair (New Mexico); David Craig (Florida); Emily Weidman-Evans (Louisiana); Virginia Ghafoor, Chair (Minnesota); Lee Kral (Iowa); Michele Matthews (Massachusetts); Mary Lynn McPherson (Maryland); Pamela S. Moore (Ohio); Mitchell Nazario (Florida); Douglas Nee (California); Suzanne A. Nesbit (Maryland); Mark Stanfield (Oregon); Scott Strassels (Texas); Jennifer Strickland (Florida); Cathy Johnson, Executive Committee Liaison (Ohio)

Committee on Nominations

Roger Klotz, Chair (California); Tim R. Brown (Ohio); Ernest Dole (New Mexico); Mary Ann Kliethermes (Illinois); Richard L. Stambaugh (Minnesota)

Educational Steering Committee

Jennifer A. Buxton, Chair (North Carolina); Tracy A. Martinez, Vice Chair (Michigan); Paige Carson (North Carolina); Kevin Chamberlin (Connecticut); Lindsey Elmore (North Carolina); Melody Hartzler (Ohio); David Hoang (Minnesota); Jeannie Kim Lee (Arizona); Lisa Lundquist (Georgia); Gina Ryan (Georgia); Anne Teichman (Maine); Pamela Stamm, Executive Committee Liaison (Alabama)

Membership and Marketing Committee

Binita Patel, Chair (Wisconsin); Tim Brown, Vice Chair (Ohio); Jenny Van Amburgh (Massachusetts); Margaret Felczak (Illinois); Starlin Haydon-Greatting (Illinois); Pamela Letzkus (California); Charmaine Rochester (Maryland); Lindsay Snyder (Indiana); Fei Wang (Connecticut); Roger Klotz, Executive Committee Liaison (California)



SEIZE THE INITIATIVE

**ASHP House of Delegates 2012
June 10 and 12, 2012**

Report on the Section of Clinical Specialists and Scientists

The mission of the Section of Clinical Specialists and Scientists is to advocate for practice advancement and improvement in patient care by creating and translating scientific advances into practice. The Section Executive Committee has developed a strategic plan linked to the Section's mission and goals. These goals are to (1) create member value by developing and providing education, creating tools and resources, providing networking opportunities, and creating a home for faculty and preceptors; (2) participate in advocacy by creating timely groups to address key issues affecting Section members; seeking greater input in policy and advocacy efforts, including practice initiatives; increasing participation in policy implementation and ASHP initiatives; and collaborating with internal and external organizations to communicate and advocate the interests of the Section; (3) promote member involvement by developing a process to simplify the path for involvement; increasing diversity of member involvement with educational sessions, network facilitators, committees, advisory groups, and policy development; encouraging Section members to run for Executive Committee office; and encouraging and facilitating recommendations of Section members for ASHP office; (4) communicating the value of the Section and ASHP by increasing recognition of Section activities and advocacy, communicating ASHP advocacy activities, and recognizing member contributions to ASHP and the profession. The Section offers members a sense of identity within ASHP and an organizational home dedicated to meeting their specialized practice, scientific, and research needs. The Section will continue to grow and expand its activities largely because of the efforts of its enthusiastic members and dedicated leaders.

Executive Committee

Erin R. Fox, Chair (Utah)
Mary M. Hess, Immediate Past Chair (Pennsylvania)
Lea S. Eiland, Chair-elect (Alabama)
Michelle E. Allen (California)
Heath R. Jennings (Illinois)
Tricia A. Meyer (Texas)
Thomas J. Johnson, Board Liaison (South Dakota)
Sandra Oh Clarke, Secretary

2011–2012 Section Highlights. Section membership reached 13,656 in 2011. Approximately 36% of the Section’s members have selected the Section as their primary membership group. There still is strong interest in the Section among students and new practitioners. Section members elected Lea Eiland as Chair and Michelle Allen as a Director-at-Large; both will be installed at the June 2012 ASHP Summer Meeting. The Section selected Susan Goodin as the winner of the Section of Clinical Specialists and Scientists Distinguished Service Award. Established in 2007, the ASHP Pharmacy Practice Sections Distinguished Service Award recognizes a member of each section whose volunteer activities have supported the section’s mission and helped advance the profession. The award was presented at the 2011 Midyear Clinical Meeting (MCM).

In addition, a number of Section leaders were very active in the Pharmacy Practice Model Initiative (PPMI) as education session presenters at 2011 MCM and with the Joint Section and Forum PPMI Coordination Committee. The Section will continue to provide support to ASHP and ASHP Foundation education and advocacy efforts related to the PPMI.

Educational and Networking Opportunities. The Section’s Educational Steering Committee is charged with developing programming at an advanced level that will be of interest to clinical specialists and scientists. Paul Szumita served as the 2010–2011 Committee Chair. The 2010–2011 Committee developed more than 50 hours of educational programming on current issues in pharmacogenomics, pain management, sedation, critical care, antimicrobial stewardship, infectious diseases, preceptor development, and clinical leadership development. The Committee also planned a session devoted to debates in areas of therapeutic controversy and coordinated the Clinical and Emergency Pharmacy Clinical Pearls sessions. The 2011–2012 Committee has identified Section member educational needs for the 2012 MCM, which includes the following topics: drug-induced diseases; neurology and psychology patient care management; hepatitis; updates in critical care; hypo- and hypernatremia; pain management with addiction/opioid abuse; what’s new in endocrine treatment; ICU sedation, pain, and delirium management; gram-negative infectious disease (double coverage, pharmacokinetics/pharmacodynamics, and dose optimization); non-ICU delirium, fall prevention, and insomnia management; ACLS update; emergency medicine; HIV for nonspecialists: new therapies and pregnancy guidelines; transitions of care--pediatric to adult care disease states; infectious disease; clinical syndromes; precepting students and residents; and biostatistics. Committee members were charged with developing proposals or seeking out individuals to submit proposals for MCM consideration. A number of the program topics align with educational suggestions from the Council on Therapeutics.

The Section’s electronic NewsLink is distributed once a month to almost 13,000 ASHP members, providing news and current information on medical research, regulatory and health policy issues, health care, clinical leadership, preceptor skills development, emergency care, and therapeutics. The Section Chair’s Message is also distributed once a month to NewsLink subscribers and provides news on Section and ASHP programs and initiatives. The Section also continues to facilitate an electronic discussion group utilizing ASHP Connect. The electronic discussion group provides a forum for Section members to exchange information and ideas on a wide variety of topics related to clinical practice and patient care challenges.

The Section has 16 specialty networks encompassing most areas of specialty pharmacy practice. Women's health was added as a new specialty area in 2010. The networks meet regularly at the MCM, with over 1,600 meeting attendees participating. In addition, the Advisory Groups on Preceptor Skills Development and Clinical Leadership held networking sessions to discuss issues in their interest area. Facilitators are appointed for a two-year period in each network by the Section's Chair. The network facilitators monitor developments and trends in their therapeutic areas and advise ASHP and the Section's membership of these developments through the Section's electronic discussion group, NewsLink, networking meetings, and other avenues. The facilitators also serve ASHP and its members as therapeutic experts and contribute to ASHP advocacy and educational efforts.

Specialty Certification. The Section was asked to prepare a policy recommendation for the ASHP Board following the approval of a new business item introduced by the Section's Executive Committee on the same subject in June 2011. The Executive Committee gathered further input from all ASHP councils during policy week and has incorporated this input in its final recommendation to the ASHP Board. The Executive Committee also discussed ASHP's role in the supporting the recognition of new specialties and supporting members who are seeking to become board certified. ASHP has been a long-standing supporter of board certification. The Executive Committee noted that ASHP has been involved in the development of petitions to recognize four of the six specialties currently recognized by the Board of Pharmacy Specialties (BPS) and is currently involved with several partnering organizations in the development of two additional petitions to recognize pediatrics and critical care. The Section's Executive Committee believes it is critical ASHP maintain a leadership role in the recognition of specialties and supporting its members who seek to become certified. The Executive Committee expressed its opinion that there should be a standardization of credentialing eligibility and recertification requirements that align with residency training and practice model.

The Committee discussed the merits of being a petitioning organization and agreed that ASHP should continue to support and selectively lead specialty petitions that represent ASHP membership as long as the current petition process and specialty council model is in place. Subsequent to the Section's efforts in the June 2011 House of Delegates, ASHP has agreed to join in the submission of three short-form requests for BPS to conduct role delineation studies (RDSes) in the areas of cardiology, infectious diseases, and immunology transplant. The Executive Committee believes that these three areas align with the proposed policy that it has submitted to the Board and encouraged the Board to join with the American College of Clinical Pharmacy in the submission of these requests. Two of the these areas are currently recognized as "added qualifications" of pharmacotherapy and significant number of postgraduate year two (PGY2) residency training programs have been developed in these areas to support the development of well-trained specialists.

Continuing to support the petitioning and specialty recognition process is a way to keep high-level clinical practitioners engaged with the organization by making appointments to specialty councils and development of examination review course and recertification materials. At the same time, the Committee noted the substantial financial and time commitment for a petitioning organization and suggested that ASHP prioritize involvement in the petitioning process based on the number of practitioners and PGY2 residency programs in the specialty.

This prioritization will help identify the largest areas of practice and training, current pressing needs in caring for patients, and help establish credibility and authority in the practice area outside of the profession.

Resources for Clinical Specialists and Scientists. The Section continues to enhance its resources for pharmacy practitioners in different specialty areas and to use multiple communication pathways to notify Section members of new resources. The “Clinical Consultation” column in the *American Journal of Health-System Pharmacy (AJHP)*, created by the Section, continues to be a popular resource for members. The Section continues to host the Anticoagulation Resource Center on the ASHP website, a compilation of educational materials, policies, best practices, and links to other organizations for practitioners looking for resources in the area of anticoagulation management. The Section also continued to coordinate ASHP’s efforts in the development of the *PharmGenEd* educational programs, live and web versions. This series of programs was developed by the University of California, San Diego, Skaags School of Pharmacy and Pharmaceutical Sciences. The goal of the program is to educate pharmacists and other health care professionals in the basic science and clinical application of pharmacogenomics.

The Section has taken a lead role in the planning of the Ambulatory Care Pharmacy Specialty Examination Review Course to assist ambulatory care practitioners prepare for the specialty examination. This work is done in collaboration with the Section of Ambulatory Care Practitioners. Review courses were held March 24–25, 2011, at the American Pharmacists Association meeting in Seattle, and June 11–12, 2011, at the 2011 ASHP Summer Meeting in Denver. The first examination was administered on October 1, 2011, and resulted in 511 new board-certified ambulatory care pharmacists.

Advocacy. The Section advocates for recognition and development of specialty pharmacy practice areas, development of clinical practitioners into pharmacy clinical leaders, and the use of evidence-based therapeutic guidelines and medication use in patient care as a responsibility of all pharmacists and pharmacy departments.

Advisory Group on Clinical Leadership. The advisory group conducted networking sessions at the 2011 MCM addressing clinical leadership in pharmacy, change management, and clinical leadership needs. The group has prioritized project initiatives and work has begun on the various projects. Advisory group members also provided input to the *Clinical Leaders Boot Camp: Practical Tools for Promoting and Establishing New Services*, held on Sunday, December 4th, prior to the MCM. In addition the group provided an education session at 2011 MCM, *Make the Change or Be Forced to Change: Change Management Principles for Clinical Leaders*. These programs were developed based on member needs identified through the Section Needs Assessment Survey and electronic communication postings.

Advisory Group on Emergency Care. As a follow-up to the *ASHP Statement on Pharmacy Services to the Emergency Department*, the group drafted the *ASHP Guidelines on Emergency Medicine Pharmacist Services* approved by the Section’s Executive Committee on June 10, 2011, and by the ASHP Board of Directors on July 15, 2011. This document was sent out for member and external review. The group also hosted a successful emergency care networking session at

the MCM that drew more than 150 participants. In addition, the group developed a webinar to meet the needs of emergency care practitioners, *Do You Know Your New Alphabet: Updates in the ACLS and PALS 2010 Guidelines*; planned educational sessions at the 2011 MCM; and launched a the Emergency Care Resource Center on the ASHP website. Committee members are also writing articles for submission to *AJHP* pertinent to emergency care practitioners. In addition, the group developed PGY2 standards for pharmacist emergency care to establish an official ASHP-accredited set of guidelines and objectives for review by the Commission on Credentialing in March 2012.

Advisory Group on Emerging Sciences. The group is charged with advising the Section and ASHP on the emerging sciences and implementing recommendations of the 2008 Task Force on Science. This group is just convening and is outlining top priorities. The group provided two education sessions at 2011 MCM, *Pharmacogenomics 101: What Pharmacists Need to Know to Lead the Genomic Revolution*, and *Putting Pharmacogenomics into Practice: Strategies for Successful Implementation*. The group also conducted a webinar in April 2012, *Gene Therapy – Is This the Future of Pharmacy?* In addition, there are plans for a resource center in the emerging sciences to include such topics pharmacogenomics, nanomedicine, gene therapy, biosimilars, and translational research.

Advisory Group on Preceptor Skills Development. This group continues to develop webinars to help residency programs develop a preceptor development program, including *Practical Approaches to Developing Residency Preceptors* and a follow-up April 2012 webinar. The group also provided an education session at the 2011 MCM, *Fit and Fabulous: Improving Precepting Skills and Program Development, Bootcamp Style*; planned a networking session at the 2011 MCM; and are currently developing a resource center in preceptor skills development. The Preceptor Skills Resource Center will be a main focus as the group continues to consolidate ASHP resources for preceptors and identify new tools and resources for ASHP members.

