House of Delegates
Session—2010

June 6 and 8, 2010
Tampa, Florida

Proceedings of the 62nd annual session of the ASHP House of Delegates June 6 and 8, 2010

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Henri R. Manasse, Jr., Secretary

The 62nd annual session of the ASHP House of Delegates was held at the Tampa Convention Center, in Tampa, FL, in conjunction with the 2010 Summer Meeting.

First meeting

The first meeting was convened at 2:00 p.m. Sunday, June 6, by Chair of the House of Delegates Gerald E. Meyer. Diane B. Ginsburg, Vice Chair of the Board of Directors, gave the invocation.

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

Chair 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 190 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 61st 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 61st House of Delegates session were received without objection.

Chair Meyer called on Rosario J. Lazzaro for the report of the Committee on Nominations.[a] Nominees were presented as follows:

President-elect

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

Kathryn R. Schultz, B.S., Pharm.D., FASHP, Director of Pharmacy, HealthEast Bethesda Hospital, St. Paul, MN

Board of Directors (2010–2012)

Eric T. Hola, M.S., M.L.S., Director Pharmacy Services, Saint Barnabas Medical Center, Livingston, NJ

Randy L. Kuiper, B.S., Pharm.D., BCPS, FASHP, Clinical Manager, Pharmacy, Benefis Hospitals, Great Falls, MT

Board of Directors (2011–2014)

Ernest R. Anderson, Jr., M.S., FASHP, System Vice President of Pharmacy, Caritas Christi Health Care System, Brighton, MA

Thomas J. Johnson, Pharm.D., M.B.A., BCPS, FASHP, Clinical Pharmacist, Adult Intensive Care, Avera McKennan Hospital and University Health Center, Professor, South Dakota State University College of Pharmacy, Sioux Falls, SD

Larry C. Clark, B.S., M.S., Pharm.D., BCPS, Director of Hospitalist and Pharmacy Programs, St. Mary's Hospital, Grand Junction, CO

Mary Ann Kliethermes, B.S., Pharm.D., Vice Chair Ambulatory Care, Associate Professor, Chicago College of Pharmacy, Midwestern University, Downers Grove, IL

Chair, House of Delegates

Timothy R. Brown, Pharm.D., R.Ph., Pharmacotherapy Specialist, Family Medicine, Akron General Medical Center, Department of Pharmacy, Akron, OH

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

Treasurer

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

Douglas E. Miller, Pharm.D., Independent Consultant, Hospital & Health-System Pharmacy Services, O'Fallon, MO

Philip J. Schneider, B.S., Pharm.D., Director of Pharmacy Services, Olathe Medical Center, Olathe, KS

A "Meet the Candidates" session to be held on Monday, June 7, was announced.

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

Report of President and Chair of the Board. President Mahaney referred to the 2009 ASHP Annual Report, which had been distributed to delegates along with summaries of actions taken by the Board of Directors over the past year. She updated and elaborated upon various ASHP initiatives. There was no discussion, and the delegates voted to accept the report of the Chair of the Board.

President Mahaney, on behalf of the Board of Directors, then moved adoption of the ASHP Statement on Bar-Code Verification during Inventory, Preparation, and Dispensing of Medications. Delegates voted to approve the statement.

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

Report of Executive Vice President. Henri R. Manasse, Jr., presented the report of the Executive Vice President.

Recommendations. Chair Meyer called on members of the House of Delegates for Recommendations. See the Appendix 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, a change in process from previous years.

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.)

John A. Armitstead, Board Liaison to the **Council on Public Policy,** presented the Council's Policy Recommendations A through H.

**A. Health Insurance Coverage for U.S. Residents*

To advocate health insurance for all ~~legal~~ residents of the United States, including coverage of medications and related pharmacist patient-care services; further,

To advocate that the full range of available methods be used to (1) ensure the provision of appropriate, safe, and cost-effective health care services, (2) optimize treatment outcomes, and (3) minimize overall costs without compromising quality; further,

To advocate that health insurers seek to optimize continuity of care in their design of benefit plans.

(Note: This policy would supersede ASHP policy 0512.)

B. Risk Evaluation and Mitigation Strategies

To advocate for research on the impact of the Food and Drug Administration's Risk Evaluation and Mitigation Strategies (REMS) on patient safety, cost effectiveness, and pharmacy workflow; further,

To advocate pharmacist involvement in the development and implementation of REMS; further,

To urge computer software vendors to assist pharmacists in the identification of and compliance with REMS; further,

To advocate that any REMS that include constraint on traditional drug distribution systems be consistent with ASHP policy on restricted drug distribution.

**C. FDA Authority on Recalls*

To strongly encourage the Food and Drug Administration (FDA) to develop a standard recall notification *process and format* to be used by all manufacturers *to facilitate the timely removal of recalled drugs;* further,

To advocate that such notification should (1) come from a single source, (2) clearly identify the recalled product, (3) explain why the product is being recalled, (4) provide a way to report having the recalled product, ~~and~~ (5) give instructions on what to do with the recalled product; *and (6) be provided concurrently to all entities in the supply chain;* further,

To advocate that the FDA be given the authority to order mandatory recalls of medications; further,

To urge the FDA to require drug manufacturers and the computer software industry to provide bar codes and data fields for lot number, expiration date, and other necessary and appropriate information on all medication packaging, including unit dose, unit-of-use, and injectable drug packaging, in order to facilitate compliance with recalls or withdrawals *to prevent the administration of recalled products to patients;* further,

To urge the FDA to encourage postmarketing reporting of adverse events and product quality issues to enhance the recall system.

D. Postmarketing Comparative Clinical and Pharmacoeconomic Studies

To advocate expansion of comparative clinical and pharmacoeconomic studies on the effectiveness, safety, and cost comparison of marketed medications in order to improve therapeutic outcomes and promote cost-effective medication use; further,

To advocate that such studies compare a particular medication with (as appropriate) other medications, medical devices, or procedures used to treat specific diseases; further,

To advocate adequate funding for the Agency for Healthcare Research and Quality and other federal agencies to carry out such studies; further,

To encourage impartial private-sector entities to also conduct such studies.

(Note: This policy would supersede ASHP policy 0513.)

**E. Medication Therapy Management*

To support medication therapy management (MTM) *services as defined in Section 3503 of the Patient Protection and Affordable care Act (PL 111-148). MTM is* ~~as~~ a partnership ~~of~~ *between* the patient (or a caregiver); *and a* pharmacist, ~~and~~ *in collaboration with* other health care professionals, that promotes the safe and effective use of medications~~, as defined in the 2004 consensus definition of MTM services by national pharmacy organizations, including ASHP; further,~~

~~To advocate that collaborative drug therapy management practices fall under the scope of MTM.~~

F. Definition of Meaningful Use of Health Information Technology

To advocate to policymakers (public and private) that definitions of "meaningful use of health information technology" address interoperability of medication orders and prescriptions, medication decision support and continuous improvement, and quality reporting; further,

To advocate with respect to interoperability of medication orders and prescriptions that (1) a common medication vocabulary be mandated to promote the semantic interoperability of medication use across the continuum of care, because a common vocabulary is essential for comparative effectiveness research and for communicating medication information; and (2) communication of orders and electronic prescriptions must be demonstrated to be functional and semantically interoperable with pharmacy information systems; further,

To advocate with respect to medication decision support and continuous improvement that (1) medication decision support should include but not be limited to allergy, drug interaction (e.g., drug-lab, or drug-disease interactions), duplicate therapy, and dose-range checking; and (2) that such a decision-support service must include an ongoing, continuous improvement process to attune the decision-support service to the needs of the providers who use it; further,

To advocate with respect to quality reporting that the ability to quantify improved patient safety, quality outcomes, and cost reductions in the medication-use process is essential, particularly in antimicrobial and adverse event surveillance.

**G. Regulation of Home Medical Equipment Medication Products and Devices*

~~To advocate that state boards of pharmacy or other regulatory agencies develop regulations concerning the medication-related aspects of suppliers of legend home medical equipment medication products and devices (e.g., oxygen, implantable pumps, respiratory, and wound care) to ensure patient safety and improve the continuity of care~~ *To advocate for consistent regulatory oversight of all home medical equipment, with the goals of continuity of care, patient safety, and appropriate pharmacist involvement whenever equipment is used for medication administration;* further,

To monitor the impact of the Centers for Medicare & Medicaid Services quality standards on the accreditation of suppliers of medication-related durable medical equipment, ~~prosthetics, orthotics,~~ and supplies.