Advisory Group on Clinical Leadership

Teresa H. Seo, Chair (Connecticut); John Clark, Vice Chair (Michigan); Michelle Allen (California); Lori Dupree (Virginia); Lynn Eschenbacher (North Carolina); Jeffrey Fudin (New York); Jamie King (Nevada); Linda Gore Martin (Wyoming); Wesley McMillian (Vermont); Amy Potts (Tennessee); Jason Schafer (Pennsylvania); Kelly M. Smith (Kentucky); Linda S. Tyler (Utah); Tricia Meyer, Executive Committee Liaison (Texas)

Advisory Group on Emergency Care

Heather Draper Eppert, Chair (Tennessee); Alison Jennett-Reznek, Vice Chair (Massachusetts); Adetola Ademolu (Texas); Megan Corrigan (Illinois); Katelyn Dervay (Florida); Christopher Edwards (Arizona); Jeremy Hampton (Missouri); Christi Jen (Arizona); Jennifer Denise Mando-Vandrick (North Carolina); Shannon Manzi (Massachusetts); Philippe Mentler (North Carolina); Megan Musselman (Indiana); Deval Patel (Pennsylvania); Derek Polly (Georgia); Katharine A. Reisbig (Nebraska); Suprat Saely (Michigan); Michael C. Thomas (Georgia); Melinda Ortmann, Network Facilitator (Maryland); Erin Fox, Executive Committee Liaison (Utah)

Advisory Group on Emerging Sciences

John Valgus, Chair (North Carolina); Wesley G. Byerly (North Carolina); Daniel Crona (North Carolina); Christine Formea (Minnesota); Christine (Tina) Gegeckas (Florida); Michael Gillette (Florida); Orly Vardeny (Wisconsin); Casey Williams (Kansas); Vivian Zhao (Georgia); Ashlie Simmons, Student (North Carolina); Mary Hess, Executive Committee Liaison (Pennsylvania)

Advisory Group on Preceptor Skills Development

Samaneh Wilkinson, Chair (Kansas); George Phillip (Phil) Ayers, Vice Chair (Mississippi); Elizabeth Sebranek Evans (Utah); Kate Farthing (Oregon); Melissa Goff (South Dakota); Katherine Marks (Tennessee); Steven Pass (Texas); Holly Philips (Colorado); Charlotte A. Ricchetti (Colorado); Carol J. Rollins, Chair (Arizona); Maureen Smythe (Michigan); S. Scott Wisneski (Ohio); Heath R. Jennings, Executive Committee Liaison (Illinois)

Committee on Nominations

Mary Hess, Chair (Pennsylvania); Kate Farthing (Oregon); Justine Gortney (Michigan); Anthony Kessels (Missouri); Robert Page (Colorado); Kelly M. Smith (Kentucky); James A. Trovato (Maryland)

Educational Steering Committee

Paul M. Szumita, Chair (Massachusetts); Ericka L. Breden, Vice Chair (Virginia); Kimberly Benner (Alabama); Kimberli Burgner (Virginia); Chad Coulter (Kentucky); Freddy Creekmore (Tennessee); Jennifer Hardesty (Louisiana); Daniel P. Hays (Arizona); Joel C. Marrs (Colorado); J. Russell May (Georgia); Douglas Slain (West Virginia); Matthew Strum (Mississippi); Michelle (Shelly) Wiest (Ohio); Michael Vozniak (Pennsylvania); Jill Bates, Council on Therapeutics Liaison (North Carolina)

Network Facilitators

Anticoagulation: Lynn Blecher (Oregon)

Cardiology: Christopher Betz (Kentucky)

Critical Care: Stacey Folse (Georgia)

Emergency Medicine: Melinda Ortmann (Maryland)

Geriatrics: Donna Adkins (Virginia)

Hematology/ Oncology: Susannah E. Koontz (Texas)

Immunology/ Transplant: Amy Krauss (Tennessee)

Infectious Diseases: Jason Schafer (Pennsylvania)

Nutrition Support: Lisa G. Hall Zimmerman (Michigan)

Pain Management: Virginia Ghafoor (Minnesota)

Pediatrics/ Neonatal: Melissa Heigham (Missouri)

Pharmacoeconomics and Drug Policy Development: Julie P. Karpinski (Wisconsin)

Primary Care/Pharmacotherapy: Kristi Kelley (Alabama)

Psychopharmacy/Neurology: Troy A. Moore (Texas)

Women's Health: Gayle A. Cotchen (Pennsylvania)



SEIZE THE INITIATIVE

**ASHP House of Delegates 2012
June 10 and 12, 2012**

Report on the Section of Inpatient Care Practitioners

The Section of Inpatient Care Practitioners was launched in September 2003 to meet the needs of the frontline pharmacist. This Section dedicates itself to achieving a vision of pharmacy practice in which pharmacists practicing in an inpatient setting safely integrate clinical, distributive, and operational functions while focused on improving inpatient and transitional care. To achieve this vision, the Section will (1) serve as a voice for inpatient care practitioners and Section members, including ASHP governance and policy; (2) facilitate the integration of drug distribution and clinical practice for inpatient care practitioners; (3) assist in a concerted rural health care strategy that strengthens ASHP's rural health care advocacy efforts, facilitates promotion of ASHP's policies and agenda in rural and frontier America, and elevates ASHP's standing in rural communities; (4) promote the professional development of inpatient care practitioners through education and skills development; (5) increase communication with Section members on key issues for both the Section and the profession; (6) encourage, facilitate, and educate for the application of ASHP best practices and evidence-based guidelines at the inpatient care practitioner level; and (7) identify and promote the development of inpatient care leaders and preceptors within the Section and mentor students by encouraging their active participation on Section advisory groups.

Executive Committee

Jennifer Edwards Schultz, *Chair* (Montana)
Brian D. Benson, *Immediate Past Chair* (Iowa)
Lynn E. Eschenbacher, *Chair-elect* (North Carolina)
Joanne G. Kowiatek, *Director-at-Large* (Pennsylvania)
Noelle R.M. Chapman, *Director-at-Large* (Illinois)
Emily Alexander, *Director-at-Large-elect* (Texas)
Randy L. Kuiper, *Board Liaison* (Montana)

2011–2012 Section Highlights. Now in its ninth year, the Section has exceeded 10,000 members. With slightly over 5,000 members selecting the Section as their primary home, the Section earned the distinction in December 2011 of becoming the largest of the five pharmacy practice sections. This achievement was a first in the Section's history. Through educational programming, networking, advocacy, and volunteer opportunities, the Section Executive Committee has worked to develop member services that support the needs of the Section's core membership component: frontline pharmacists, inpatient care practitioners, investigational drug service pharmacists, medication safety officers, operating room (OR)/anesthesiology pharmacists, rural health care practitioners and technician educators. Advocacy efforts for rural health care initiatives have been enhanced, and collaborative partnerships have been expanded. The mentoring of students, one of the Section's strategic goals, was enhanced by increasing student representation on all four of the Section's advisory groups. The Section's Advisory Group on Medication Safety made a significant educational footprint, in collaboration with ASHP's Educational Services Division (ESD), with its innovation, development, and collaborative marketing of ASHP's 2011 Summer Meeting (SM) Medication Safety Track. This event represented the Section's inaugural provision of educational content at an ASHP SM. Furthermore, the safety series was unprecedented as this represented ASHP's first time offering of physician and nursing continuing medical education (CME) and continuing education (CE) at one of its national meetings. Post-meeting survey results revealed 43% of meeting registrants attended the meeting because of the medication safety programming. Due to ASHP's continued commitment to medication safety, its laser focus on leadership in safe medication practices, as well as the positive feedback received from attendees, the medication safety track will return for SM 2012. The section hosted several networking sessions during the 2011 Midyear Clinical Meeting (MCM). All advisory groups, including specialty practice areas Investigational Drug Services and OR/Anesthesiology, were represented. The Executive Committee selected Deb Saine as its fifth recipient of the Section's Distinguished Service Award. Ms. Saine received her award at the Distinguished Service Award reception during the 2011 MCM. The Section continues to keep the Pharmacy Practice Model Initiative (PPMI) a focus of its strategic priorities through education and advocacy efforts. Several Section members and leaders have been PPMI champions by encouraging individuals at their respective institutions and states to partake in the PPMI Hospital Self-Assessment Survey. The Combined efforts of the four advisory groups and the educational steering committee have yielded, over the past three years, nine webinars that are available to members on the ASHP website. This speaks to the commitment the Section has to addressing the needs of its diverse membership. The Section's Committee on Nominations works to aggressively recruit highly qualified candidates for nomination and develop a slate of candidates that will serve to fulfill Section initiatives. The committee typically begins its work in February or March and will present a slate of candidates for the Chair and Director-at-Large.

Educational Programming. The Section conducted over 10 hours of successful educational sessions at the 2011 MCM. Additionally, the Section Advisory Group on Small and Rural Hospitals hosted its sixth Programming for Small and Rural Hospitals. This all-day program, traditionally held on the Sunday during the MCM, is targeted to rural health care practitioners and focuses on the issues facing health care facilities in rural and frontier areas of the country.

The Advisory Group on Medication Safety hosted its fifth pearls session, *Safety and Quality Pearls 2011*, and covered a number of topics such as *Pharmacy Technicians—Part of the Medication Safety Team*, *Give Me a C for Culture*, and *Kiss My GRITS!* One of the Section's branded programs was also featured: the ever-popular *Pediatrics for the Non-Pediatric Specialist* series (now in its fourth year), which featured "Timely Topics for Tots." The Section's Educational Steering Committee met during the 2011 MCM to discuss and select potential topics for educational programming for the 2012 MCM. The committee utilized the Section's Needs Assessment Survey, electronic discussion group reports, networking session discussions, and conversations with peers to guide them in their topic selections. Other significant educational content developed by the Section was the educational content for the 2011 SM medication safety track, planned in collaboration with the Section Advisory Group on Medication Safety and ASHP's ESD.

Resources for Inpatient Care Practitioners. The Section's webpage on the ASHP website features information pertinent to the needs of its membership. The information includes recent news, practical tools, webinars, and member spotlights. All Section members receive a monthly Chair's Message and NewsLink containing information relevant to the Section's membership. These communication vehicles also serve to notify members of opportunities within the Section and ASHP. To facilitate member interaction and networking, the Section maintains five ASHP Connect communities: inpatient care, clinical research pharmacists-IDS and IRB, OR/Anesthesiology pharmacists, rural healthcare practitioners, and patient safety. These discussion boards continue to be an effective networking mechanism and serve as a necessary resource for these component groups.

Advocacy. Through occasional presentations at senior citizen nursing homes and senior citizen organizations, the Section continues to embrace opportunities to reach out to this segment of the population and educate them about safe medication practices and adverse drug reactions. Furthermore, these presentations demonstrate the value of pharmacists, encourage seniors to develop meaningful relationships with their pharmacist, and promote the roles of hospital and health-system pharmacists to the public. To further enhance its reach to this segment of the population, the Section is exploring opportunities for collaboration with various state and/or federal agencies on aging.

The Section Advisory Group on Medication Safety continues to advocate for robust education and training for medication safety officers and seeks to align its efforts to support ASHP initiatives, as well as the organization's leadership, in the area of medication safety. The advisory group hopes the success of the medication safety track will make the business case for the SM to serve as a venue for medication safety officer education, training, and networking. The advisory group remains involved in drug shortage advocacy efforts as well.

Upon the recommendation of the Section Advisory Group on Small and Rural Hospitals, the Executive Committee has sought ways to expand its network with rural health care organizations and agencies. The Section has initiated building relationships with the Centers for Medicare & Medicaid Services (CMS), National Organization of State Offices of Rural Health (NOSORH), United States Department of Agriculture, and the Center for Health Literacy within the University of Maryland School of Public Health. ASHP staff have facilitated efforts to

strengthen ASHP's relationship with the National Rural Health Association (NRHA), the Office of Rural Health Planning (ORHP), and other rural organizations and agencies. Additionally, the Section has sought unique opportunities for collaboration with the Institute for Healthcare Improvement (IHI) and Institute for Safe Medication Practices (ISMP). The Section Advisory Group on Small and Rural Hospitals has used its MCM Sunday *Programming for Small and Rural Hospitals* and the Section webpage to help communicate efforts of the HRSA/OPA Patient Safety Pharmacy Collaborative and the IHI 5 Million Lives Campaign. Partnership with ISMP has included appointing ISMP staff representatives to the Section Advisory Group on Medication Safety and the Section Advisory Group on Small and Rural Hospitals. It is the Executive Committee's belief that a concerted rural health care strategy will strengthen ASHP's rural health care advocacy efforts, facilitate promotion of ASHP's policies in rural and frontier America, and elevate ASHP's standing in rural health care centers, organizations, and communities.

Advisory Group on Medication Safety. Now in its seventh year, the Section Advisory Group on Medication Safety is charged with providing tools and resources for medication safety officers or pharmacists who have medication safety responsibility as a component of their positions. The group provided quality educational content for the 2011 MCM in the form of its fifth *Safety and Quality Pearls* session as well as a three-hour session focused on improving transitions of care at discharge with pharmacist involvement. The advisory group has continued its safety webinar series and recently hosted its fourth annual webinar and the first in the series to offer CE. An ASHP statement on the role of the medication safety officer has been drafted. After Board approval, it will be presented for a vote at the 2012 House of Delegates. The groundbreaking, multidisciplinary Medication Safety Track introduced at the 2011 SM was a collaborative effort between this advisory group and ASHP's ESD. This track provided over 18 hours of targeted pharmacist CE in medication safety, a necessary requirement in several states. Thirteen hours of medication safety physician CME and nursing CE were offered as well. The three-day programming track provided attendees with a much-needed focus on critical and practical safety issues. The Best Practices session focused on key, safety-vulnerable practice areas, including OR/Anesthesiology, Investigational Drug Service, Ambulatory Care, and the Emergency Department. A Patient Safety Priority Tool Kit, developed by the advisory group, was a value-added benefit for all meeting registrants. This group was successful in making the 2011 SM more than just another conference about medication safety; rather, they transformed it into a medication safety experience. Riding high on the excellent reviews from last year, the advisory group is currently working with ESD to deliver high-quality educational content for the medication safety track for the 2012 SM.

Advisory Group on Pharmacy Practice Experiences. This advisory group provides tools and resources for frontline pharmacist preceptors and potential preceptors that foster favorable student experiences as students matriculate through their pharmacy rotations. The group continually updates and maintains its primary resources, *How to Start a New Student Rotation* and the *ASHP Preceptor Tool Kit*. Both are posted on the Section's webpage. The group collaborated with the Student Forum and launched a survey to assist health-system pharmacists and pharmacy students to identify ideal qualities of a preceptor or pharmacy

student and how to incorporate best qualities into practice to create a more successful learning and teaching experience. The results of this survey were shared with the public during a networking session at the 2011 MCM. Feedback was solicited from the audience on how to improve pharmacy students' learning experiences. The advisory group plans to use both the survey results and discussion point from the networking session to aid in the development of future educational programs and additional resources. Members of this advisory group collaborated with the Advisory Group on Medication Safety and developed a student rotation template on medication safety. Plans are underway to create a portfolio of templates for various student rotations. In addition, the group is working to develop a template to assist and guide preceptors in small and rural hospital settings.

Advisory Group on Pharmacy Support Services. Formed in 2009, this advisory group works to assist and support ASHP's Pharmacy Technician Initiative (PTI). The advisory group hopes to work with ASHP state affiliates to provide high-quality CE for certified pharmacy technicians. The group also developed its first webinar addressing the professional imperative for standardization of pharmacy technician education and training. The group recognizes the importance of conducting surveys and gap analyses to address the value of pharmacy technicians and the needed practice resources for pharmacy personnel support and their supervisors. Consequently, the advisory group conducted a survey to investigate innovative roles for pharmacy support personnel as it relates to PPMI. The overwhelming response the advisory group received demonstrates the advisory group is poised to address unmet needs of a component of the Section's membership. Survey results were shared during the 2011 MCM at the advisory group's first networking session, *Critical Analysis of the Role of Pharmacy Technicians in the Future Pharmacy Practice Model: Challenges and Opportunities*.

Advisory Group on Small and Rural Hospitals. The Section Advisory Group on Small and Rural Hospitals planned a successful educational track featuring eight hours of pharmacist CE for its sixth consecutive *Programming for Small and Rural Hospitals* during ASHP's 2011 MCM. Outgoing ASHP CEO Dr. Henri Manasse and CEO-designate, Dr. Paul Abramowitz brought greetings on behalf of ASHP. Both men stressed the important role of rural health care institutions and recognized the unique needs and challenges faced by pharmacists practicing in rural and frontier areas of the country. The session's keynote speaker, George N. Miller, was the 2007 President of the NRHA and is currently serving in his second consecutive term on the Medicare Payment Advisory Commission (MedPAC). Other rural program topics included *Strategies for Implementing Telepharmacy Services*, *I'll Huff and I'll Puff: Using Spirometry to Expand Pharmacist Led Services within the Medical Home*, *Oncology Care in Small and Rural Hospitals: Pharmacy's Role and Responsibility*, *340b and Partnership for Patients: Game Changers and the Impact on Rural Healthcare*, and *Residency Programs in Rural Areas: Why Do It? Can it be Done?* Additionally, the advisory group organized a networking session at the 2011 MCM and established a historic high in attendance compared to previous networking sessions. The advisory group has already begun the planning and development of content for the 2012 MCM. The advisory group has been very active in the areas of advocacy, educational programming, publications, and health policy. The group collaborated with the Department of Health and Human Services and CMS Innovation Center to develop a webinar educating

members about the Partnership for Patients, a federal initiative aimed at improving quality, safety, and affordability of health care for all Americans through public-private partnerships. For the first year, the advisory group represented ASHP through a plenary session at NRHA's 2011 Quality and Clinical Conference. The advisory group remains committed to contributing to the literature, as evidenced by recent articles accepted for publication in the *American Journal of Health-System Pharmacy* by its former and current members. The Executive Committee will continue to advocate on behalf of small and rural hospitals, critical access hospitals, and other rural health care institutions.

Advisory Group on Medication Safety

Jorge D. Carillo, Chair (Texas); Deborah Wagner, Vice Chair (Michigan); May Alomari (Michigan); Beverly "Jane" Adams (Texas); Jason Andree (Massachusetts); Dean Bennett (Delaware); Peggy S. Bickham (Illinois); Jennifer Burgess (North Carolina); Angela Cassano (Virginia); Dan Degnan (Indiana); Keli Edwards, New Practitioner (Washington DC); Catherine A. Hartman (Massachusetts); Constance D. Hogrefe (Florida); Janice L. Hoyt (Washington); Molly Billstein Leber (Connecticut); Ambra King, New Practitioner (Georgia); Lynne M. Lee (New York); Marie Link (Ohio); Jeannell M. Mansur (Illinois); Donald McKaig (Rhode Island); Kymberlee Moline (Michigan); Jason Nickisch (Montana); Kimberly Redic (Michigan); Jennifer Robertson (Tennessee); Jeffrey Schnoor (Vermont); Victoria (Vicki) Tamis (Washington); Michelle Thomas (Maryland); Allen Vaida, ISMP Liaison (Pennsylvania); Lynn Eschenbacher, Executive Committee Liaison (North Carolina); Bona E. Benjamin, ASHP Staff (Maryland)

Advisory Group on Pharmacy Support Services

Cynthia Jeter, Chair (Arkansas); Terri K. Mundy, Vice Chair (Louisiana); Charity D. Andrews (Kentucky); Sylvia Q. Banzon (California); Helen M. Calmes (Louisiana); Sarah L. Clement (North Carolina); Stephen M. Kessinger (Florida); Barbara E. Lacher (North Dakota); Scott A. Meyers (Illinois); Wendy Mobley-Bukstein (Illinois); Robert Sobolik (Montana); Winona T. Thomas (Louisiana); Trish Wegner (Illinois); Aubrey Wynn (Texas); Brian Benson, Executive Committee Liaison (Iowa); Karen Noonan, ASHP Staff (Maryland)

Advisory Group on Small and Rural Hospitals

Debby Cowan, Chair (North Carolina); Debbie Sisson, Vice Chair (Minnesota); Ann M. Carder (Iowa); Navy Chaay (Wisconsin); Paul S. Driver (Idaho); Matthew P. Fricker, Jr., ISMP Liaison (Pennsylvania); Angela George (Minnesota); Amanda J. Hays (Alaska); Todd Lemke (Minnesota); Robert Long (Nevada); Steve Olsen (Idaho); Jim Rorstrom (Kansas); Timothy S. Seeley (Wyoming); William R. Simpson (Pennsylvania); John Worden NRHA Liaison (Kansas); Bissy Obi, Student Member—University of Charleston, Class of 2013 (West Virginia); Dazhi Liu, Student Member—University of Iowa, Class of 2012 (Iowa); Emily Alexander, Executive Committee Liaison (Texas)

Advisory Group on Pharmacy Practice Experiences

Rony Zeenny, Chair (Lebanon); Lijian "Leo" Cai, Vice Chair (Wisconsin); David Bowyer (West Virginia); Aaron Burton (Pennsylvania); Joseph Dikun, New Practitioner (Ohio); Dale E. English II

(Ohio); Beth D. Ferguson, (Minnesota); Nicole M. Glasser (New York); Scott D. Greene (Pennsylvania); Lori Prater (New Mexico); Rachael Y. Prusi (Illinois); Davina Dell-Steinback (Montana); Stephanie Thomas (Pennsylvania); Thomas V. Thomas; Laura Watcher (Maryland); Kurt Wargo (Alabama); Felix Yam (California); Sali Mahmoud, New Practitioner (Maryland); Ayotunde Ayoola, Student Member-Howard University, Class of 2013 (Washington DC); Noelle R.M. Chapman, Executive Committee Liaison (Illinois)

Committee on Nominations

Debra L. Cowan, Chair (North Carolina); Brian D. Benson, Vice Chair (Iowa); Helen Calmes (Louisiana); Dale English, (Ohio); Deb Saine (Virginia)

Educational Steering Committee

Lois F. Parker, Chair (Massachusetts); Wes Pitts, Vice Chair (Mississippi); Terri Albarano (Pennsylvania); Lori Dupree (Virginia); Shishir Gupta (Virginia); Sum Lam (New York); Tyrone Lin (Washington); Darlette G. Luke (Minnesota); Jacqueline L. Olin (North Carolina); Kimberly Pesaturo (Massachusetts); Elizabeth McGowan Rebo (North Carolina); Ronald Seto (Canada); Michelle L. Shah (Illinois); Susan Jean Skledar (Pennsylvania); Linda Spooner (Massachusetts); Lori Tsukiji (California); Joanne Kowiatek, Executive Committee Liaison (Pennsylvania); Michelle Abalos, ASHP Staff (Maryland); Pamela Hsieh, ASHP Staff (Maryland)



SEIZE THE INITIATIVE

**ASHP House of Delegates 2012
June 10 and 12, 2012**

Report on the Section of Pharmacy Informatics and Technology

The mission of the Section of Pharmacy Informatics and Technology is to improve health outcomes through the use and integration of data, information, knowledge, technology, and automation in the medication-use process. In that role, the Section continually seeks to define and promote the optimal synergy between technology and the pharmacy professional in an effort to enhance and support practice models that bring the full benefit of the pharmacist's training and experience to the medication-use process. The Section is dedicated to achieving a vision in which members will (1) be enabled by technology to focus on providing optimal pharmaceutical care to each patient; (2) participate in all aspects of medical informatics that support the medication-use process through multidisciplinary collaboration across the entire health care system; (3) collaborate domestically and internationally with other organizations and governmental agencies to promote the use of medical informatics in the provision of quality health care; (4) take a leadership role in medical informatics, at all levels of health care, to ensure that health information technology (HIT) supports safe medication use; (5) promote the development of a set of practical medical informatics competencies to manage medication-related data and information challenges across the continuum of care; and (6) stimulate an environment that focuses on setting the agenda for designing and conducting research to expand medical informatics knowledge and its use in supporting patient care. The Section has focused its goals and objectives to support the ASHP Leadership Agenda: "Influence the development and implementation of health information technologies and standards that help improve patient care."

Executive Committee

Allen J. Flynn, *Chair* (Michigan)
Kevin C. Marvin, *Chair-elect* (Vermont)
Christopher J. Urbanski, *Immediate Past Chair* (Indiana)
Leslie R. Mackowiak, *Director-at-Large* (Tennessee)
Sylvia M. Thomley, *Director-at-Large* (South Dakota)
Gwendolyn R. Volpe, *Director-at-Large-elect* (Indiana)
Michael D. Sanborn, *Board Liaison* (Texas)
Karl F. Gumper, *Secretary*

2011–2012 Section Highlights. During 2011, the Section added more than 6000 members. About 20% of the Section’s members have selected this group as their primary membership group. Total Section membership has increased by 25% from the previous year. Nearly one third of the Section membership is student members. In the 2011 elections, the Section’s membership elected Mr. Kevin C. Marvin as Chair-elect. Ms. Gwendolyn R. Volpe was elected as a Director-at-Large; both will be installed at the June 2011 ASHP Summer Meeting. The Section also selected Dennis A. Tribble as the winner of the Section of Pharmacy Informatics and Technology Distinguished Service Award. Established in 2007, the ASHP Pharmacy Practice Sections Distinguished Service Award recognizes a member of a section whose volunteer activities have supported the mission of the section and helped advance the profession. The award was presented at the 2011 Midyear Clinical Meeting (MCM). Allen J. Flynn represents the Section in a Joint Section/Form Coordination Committee of the Pharmacy Practice Model Initiative Summit (PPMI). The Section will continue to provide support to ASHP and ASHP Foundation education and advocacy efforts related to the PPMI. The Section is working on a guidance document for the use of telepharmacy within pharmacy practice.

ASHP continues to participate with the Pharmacy e-Health Information Technology Collaborative (the Collaborative). The Collaborative was formed by the Academy of Managed Care Pharmacy (AMCP), American Pharmacists Association (APhA), ASHP, and the National Community Pharmacists Association (NCPA). These four organizations will be the steering committee for the Collaborative, and they will work with the other organizations to meet the objectives of the Collaborative. The other organizations that participate in the Collaborative are the American Association of Colleges of Pharmacy (AACP), American College of Clinical Pharmacy (ACCP), American Society of Consultant Pharmacists (ASCP), and the National Alliance of State Pharmacy Associations (NASPA). The Collaborative continues to recruit associate members to support the work of the Collaborative.

The Collaborative has accomplished the following activities in 2011:

- “The Roadmap for Pharmacy Health Information Technology Integration in U.S. Health Care” was published, and a webinar was conducted with HIT stakeholders.
- Pharmacist/Pharmacy Provider Electronic Health Record Functional Profile (PP-EHR) successfully became an international standard and provided a high level of national awareness within the HIT community.
- Over 250 Medication Therapy Management (MTM) clinical terms were submitted to National Library of Medicine (NLM) for “SNOMED-CT” international codes.
- An MTM documentation of specialized transactions was published by National Council for Prescription Drug Programs (NCPDP).
- The restructure of the Pharmacist Services Technical Advisory Coalition (PSTAC) under the Collaborative was accomplished to provide a structure for all Collaborative Council members to participate in pharmacist professional service billing and coding projects.

The Collaborative was asked to participate in four work groups for an Office of the National Coordinator for Health Information Technology (ONC) and U.S. Presidential driven electronically integrated solution to Prescription Drug Monitor Programs (PDMP) for controlled substances.

Educational Programming. The Section's programming for the 2011 MCM consisted of over 15 hours of continuing education. Topics that were presented included advancing pharmacy practice models through automation, EHR implementations, clinical decision support, and HIT team structures. Armen Simonian of the Section's Educational Steering Committee coordinated the Informatics Bytes: Pearls Session. Robert Christiansen was the Chair of the Section's 2011–2012 Educational Steering Committee.

Planning for the 2012 MCM is currently in progress. The Educational Steering Committee is searching for proposals that include enhancing clinical decision support, e-Prescribing and improved patient care and coordination of care, updates on meaningful use and other federal initiatives, patient safety and HIT issues, fully automated pharmacy, career planning in pharmacy informatics, mobile apps in healthcare, business intelligence applications for pharmacy leaders, risk management consideration surrounding the electronic medical record, cutting-edge strategies for training simulation in health care information technology, standard health care terminologies supporting pharmacy practice and enhanced patient care, and data-mining and data integrity. Laura Tyndall of the Section's Educational Steering Committee will coordinate the Informatics Bytes: Pearls Session.

Drs. Fox and Fortier worked with the ASHP Educational Services Division to plan an informatics series at the 2011 Summer Meeting. An informatics session was scheduled during five of the meeting's educational opportunities. The Section conducted a joint session on medication safety with the Medication Safety program chairs. Topics that were presented included clinical decision support systems that support meaningful use core measures, electronic dashboards and patient scorecards, incorporating the PPMI recommendations for a fully automated pharmacy, establishing standard structured terminologies to enable pharmacy practice electronic health records on the national level, and strategies to enhance safety of medication use technologies.

The Section also planned and implemented five networking sessions at the 2011 MCM. Each of the Section's advisory groups planned a thematic program related to its primary charge. A networking session is planned for the 2012 Summer Meeting to be facilitated by the Executive Committee.

Electronic Networking Opportunities. The Section's electronic NewsLink is distributed monthly to more than 6000 ASHP members. The NewsLink provides information on current issues relating to informatics and technology, research, legislative and regulatory facts, and health policy and health care news. The Section has promoted ASHP Connect to its members over the past year. The most visited websites of the Section were Pharmacy Informatics Job Descriptions, Pharmacy Informatics Career Development, and Bar Code Medication Administration Resources. The Section will continue to monitor the use of the Section's website and promote its available resources to members. The Section updated the Bar Code Resource Page and the Computerized Provider Order Entry (CPOE) Resource Page. The Executive Committee is interested in expanding the Section's presence utilizing existing social media tools (e.g., Twitter, FaceBook, linkedIn, etc.) and developing new tools and strategies.

Charges for Section Advisory Groups. The Section's Executive Committee has formalized and standardized the charge of each of the four advisory groups. Each advisory group will share

eight common charges: (1) contribute to the “Informatics Interchange” column in the *American Journal of Health-System Pharmacy (AJHP)*, (2) coordinate a webinar for the Section membership on a related topic area, (3) review the relevant content area on the Section’s website on an annual basis, (4) develop programming for the MCM, (5) appoint a working group to manage the frequent calls for comments for various government and regulatory groups, (6) encourage members to contribute and post to ASHP Connect, (7) coordinate a networking session at the MCM on a topic relevant to the advisory group’s purview, and (8) coordinate a spotlight on a member’s contribution to the Section for the Section’s website. Each Section advisory group and committee will further have projects and deliverables focused on the group’s scope and content knowledge.