**H. Employment Classification and Duty Hours of Pharmacy Residents*

To advocate that pharmacy residents~~, as part of the organization's graduate medical education program,~~ should be classified as exempt employees; further,

To advocate that pharmacy residents be subject to duty hour limits (similar to resident physicians) with respect to all clinical and academic activities during their training program in accordance with the Accreditation Council on Graduate Medical Education (ACGME) standards and ASHP accreditation standards for pharmacy residency programs.

Janet A. Silvester, Board Liaison to the **Council on Therapeutics,** presented the Council's Policy Recommendations A through E.

**A. Preservation of Antimicrobials for Medical Treatment*

To advocate that the Food and Drug Administration (FDA) eliminate future approval of antimicrobials for nontherapeutic uses in agricultural animals that represent a safety risk by contributing to antibiotic resistance; further,

To encourage efforts to phase out and eliminate the nontherapeutic uses of antimicrobials previously approved by the FDA; further,

To support the therapeutic use of antimicrobials in animals only ~~by prescription and~~ under the supervision of a veterinarian; further,

To encourage the FDA, Centers for Disease Control and Prevention, and other stakeholders to monitor and limit, when effective alternatives are available, the therapeutic use of antimicrobials that are essential to the treatment of critically ill human patients; further,

To advocate for the inclusion of pharmacists in antimicrobial surveillance and related public health efforts based on pharmacists' knowledge of antimicrobial drug products and antimicrobial resistance.

B. Safety and Effectiveness of Ethanol for Treatment of Alcohol Withdrawal Syndrome

To oppose the use of oral or intravenous ethanol for the prevention or treatment of alcohol withdrawal syndrome (AWS) because of its poor effectiveness and safety profile; further,

To support hospital and health-system efforts that restrict or prohibit the use of oral or intravenous ethanol therapies to treat AWS; further,

To educate clinicians about the availability of alternative therapies for AWS.

**C. Use of Surrogate Endpoints for FDA Approval of Drug Uses*

To support the continued use of *qualified* surrogate endpoints by the Food and Drug Administration (FDA) as a mechanism to evaluate the effectiveness and safety of new drugs and new indications for existing therapies, *when measurement of definitive clinical outcomes is not feasible;* further,

To support efforts by the FDA and other stakeholders to *qualify* surrogate endpoints; further,

To advocate that the FDA consistently enforce existing requirements that drug product manufacturers complete postmarketing studies for drugs approved based on *qualified* surrogate endpoints in order to confirm that the expected improvement in outcomes occurs, and to require that these studies be completed in a timely manner.

**D. Quality Consumer Medication Information*

To support efforts by the Food and Drug Administration (FDA) and other stakeholders to improve the quality, consistency, and simplicity of written consumer medication information (CMI); further,

To encourage the FDA to work in collaboration with *patient advocates and other* stakeholders to create evidence-based models and standards, *including establishment of a universal literacy level,* for CMI; further,

To advocate that research be conducted to validate these models in actual-use studies in pertinent patient populations; further,

To advocate that state boards of pharmacy require that pharmacies comply with FDA-established standards for content, format, and distribution of CMI.

E. Research on Drug Use in Obese Patients

To encourage drug product manufacturers to conduct pharmacokinetic and pharmacodynamic research in obese patients to facilitate safe and effective dosing of medications in this patient population, especially for medications most likely to be affected by obesity; further,

To encourage manufacturers to include in the Food and Drug Administration (FDA)-approved labeling detailed information on characteristics of individuals enrolled in drug dosing studies; further,

To advocate that the FDA develop guidance for the design and reporting of studies that support dosing recommendations in obese patients; further,

To advocate for increased enrollment of obese patients in preapproval clinical trials of new medications; further,

To encourage independent research on the clinical significance of obesity on drug use, as well as the reporting and dissemination of this information via published literature, patient registries, and other mechanisms.

Janet L. Mighty, Board Liaison to the **Council on Education and Workforce Development,** presented the Council's Policy Recommendations A through C.

A. Interprofessional Education and Training

To support interprofessional education as a component of didactic and experiential education in Doctor of Pharmacy degree programs; further,

To support interprofessional education as a part of professional development for pharmacy practitioners and to collaborate with other disciplines to facilitate and promote programs that support this goal; further,

To encourage and support pharmacists' collaboration with other health professionals and health care executives in the development of team-based, patient-centered care models; further,

To foster documentation and dissemination of outcomes achieved as a result of interprofessional education of health care professionals.

(Note: This policy would supersede ASHP policy 0608.)

**B. Minimum Hiring Standards for Pharmacy Technicians*

To encourage employers to ~~require individuals who are hired as~~ *hire* pharmacy technicians ~~to~~ *who* have successfully completed an ASHP-accredited pharmacy technician training program and ~~be~~ *are* certified by the Pharmacy Technician Certification Board (PTCB); further,

To support employment practices that would permit hiring of pharmacy technician trainees only if those individuals (1) are required to successfully complete an ASHP-accredited pharmacy technician training program followed by PTCB certification within 12 months of employment, and (2) are limited to positions with lesser responsibilities until they successfully complete such training and certification; further,

To encourage employers to require ongoing PTCB certification as a condition of continued employment; *further,*

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

(Note: This policy would supersede ASHP policy 0702.)

C. Professional Development

To discontinue ASHP policy 0511, which reads:

To recognize that providing professional development opportunities for health-system pharmacy practitioners is an essential component of staff recruitment and retention as well as quality of work life; further,

To strongly encourage health-system pharmacy directors and administrators to support professional development programs as an employee benefit that ultimately improves patient care and aids in recruiting and retaining qualified practitioners; further,

To recognize that professional development encompasses more than staff development programming and includes informal learning among colleagues, mentoring, and other types of learning; further,

To develop educational programs, services, and resources to assist health-system pharmacies in supporting professional development.

Lisa M. Gersema, Board Liaison to the **Council on Pharmacy Management,** presented the Council's Policy Recommendations A through C.

A. Pharmaceutical Distribution Systems

To support wholesaler/distribution business models that meet the requirements of hospitals and health systems with respect to timely delivery of products, minimizing short-term outages and long-term product shortages, managing and responding to product recalls, fostering product-handling and transaction efficiency, preserving the integrity of products as they move through the supply chain, and maintaining affordable service costs.

(Note: This policy would supersede ASHP policy 0605.)

**B. Impact of Insurance Coverage Design on Patient Care Decisions*

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

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

To advocate for the exclusion of ~~hospital~~ *health-system* outpatient settings from restrictive reimbursement requirements.

C. Prudent Purchasing of Pharmaceuticals

To discontinue ASHP policy 0524, which reads:

To support existing laws and legitimate practices that ensure product integrity and allow organized health care settings to purchase drug products and related supplies at prices that minimize health care costs; further,

To support the principle of purchase of pharmaceutical products and related supplies by public and private entities using appropriate professional practices to achieve that end; further,

To encourage government acknowledgement of existing local professional activities (e.g., drug-use review, formulary systems, pharmacy and therapeutics committees, and patient counseling) already practiced in organized health care settings that are methods of promoting quality and cost-effective pharmacist patient-care services.

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

**A. Standardization of Device Connections to Avoid Wrong-Route Errors*

To advocate for development and use of medication administration device connectors and fittings that are designed to prevent misconnections and wrong-route errors; further,

To support the use of oral syringes that are readily distinguishable from hypodermic syringes and connect only to oral or enteral adapters and fittings; further,

~~To strongly discourage the use of hypodermic syringes for other than parenteral routes of administration; further,~~

To identify and promote the implementation of best practices for preventing wrong-route errors.

B. Medication Safety Officer Role

To advocate that accountability for development and maintenance of a medication safety program in hospitals and health systems be assigned to a qualified individual (i.e., a medication safety officer or leader of a medication safety team); further,

To advocate that individuals in these roles have the authority and autonomy to establish priorities for medication-use safety and make the necessary changes as authorized by the medical staff committee responsible for medication-use policy; further,

To affirm that pharmacists are uniquely prepared by education, experience, and knowledge to assume the role of medication safety officer or other leadership role in all activities that ensure the safety, effectiveness, and efficiency of the medication-use process; further,

To support all pharmacists in their leadership roles in organizational medication-use safety, reflecting their authority over and accountability for the performance of the medication-use process.