Advisory Group on Ambulatory Care Informatics. Activities of the Section Advisory Group on Ambulatory Care Informatics include sharing information and providing guidance to improve e-prescribing; supporting the work of the Pharmacy e-Health Information Technology Collaborative; influencing HIT standard-developing organizations (e.g., HL7) and certification bodies (e.g., CCHIT) to include the practice needs of the pharmacist in their requirements and criteria to achieve the safe, effective use of medications; and identifying strategies and best practices for pharmacist online documentation of pharmaceutical care. The advisory group is still reviewing survey results on drug-drug interactions (DDI) to direct its efforts on developing recommendations concerning DDIs in pharmacy and integrated electronic systems. A plan is being developed to share the survey results and develop a commentary or editorial for *AJHP*. The advisory group is developing an editorial on e-prescribing. The advisory group conducted a webinar networking session, *Driving E-prescribing Quality - A Dialogue between Practicing Pharmacists and Technology Implementers*, conducted in May 2011. The advisory group is continuing work to educate health-system pharmacists on ambulatory care informatics issues such as electronic prescribing and electronic medication reconciliation. The networking session that was developed by the advisory group at the MCM was related to the use of electronic prescribing in hospitals and health systems.

Advisory Group on Clinical Information Systems. Activities of the Section Advisory Group on Clinical Information Systems include supporting pharmacy involvement in “Meaningful Use”; developing recommendations on the content of clinical decision support (CDS) for medication ordering and dispensing systems; educating in regards to considerations and processes to create and implement CDS rules; identifying sites in which pharmacists are using data to enhance practice (e.g., PPMI), for surveillance, to add efficiency to rounding models, for clinical drug use changes and quality monitoring; continuing to define pharmacy informatics roles and responsibilities; and promoting original research within clinical information systems and patient safety. CDS alerts and alert fatigue continue to be priority issues with the advisory group for the coming year. The advisory group conducted a survey in spring 2011, and they are reviewing the results for publication for the end of 2012. The advisory group is interested in assessing the pharmacy resources required to manage and implement clinical information systems within hospitals and health systems. In supporting the federal government’s requirements for “meaningful use” of the EHR, the advisory group will focus on quality outcomes and measure reporting. The advisory group conducted a networking webinar in April 2011, “Meaningful Use

Summary Tools for Pharmacists.” The advisory group continues to investigate the sharing of CDS rules to better meet the needs of its members.

Advisory Group on Pharmacy Informatics Education. Activities of the Section Advisory Group on Pharmacy Informatics Education include defining the scope and standards of practice for pharmacy informatics practitioners, continuing to identify and enroll new authors for the "Informatics Interchange" column, determining a means to highlight key pharmacy informatics research that may include a journal club via ASHP Connect on informatics topics, developing awareness and opportunities regarding careers in pharmacy informatics, assessing the professional educational needs of pharmacy informaticists, and determining a strategy for pharmacy informaticist professional certification. With the establishment of the "Informatics Interchange" column in *AJHP*, there have been over 22 publications since June 2008. With the changing responsibilities of pharmacy informatics practitioners, the advisory group will be revising the *ASHP Statement on the Role of the Pharmacist in Informatics* during the upcoming year. This advisory group is developing strategies to engage practitioners in informatics to support the clinical role of the pharmacist. Educational needs of students, residents, practitioners, and pharmacy technicians are a concern for members of the Section. The advisory group completed a resource document, titled "Development of Pharmacy Informatics Competencies for Health-System Pharmacists," which is posted on the Section's webpage.

Advisory Group on Pharmacy Operations Automation. Activities of the Section Advisory Group on Pharmacy Operations Automation include investigating specifications and requirements to ensure interoperability and standardization for communication of data across databases, technology and information systems; developing a pharmacy self-assessment for safety related to distribution utilizing technology which includes robots, carousels, packagers, tracking systems, and IV workflow systems; developing a training guideline to ensure competency for pharmacy technicians related to technology to include understanding databases, concepts of FMEA/RCA, medication safety, optimization, and testing; developing resources on current state of IV workflow systems and IV preparation robotics; and updating smart pump resources. The advisory group is developing resources on many important areas of automation and pharmacy devices. The advisory group conducted a networking webinar in July 2011, titled "Project Management Support and Lessons Learned." The advisory group continues to develop resources for members to better utilize technology within hospital pharmacies. The advisory group is working with the Association for the Advancement of Medical Instrumentation (AAMI) to develop standardized utilization of smart pumps and management of drug libraries.

Advisory Group on Ambulatory Care Informatics

Shobha Phansalkar, Chair (Massachusetts); Kathleen Vieson (Florida); Mary E. Burkhardt (Michigan); Gaurang J. Gandhi (Florida); J. Chad Hardy (Texas); John Horn (Washington); Kevin Marvin (Vermont); Navin B. Philips (New Jersey); Muhammad A. Qudoos (Texas); George A. Robinson (Indiana); Bob E. Rocho (Colorado); James Russell (Wisconsin); Mark H. Siska (Minnesota); Marc T. Young (Texas); Wing Liu, Informatics Resident (Tennessee); Patrick McDonnell, Council on Therapeutics Liaison (Pennsylvania)

Advisory Group on Clinical Information Systems

Trinh T. Le, Chair (North Carolina); Franklin Crownover, Vice Chair (Massachusetts); Benjamin Anderson (Minnesota); Michelle V. Bell (Virginia); Dean Bennett (Delaware); Christine M. Beuning (Washington); Anne M. Bobb (Illinois); Lynn Boecler (Illinois); Michael Bonter (Michigan); Denny C. Briley (Kansas); James Carpenter (Oregon); Bruce Chaffee (Michigan); Raymond Chan (Virginia); Amy P. Davis (Florida); Kelly Duarte (West Virginia); W. Lynn Ethridge (South Carolina); Maren Everton (Utah); Randy Herring (Georgia); Tara K. Jellison (Indiana); Michael A. Jones (Colorado); Tamara Joseph (New York); Thomas P. Jurewitz (California); Joan E. Kapusnik-Uner (California); Abraham K. Kim (California); Andrew Laegeler (Texas); Gregory T. Matsuura (Washington); Christy C. Nielsen (Washington); Darshika Patel (Ohio); Adelaide Quansah-Arku, Technician Member (District of Columbia); Brendan Reichert (Maryland); Eric Rose (Florida); Lynn C. Sanders (Pennsylvania); Mohammad Aslam Siddiqui (Kentucky); Nancy R. Smestad (North Dakota); Andrew Smith (North Carolina); Robert Stein (California); Anne-Marie Toderico (Maine); David L. Troiano (Texas); Lolita White (Maryland); Cynthia Williams (Virginia); Allison D. Woods (Oregon); DeWayne A. Davidson, Student Representative (Texas); Soranarom B. Kumsaitong, Student Representative (Georgia); Van T. Do, Informatics Resident (Maryland); David P. Mulherin, Informatics Resident (Michigan)

Advisory Group on Pharmacy Informatics Education

Elizabeth A. Breeden, Chair (Tennessee); Joseph Lassiter, Vice Chair (Oregon); Louis Barone (Ohio); Gail L. Bigelow (New Jersey); Jennifer Boehne (Minnesota); Kevin Clauson (Florida); Helen L. Figge (New York); Jonna Fink (Illinois); Brent I. Fox (Alabama); Carol Hope (Utah); Jo B. Lazarou (Michigan); Maritza Lew (California); Tommy J. Mannino (Louisiana); Sean M. Mirk (Illinois); Gina Moore (Colorado); Gwendolyn B. Moscoe (Washington); Eric Nemec (Connecticut); Pamela Schindler (Alabama); Beju Shah (South Carolina); Phillip W. Stewart (Tennessee); Ray B. Vrabel (California); Yannan Dong, Informatics Resident (Oregon); Michael Schroeder, PGY1 Resident (Virginia); Ryan Markham, Student Representative (Georgia); Hong Wei, Student Representative (California)

Advisory Group on Pharmacy Operations Automation

Barbara Lane Giacomelli, Chair (New Jersey); Kavish J. Choudhary, Vice Chair (Utah); Leslie Brookins (Missouri); Ron Burnette (Florida); Seth Aaron Cohen (Maryland); Thomas W. Cooley (Massachusetts); Doina Dumitru (Texas); Darren S. Ferer (New York); Staci Hermann (Kansas); Craig C. Herzog (Utah); Jennifer J. Howard (California); Isha S. John (Maryland); Ameet C. Joshi (Maryland); Larry M. Kaplan (Illinois); Seth A. Kuiper (Ohio); James T. Lund (Illinois); Silvia Maranian (Colorado); Nicholas A. Marsico (Ohio); Michael E. McGregory (Indiana); Rhonda B. McManus (South Carolina); Nancy A. Nickman (Utah); Brendon Ordway (Minnesota); Beth E. Prier (Ohio); Brad T. Rognrud (Minnesota); Kevin A. Scheckelhoff (Ohio); Allen Sieger (Oklahoma); Kimberly C. Sherman (Wisconsin); Steven Silverstein (Illinois); Chad S. Stashek (Massachusetts); David A. Tjhio (Illinois); Dennis A. Tribble (Florida); Gwen Volpe (Indiana); Robynn P. Wolfschlag (Colorado); Aaron Speak, Resident Representative (Kentucky)

Committee on Nominations

Christopher J. Urbanski, Chair (Indiana); Brent Fox (Alabama); J. Chad Hardy (Texas); Kevin A. Scheckelhoff (Ohio); Dennis A. Tribble (Florida)

Educational Steering Committee

Robert Christiansen, Chair (Pennsylvania); Armen I. Simonian, Vice Chair (California); Alan Chung (District of Columbia); Christopher R. Fortier (South Carolina); John Manzo (New York); Michael D. Schlesselman (Connecticut); Laura L. Tyndall (Pennsylvania)



SEIZE THE INITIATIVE

**ASHP House of Delegates 2012
June 10 and 12, 2012**

Report on the Section of Pharmacy Practice Managers

The mission of the Section of Pharmacy Practice Managers is to help members manage pharmacy resources, maximize the safety of medication-use systems, develop future leaders, and promote the pharmacist's role in patient care. The Section Executive Committee has developed a strategic plan linked to the mission and goals of the Section. These goals are (1) maximize communications and interactions with and among Section members; (2) enhance effectiveness of managers and leaders through development of education, training, and cultivating mentoring relationships; (3) recommend professional policy and advocacy on issues of importance to Section members; (4) define strategies to enhance the stature of the pharmacy enterprise within the health care delivery system and demonstrate the value of the profession; and (5) drive the advancement of the future practice model to support health care reform. The ASHP Section of Pharmacy Practice Managers represents ASHP's continued commitment to meeting the needs of pharmacists who lead and manage departments of pharmacy. The Section provides pharmacy directors and managers with a sense of identity within ASHP and an organizational home dedicated to meeting their special needs.

Executive Committee

Michael F. Powell, *Chair* (Nebraska)
Patricia J. Killingsworth, *Chair-elect* (Colorado)
Scott J. Knoer, *Immediate Past Chair* (Ohio)
James M. Hoffman (Tennessee)
Todd A. Karpinski (Wisconsin)
Laura K. Mark (Pennsylvania)
Lisa M. Gersema, *Board Liaison* (Minnesota)
David F. Chen, *Secretary*

2011–2012 Section Highlights. The Section has 9435 members, with approximately 44% of the Section’s members having selected the Section as their primary membership group. Section members elected Patricia Killingsworth as Chair and James Hoffman as a Director-at-Large; both will be installed at the June 2011 ASHP Summer Meeting. The Section recognized Audrey Nakamura as the winner of the Section of Pharmacy Practice Managers Distinguished Service Award. Established in 2007, the ASHP Pharmacy Practice Sections Distinguished Service Award recognizes a member of each section whose volunteer activities have supported the Section’s mission and helped advance the profession. The award was presented at the 2011 Midyear Clinical Meeting (MCM).

In addition, a number of Section leaders were very active in the Pharmacy Practice Model Initiative (PPMI) as webinar presenters and document authors. The Section will continue to provide support to ASHP and ASHP Foundation education and advocacy efforts related to the PPMI. The Section has established an advisory group to facilitate the Section role in translating the recommendations of the Summit into practice.

Educational and Networking Opportunities. Under the leadership of Ryan Forrey, the 2010-2011 Educational Steering Committee designed educational sessions for pharmacy managers and directors that were presented at the 2011 MCM. Topics included inpatient and outpatient prospective payment system rules and regulations, accountable care organizations, managing IT implementations, multi-hospital health systems, specialty pharmacy, and management pearls. All of these sessions were recorded and synchronized with the presentation slides so that they can be made available to members. For the 2012 MCM, the committee is planning sessions on re-admissions, managing practice model change, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and discharge management, accountable care organizations, leadership challenges for multi-hospital pharmacy leaders, inpatient and outpatient prospective payment system rules and regulations, dashboards and score cards, managing staff competencies and development, and supply chain management (including drug shortages best practices). The Section also planned and implemented networking sessions at the 2011 MCM addressing issues and opportunities with administrative residencies, pharmacy enterprise management, practice model innovations, specialty pharmacy integration, and multi-hospital pharmacy leaders.

Section members participated in the planning and presentation of a practice model change management program at the 2011 Summer Meeting led by Dr. Max Ray. In addition, the Section held a networking session focusing on issues and opportunities around health care reform.

The Section continues to distribute a monthly electronic NewsLink that serves over 8000 ASHP members. The NewsLink provides Section information, business information, leadership and management information, relevant research, legislative updates, regulatory alerts, and health policy/health care news. The Section also continues to facilitate an electronic discussion group utilizing ASHP Connect. The electronic discussion group provides a forum for Section members to exchange information and ideas on a wide variety of topics related to pharmacy management and leadership.

Conference for Leaders in Health-System Pharmacy. The Section, in collaboration with ASHP Advantage, planned and implemented another successful leadership conference. This event again reached capacity in 2011 with over 400 participants, and included key programs in areas such as innovation change management, technician role advancement, health reform, and the leadership skills for the evolving pharmacy enterprise. The overarching theme of the Conference was practice model transformations focusing on leadership accountabilities and innovation. In addition, a pre-conference Managers' Boot Camp was conducted for its fourth year as a freestanding workshop focusing on key drivers resulting from health reform, leading an accountable culture, strategic planning, and alignment of skills and strengths when developing teams. In addition, 16 Section leaders provided facilitation for networking tables on hot topics. As part of the conference proceedings, the John W. Webb Lecture Award was presented to Paul Bush.

Multi-hospital Health-System Pharmacy Leaders. This group of Section members is a growing area of membership. For the third year the Section organized a networking session at the 2011 MCM for these practitioners. The Section conducted a survey on pharmacy service characteristics of these evolving multi-hospital health systems that was provided to members, and the data was used in the 2011 MCM programming. The Section leadership is working on developing additional services and resources to meet the needs of members associated with multi-hospital health systems.

Advocacy. The Section continues to be very active in advocacy in the areas of workload and productivity measures, the expansion of restricted drug distribution systems, the affordability of drugs, and reimbursement. In addition, the Section will continue to be engaged in promoting, fostering, and expanding the opportunities for pharmacy leadership and the benefits of pharmacist leadership in improving the medication use system.