**C. Role of Pharmacists in Safe Technology Implementation*

To affirm the essential role of the pharmacist in the evaluation ~~and~~ implementation, *and ongoing assessment* of all technology intended to ensure safety, effectiveness, and efficiency of the medication-use process.

**D. Just Culture and Reporting Medication Errors*

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

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

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

(Note: A just culture is one that has a clear and transparent process for evaluating errors and separating events arising from flawed system design or inadvertent human error from those caused by ~~willful disregard for safety~~ *reckless behavior, as defined as a behavioral choice to consciously disregard a substantial or unjustifiable risk.*)

(Note: This policy would supersede ASHP policy 0910.)

E. Patient Access to Pharmacy Services in Small and Rural Hospitals

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

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

(Note: This policy would supersede ASHP policy 0503.)

F. Scope and Hours of Pharmacy Services

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

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

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

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

(Note: This policy would supersede ASHP policy 0403.)

**G. Use of Two Patient Identifiers in the Outpatient Setting*

To encourage the use of two identifiers to confirm patient identity when transferring filled prescriptions to the patient's *or patient agent's* possession in outpatient settings.

Candidates for the positions of Chair of the House of Delegates and for Treasurer made brief statements to the House of Delegates. The meeting adjourned at 6:11 p.m.

Second meeting

The second and final meeting of the House of Delegates session convened on Tuesday, June 8, 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 Jeffrey R. Little (KS), Robert N. Mains (OH), Miriam A. Mobley-Smith (IL), Robert M. Parsons (OH), Nicole M. Allcock (MO), and Brian A. Cohen (TX).

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.

Board of Directors duly considered matters. Pursuant to Bylaws section 7.3.1.1, the Board met on the morning of June 8, 2010, to "duly consider" the amended policies. The Board reported on 13 professional policies that were amended at the first House meeting and one that was amended and then referred to the Board for clarification. The Board presented its recommendations as follows:

1. Council on Public Policy, Policy A, "Health Insurance Coverage for U.S. Residents": The Board of Directors has agreed that the amended language is acceptable.

2. Council on Public Policy, Policy C, "FDA Authority on Recalls": The Board of Directors agreed that the amended language is acceptable with editorial changes. As edited, the policy reads as follows:

C. FDA Authority on Recalls

To strongly encourage the Food and Drug Administration (FDA) to develop a standard recall notification process and format to be used by all manufacturers to facilitate the timely removal of recalled drugs; further,

To advocate that such notification should (1) come from a single source, (2) clearly identify the recalled product, (3) explain why the product is being recalled, (4) provide a way to report having the recalled product, and (5) give instructions on what to do with the recalled product, and (6) be provided concurrently to all entities in the supply chain; further,

To advocate that the FDA be given the authority to order mandatory recalls of medications; further,

To urge the FDA to require drug manufacturers and the computer software industry to provide bar codes and data fields for lot number, expiration date, and other necessary and appropri-

ate information on all medication packaging, including unit dose, unit-of-use, and injectable drug packaging, in order to facilitate compliance with recalls or withdrawals and to prevent the administration of recalled products to patients; further,

To urge the FDA to encourage postmarketing reporting of adverse events and product quality issues to enhance the recall system.

3. Council on Public Policy, Policy E, "Medication Therapy Management": The Board agreed that the amended language is acceptable with editorial changes. As edited, the policy reads as follows:

E. Medication Therapy Management

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

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

4. Council on Public Policy, Policy G, "Regulation of Home Medical Equipment Medication Products and Devices": The Board of Directors has agreed that the amended language is acceptable.

5. Council on Public Policy, Policy H, "Employment Classification and Duty Hours of Pharmacy Residents": The Board of Directors has agreed that the amended language is acceptable.

6. Council on Therapeutics, Policy A, "Preservation of Antimicrobials for Medical Treatment": The Board of Directors has agreed that the amended language is acceptable.

7. Council on Therapeutics, Policy C, "Use of Surrogate Endpoints for FDA Approval of Drug Uses": The Board of Directors has agreed that the amended language is acceptable.

8. Council on Therapeutics, Policy D, "Quality Consumer Medication Information": The Board of Directors has agreed that the amended language is acceptable.

9. Council on Education and Workforce Development, Policy B, "Minimum Hiring Standards for Pharmacy Technicians": The Board clarified the language of the second clause and encouraged delegates to reconsider the policy and adopt revised language. A motion was made to reconsider and the revised policy proposed by the Board was adopted. The policy reads as follows:

B. Minimum Hiring Standards for Pharmacy Technicians

To encourage employers to hire pharmacy technicians who have successfully completed an ASHP-accredited pharmacy technician training program and are certified by the Pharmacy Technician Certification Board (PTCB); further,

To support employment practices that would permit hiring of pharmacy technician trainees only if those individuals (1) are required to both successfully complete an ASHP-accredited pharmacy technician training program and successfully complete PTCB certification within 24 months of employment, and (2) are limited to positions with lesser responsibilities until they successfully complete such training and certification; further,

To encourage employers to require ongoing PTCB certification as a condition of continued employment; further,

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

10. Council on Pharmacy Management, Policy B, "Impact of Insurance Coverage Design on Patient Care Decisions": The Board agreed that the amended language is acceptable with editorial changes. As edited, the policy reads as follows:

B. Impact of Insurance Coverage Design on Patient Care Decisions

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

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

To advocate for the exclusion of hospital and health-system outpatient settings from restrictive reimbursement requirements.

11. Council on Pharmacy Practice, Policy A, "Standardization of Device Connections to Avoid Wrong-Route Errors": The Board encouraged delegates to reconsider the policy and adopt revised language. A motion was made to reconsider and the revised policy proposed by the Board was adopted. The policy reads as follows:

A. Standardization of Device Connections to Avoid Wrong-Route Errors

To advocate for development and use of medication administration device connectors and fittings that are designed to prevent misconnections and wrong-route errors; further,

To support the use of oral syringes that are readily distinguishable from injectable syringes and connect only to oral or enteral adapters and fittings; further,

To oppose the use of injectable syringes for other than injectable routes of administration; further,

To identify and promote the implementation of best practices for preventing wrong-route errors.

12. Council on Pharmacy Practice, Policy C, "Role of Pharmacists in Safe Technology Implementation": The Board of Directors has agreed that the amended language is acceptable.

13. Council on Pharmacy Practice, Policy D, "Just Culture and Reporting Medication Errors": The Board agreed that the amended language is acceptable with editorial changes. As edited, the policy reads as follows:

D. Just Culture and Reporting Medication Errors

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

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

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

(Note: A just culture is one that has a clear and transparent process for evaluating errors and separating events arising from flawed system design or inadvertent human error from those caused by reckless behavior, defined as a behavioral choice to consciously disregard what is known to be a substantial or unjustifiable risk.)

14. Council on Pharmacy Practice, Policy G, "Use of Two Patient Identifiers in the Outpatient Setting": The Board agreed that the amended language is acceptable with editorial changes. As edited, the policy reads as follows:

G. Use of Two Patient Identifiers in the Outpatient Setting

To encourage the use of two identifiers to confirm patient identity when transferring filled prescriptions to the possession of the patient or patient's agent in outpatient settings.

New Business. Chair Meyer announced that, in accordance with Article 7 of the Bylaws, there were two items of New Business to be considered.

Chair Meyer called on Rosario J. Lazzaro (NJ) to introduce the first item of New Business, titled "Medical Use of Marijuana." Following discussion, the item was approved for referral. It reads as follows:

Medical Use of Marijuana

Motion: To have ASHP Board of Directors develop guidelines and recommendations, through the Council on Public Policy, concerning the safe use/or restrictions for the use of medical marijuana, as it relates to non-FDA forms.

Background: Currently a number of states have already approved the use, approximately 15 or more, and the State of New Jersey has approved it, although all details concerning distribution and use have not yet been delineated. However, Pharmacists are not currently involved nor are pharmacies involved as "dispensaries." Additional direction is needed concerning standards of efficacy and use of a smoking product within health-care institutions where no smoking is permitted anywhere on the campus. An FDA approved form of the active ingredient already exists. Hence, why the need for non-FDA approved forms of marijuana? Also, the concern and potential liability for institutions and pharmacists having to verify a patient's "own medication" is another issue.

Suggested Outcome: Create a policy members can refer to when confronted with the issue having to deal with patient and/or prescribers asking of writing for the non-FDA approved forms of medical marijuana.

Chair Meyer called on Dennis M. Williams (NC) to introduce the second item of New Business, titled "Statement on the Role of the Pharmacist in Providing Medication Therapy Management (MTM) Services." Following discussion, the item was approved for referral. It reads as follows:

Statement on the Role of the Pharmacist in Providing Medication Therapy Management (MTM) Services

Motion: ASHP should assume leadership in working with other pharmacy organizations to develop a statement about the role of the pharmacist in providing medication therapy management (MTM) Services. The Statement should incorporate components from Section 3503 of the Patient Protection and Affordable Care Act and applicable ASHP policies and documents (including those addressing MTM, CDTM, Credentialing and Privileging).

Background: A comprehensive document will allow opportunities to address the numerous issues related to this topic. Medication Therapy Management (MTM) services are provided by a pharmacist through a collaborative, multidisciplinary, interprofessional approach to the treatment of chronic diseases to improve the quality of care and reduce overall costs of treatment. MTM services include the following as allowed by State law (including collaborative pharmacy practice agreements):

(1) performing or obtaining necessary assessments of the health and functional status of each patient receiving MTM services;
(2) formulating a medication treatment plan according to therapeutic goals agreed upon by the prescriber and the patient, caregiver, or authorized representative;
(3) selecting, initiating, modifying and recommending changes to, or administering medication therapy;
(4) monitoring, which may include access to, ordering or performing laboratory assessments, and evaluating the response of the patient to therapy, including safety and effectiveness;
(5) performing an initial comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse events, quarterly targeted medication reviews for ongoing monitoring, and additional follow-up interventions on a schedule developed collaboratively with the prescriber;
(6) documenting the care delivered and communicating essential information about such care, including a summary of the medication review, and the recommendations of the pharmacist to other appropriate health care providers of the patient in a timely fashion;
(7) providing education and training designed to enhance the understanding and appropriate use of the medications by the patient, caregiver, and other authorized representative;
(8) providing information, support services, resources, and strategies designed to enhance patient adherence with therapeutic regimens;
(9) coordinating and integrating MTM services within the broader health care management services provided to the patient; and
(10) such other patient care services allowed under pharmacist scopes of practice in use in other Federal programs that have implemented MTM services.

Suggested Outcome: A joint document from numerous pharmacy organizations or an ASHP Statement.

Recommendations. Chair Meyer called on members of the House of Delegates for Recommendations. See the Appendix 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 Mahaney with an inscribed gavel commemorating her term of office. Dr. Mahaney recognized the service of Chair Meyer as Chair of the House of Delegates and a member of the Board of Directors.

Chair Meyer recognized Kevin J. Colgan'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: Mary M. Hess, Chair of the Section of Clinical Specialists and Scientists; Roger S. Klotz, Chair of the Section of Home, Ambulatory and Chronic Care Practitioners; Brian D. Benson, Chair of the Section of Inpatient Care Practitioners; Christopher J. Urbanski, Chair of the Section of Pharmacy Informatics and Technology; Emily C. Dotter, Chair of the Pharmacy Student Forum; and John B. Hertig, Chair of the New Practitioners Forum.

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

Chair Meyer then called on Vice Chair Colgan to preside over the House for the remainder of the meeting.

Vice Chair Colgan announced that Gerald Meyer had been elected as Chair of the House.

Installation. Vice Chair Colgan installed Diane B. Ginsburg as President of ASHP, Christene M. Jolowsky and Michael D. Sanborn as members of the Board of Directors, and Gerald E. Meyer as Chair of the House of Delegates.

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

Adjournment. The 62nd annual session of the House of Delegates adjourned at 5:49 p.m.

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[a]The Committee on Nominations consisted of Rosario J. Lazzaro (NJ), Chair; Janet A. Silvester (VA), Vice Chair; Michael B. Cockerham (LA), Kristina R. De Los Santos (AZ), Amber J. Lucas (KS), Jennifer E. Tryon (WA), and Paul C. Walker (MI).

APPENDIX

2010 House of Delegate Recommendations

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

Recommendations by Delegates on Sunday, June 6:

1. ***Emily Dotter (MD):*** *Growth of PGY1 Residency Positions to Meet Demand*

Recommendation: We would like to commend ASHP for driving interest among pharmacy graduates across the country to pursue residency training. The 2010 match statistics revealed that pharamcy graduates are facing a climate of increasing competitiveness for residency training programs with over 1,000 applicants unmatched. We recommend that ASHP seek input on, develop and promote a plan by which the requirement for a residency (policy 0701) may be a ttained. The plan should be reviewed and revised annually through input gathered at the national residency preceptors conference and instructional and workshop programming on the value of residents and funding for residency training.

Background: The Pharmacy Student Forum Executive Committee commends ASHP for driving interest among pharmacy graduates across the country to pursue residency training. The PSFEC supports policy position 0701 regarding the requirement for residency training for all pharmacy graduates and strongly believes that this is integral to move our profession forward. Realizing that an active approach is necessary to attain this important goal, in order to ensure an adequate supply of PGY1 residencies, we recommend that ASHP develop a plan for attainment of this goal. We encourage ASHP to dedicate resources to enable existing programs to expand and new programs to be developed.

2. ***Lourdes Cuellar (TX):*** *Medical (Health) Home Model*

Recommendation: ASHP advocate that a pharmacist MUST be part of the medical (health) home model in order to receive AHRQ accreditation/designation

Background: (No background was provided.)

3. ***Lourdes Cuellar (TX):*** *Annual Pharmacy Services Survey*

Recommendation: That the annual pharmacy survey include all practices sites within health-systems and not be limited to acute care and pediatric facilities only.

Background: The annual survey is a member benefit and therefore should be able to be utilized by members at all practice sites; to date this has not been feasible. If it is a member benefit it should reflect critical information from as many of the diverse practices that exist within a health-system environment or else it is not representative or helpful to all ASHP members.

4. ***Jennifer Edwards (MT), Tricia Killingsworth (ID), Paul Driver (ID), Melanie Townsend (MT):*** *Expansion of pharmacy residency programs in small and/or rural health systems*

Recommendation: Recommend that ASHP Residency Accreditation Services offer provisions for small and/or rural health-systems in order to establish PGY1 residency programs to meet ASHP accreditation standards.

Background: In order to help meet the 2020 standards for pharmacists to have completed residency programs, we are requesting for guidelines and best practices and/or provisions in residency accreditation standards to allow and help small and/or rural settings to establish residency programs. Current standards are difficult to meet in thse settings. Residency programs will also help small and rural settings with staffing challenges and training for these unique practice settings.

5. ***Vickie Powell (NY):*** *One Accrediting body for the certification of Technician training programs and certification*

Recommendation:
Background: Pharmacists have a standardized exam which is accredited by one institution (EXNABP) and one group that accredits colleges of pharmacy (NABP). The same standard established for Pharmacists must be established for technicians.

6. ***Eric Tomasz Hola (NJ):*** *Caucus of the Chair of the House*

Recommendation: ASHP should book a room large enough to allow a seat for all attendes at the Caucus of the Chair of the House.

Background: After experiencing standing room only for the past 12 years at the general caucus, sufficient

seating for the delegates and other attendees would be appreciated.

7. ***Deb Saine (VA), John Santell (MD):*** *Alcoholic Beverages*

Recommendation: *Recommend ASHP consider a policy statement that health-system pharmacies should not stock or dispense alcoholic beverages.*

Background: Council on Therapeutics policy proposal B addresses ethanol for alcohol withdrawal syndrome. The Council also discussed pharmacy's role in dispensing alcoholic beverages to create a "home environment," though they did not reach consensus. Alcoholic beverages should not be dispensed as medications by pharmacists to patients in absence of evidence based guidance.

8. ***Fred Eckel (NC):*** *ASHP support of Pharmacy Compounding Accreditation Board (PCAB)*

Recommendation: ASHP should formally adopt a policy recommending that health-systems only utilize PCAB-Accredited compounding pharmacies when outsourcing compounding services.