Advisory Group on Communications and Publications. This advisory group has worked on coordinating communication of the Section's activities and the completion of publications focused on the needs of pharmacy practice managers. The group oversees the Section's communication and marketing plan. Members of this group have facilitated submissions for the "Manager's Consultation" column in the *American Journal of Health-System Pharmacy (AJHP)*, with three publications on human resource management and business management. The advisory group has completed four Member Spotlights for the Section webpage to recognize Section members that have been active in the success of Section goals.

Advisory Group on Leadership Development. This advisory group was successful in completing a webinar focused on team building, incorporating personality differences and strengths, and participated in the multi-hospital health-system pharmacy leadership educational programming. In addition, a group member successfully published a column in *AJHP* on pharmacy workflow redesign.

The group continues to oversee the Student Leadership Development (SLD) Workshop. This workshop is a three-hour program to introduce students to leadership opportunities and to facilitate networking with other students interested in leadership. The program has been

implemented at 18 ASHP state affiliates and one college of pharmacy. The advisory group is working in collaboration with the ASHP Affiliate Relations Division, Pharmacy Student Forum, and the Center for Health-System Pharmacy Leadership to continue the expansion of the program, including the development of online tools for interested faculty. The advisory group has organized networking sessions to promote administrative residencies and the benefits of residency training the past four MCMs. The group has also been engaged with the ASHP Foundation and its efforts to identify opportunities for new practitioner and student leadership development.

Advisory Group on Manager Development. This advisory group focused on tools and education to support health-system pharmacy manager development, including a successful webinar addressing management strategies for advancing pharmacy practice models and a 2011 MCM networking session on managing outcomes across the pharmacy enterprise continuum. In addition, the advisory group coordinated the fourth annual Managers' Boot Camp held prior to the Conference for Leaders in Health-System Pharmacy.

Advisory Group on Pharmacy Business Development. This advisory group completed a project of developing a set of standardized slide presentations correlating to core areas of the two-part paper published in *AJHP*, "Effective use of workload and productivity monitoring tools in health-system pharmacy." This paper was also the result of the efforts of this group. In addition, this advisory group finalized its Financial Management Self-Assessment Tool and Web Resource. This tool is a comprehensive self-assessment instrument for members to determine their level of accomplishing over 80 different financial management strategies. The group led a 2011 MCM networking session addressing specialty pharmacy challenges and integration into health systems and conducted a successful webinar addressing opportunities for pharmacy with transitions of care and re-admissions.

Advisory Group on Pharmacy Practice Model Initiative. This advisory group was established in 2011 to guide the Section in its effort to support the PPMI. The group was successful in determining priorities for the group to focus on, including educational programming, networking, and PPMI-focused case studies. The group was instrumental in helping create and participate in the 2011 MCM PPMI-dedicated educational session and leading the PPMI-focused networking session. The efforts of this advisory group have also been incorporated into the Joint Section and Forum PPMI Coordination Committee.

Advisory Group on Quality and Compliance. This advisory group was very active with issues surrounding REMS, reimbursement compliance, and Medicare Conditions of Participation (CoP) challenges. At the 2011 MCM an educational session on reimbursement compliance and the new inpatient and outpatient prospective payment systems (IPPS and OPPS) rules was provided for the third year. The advisory group is continuing work on creating a "Tip of the Month" that will provide members with ideas and resources on how to improve their compliance and success with quality and regulatory goals. The group was instrumental in working with ASHP staff on seeking more patient-safe interpretation of CMS's medication administration CoPs surrounding the "30-minute" rule, which in collaborative efforts with the Institute for Safe

Medication Practices has resulted in changes in CMS's interpretative guidelines. Group members have contributed to the maintenance of the ASHP REMS Resource page and saw the results of their counsel to ASHP reflected in the 2011 CMS Medication Guide guidance document.

Advisory Group on Communications and Publications

Rabiah Dys, Chair (Massachusetts); Mark Sullivan, Vice Chair (Tennessee) Audrey Nakamura, Immediate Past Chair (California); Glen Albracht, (North Carolina); John P. Gray (Wisconsin); Nishaminy Kasbekar (Pennsylvania); Patricia Killingsworth (Colorado); Bonnie Labdi (Texas); Ali McBride (Minnesota)

Advisory Group on Leadership Development

Karol Wollenburg, Chair (New York); Jennifer Cimoch, Vice Chair (Pennsylvania); Edward Nold, Immediate Past Chair (Florida); Stephen Adams (New Mexico); Richard Burnett (Texas); Arash Dabestani (California); Joe Gonzaga (Pennsylvania); John Hertig (Indiana); Brian Kawahara (California); Stephen Kessinger (Florida); Justin Paul Konkol (Wisconsin); Kelly Martin (Wisconsin); David B. Moore (Florida); Veena Rajanna (Michigan); Jacob Spangler (North Carolina); Erin Taylor (Massachusetts); Jeffrey Wagner (Texas)

Advisory Group on Managers Development

Lindsey R. Kelley, Chair (Michigan); Karl Kappeler, Vice Chair (Ohio); Trent A. Beach (Delaware); Meghan Davlin (Maryland); Osmel Delgado (Florida); Robert Granko (North Carolina); Matthew Jenkins (Pennsylvania); Timothy W. Lynch (Washington); Ursula Tachie-Menson (District of Columbia); Carolyn (Carrie) S. Morton (Indiana); Adam Orsborn (North Carolina); Melissa Ortega (Wisconsin); Don Roberts (Arkansas); Joseph Sceppa (Massachusetts); Kate Schaafsma (Wisconsin); Jeffrey Thiel (Illinois); Jacob Thompson (New York); Andrew J. Wilcox (Wisconsin)

Advisory Group on Pharmacy Business Management

Philip Brummond, Chair (Michigan); Michael DeCoske, Vice Chair (North Carolina); Rick Couldry (Kansas); Edward H. Eiland III (Alabama); Patti Hawkins (Mississippi); Paul R. Krogh (Minnesota); Erin Maroyka (Virginia); Carisa Masek (Nebraska); Patrick McMahon (Massachusetts); Joel Melroy (South Carolina); Greg Polk (Michigan); Brian Paul Romig (North Carolina); Chad Stashek (Massachusetts); Aaron Webb (Wisconsin); Cynthia Williams (Virginia); John Williamson (Pennsylvania); Matthew Wolf (Pennsylvania); David Wolfrath (Florida); John Worden (Kansas)

Advisory Group on Quality and Compliance

Margaret A. Huwer, Chair (Ohio); Christine Manukyan, Vice Chair (California); James M. Hoffman, Immediate Past Chair (Tennessee); Steven Allison (North Carolina); Jennifer Burgess (North Carolina); Joseph Cesarz (Wisconsin); Jordan Dow (Wisconsin); Kristine Gullickson (Minnesota); Tara K. Jellison (Indiana); Bonnie Kirschenbaum (Colorado); Julie Lenhart (California); Ben Lopez (Ohio); Richard Montgomery (Florida); Robert James Moura (Massachusetts); Lee Murdaugh (Tennessee); Kuldip Patel (North Carolina); Maria Serpa (California); Doris Wong (California)

Committee on Nominations

Kathleen S. Pawlicki, Chair (Michigan); David A. Kvancz (California); James R. Rinehart (Nebraska); Steve Rough (Wisconsin); Andrew L. Wilson (Virginia)

Educational Steering Committee

Thomas E. Kirschling, Chair (Pennsylvania); Rebecca Taylor, Vice Chair (Ohio); Ryan Forrey, Immediate Past Chair (Ohio); John Armitstead (Florida); John Clark (Michigan); Tammy Cohen (Texas); Doina Dumitru (Texas); Matthew Eberts (Pennsylvania); Nancy A. Huff (Massachusetts); John D. Pastor III, (Minnesota); Stephanie Peshek (Florida); Jay P. Rho (California); Deepak Sisodiya (California)

Advisory Group on Pharmacy Practice Model Initiative

Steve Rough, Chair (Wisconsin); Jennifer Brandt (District of Columbia); Sam Calabrese (Ohio); Stephen Eckel (North California); Brian Erstad (Arizona); Anita Harrison (Texas); Shannon Hays (Arkansas); Todd Karpinski (Wisconsin); Brian Marden (Maine); Pamela Phelps (Minnesota); Steve Pickette (Washington); Rita Shane (California); Suzanne Turner (Florida); Jennifer Tryon (Washington); Julie Williams (Indiana)



NEW HORIZONS

ASHP House of Delegates 2013
June 2 and 4, 2013

REPORT ON IMPLEMENTATION OF 2012

ASHP HOUSE OF DELEGATES ACTIONS AND RECOMMENDATIONS

Council on Education and Workforce Development A (1201): Preceptor Skills and Abilities

To collaborate with pharmacy organizations on the development of standards to enhance the quality of experiential education and pharmacy residency precepting; further,

To provide tools, education, and other resources to develop preceptor skills.

ASHP staff discussed preceptor development needs with Pharmacy Deans attending the Midyear Clinical Meeting (MCM) in December 2012 and convened a staff committee to assess existing and additional tools that ASHP might offer for preceptor development.

Council on Education and Workforce Development B (1202): Qualifications and Competencies Required to Prescribe Medications

To affirm that prescribing is a collaborative process that includes patient assessment, understanding of the patient's diagnoses, evaluation and selection of available treatment options, monitoring to achieve therapeutic outcomes, patient education, and adherence to safe and cost-effective prescribing practices; further,

To affirm that safe prescribing of medications, performed independently or collaboratively, requires competent professionals who complement each others' strengths at each step; further,

To explore the creation of prescribing standards that would apply to all who initiate or modify medication orders or prescriptions and that would facilitate development of competencies and training of prescribers; further,

To encourage research on the effectiveness of current educational processes designed to train prescribers.

This policy has been used in ongoing ASHP advocacy. Other specific actions are under consideration.

Council on Education and Workforce Development C (1203): Qualifications of Pharmacy Technicians in Advanced Roles

To recognize that highly trained and skilled pharmacy technicians working in advanced roles regularly perform complex and critical medication-use procedures, and that a safe and effective medication-use process depends significantly on the skills, knowledge, and competency of those pharmacy technicians to perform those tasks; further,

To reaffirm that all pharmacy technicians should complete an ASHP-accredited training program, be certified by the Pharmacy Technician Certification Board, and be licensed by state boards of pharmacy; further,

To advocate that beyond those requirements pharmacy technicians working in advanced roles should have additional training and should demonstrate ongoing competencies specific to the tasks to be performed; further,

To advocate that expansion of pharmacy technician duties into expanded, advanced roles should include consideration of potential risk to patients and that ongoing quality assurance metrics should be established to assure patient safety.

This policy has been used in ongoing ASHP advocacy and communications related to pharmacy technicians.

Council on Education and Workforce Development D (1204): Role of Students in Pharmacy Practice Models

To encourage pharmacy practice leaders to incorporate students, including those in introductory and advanced pharmacy practice experiences and interns, into active, meaningful roles in new and evolving practice models.

ASHP staff is seeking ways to promote innovative models that involve pharmacy students.

Council on Pharmacy Management A (1205): Revenue Cycle Compliance and Management

To encourage pharmacists to serve as leaders in the development and implementation of strategies to optimize medication-related revenue cycle compliance, which includes billing, finance, and prior authorization, for the health care enterprise; further,

To advocate for the development of consistent billing and reimbursement policies and practices by both government and private payers; further,

To advocate that information technology (IT) vendors enhance the capacity and capability of IT systems to support and facilitate medication-related billing and audit functions; further,

To investigate and publish best practices in medication-related revenue cycle compliance and management.

ASHP staff established a group of member experts to develop guidelines on revenue cycle management. ASHP has continued its involvement with the e-HIT Collaborative, which works to ensure health-system pharmacies' interests are addressed in the development of electronic health records (EHRs) and the associated billing and reimbursement functions. ASHP conducted [webinars](#) and developed educational content addressing billing and compliance in the ambulatory care settings and continues to send "Tips of the Month" related to issues with medication billing, patient care billing, and other related compliance issues. ASHP also continues efforts to preserve ASP plus 6% pricing for covered drugs.

Council on Pharmacy Management B (1206): Payment Authorization and Verification Processes

To advocate that public and private payers work together and in collaboration with providers to create standardized and efficient strategies for payment authorization and verification processes, such as local and national coverage determinations, that facilitate communication between patients, providers, and payers prior to therapy; result in timely coverage decisions; and do not disrupt patient care.

ASHP continues to maintain the ASHP REMS Web Resource Center and established a group of member experts to develop guidelines on managing specialty pharmacies, including approaches for dealing with prior authorizations.

Council on Pharmacy Management C (1207): Financial Management Skills

To foster the systematic and ongoing development of management skills for health-system pharmacists in the areas of (1) health-system economics, (2) business plan development, (3) financial analysis, (4) metrics for clinical and distributive services, (5) pharmacoeconomic analysis, (6) diversified pharmacy services, (7) compensation for pharmacists' patient-care services, and (8) revenue cycle compliance and management; further,

To encourage colleges of pharmacy to incorporate these management areas in course work and experiential education; further,

To encourage financial management skills development in pharmacy residency training programs and new practitioner orientation.

ASHP launched a [C-Suite Web Resource Center](#) at the 2012 MCM. ASHP staff established a group of member experts to develop guidelines on managing specialty pharmacies, including approaches for dealing with prior authorizations. ASHP organized a [webinar](#), "Financial Basics: Justification of New Pharmacy Programs," that was presented in late April. In addition, the Section of Pharmacy Practice Managers (SPPM) Managers Boot Camp includes financial basics lecture and workshop activities. The ASHP Foundation's [Pharmacy Forecast 2013-2017: Strategic Planning Advice for Pharmacy Departments in Hospitals and Health Systems](#) providing important health care economic trends, in collaboration with the Pharmacy Practice Sections. The Section of Ambulatory Care Pharmacists (SACP) had a networking sessions at the 2012 MCM on "Current Issues for Ambulatory Care Pharmacists: Provider Status, Collaborative Practice, Health-Homes, and Billing for Services" and "Ambulatory Care Pharmacist Reimbursement Opportunities: Hospital-based, Physician-based, and Retail Pharmacy-based." (See additional notes under the recommendation regarding ASHP SPPM website resource offerings [Steve Novak] below.)

Council on Pharmacy Management D (1208): Transitions of Care

To recognize that continuity of patient care is a vital requirement in the appropriate use of medications; further,

To strongly encourage pharmacists to assume professional responsibility for ensuring the continuity of care as patients move from one setting to another (e.g., ambulatory care to inpatient care to home care); further,

To encourage the development, optimization, and implementation of information systems that facilitate sharing of patient-care data across care settings and providers; further,
 To advocate that payers and health systems provide sufficient resources to support effective transitions of care; further,
 To encourage the development of strategies to address the gaps in continuity of pharmacist patient care services.