Background: PCAB has received recognition from various organizations internal and external to pharmacy, and ASHP needs to formally adopt policy and guidance to ASHP members recognizing the value of PCAB Accreditation in promoting quality pharmacy compounding. ASHP has direct experience in the broad area of accreditation. ASHP could greatly contribute to the advancement of PCAB through involvement in the PCAB Board of Directors. ASHP should make a direct inquiry to PCAB President Tom Menighan and/or PCAB Executive Direct Tom Murry to discuss this opportunity.

Recommendations by Delegates on Sunday, June 8:

9. ***Stephen Eckel (NC):*** *Student Pharmacy Business Plan Competition*

Recommendation: Evaluate whether a health-system pharmacy stdent business plan competition should be initiated to compliment existing clinical skills competition.

Background: One of the leadership planks of ASHP is to develop and train the next generation of leaders. Part of this is to teach them how to write a business plan and to understand entrepreneurship. Having a business plan competition would introduce them to these skills and hopefully drive more people to leadership training programs.

10. ***Sal Morana (VT), Michael Carroll (VT):*** *A request for development of 24/7 Pharmacist review of all medication orders*

Recommendation: We would like ASHP to develop and distribute Self-Assessment tools and stepwise recommendations for interim measures and progression to 24/7 Pharmacist review of all medication orders, even when the on-site Pharmacy department is closed.

Background: Small or rural hospitals are striving to provide the same level of pharmaceutical care and medication safety within the context of limited resources. The stepwise progression to 24/7 medication order review involved optimal use of technology, electronic medical record, collaboration with nursing and medical staff, and provisions for additional staffing and technological resources when needed. The goal is to create a tool for site self-assessment for progress in collaboration with state boards of pharmacy.

11. ***Steven Gray (CA):*** *Prescriber Discretion Regarding Use of Recalled Products*

Recommendation: ASHP should assign an special group to develop a position statement that recognizes the right and duty of prescribing clinicians, pharmacists and patients to ultimately determine whether to use any recalled for "market-withdrawn" product that is still available in the clinical setting, hospital or otherwise.

Background: "Drug Recall" and "Market Withdrawals" are voluntary manufacturers actions and do not have to be approved by the FDA. Often Recalled and Withrawn products do NOT pose a significant threat of harm to patients. However, such products could be the only feasible option and not using them coul dhbe even "life saving" therapy for individual patients. The use of any "Rx only" is by definition based on an evaluation of the risk vs. benefits by the prescriber and should not be left to arbitrary local rules.

12. ***Tricia Killingsworth (ID)*****:** *Medication Safety Officer (MSO) Standards*

Recommendation: ASHP should lead the collaboration with other organizations to develop recommended practice, education & training

standards for MOS's, further to recognize while pharmacists are poised for this leadership position basic pharmacy education does not include specialty education & training for this unique practice.

Background: Pharmacysts have recently been identified as leaders in medication safety by the NQF and ASHP in the "Medication Safety Officer Role" policy. It is important that we recognize other clinicians, (i.e. nursing, physicians) are being trained in these roles, that med. Safety is a team approach & that other organizations (i.e. ISMP, ASMSO) have developed medication safety education, fellowships & recognition programs. ASHP needs to work in collaboration with these organization to develop MSO standards.

13. ***Ted Friedman (NY):*** *Labeling of latex free medications*

Recommendation: I would like ASHP to advocate for manufacturers who prepare latex free medications & distributers who sell these medications to prominently label this feature.

Background: Manufacturers who prepare latex free medication many times only document on the package insert. It is rarely in the description a wholesaler will place in their catalog. This does not allow a purchasing agent to know in advance of the purchase that the product may contain latex.

14. ***Bonnie Kirschenbaum (CO):*** *REMS and ASHP Editorial Content*

Recommendation: That ASHP include REMS requirements as part of the content for drugs

Background: Knowing which products have REMS requirements and what they are are an important part of using the drug product. This information should be readily available in databases. To stay competitive with other databases (eg. Micromedex, etc.). ASHP needs to take this step. This action is supported by Colorado, Florida, MA and all attendees of Monday's REMS session.

15. ***Steve Novak (NC):*** *Review of USP Chapter 51 for Extension of Antimicrobial Effectiveness Testing Criteria Beyond 28 Days*

Recommendation: To advocate for review of USP Chapter 51 for possible extension of criteria for antimicrobial effectiveness testing beyond 28 days for the purpose of standardizing or closing the gap between beyond use and expiration dating of multiple-dose injection containers.

Background: USP 797, TJC and CMS base beyond use dating for multiple-dose vials on USP Chapter 51 (Antimicrobial Effectiveness Testing) which only requires antimicrobial testing by manufacturer to 28 days. CDC currently makes recommendation that the beyond use date is the expiration date labeled by the manufacturer and all agree on expiration dating for vaccines. APIC recommendations acknowledge both. Extension of testing criteria dating would help standardize recommendations based on USP Chapter 51.

16. ***Steven Sheaffer (Past President):*** *RDCs: Impact of current scheduling practices on RDC attendance & costs to state affiliates & delegates*

Recommendation: ASHP should assess how to optimize attendance at RDCs while minimizing costs of RDCs to ASHP as well as state affiliates and individual delegates

Background: This year RDCs were limited to only 3 cities. Some dates/sites were filled well before the dates of the RDCs. This resulted in delegates not attending or attending at distant sites with additional costs incurred by the delegate or state affiliate. Having only 3 locations (same location for weekend and Mon/Tues) have saved expenses for ASHP but may have also required delegates to travel longer distances or use travel option that were more expense. Use of technology to limit travel should also be explored.

17. ***Steven Sheaffer (Past President):*** *Meeting Registration for New ASHP Fellows*

Recommendation: ASHP should re-assess its policy to require full summer meeting registration for those being honored as new ASHP Fellows.

Background: Recognition as an ASHP Fellow reflects sustained commitment & contributions to health system pharmacy practice. In doing so, ASHP fellows contribute to the goals of ASHP and often the success of ASHP. Many often have family or friends that also attend the Summer meeting creating additional costs. Offering a free or a reduced rate for meeting registration would be a positive statement of the value of our Fellows. ASHP should also evaluate how other pharmacy organizations manage their Fellow recognition process.

18. ***William Churchill (MA):*** *Standardization of I.V. drug packages to optimize robotic compounding*

Recommendation: To advocate ASHP to work with pharmaceutical industry and robotic vendors to standardize drug packaging, concentration and labeling to support optimal productivity, cost efficiency and quality outcomes expected from the use of i.v. robotic technology.

Background: Utilization of i.v. robots for compounding sterile products can significantly improve patient safety, efficiency and cost effectiveness. However, there is a strong need for standardization of drug packaging, labeling and concentrations to optimize efficiency, cost effectiveness and productivity. Availability of larger vial size or more concentrated solutions with uniform dimension of vials and caps would significantly optimize efficiency of i.v. robots.

19. ***Roy Guharoy (MA), William Churchill (MA):*** *Work with the FDA to evaluate the impact of DTC on medication utilization, cost and patient outcomes*

Recommendation: Direct to consumer advertising is resulting in usage of high cost drugs that often have lower cost alternatives. On the other hand, there may be some benefits where untreated or undiagnosed conditions are treated earlier. However, there are more downsides than benefits

Background: Primary care physicians are often confronted by patients with demands for prescribing a high cost drug as a result from exposure to DTC advertising. Many physicians are reluctant or do not have time to convince the patient that an effective less costly drug would work as well. Because of DTC advertising, we believe that health care costs are unnecessarily elevated. These costs could be avoided by including expertise of professional health system pharmacists and ASHP

20. ***Paul Driver (ID):*** *Location of Summer Meeting*

Recommendation: ASHP to hold Summer Meeting only in control or maintain time zones in order to allow more complete attendance by Delegates

Background: Travel distance is a huge concern. This year we have no Delegates from Hawaii & the Alaska Delegate is present primarily due to Tampa being their home town. Hawaii has a 6 hour time change & Alaska has 5-6 hour time change to get to East Coast.

21. ***Paul Driver (ID):*** *Technician as career choice*

Recommendation: ASHP to take a proactive role in promoting that being a technician is a career choice.

Background: In order to support the new model of practice, ASHP should look at the medical model of radiology & pathology. Each of these created technical career choices (Rad Tech, Med Tech) to perform their routine tasks. This helps in that many (not all) persons enter as a tech use stepping stone to pharmacy. Therefore, we are always retaining techs.

22. ***Mitch Sobel (NJ):*** *Establish a Council on Medication Safety*

Recommendation: To have ASHP Board of Directors establish a Council on Medication Safety to address the numerous issues, policies, and practices involved with medication safety.

Background: Current ASHP Councils and Policy Positions contain numerous statements and policies regarding patient safety. Medication Safety has become a prime public and professional focus for clinical and operational pharmacy practice. The numerous regulatory and complex safety issues warrant the creation of its own council and would provide the attention, resources, and leadership necessary. The formation of this new council is aligned with ASHP's vision of cognitive pharmacy professional practice.

23. ***Amanda Hays (AK), Debbie Cowan (NC):*** *Membership Drive Focused on Small & Rural Hospital Pharmacists*

Recommendation: ASHP to develop a membership drives targeted to small/rural pharmacies which highlight current issues as well as provide expanded small/rural resources

Background: Small/rural hospitals are underrepresented as ASHP members. ASHP can benefit from additional revenue stream of untapped membership resources. Recommend ASHP package a MCM Sunday only (small/rural) session, S/R hospital networking session. Current resources center has some old articles; other resources would be helpful.

24. ***Thomas Johnson (SD):*** *Remote Pharmacy Services*

Recommendation: ASHP should continue to develop guidance, standards, tools, and other resources in regards to "ePharmacy" or remote pharmacy services.

Background: Remote pharmacy services are increasing and application of those services is expanding. While ASHP has policies in place to address these types of services, further review of existing policies and creation of guidance documents or standards may be very helpful in maintaining high quality of such services.

25. ***Thomas Johnson (SD), Debra Cowan (NC):*** *In Support of Policy Items E & F from Council on Pharmacy Practice*

Recommendation: Recommend that ASHP continue to develop tools and resources to help small and rural practice areas meet national medication management and patient safety standards.

Background: Policy items E&F from the Council on Pharmacy Practice this year require all hospitals to provide adequate services. ASHP's current resources are very helpful, but this could/should be further expanded as able to ensure all institutions are able to meet national standards.

26. ***Kelly M. Smith (KY), David D. Allen (OH):*** *Requiring Pharmacy Resident Participation in PharmD Education*

Recommendation: We recommend that ASHP residency accreditation guidelines require that pharmacy residents be involved in teaching PharmD students.

Background: ASHP should work with ACPE, NABP, AACP, and other professional organizations to convene a taskforce to bring forth recommendations allowing increased experimentation in experiential and residency training models enabling this to be brought to fruition. David D. Allen, PhD and Kelly M. Smith, PharmD, A Hand and Glove Approach to Pharmacy Experiential Education. American Journal of Pharmaceutical Education 2010; 74(4) Article 65.

27. ***John Santell (MD), Deb Saine (VA):*** *ASHP Guidelines Document on Bar Coding*

Recommendation: Recommend that ASHP consider developing a companion Guidelines document on Bar-code verification that compliments the new ASHP Statement on Bar-code verification.

Background: The new Statement does not go into sufficient detail to address key implementations issues such as: 1) Use of bar coding in procurement 2) Recognizing the role of human-error in use of this technology 3) Provide quantitative goals for the percentage of doses that should be bar coded; 4) Guidance on what to include in policies & procedures to optimize implementation; 5) Suggestions for applying bar coding to problematic products; 6) Suggestions for overcoming the limitation outlined in the Limitations Section of the new St.

28. ***Julie Nelson (TX), Laura Bateh, Andrea Passarelli (Student Section):*** *Development of Educational Programs on Devices*

Recommendation: That ASHP will develop educational programs for pharmacists and pharmacy students on devises used to administer medications.

Background: At the regional delegates conference we discussed this issue in conjunction with the policy recommendation on devices used to administer medications. It was felt that there was a great need to develop educational programs for use of these devices since most pharmacists do not know how to use them. Currently, the pharmacists who use them have had to learn on their own in one-the-job training and it would be helpful to have a more organized process.

29. ***Lourdes Cuellar (TX):*** *Single National National Meeting*

Recommendation: ASHP evaluate and report to the HOD the current financial impact of holding two annual meetings, and explore the feasibility of a single meeting that would encompass the business, clinical, residency and HOD activities of the organization.

Background: N/A

30. ***Lourdes Cuellar (TX):*** *Unit (Workload Unit)*

Recommendation: ASHP develop a standarized pharmacy workload unit 9PVU) that is applicable to all practice sites and includes professional cognitive services, diverse practice settings, medication safety, and medication management processes both and outside the walls of the physical pharmacy.

Background: N/A

31. ***Deb Saine (VA):*** *Medication Management Safety and Quality Improvement Forum*

Recommendation: recommend ASHP consider creation of a community, forum, or section for practitioners focusing on medication safety and quality improvement initiatives.

Background: The current ASHP groups addressing med safety and QI have accomplished much, however, their efforts remain fragmented. Although there are perceptions that QI and Safety are separate functions, the goals of PI are basic to both. Creating an ASHP "home" would help achieve a united critical mass to capitalize on shared resources/talents, and enhance pharmacy leadership, education. Research and practice in the areas of med safety and QI

32. ***John Pastor, Jamie Sinclair, Judy Schneider (MN):*** *Start time for the first session of the house of Delegates*

Recommendation: Begin the first session of the House of Delegates earlier depending on the number of agenda items to be considered.

Background: The House of Delegates deliberates on important policies and statements for ASHP. Ehen the first day's agenda is very full. The house runs over time and delegates are exhausted, not giving council reports near the end their attention. Adjusting the starting time of the first session of the House allows for more attentive delegates and improved deliberation.

33. ***Debby Cowan: (SICP)*** *Literature and Research Review for Small and Rural Hospital Topics.*

Recommendation: ASHP to conduct or promote the review, cataloging, and provision of literature and research related to small and rural hospital pharmacy.

Background: Several federal agencies, (e.g. ORHD HRSA) have previously conducted research or have data available on topics related to med use in small and rural settings. However, this information is not published in pharmacy journals or is not widely known how to access. It would be helpful for both pharmacy practice model and professional development activities to open access to this information and provide links to it via ASHP's small and Rural Resource Center.

31. ***Debby Cowan (SICP):*** *Statement for Expression of Appreciation to House of Delegates*

Recommendation: The section of Inpatient Care Practitioners on behalf of our section Advisors Group on Medication Safety would like to express its appreciation to ASHP for highlighting "Medication Safety" as the focus for the 2010 ASHP's summer meeting.

Background: The SAG recommends ASHP consider ongoing programming on this important issue.

35. ***John Pastor, Judy Schneider Jamie Sinclair:*** *Supervisory Skills for Pharmacists*

Recommendation: ASHP should advocate that pharmacy education include the necessary skills for pharmacists to effectively supervise pharmacy technicians in their work area(s0

Background: Pharmacy curriculums do not contain adequate supervisory training for pharmacists. Pharmacists are expected to provide direct supervision of technicians in their work area, and many do not feel that they are prepared when assuming their first pharmacist position. Even seasoned practitioners have inconsistent supervisory skill sets, depending on mentoring and practice experiences.

36. ***James Rorstrom RPH (KS)***
Robert Long RPH (NV)***:*** *Innovative ASHP Accredited Technician Training Programs*

Recommendation: Encourage the development of Innovative Non-traditional ASHP accredited Technician Training programs that meet the needs of working technicians and trainee in order to meet the minimum hiring standards for pharmacy technicians

Background: while internet based programs based programs are helpful, challenges exist in isolated rural areas. The issue is a barrier in rural states, preventing them from considering legislation to raise the requirements for technician training to ASHP standards.

37. ***James Rorstrom RPH (KS):*** *Continue support for the Medication Use in Rural America (MURA) Conference*

Recommendation: For ASHP to continue programming support for the Medication Use in

Rural America (MURA) Conference in collaboration with the National Rural Health Association (NRHA)

Background: To better meet needs of pharmacists in small and rural hospitals. Meet the needs and reach out to pharmacists in dual retail/hospital roles pertaining in a rural setting. In connection with other recommendations to seek membership of pharmacists in this setting

38. Robert Long (NV): *Transition of Community/retail Pharmacy Practitioners Into Small Rural Hospital Practice*

Recommendation: Development of training and competency materials specific for transitioning community/retail pharmacy practitioners into small and rural hospital pharmacy practices.