ASHP conducted a workshop on transitions of care business development at the 2012 [Conference for Leaders in Health-System Pharmacy](#). ASHP created a Task Force on Accountable Care Organizations (ACOs), with an emphasis on new models and practitioner skills needed to achieve goals of ACOs. ASHP issued the [ASHP/APhA Medication Management Transitions of Care Best Practices](#) report in February 2013, which showcases eight model programs to improve patient outcomes and prevent readmissions. Winning programs were highlighted at the 2012 MCM, 2012 Conference for Leaders in Health-System Pharmacy, and 2013 APhA Annual Meeting. ASHP is exploring potential collaboration on phase 2, which might include a dedicated web site on this topic, grants for pilot programs, and collection of models on specific program aspects (e.g., use of technology). A “Leading an Innovative Practice in Ambulatory Settings” learning community is planned for the 2013 Summer Meeting. ASHP continues its involvement with the e-HIT Collaborative, which works to ensure health-system pharmacy’s interests are addressed in the development of EHRs and the associated information exchanges necessary for transitions of care.

Council on Pharmacy Management E (1209): Value-Based Purchasing

To support value-based purchasing reimbursement models when they are appropriately structured to improve health care quality, patient satisfaction, and clinical outcomes, and encourage medication error reporting and quality improvement; further,
 To encourage pharmacists to actively lead in the design and interdisciplinary implementation of medication-related value-based purchasing initiatives.

ASHP has engaged in continued advocacy with payers, most notably the Centers for Medicare & Medicaid Services (CMS), on the role of pharmacists in achieving value-based purchasing (VBP) goals. ASHP has presented educational sessions at meetings, and the *American Journal of Health-System Pharmacy (AJHP)* publications providing information on rules and best practices to achieve VBP targets.

Council on Pharmacy Management F (1210): Role of Corporate Pharmacist Leadership in Multifacility Organizations

To advocate that a pharmacist must be responsible for leadership and have responsibility for standardization and integration of pharmacy services in multiple business units across the entire pharmacy enterprise of multifacility health systems and integrated delivery networks; further,
 To educate health-system administrators about the importance of pharmacy leadership in setting system-wide policy regarding the safe and effective use of medications.

ASHP members presented at the American College of Healthcare Executives on pharmacy practice. The SPPM Advisory Group on Multi-Hospital Health System Pharmacy Executives provided peer networking and educational programs at the 2012 MCM and the [Leadership Conference](#).

Council on Pharmacy Management G (1211): Pharmacist’s Role in Health Care Information Systems

To strongly advocate key decision-making roles for pharmacists in the planning, selection, design, implementation, and maintenance of medication-use information systems, electronic health records, computerized provider order entry systems, and e-prescribing systems to facilitate clinical decision support, data analysis, and education of users for the purpose of ensuring the safe and effective use of medications; further,
 To advocate for incentives to hospitals and health systems for the adoption of patient-care technologies; further,
 To recognize that design and maintenance of medication-use information systems is an interdisciplinary process that requires ongoing collaboration among many disciplines; further,
 To advocate that pharmacists must have accountability for strategic planning and direct operational aspects of the medication-use process, including the successful deployment of medication-use information systems.

This policy has been utilized in comments to the Office of the National Coordinator for Health Information Technology (ONC) in ASHP’s comments on Meaningful Use of the EHR.

Council on Pharmacy Management H (1212): Clinical Decision Support Systems

To advocate for the development of clinical decision support (CDS) systems that are proven to improve medication-use outcomes and that include the following capabilities: (1) alerts, notifications, and summary data views provided to the appropriate people at the appropriate times in clinical workflows, based on (a) a rich set of patient-specific data, (b) standardized, evidence-based medication-use best practices, and (c) identifiable patterns in medication-use data in the electronic health record; (2) audit trails of all CDS alerts, notifications, and follow-up activity; (3) structured clinical documentation functionality linked to individual CDS alerts and notifications; and (4) highly accessible and detailed management reporting capabilities that facilitate assessment of the quality and completeness of CDS responses and the effects of CDS on patient outcomes.

The Section of Pharmacy Informatics and Technology (SOPIT) published a commentary, [The need for collaborative engagement in creating clinical decision-support alerts](#), in *AJHP*. SOPIT also brought EHR and knowledge vendors together at the MCM 2012 meeting to discuss opportunities for collaboration. SOPIT is in development of a mechanism for members to share CDS rules. Another commentary on managing Drug-Drug Interactions is awaiting publication in *AJHP*. The policy has been utilized in comments to the Office of the National Coordinator for Health Information Technology (ONC) in the Society’s comments on Meaningful Use of the EHR.

Council on Pharmacy Practice A (1213): Pharmacist Prescribing in Interprofessional Patient Care

To define pharmacist prescribing as follows: patient assessment and the selection, initiation, monitoring, adjustment, and discontinuation of medication therapy pursuant to diagnosis of a medical disease or condition; further,
To advocate that health care delivery organizations establish credentialing and privileging processes that delineate the scope of pharmacist prescribing within the hospital or health system and to ensure that pharmacists who prescribe are competent and qualified to do so.

This policy implements a working definition of pharmacist prescribing and recommends a means for ensuring competency in that role. The policy has been used to support ASHP’s ongoing advocacy efforts with credentialing, accreditation, regulatory, and legislative organizations.

Council on Pharmacy Practice B (1214): Pharmacist’s Role in Accountable Care Organizations

To recognize that pharmacist participation in collaborative health care teams improves outcomes from medication use and lowers costs; further,
To advocate to health policymakers, payers, and other stakeholders for the inclusion of pharmacists as health care providers within accountable care organizations (ACOs) and other models of integrated health care delivery; further,
To advocate that pharmacist-provided care (including care coordination services) be appropriately recognized in reimbursement models for ACOs; further,
To advocate that pharmacists be included as health care providers in demonstration projects for ACOs; further,
To encourage comparative effectiveness research and measurement of key outcomes (e.g., clinical, economic, quality, access) for pharmacist services in ACOs; further,
To encourage pharmacy leaders to develop strategic plans for positioning pharmacists in key roles within ACOs.

ASHP convened Task Force on ACOs in June 2012. ASHP has provided members with ACO-related information and products in a variety of formats, including publications (e.g., articles in *AJHP*, a January 2011 ASHP [policy analysis](#) on the pharmacist’s role in ACOs); continuing education and networking sessions at meetings; and a one-hour, archived [webinar](#) on the Affordable Care Act and ACOs.

Council on Pharmacy Practice C (1215): Pharmacist’s Role in Team-Based Care

To recognize that pharmacist participation in interprofessional health care teams as the medication-use expert increases the capacity and efficiency of teams for delivering high-quality care; further,
To advocate to policymakers, payers, and other stakeholders for the inclusion of pharmacists as care providers within team-based care; further,
To assert that pharmacists are responsible for coordinating the care they provide with that provided by other members of the health care team and are accountable to the patient and to the health care team for the outcomes of that care; further,

To urge pharmacists on health care teams to collaborate with other team members in establishing quality measures for care provided by those teams.

Policy concepts included in “Common Principles of Team-Based Care,” a position document developed by the [Hospital Care Collaborative](#), an interprofessional group promoting team-based hospital care.

Council on Public Policy A (1216): Pharmacy Technicians

To advocate that pharmacy move toward the following model with respect to the evolving pharmacy technician workforce as the optimal approach to protecting public health and safety: (1) development and adoption of uniform state laws and regulations regarding pharmacy technicians, (2) mandatory completion of an ASHP-accredited program of education and training as a prerequisite to pharmacy technician certification, (3) mandatory certification by the Pharmacy Technician Certification Board as a prerequisite to licensure by the state board of pharmacy, and (4) licensure of pharmacy technicians by state boards of pharmacy granting the technician permission to engage in the full scope of responsibilities authorized by the state; further,

To advocate, with respect to certification, as an interim measure until the optimal model is fully implemented, that individuals be required either (1) to have completed an ASHP-accredited program of education and training or (2) to have at least one year of full-time equivalent experience as pharmacy technicians before they are eligible to become certified; further,

To advocate that all pharmacy functions be performed under the general supervision of a licensed pharmacist and that licensed pharmacists and technicians be held accountable for the quality of pharmacy services provided. (Note: Licensure is the process by which an agency of government grants permission to an individual to engage in a given occupation upon finding that the applicant has attained the minimal degree of competency necessary to ensure that the public health, safety, and welfare will be reasonably well protected. Certification is the process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.)

This policy is inherent to the ongoing work of ASHP’s Pharmacy Technician Initiative, which partners with state affiliates to achieve adoption of the policy’s elements. State affiliates have been surveyed about the prospect for legislative and regulatory changes to incorporate this policy. Assistance has been provided to select state affiliates as requested.

Council on Public Policy B (1217): Collaborative Drug Therapy Management

To pursue the development of federal and state legislative and regulatory provisions that authorize collaborative drug therapy management by pharmacists; further,

To advocate expansion of federal and state legislative and regulatory provisions that optimize pharmacists’ ability to provide the full range of professional services within their scope of expertise; further,

To acknowledge that as part of these advanced collaborative practices, pharmacists, as active members in team-based care, must be responsible and accountable for medication-related outcomes; further,

To support affiliated state societies in the pursuit of state-level collaborative drug therapy management authority for pharmacists.

State legislative and regulatory initiatives have been supported by ASHP. Most initiatives involve expansion of existing collaborative drug therapy management authority to ambulatory and community settings.

Council on Public Policy C (1218): Approval of Biosimilar Medications

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

To encourage research on the safety, effectiveness, and interchangeability of biosimilar medications; further,

To support legislation and regulation to allow Food and Drug Administration (FDA) approval of biosimilar medications; further,

To support legislation and regulation to allow FDA approval of biosimilar medications that are also determined by the FDA to be interchangeable and therefore may be substituted for the reference product without the intervention of the prescriber; further,

To require postmarketing surveillance for all biosimilar medications to ensure their continued safety, effectiveness, purity, quality, identity, and strength; further,
 To advocate for adequate reimbursement for biosimilar medications that are deemed interchangeable; further,
 To promote and develop ASHP-directed education of pharmacists about biosimilar medications and their appropriate use within hospitals and health systems; further,
 To advocate and encourage pharmacist evaluation and the application of the formulary system before biosimilar medications are used in hospitals and health systems.

State affiliates have been supported by ASHP in their advocacy on proposals that regulate the interchangeability of biosimilars. ASHP will use this policy in ongoing advocacy with FDA as it finalizes its guidance on implementation of the approval pathway for biosimilars. In addition, educational materials and programming have been developed for members.

Council on Public Policy D (1219): Stable Funding for HRSA Office of Pharmacy Affairs

To advocate for a sustainable level of funding, including appropriations, sufficient to support the public health mission of the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs; further,
 To support initiatives of the Office of Pharmacy Affairs, including the 340B Drug Pricing Program and innovative pharmacy service models in HRSA-funded programs; further,
 To encourage research on the potential impact of any proposed fees or alternative funding sources for the Office of Pharmacy Affairs.

This policy has been used in ongoing advocacy with Congress, HRSA, and other stakeholders as the program continues to be closely reviewed.

Council on Public Policy E (1220): Standardized Immunization Authority to Improve Public Health

To advocate that, to improve public health and patient access to immunizations, states grant pharmacists the authority to initiate and administer all adult and child immunizations through a universal protocol developed by state health authorities; further,
 To advocate that only pharmacists who have completed a training and certification program acceptable to state boards of pharmacy and meeting the standards established by the Centers for Disease Control and Prevention may provide such immunizations; further,
 To advocate that state health authorities establish a centralized database for documenting administration of immunizations that is accessible to all health care providers.

This policy is used in ongoing advocacy at the state level as pharmacists are granted the authority to provide immunizations.

Council on Therapeutics A (1221): Criteria for Medication Use in Geriatric Patients

To support medication therapy management, including assessment of physiologic and pharmacokinetic factors, as a central component of providing safe and effective drug therapy to geriatric patients; further,
 To oppose use of the Beers criteria or similar criteria by the Centers for Medicare & Medicaid Services and other accreditation and quality improvement entities as the sole indicator to assess the appropriateness of prescribing for geriatric patients based on known limitations in the evidence evaluating the association between use of medications listed in such criteria and subsequent adverse drug events; further,
 To advocate for the development, refinement, and validation of new criteria that consider drug-, disease-, and patient-specific factors and demonstrate the ability to decrease the occurrence of adverse drug events in geriatric patients; further,
 To support research to assess the clinical application of existing and proposed criteria, including assessment of their correlation to patient outcomes and strategies for implementation; further,
 To encourage inclusion of validated criteria in clinical decision support systems and other information technologies to facilitate prescribing for geriatric patients; further,
 To acknowledge that such criteria are intended as a guide and should not replace the clinical judgment of pharmacists and other clinicians.

This policy was communicated to staff at the American Geriatric Society (AGS), the Pharmacy Quality Alliance (PQA), and CMS. AGS and PQA were involved in developing the content and specific quality measures and CMS implements their assessments as part of their long-term care standards. The letters were tailored to the specific role each organization plays in developing and using the Beers criteria. ASHP staff participated in interview for cover story in the [August 2012 issue](#) of *Drug Topics*. Among other aspects, ASHP staff was quoted as opposing use of the Beers criteria as a sole indicator to assess quality of patient care. An educational session on geriatric care at the 2012 MCM provided a comparison of new Beers criteria and the version published in 2003.

Council on Therapeutics B (1222): Medication Adherence

To recognize that improving medication adherence should be a key component of strategies to improve the quality and safety of patient care only when adherence improvement efforts include the following as required elements: (1) assessing the appropriateness of therapy, (2) providing patient education, and (3) ensuring patient comprehension of information necessary to support safe and appropriate use of prescribed therapies; further,

To advocate that pharmacists, because of their distinct knowledge, skills, and abilities, should take a leadership role in multidisciplinary efforts to develop, implement, monitor, and maintain effective strategies for improving medication adherence; further,

To recognize that clinicians, patients, and caregivers share accountability for the outcomes of medication therapies, and that the central role patients and their caregivers have in disease management includes responsibility for following instructions for safe and effective medication use; further,

To encourage development, evaluation, and dissemination of models that improve adherence, including those that combine existing strategies that have demonstrated effectiveness; further,

To discourage practices that inhibit education of or lead patients to decline education and clinical information regarding their medication therapy; further,

To support the development of mechanisms to document medication adherence interventions, including information technology solutions; further,

To advocate for payment models that facilitate an expanded role for pharmacists in medication adherence efforts.

An ASHP member was appointed to serve on a Pharmacy Quality Alliance adherence workgroup that is developing quality measure concepts for adherence. The [ASHP-APhA Medication Management in Care Transitions](#) project identified eight best practices for models of care to improve patient outcomes and prevent readmissions. Strategies to improving medication adherence and medication access were a central component of these programs.

Council on Therapeutics C (1223): Globalization of Clinical Trials

To encourage the Food and Drug Administration (FDA) to use its existing authority to increase monitoring and inspection of foreign clinical trials to ensure the integrity and quality of those studies; further,

To advocate that the FDA expand its oversight of clinical trials conducted abroad by continuing to pursue innovative strategies, such as increased collaboration with foreign regulatory agencies and changes in domestic regulatory processes that support timely submission of foreign clinical trial information; further,

To encourage the FDA to establish a standardized electronic format and reporting standards that would be required for submission of data from foreign clinical trials; further,

To support the ethical treatment of patients in foreign clinical trials in accordance with international standards designed to protect human subjects; further,

To encourage public and private research to study the impact of the globalization of clinical trials on patient care.