Background: Community/retail pharmacists are often the only practicing pharmacists available to cover or provide service in small, rural, medially underserved areas. Materials, in an easy to use, brief format are needed to provide training and competency assessment for practitioners making transition from community/retail pharmacy practice to hospital-health system pharmacy practice. Pne facet may be to support the medication use in rural American (MURA) via the National Rural Health Association (NRHA)

39. Barbara Poe, Darin Smith, Nancy Williams (OK): *Relevant Communications with Boards of Pharmacy.*

Recommendation: ASHP staff keeps the Boards of Pharmacy up to date on communication with AMA and other organizations on scope of practice data serious on pharmacists

Background: COTM has not been written into the Pharmacy Practice Act in some states not due to lack of effort on the pharmacists part but through physician organization opposition and misperception

40. Richard Demers (PA): *To Establish a Practice Model Change to Support Patients Through Collaboration*

Recommendation: ASHP should develop a statement to describe a practice model to support patients through collaboration of institutional and community Pharmacists.

Background: Hospitals recognize a challenge of patients who experience unplanned readmissions within 30 days of discharge. A significant contributor to these situations are related to medication therapy issues. Medication therapy is often the most important therapeutic relative to patient outcome. Pharmacy practice models need to change to manage patients through the direct interaction of hospital and community Pharmacists. ASHP should take a leadership position in this endeavor.

41. Andrew Ostrenga Pharm. D (MS): *FDA Ruling on Charging for Investigational Drugs*

Recommendation: I recommend that ASHP encourage the FDA to reconsider their ruling to allow drug companies to charge for investigational drugs

Background: Recently, the FA ruled under 21 CFR Parts 312 and 316, that drug companies may now charge for investigational drugs. Insurance will not reimburse for investigational drugs, so this puts the institution in a situation of deciding to deny care, bill the patient for thousands of dollars, or eat the cost. A perfect example is Erwinia-asparinas,that is the standard of care to substitute for other forms of asparaginase in the treatment of ALL if the child has a reaction.

42. Lea Eiland (AL): *Residency Availability Search Post Match.*

Recommendation: Encourage ASHP to develop ways that allow applicants to identify open and new residency positions that are available post-match as well as create a single application process for those positions.

Background: Due to overwhelming number of applicants in 2010 was scrambled, an easier way to identify and apply for open and new positions post-match is needed. Students and advisors so not have a way to see if positions are still open or closed after the post-match list is released or if new positions are available. This is burdensome and stressful for the RPD and students in regards to the application process as well. ASHP should assist wit this and consider a central on going application process post-match.

43. Melanie Townsend, Paul Driver, and Robert Long (MT, Id, NV SICP SAG; Small/Rural Hosp): *Small and Rural Practice Site Representation at Upcoming residency Training Stakeholders Meeting*

Recommendation: recommend that key representatives from small and rural practice sites be

invited to actively participate in the upcoming residency training stakeholders meeting in order to foster expansion of residency programs to small and rural settings.

Background: Small/rural settings have unique issues in pharmacy practice but could provide valuable training sites for pharmacy residents. In return, residents could help address workforce issues and expansion of pharmacy services to such settings. Key issues: 1. Alternate/supplementary PGYI accreditation standards for small/rural settings. 2. Use of technology for preceptor interaction, 3. Expansion of pharmacy services through utilization of pharmacy residents, and 4. Demonstrating value of residency in these settings.

44. Caryn Bing(NV): *Residency Accreditation Process Enhancements*

Recommendation: ASHP should work to streamline the administrative requirements for startup and management of residency programs, and explore methods to shorten time line between survey and notification of accreditation results while maintain core standards essential to post graduate learning

Background: The administrative process for residency accreditation serves as a real and perceived barrier to startup or expansion of residency programs ASHP could increase the type and scope of training for new program startup, develop template materials that any program can use to tart up a residency in a variety of practice settings, and support electronic methods of communication of residency accreditation materials to ASHP. The COC meets only 2/year, which can delay accreditation decisions by up to 10 months.

45. Caryn Bing (NV): *Green Process for ASHP Accreditation*

Recommendation: ASHP should incorporate systems and processes which significantly reduce or eliminate the need for printing and shipping paper for accreditation surveys, reports, and other communications.

Background: The current requirements to submit 3 copies of all accreditation materials before each survey, and to submit 3 copies of all survey and progress reports is very paper intensive. Most documents are generated electronically or can be scanned to .pdf files. ASHP needs to find a way to accept electronic information for the accreditation process.

46. Robert Moura William Churchill, Roy Guharoy (MA): *usage of Electronic devices During Future House of Delegates sessions*

Recommendation: To advocate ASHP to utilize electronic devices during future HOD meetings

Background: the process would be significantly streamline the HOP process via timely accurate vote count and further, it shall provide anonymous voting buy the delegates.

47 . (Jesse Hougue (MI): *ensuring an Efficient Amendment Process*

Recommendation: That ASHP leadership more strongly encourage delegates to thoroughly vet policy amendments through the available channels (Delegate Caucuses, Open Forum, etc) and expand the time allowed for the Delegate caucus so that all the delegates have sufficient time to consider and discuss the merits of the amendments.

Background: The amendment process in the House has gone very smoothly the past couple years because all the major amendments have been thoroughly debated in Caucus. This was not the case this year, resulting in less than optimal use of time. Some of this may have been due to insufficient time fir the general caucus this year, so I would also encourage ASHP leadership to consider expanding the time slot for the first delegate caucus in the future.

48. J Anderson, M Burnworth, K De Los Santos, M. Dodd (NM AZ): *Standarized Credentialing for Advanced Medication Therapy Management (MTM)*

Recommendation: To strongly encourage ASHP to identify the required credentials beyond pharmacists licensure to grant privileges for advanced practice activities identified in the MTM definition in Section 3503 of the Patient Protection and Affordable Care Act

Background: The new definition of MTM with broad scope of duties for any licensed pharmacist requires development of standard accepted credentials for advanced practice pharmacists. As the new definition of MTM encompasses that of CDTM, tere is a need for privileges to be granted only based upon recognized, standarized credentials. Privileging based upon sound credentials is crucial to ensure qualified practitioners are providing safest patient care at the appropriate scope.

49. Melanie Dodd, Emily Dotter (NM Student Forum): Creation of an Inter-professional Clinical Skills Student Competition

Recommendation: we recommend that ASHP provide the leadership to explore the creation of an intraprofessional clinical skills student competition

Background: in order to provide t he best clinical care for our patients it is essential that we work as intraprofessional teams. In order to prepare healthcare students to work as teams it is important that they are provided with inter professional training opportunities during their professional education. An opportunity for healthcare students to compete in an inter professional clinical competition would enhance this educational experience.

50. Joe Anderson and Melanie Dodd (NM): *Incorporation of Continuing Professional Development (CPD) concepts into ASHP Educational Programs*

Recommendation: We strongly encourage that ASHP incorporate concepts of continuing professional development (CPD) into all ASHP educational programs

Background: ASHP policy 0916 endorses and promotes the concepts of CPD. These concepts involve personal self-appraisal, educational plan development, plan implementation, documentation, and evaluation. Current ASHP educational programs do not include these elements in the program evaluation process that is completed by pharmacists. By including these concepts in the assessment process, such as self-reflection, ASHP will facilitate the acceptance into pharmacists learning processes.

ASHP Statement on Bar-code Verification During Inventory, Preparation, and Dispensing of Medications

DEVELOPED THROUGH THE ASHP SECTION OF PHARMACY INFORMATICS AND TECHNOLOGY AND APPROVED BY THE ASHP BOARD OF DIRECTORS ON APRIL 15, 2010, AND BY THE ASHP HOUSE OF DELEGATES ON JUNE 6, 2010

Am J Health-Syst Pharm. 2011; 68:In Press

Position

The American Society of Health-System Pharmacists encourages hospital and health-system pharmacies to incorporate bar-code scanning into inventory management, dose preparation and packaging, and dispensing of medications. The purpose of such scanning is to ensure that drug products distributed, deployed to intermediate storage areas, or used in the preparation of patient doses are the correct products, are in-date, and have not been recalled. Such bar-code scanning should be employed in:

- stocking of inventory both in the pharmacy and in other locations from which patient medications may be dispensed (e.g., an automated dispensing device);
- manual packaging of oral solid and liquid medications;
- compounding, repackaging, and labeling processes (e.g., scanning of source ingredients);
- retrieving medications from automated dispensing devices; and
- dispensing from the pharmacy to any location.