This policy was communicated to FDA in an official comment letter regarding reauthorization of the Prescription Drug User Fee Act (PDUFA).

Council on Therapeutics D (1224): Tobacco and Tobacco Products

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

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

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

To promote the role of pharmacists in tobacco-cessation counseling and medication therapy management; further, To join with other interested organizations in statements and expressions of opposition to the use of tobacco and tobacco products.

This was a revision of existing ASHP policy with a minor alternation to acknowledge the pharmacist's role in medication therapy management in addition to counseling. The policy will be used in ongoing ASHP advocacy.

Section of Clinical Specialists and Scientists (1225): Board Certification for Pharmacists

To support the principle that pharmacists who practice where a pharmacy specialty has been formally recognized by the profession should become board certified in the appropriate specialty area; further,

To recognize the Board of Pharmacy Specialties (BPS) as an appropriate organization through which specialties are formally recognized and specialty pharmacy certification should occur; further,

To advocate prioritization for recognition of new specialties in those areas where sufficient numbers of postgraduate year two residency training programs are established and where adequate numbers of pharmacists are completing accredited training programs to prepare them to practice in the specialty area; further,

To advocate for standardization of credentialing eligibility and recertification requirements to include consistent requirements for advanced postgraduate residency training; further,

To promote a future vision encouraging accredited training as an eventual prerequisite for board certification; further,

To encourage BPS to be sensitive to the needs of current practitioners as prerequisites evolve; further,

To actively encourage and support the development of effective training and recertification programs that prepare specialists for certification examination and ensure the maintenance of core competencies in their area of specialization.

The Section of Clinical Specialists and Scientists (SCSS) coordinated an open hearing at the 2012 MCM for members to provide comments to BPS regarding recognition of pediatrics and critical care as Board-certified specialties, and section members participated in writing the petitions to BPS for recognition of those two specialties, which were [recognized by BPS](#) in April. SCSS members were also involved in the BPS practice analysis task force that conducted role delineation studies in cardiology and infectious diseases. SCSS members helped develop ASHP educational offerings, review courses, and core therapeutic modules to help pharmacists prepare for the BCPS, BCACP, and BCOP specialty examinations and recertification programs. SCSS is also hosting a networking session on credentialing and privileging at the 2013 Summer Meeting and has proposed educational programming on the topic at the 2013 MCM.

Council on Education and Workforce Development E (1226): ASHP Statement on the Role of the Medication Safety Leader

To approve the ASHP Statement on the Role of the Medication Safety Leader.

The statement was published in *AJHP* and *Best Practices for Hospital and Health-System Pharmacy* and has been used in ongoing advocacy with The Joint Commission, the National Quality Forum (NQF), and CMS.

Council on Pharmacy Practice D (1227): ASHP Statement on the Pharmacist's Role in Medication Reconciliation

To approve the ASHP Statement on the Pharmacist's Role in Medication Reconciliation.

The statement was published in *AJHP* and *Best Practices for Hospital and Health-System Pharmacy* and has been used in ongoing advocacy with The Joint Commission in support of National Patient Safety Goal (NPSG).03.06.01 on medication reconciliation.

Pharmacy Student Forum and Section of Pharmacy Informatics and Technology (1228): ASHP Statement on Use of Social Media by Pharmacy Professionals

To approve the ASHP Statement on Use of Social Media by Pharmacy Professionals.

The statement was published in *AJHP* and *Best Practices for Hospital and Health-System Pharmacy* and has been used in ongoing advocacy.

Recommendation: Vickie Powell (on behalf of NY delegation)

ASHP should create a certification program on financial management skills to provide baseline and ongoing competency that is consistent across the health system.

ASHP has not considered a certification or certificate program for financial management skills but has devoted resources to regular education, advocacy, publications, news reports, and web resources to addressing this critical area for pharmacy leaders. The Section of Pharmacy Practice Managers (SPPM) has two advisory groups specifically on the business management of pharmacy and the associated quality and compliance aspects. The 2012 House of Delegates approved changes to ASHP’s policy on Financial Management Skills (see Council on Pharmacy Management Policy Recommendation C, above) to include metrics for clinical and distributive services and revenue cycle compliance and management. Examples of useful ASHP references include:

- 1) The [SPPM website](#) has a number of resources and a financial self-assessment tool.
- 2) Each year the [Conference for Leaders in Health-System Pharmacy](#) has components based on financial management.
- 3) The ASHP publication, [Financial Management for Health-System Pharmacists](#).

This timely recommendation is reflective of the increasing demands on pharmacy leaders to more effectively manage all aspects of the pharmacy enterprise and the complexities of the business of pharmacy. Section leadership will continue to identify the products and services to be developed for our members.

Recommendation: Melanie Dodd (NM)

ASHP should replace terms such as “multidisciplinary” and “interdisciplinary” with “interprofessional” in ASHP policies.

ASHP has started replacing these terms, when appropriate, with "interprofessional" and will do so in a stepwise fashion as policies and documents are developed or revised.

Recommendation: Casey White (TN)

ASHP should develop clear, delineated, and implementable guidelines for transition of pharmacists traditionally involved in primarily operational activities to direct patient care roles.

This topic was included on the agenda of the Council on Pharmacy Education and Workforce Development when they met in September as part of a broader discussion of how to ensure that both new graduates and existing pharmacists are prepared for the needs of the future pharmacy workforce (see the “Other Council Activity” section of the Board Report).

Recommendation: Allen Flynn (SOPIT)

The Section on Pharmacy Informatics and Technology recommends that ASHP establish by consensus a medication-use process model with a set of measurable patient-focused criteria for use by ASHP to certify or accredit the medication-use process within hospitals and health systems.

This topic is a subject of ongoing discussion and exploration by ASHP staff and members. ASHP recently joined the governing body of the Center for Pharmacy Practice Accreditation (CPPA). CPPA oversees the development and implementation of voluntary accreditation standards for pharmacy practice sites. Although CPPA's initial focus will be community pharmacy settings, CPPA anticipates the development of accreditation standards for other pharmacy practice settings. In addition, the Section of Inpatient Care Practitioners (SICP) is exploring the development of essential medication safety measures, and ASHP Foundation is developing a patient complexity index.

Recommendation: Jennifer Tryon, Ian Doyle, and Kate Farthing (OR)

ASHP should develop a statement on the roles of pharmacy team members (technicians, students, interns, etc.) in medication reconciliation.

In 2012, the ASHP House of Delegates approved the ASHP Statement on the Pharmacist’s Role in Medication Reconciliation. Although the statement mainly addresses the pharmacist's role in medication reconciliation, roles of technicians and others are also included. The Council on Pharmacy practice considered the statement and the recommendation at its September meeting and, in light of evidence supporting the recommendation, voted to develop a separate statement that focuses specifically on a standardized approach to including pharmacy technicians, students, and residents in the medication reconciliation process. The Council referred development of the document to the Pharmacy Student Forum and New Practitioners Forum, and requested follow-up at the 2013–2014 Council Meeting. ASHP is also engaged in a number of activities that promote optimal deployment of other qualified pharmacy staff, including technicians, students, and residents in transitions of care, including medication reconciliation roles.

Recommendation: Dale English II (OH)

ASHP should work with all other interested stakeholders to provide appropriate and accurate information to the general public about their specific rights as patients and the professional obligation of pharmacists to provide them with education about their medications.

ASHP policy supports the recommender’s views on this topic. ASHP will continue to advocate these policies when opportunities present themselves, through media outreach and other outreach to consumers and consumer groups. In addition, this policy is often a subject in meetings with community and chain pharmacy organizations.

Recommendation: Jennifer Schultz (SICP)

ASHP should pursue the creation of grants to support nontraditional residency programs and provide a toolkit that demonstrates components of successful nontraditional programs.

Although ASHP would like to see grants created to help nontraditional residency programs, ASHP is the accrediting body and therefore cannot directly seek grants to help ASHP-accredited programs. The recommendation has been shared with the ASHP Foundation, as only they can seek and award grants related to residencies. Regarding the request for toolkits for successful nontraditional programs, ASHP is exploring whether some of the programs can provide input for creating such a toolkit. Because each of these programs is usually uniquely suited to its site and particular situation, there is not necessarily a one-size-fits-all template for nontraditional programs. These programs are also often short-lived for many organizations, yet they cannot see what works until after 2–3 years of running the programs, making the suggestion even more challenging. ASHP has included nontraditional programs in educational sessions at the [National Residency Preceptors Conferences](#) and the 2012 Summer Meeting, as well as with articles in *AJHP* to share the variety of ways individuals have approached nontraditional residencies. More programming is being planned around this topic at future ASHP meetings. Programs have been encouraged to submit proposals and management case studies on the topic.

Recommendation: Jennifer Schultz (SICP), Steve Rough (WI), and Lynn Eschenbacher (NC)

ASHP should develop a strategy in the form of a toolkit to assist pharmacy leaders in achieving pharmacist credentialing as providers within the medical staff as allowed by the new CMS language.

This recommendation is very timely, as ASHP and its members implement the opportunity to make full use of expanded allowance for practitioner credentialing under the Medicare and Medicaid Programs Reform of Hospital and Critical Access Hospital Conditions of Participation. The Council on Education and Workforce Development discussed the idea for ASHP guidelines on pharmacist privileging and credentialing at its September meeting. They noted that the Council on Credentialing in Pharmacy (CCP) is developing a document on the topic and concluded that ASHP, being a founding member of CCP, will likely endorse the new guidance document. The Council concluded that two very similar documents are not needed, and that resources could be better spent on education and other ways to implement these systems. They recommended that ASHP not initiate development of its own guidelines at this time but were willing to reconsider after reviewing the CCP document. In addition, the ASHP Foundation has a grant to develop tools for health-system pharmacy leaders in working with the C-suite and they have agreed to include this recommendation as part of the charge to expert panel.

Recommendation: Jennifer Schultz (SICP), Steve Rough (WI), and Lynn Eschenbacher (NC)

ASHP should assist state affiliates with strategies for improving relationships and influence with state boards of pharmacy to support practice advancement initiatives.

ASHP has a close liaison relationship with the leadership of the National Association of Boards of Pharmacy (NABP). In addition, ASHP sponsors a meeting of health-system pharmacists who serve on individual state boards of pharmacy during the MCM. Moreover, ASHP staff attend the annual NABP meeting and will be making presentations at a number of upcoming NABP District meetings. ASHP has existing policy 0518 (below) that addresses the funding, expertise, and oversight of state Boards of Pharmacy. As recently adopted policies will require advocacy before state boards, policy 0518 provides the overall direction to ASHP to support state affiliates to advocate for these practice advancement initiatives. ASHP also provides ongoing support and strategic direction to state affiliates on legislative and regulatory matters under consideration in a particular state.

0518, Funding, Expertise, and Oversight of State Boards of Pharmacy

To advocate appropriate oversight of pharmacy practice (including nontraditional practice) and the pharmaceutical supply chain by state boards of pharmacy and other state agencies whose mission it is to

protect the public health; further,

To advocate adequate representation on state boards of pharmacy and related agencies by pharmacists who are knowledgeable about hospitals and health systems to ensure appropriate oversight of hospital and health-system pharmacy practice; further,

To advocate adequate funding for state boards of pharmacy and related agencies to ensure the effective oversight and regulation of pharmacy practice and the pharmaceutical supply chain.

Recommendation: Ken Jozefczyk, Pat Knowles, and Megan Freeman (GA)

ASHP should oppose displacement of regulatory and enforcement authority away from state boards of pharmacy.

ASHP's existing policy 0518 (see above) addresses the importance of state boards of pharmacy and representation of health-system pharmacists on these boards to ensure appropriate oversight of the profession. ASHP has used policy 0518 and its predecessors to assist state affiliates in advocating for the autonomy of state pharmacy boards and opposing its consolidation into a "super board" that regulates other health professions and will continue to do so.

Recommendation: James Hoffman (TN)

ASHP should implement a strategy to communicate and collaborate with national and state hospital associations to increase hospital leaders' understanding of contemporary pharmacy services.

ASHP has well-established relationships with national hospital associations, including AHA, NRHA, HIMSS, and ACHE. ASHP routinely works with these organizations on professional and advocacy issues. For example, ASHP and AHA regularly discuss proposed and final rules as well as guidance documents to align positions before commenting. In addition, ASHP recently worked with AHA very closely on the drug shortages issue with Congress, with numerous joint Capitol Hill and FDA visits, as well as a joint press conference and several joint ads in local DC press. ASHP also has a representative on the AHA Committee on Health Professions. In addition, each year we have ASHP representation at HIMSS and NRHA meetings. More recently, ASHP and Section leaders have worked to provide presentations at the annual ACHE conference on pharmacy-related issues and the value of pharmacy and pharmacists. The Section of Pharmacy Practice Managers has as a primary goal to present at this meeting each year, with this past year being the third time. Part of this goal is to develop guidance and template tools the Section can share with ASHP and ASHP affiliate leaders to use at the state level with these national organizations' affiliates. In addition, communications and efforts of education and outreach to organizations such as AHA, ACHE, and NRHA are included and tracked for report to the ASHP Board as a tactic for promoting health system pharmacy.

Recommendation: Katherine Palmer (NPF)

ASHP should encourage and facilitate new practitioners to consider practice in small and rural hospitals to help ensure access to direct pharmacist patient care.

The New Practitioners Forum and Section of Inpatient Care Practitioners executive committees have initiated discussion on ways to get new practitioners engaged in small and rural practice settings. ASHP will begin promotion of existing federally funded programs that offer repayment programs as incentives for pharmacy practitioners to go to rural settings as well as Section-generated resources such as *AJHP* articles and a web-based resource center.

Recommendation: Carrie Sincak (on behalf of IL delegation)

ASHP should establish a turnkey training program that all pharmacy practice settings can purchase and implement to achieve accreditation at their own practice sites, when technician training accreditation transition to the Accreditation Council for Pharmacy Education (ACPE) has occurred.

Because ASHP is the accrediting body for pharmacy technician training programs, we are not permitted to develop and market an accredited training program that would compete with those we accredit. Should ASHP not be the accrediting body for technician training programs in the future, it is likely that we would evaluate developing such a program and consider offering it to practice sites.

Recommendation: Dale English II (OH)

ASHP should continue to identify areas of inefficiency and to maximize efficiencies in the current structure, process, function and execution of the ASHP House of Delegates and its associated activities.

The ASHP Task Force on Organizational Structure will be reviewing and making recommendations on improvements to the entire ASHP policy development process, including the House of Delegates. The recommendation has been shared with the Task Force.

Recommendation: Lisa Scherkenbach (PSF)

In consideration of the significant growth in ASHP student membership, ASHP should ensure sufficient representation on any and all existing and future decision-making entities within ASHP as appropriate.

ASHP views involving students as vital to our success, and we are constantly looking for new ways to involve students in key activities. The vast majority of ASHP's committees, for example, include a student representative, as do many of our ad hoc committees. Although the new Task Force on Organizational Structure does not include a student representative, it does include a number of new practitioners, some of whom were recent student leaders within ASHP. The Task Force's work will continue for 17 months, and we were concerned that most third- and fourth-year students would not have the time to participate in such an intensive, 17-month-long activity, and many would have graduated before the Task Force concluded its work. In addition, we felt that the charge of this particular task force lent itself to including members who could reflect on a few years of experience as participants in ASHP's organizational structure, governance, and policy development process, which is why recent Pharmacy Student Forum Executive Committee members (now new practitioners) were included. There will be many opportunities for ASHP members to make suggestions to and review the work of the Task Force, and we will especially be reaching out to ASHP sections and forums. The Chair of the Task Force recognizes that input from students will be vital to the success of the Task Force, and that input will be given every consideration.

Recommendation: John Pastor, Paul Krogh, and Shane Madsen (MN)

ASHP should, as part of the Pharmacy Practice Model Initiative (PPMI), develop and provide specific tools for pharmacists to improve their ability to effectively supervise technicians.

This topic was discussed by the Council on Education and Workforce Development at its September meeting (see the "Other Council Activity" section of the Council's Board report).

Recommendation: Diane Fox (TX)

ASHP should develop an application for tablet computers containing all information for the House of Delegates so that it is easily downloaded and updated.

ASHP will continue to provide House of Delegates-related information via the House of Delegates section of the ASHP website, ASHP Connect, and the Summer Meeting application. In addition, we will also share this recommendation with the ASHP Task Force on Organizational Structure, which will be reviewing and making recommendations on ASHP's membership structure and the ASHP policy development process.

Recommendation: Paul Driver (ID)

ASHP should review existing ASHP policies on immunization and vaccination (policies 0213, 0601, 0615) for consolidation into the new policy (Council on Public Policy: G. Standardized Immunization Authority to Improve Public Health).

The Council on Public Policy reviewed the four policies ([0601](#), [0615](#), [1220](#), and [0213](#)) at its September meeting to consider consolidating them. The Council believed and the Board concurred that combining all four would dilute the impact of the policies. Instead, the Council identified two policies (1220 and 0213) that related to promotion and administration of vaccines, and two others (0601 and 0615) that related to the importance of the influenza vaccine. The Council combined ASHP policies 1220 and 0213 (see Policy Recommendation C in the Council's Board report) and suggested that the Council on Therapeutics and the Council on Pharmacy Practice combine policies 0601 and 0615 and consider specific revisions; those councils will consider those suggestions at their meetings in September 2013.

Recommendation: Kerry Haney and Melanie Townsend (MT)

ASHP should support regulations to limit PBM auditing practices in outpatient pharmacies, as have other national pharmacy organizations (APhA, NCPA) and several state associations.

The Council on Public Policy discussed this issue at its September meeting (see the "Other Council Activity" section of the Council's Board report). The Council concluded that more discussion with other pharmacy organizations is needed to determine the proper role and interests of ASHP in advocacy on the issue.

Recommendation: Brian Marden (ME)

ASHP should consider a change in its name, with resulting changes in scope of mission and vision, from the American Society of Health-System Pharmacists to the American Society of Health-System Pharmacy.

This recommendation was shared with the ASHP Task Force on Organizational Structure, which will be reviewing ASHP's membership structure, governance, and policy process.

Recommendation: Brian Marden (ME)

ASHP should consider revisions to [policy 0305](#) with the intent of advocating for mandatory inclusion of therapeutic purpose with all medication orders and prescriptions.

The Council on Pharmacy Practice considered this recommendation at its September meeting (see the “Other Council Activity” section of the Council’s Board report). Although the Council agreed that inclusion of indication would facilitate counseling in outpatient settings and improve patient safety, they concluded that mandating this practice would not be likely to achieve the intent of the policy. The Council also noted that there is no standard for information systems for translation of medical terms to layman’s terms for labeling prescription containers, although the Section of Pharmacy Informatics and Technology is advocating for such standards. The Council therefore recommended that the current policy be reaffirmed, and the Board agreed.

Recommendation: Melinda Throm Burnworth and Carol Rollins (AZ, with CA, NM, MI, NC, NE, and ID)

ASHP should develop policy to actively pursue legislative changes in the Social Security Act to require CMS to recognize pharmacists as nonphysician practitioners (providers of patient care) with authority to bill Medicare directly for compensation of clinical services in any health-system setting. Further, ASHP should pursue changes in other federal, state, and third-party payment programs to achieve similar recognition.

The Council on Public Policy discussed this recommendation at its meeting in September and developed policy (see Policy Recommendation A in the Council’s Board report). Provider status will be ASHP’s top advocacy priority for the foreseeable future.

Recommendation: Christina Rivers (on behalf of IL delegation)

ASHP should continue and accelerate discussions with ACPE to move the Technician Training Accreditation program to ACPE so that all pharmacy-related education accreditation is housed within ACPE.

ASHP recognizes the importance of accreditation of pharmacy technician training programs and the role we play in that process. ASHP will continue to engage in constructive dialogue with the Accreditation Council for Pharmacy Education (ACPE) on pharmacy technician training, among other vital issues. Although it is not possible to predict which organization will ultimately have primary authority over and responsibility for pharmacy technician accreditation, we understand and appreciate the intent of this recommendation and will take it into consideration as we work with ACPE.

Recommendation: Lynn Eschenbacher (NC, SICP)

ASHP should re-examine the 2002 Summit on Measuring Medication Safety with recent technological advances and just culture to develop a consensus statement of two or three national medication safety metrics to demonstrate safety in hospitals.

The development of meaningful metrics for medication safety has been a challenge for the various initiatives on this topic. The Council on Pharmacy Practice reviewed several proposed measures at its September meeting (see the “Other Council Activity” section of the Council’s Board report) but could not develop a proposed consensus statement within the constraints of its meeting.

Recommendation: Jason Strow (WV)

ASHP should consider updating its policies concerning controlled substances to reflect the availability and appropriate use of controlled-substance prescription databases.

In 2011, the House adopted policy 1122, State Prescription Drug Monitoring Programs, which reads:

- To advocate for uniform state prescription drug monitoring programs that collect standard information about controlled substances prescriptions; further,
- To advocate that the design of these programs should balance the need for appropriate therapeutic management with safeguards against fraud, misuse, abuse, and diversion; further,
- To advocate that such programs be structured as part of electronic health records and exchanges to allow prescribers, pharmacists, and other practitioners to proactively monitor data for appropriate assessment; further,
- To advocate for interstate integration to allow for access by prescribers, pharmacists, and other practitioners across state lines; further,
- To advocate for federal and state funding to establish and administer these programs.

This policy will be sunset-reviewed by the Council on Public Policy in 2015, or earlier if circumstances warrant.

Recommendation: Jason Strow (WV)

ASHP should create a Section Advisory Group for Inpatient Rehabilitation Facilities (IRFs) to facilitate best practice development and advocacy for pharmacists practicing in this setting.

Section advisory groups fall under the purview of the executive committees of ASHP sections. These groups are typically created when a critical mass of members demonstrate they are representative of an emerging practice area or a practice-related issue surfaces that has a major impact on a particular group of practitioners. The recommendation was submitted to the Section of Inpatient Care Practitioner's Executive Committee, which considered the suggestion at its December meeting and declined to form such a group at this time.

Recommendation: Melinda Throm Burnworth and Carol Rollins (AZ, with CA, NM, MI, NC, NE, and ID)

ASHP should investigate opportunities to further strengthen available literature that supports the proven value of pharmacists as providers and to educate and assist pharmacists in their efforts to continue to strengthen available literature to receive compensation for patient-care services.

ASHP is actively advocating for changes in the Social Security Act to recognize pharmacists as nonphysician practitioners. That advocacy requires ASHP to educate policymakers about the value that pharmacists provide to improving patient outcomes. In 2013 alone, the ASHP Research and Education Foundation will offer \$350,000 to support research that focuses on advancing patient care and pharmacy practice. In addition, the Foundation provides extensive web-based and live programs to support new investigators striving to undertake practice-based research.

Recommendation: John Hertig and Daniel Degnan (IN)

ASHP should further explore and endorse a credential that deems a pharmacist an expert in the field of medication safety.

The Council on Education and Workforce Development discussed this topic at its meeting in September (see the "Other Council Activity" section of the Council's Board report). The Council concluded that medication safety is too new and evolving to have a specialty credential at this time.

Recommendation: Steve Novak (NC)

ASHP should expand, update, and improve accessibility of its current website resource offerings under the Pharmacy Practice Managers Section, and then formalize and maintain those as an ASHP resource center for revenue cycle compliance and financial management.

Financial management education and resources are important areas of focus for ASHP and the Section of Pharmacy Practice Managers (SPPM). SPPM has two advisory groups specifically on the business management of pharmacy and the associated quality and compliance aspects. ASHP's web resource center on reimbursement and financial management did not receive much traffic and was difficult to maintain. ASHP and SPPM have continued to provide a portfolio of regular education, advocacy, publications, news reports, and web resources related to this critical area for pharmacy leaders, including:

- 1) The [SPPM website](#) has a number of resources and a financial self-assessment tool.
- 2) Each year the [Conference for Leaders in Health-System Pharmacy](#) has components based on financial management.
- 3) The ASHP publication, [Financial Management for Health-System Pharmacists](#).
- 4) One of SPPM's advisory group members created a podcast: [JW Modifiers: A model for automating compliance documentation](#).
- 5) For the past 3 years at the MCM, ASHP has conducted an IPPS/HOPPS update session.
- 6) SPPM will continue to identify products and services to be developed by and for our members and seek to provide more streamlined methods to routinely share those with ASHP members.

Recommendation: Steve Novak (NC)

ASHP should work with the Drug Enforcement Administration (DEA) to seek revisions in the Controlled Substance Act to develop regulations for health-system central-fill pharmacies that enable centralized repackaging, dispensing, or distribution of all controlled substances to hospitals within a system and do not require registration of hospital or health-system pharmacies as manufacturers.

ASHP's existing policy 9813, [Regulation of Automated Drug Distribution Systems](#), provides sufficient direction to ASHP to approach the DEA to seek the agency's assistance in more fully utilizing central fill pharmacies within a health system without registering as a manufacturer. ASHP will continue to advocate this policy to the DEA.

Recommendation: Brian O’Neal (KN)

ASHP should create ASHP guidelines for controlled substance diversion prevention and detection.

The Council on Pharmacy Practice voted to develop guidelines on detecting and preventing controlled substance diversion in hospitals and health systems at its September meeting (see the “Other Council Activity” section of the Board Report).

Recommendation: Julie Lenhart (CA)

ASHP should review policy 0710 for its continued relevance, and, to specifically expand the section on education to include medications (e.g., over-the-counter [OTC] medications and dietary supplements) that may impact doping control results.

The Council on Pharmacy Practice discussed this recommendation at its September meeting and incorporated this recommendation into a revised policy recommendation (see Policy Recommendation A in the Council’s Board report).

Recommendation: Ernest Dole (NM)

ASHP should develop policy that advocates for accountability by third-party payers for delay in therapy.

The Council on Public Policy discussed this recommendation at its September meeting and concluded that policy 1206, [Payment Authorization and Verification Processes](#), adequately addresses the issue. The Council recommended that the impact of policy 1206 be monitored by ASHP staff and that ASHP consider collaboration with other stakeholders (e.g., Academy of Managed Care Pharmacy) to improve processes and decrease or avoid delays in therapy.

Recommendation: Jeanne Ezell (TN)

ASHP should develop a model technician training program curriculum to provide easier access to affordable training throughout the country.

ASHP developed a [Model Curriculum for Pharmacy Technician Training](#) in 1996 and published a second edition published in 2001. ASHP is currently revising both the accreditation standards for pharmacy technician training programs and the model curriculum. The current format for the model curriculum is a list of learning objectives for the training program. We are evaluating other formats for the revision, and these changes might address the suggestions made in the recommendation.

Recommendation: Jeanne Ezell (TN)

ASHP should implement a leadership development program for technicians focused on management skills needed to fulfill the role of pharmacy operations manager.

This recommendation is consistent with a number of activities ASHP and the ASHP Foundation have in motion. The future of health-system pharmacy practice is dependent on the continued development and expansion of roles of well-educated and trained technicians. ASHP has a number of efforts supporting this vision through the [Pharmacy Practice Model Initiative](#) (PPMI) and the [Pharmacy Technician Initiative](#). For example, one of the PPMI National Dashboard objectives measures the percentage of hospitals and health systems utilizing pharmacy technicians in three or more nontraditional or advanced responsibilities or activities.

In addition, both the Section of Inpatient Care Practitioners and the Section of Pharmacy Practice Managers have advisory groups that have technicians’ development and role advancement as part of their activities. A joint project of the two groups is publishing *AJHP Management Consultation* columns on leadership development of technicians, which is running parallel to efforts to share regular case studies on how pharmacies have expanded the roles of technicians. The first of these columns, addressing developing pharmacy technicians across the leadership spectrum, was published in the December 1, 2012 edition of *AJHP* (Thompson J, Swarthout MD. Developing pharmacy technicians across the leadership spectrum. *Am J Health-Syst Pharm.* 2012;69:2040-2. [doi:10.2146/ajhp120124]). In August ASHP presented a [webinar](#) on tech-check-tech case studies and other technician-related topics. The section executive committees and the ASHP Foundation will continue to develop tools and resources to support pharmacy leaders and technicians in their efforts to advance technician practice and leadership skills.

Recommendation: James Rinehart (IN) and Kathy Donley (OH)

ASHP should expand upon the Council on Pharmacy Management’s support of uniform workload and productivity measures and establish a minimum of three such measures by the time of the 2014 ASHP Summer Meeting.

Since a two-part white paper on the topic was published in *AJHP* (2010; 67:300-11 and 380-8), more resources have been made available on the Section of Pharmacy Practice Managers (SPPM) [Practices Resources web page](#). ASHP and SPPM continue to address this issue through resource development and advocacy.

Recommendation: Patricia Kienle (PA) and Natasha Nicole (SC)

ASHP should develop an appropriate component group to represent health-system medication safety leaders of all disciplines.

This recommendation was shared with the ASHP Task Force on Organizational Structure, which is charged with reviewing and making recommendations on ASHP's membership structure, governance, and policy process.

Recommendation: Bonnie Kirschenbaum (CO)

ASHP should continue to fund its REMS Resource Center and keep it updated at least on a monthly basis.

In January 2012, ASHP staff and member volunteers refreshed and updated the [REMS Resource Center](#) to ensure that each drug with a REMS appeared on the website with accurate information about each drug's REMS requirements. ASHP staff continues to maintain the REMS Resource Center by ensuring that drugs that are taken off REMS are removed. ASHP is considering hiring an outside contractor to help keep the Resource Center up to date. In addition, ASHP staff is developing a database to simplify the manner in which the updates are applied to the Resource Center. ASHP staff also regularly communicates with FDA staff on REMS-related requirements.