Prudent use of bar-coding technology in these processes will enhance patient safety and the quality of care by improving the accuracy of core pharmacy functions, closing potentials gaps in the bar-code-enabled medication administration (BCMA) process, and allowing better allocation of pharmacists' knowledge and skills.

Background

Discussion of the role of technology in improving medication safety almost universally focuses on BCMA or computerized provider order entry (CPOE), despite evidence of medication errors that neither CPOE nor BCMA could prevent.[1,2] A number of activities in the medication-use process create opportunities for error outside of medication ordering and administration systems, such as:

- Receiving of inventory from suppliers and stocking of inventory locations

This statement was drafted by the ASHP Section of Pharmacy Informatics and Technology 2009–2010 Section Advisory Group on Pharmacy Operations Automation (Dennis A. Tribble, Pharm.D.; Ron Burnette, B.S.Pharm., M.B.A.; Dawn M. Biller; Leslie Brookins, M.S.; Richard Capps III, Pharm.D.; Marvin H. Choi; Kavish J. Choudhary, Pharm.D., M.S.; Seth Aaron Cohen, Pharm.D.; Thomas W. Cooley M.B.A.; Arash T. Dabestani, Pharm.D., M.H.A., FABC; Charles De la Torre, M.S., MIS; Doina Dumitru, Pharm.D., M.B.A.; Christopher Fortier, B.S.Pharm.; Barbara Giacomelli, Pharm.D., MBA, FASHP; Staci Hermann, M.S., Pharm.D.; Gary L. Johnson, Jr., Pharm.D., M.H.A.; Seth A. Kuiper, Pharm.D.; Denise Mckenzie, B.S.Pharm.; Rhonda B. McManus, Pharm.D.; Eric C. Nemec, II, Pharm.D.; Beth Prier, Pharm.D., M.S.; Brad Rognrud, M.S., R.Ph.; Kevin A. Scheckelhoff, M.B.A.; Paul M. Seelinger, B.S.Pharm.; Suzanne B. Shea, M.B.A.; David A. Tjhio, M.S., Pharm.D.; Christopher J. Urbanski, M.S.; Gwen Volpe, B.S.Pharm.; Rayburn Brian Vrabel, Pharm.D.; and Robynn P. Wolfschlag, M.B.A.).

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Index terms: American Society of Health-System Pharmacists; Codes; Drug administration; Errors, medication; Hospitals; Technology

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from which patient medications may be dispensed (e.g., stocking unit-based automated dispensing devices with medications that may not be delivered to the bedside in their original packaging).
- Packaging of medications, which has become more prevalent as BCMA systems are more widely adopted by health systems and manufacturers have discontinued unit dose packaging of medications.
- Manual packaging of liquid medications in ready-to-administer form.
- The compounding of medications.
- The dispensing of patient-specific medications (e.g., 24-hour medication carts, nurse servers).

In addition, for BCMA to function, a vast majority of doses must be accurately bar coded, meaning there must be a highly reliable relationship between the information in the bar code and the contents of the dose. Additionally, the bar code must be readable by commercially available scanners. Although doses delivered directly from manufacturer-labeled packages generally meet these conditions, there are numerous drug products that may not:

- Commercial products may lack a readily readable bar code, may have an irregular package shape that confounds the ability of scanning equipment to read the bar code, or may have a bar code in a symbology format that cannot be interpreted by the institution's bar-code scanning software.
- Nurse-prepared medications (e.g., insulin doses, heparin boluses, or syringes pre-drawn in the operating room) may be prepared at a location other than the patient's bedside, with the result that there is no labeling of any kind on the dose when it is administered.
- Compounded medications (e.g., sterile preparations) are often labeled by the pharmacy with a bar code that references a prescription or order number that describes the intended contents of the prescribed dose but provides no assurance that the prescribed contents were actually used in the product's preparation.

Benefits of Bar-code Verification During Inventory, Preparation, and Dispensing

Initial estimates of the contribution of pharmacy dispensing errors to the overall medication errors were quite low.[3] However, recent reports have suggested that adding bar coding to the pharmacy dispensing process can significantly reduce opportunities for medication errors at the bedside and reduce the occurrence of potential adverse drug reactions.[4-6] Incorporating bar-code scanning in inventory management, dose preparation and packaging, and dispensing can improve patient safety in the following ways:

- Scanning during stocking in the pharmacy or patient-care locations (e.g., loading of an automated dispensing device) can help ensure that the product is placed in the correct location.
- Scanning during the retrieval of medications mitigates the hazards of erroneous medication stocking, which is especially important in the case of automated dispensing devices, where there is a potential risk that caregivers will override controls and remove medications for immediate use.
- Scanning of source ingredients during compounding, repackaging, or labeling processes can ensure that labeled doses contain the appropriate ingredients. Additionally, such scanning creates a reliable link between the information in the final package's bar code, its contents, and the National Drug Code (NDC) of the source container, which may be required to satisfy billing requirements (e.g., those of the Centers for Medicare & Medicaid Services).
- Scanning on dispensing can help prevent look-alike, sound-alike medication substitution errors that are difficult to visually detect, can identify and remove from distribution drug products whose bar codes are missing or unreadable, and prevent the distribution of expired or recalled products or facilitate retrieval in case of a recall.
- Scanning during any of these activities permits accumulation of an audit trail for each transaction in the inventory, preparation, and dispensing

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process. This information provides indications of the frequency of error encounter and detection, a record of the amount of time needed to perform selected functions, and evidence of success or failure of manual processes to deliver the correct medication.

Bar-code verification is optimized, and its potential negative impacts on productivity minimized, when the scanning system is configured to use bar codes on bulk packages (e.g., the bar code on an unopened case of unit-dose-packaged tablets) to confirm the contents of each item in the case, especially during batch processes. For patient-specific doses, each individual container used for the dose must be scanned.

The equipment and training costs for a pharmacy-based bar-code scanning implementation is quite small, especially when compared to those of BCMA systems.[7] Pharmacy-based bar-code scanning implementation may be considered a prerequisite for BCMA success, because unreadable bar codes are a significant cause of BCMA implementation failures.[8,9]

Limitations

As with BCMA, adoption of bar-code scanning within distribution processes creates the necessity to ensure that the scanning system will recognize and appropriately respond to every bar code it scans. This verification activity is likely to create significant additional work for the pharmacy. Pharmacies planning on implementing such systems must plan for the resources needed to ensure that properly bar-coded products are presented to, and readable by, the scanning system.

In addition, as with other bar-code technology implementations, pharmacy-based bar-code scanning systems will only be beneficial if appropriately deployed. For example, given the need to scan three vials of medication to prepare an IV admixture, such a system cannot distinguish between scanning each vial and scanning the same vial three times, although the latter defeats the purpose of the scanning. Any program of pharmacy-based bar-code scanning should be accompanied by appropriate training, policies, and procedures to promote and optimize safe use of the system, as well as a regular program of auditing to ensure that the program is being properly deployed by staff. Additionally, such programs require hospitals and health systems to compile and maintain a complete database of bar codes in use throughout the institution. The availability of such information in a timely fashion is a well-recognized problem.[10] An incomplete database or the absence of bar codes on drug products can undermine the entire system, as the system cannot properly recognize and evaluate the drug products being scanned. Procedures should address such issues as the expected behavior while scanning occurs, specific prohibited acts, and the penalties associated with known at-risk behavior.[11]

In addition, this statement should not be interpreted to express a preference for bar-code scanning over other forms of automated identification of medications. Currently, bar coding is the least-expensive mechanism to introduce and deploy throughout the medication management cycle.[12] Should other technologies (e.g., radio-frequency identification) demonstrate similar or better capabilities, the principles articulated in this statement will continue to apply.

Validation

As with all such systems, bar coding on dispensing presumes that the scanning software, the scanning hardware, and the associated underlying database are accurate and complete. To ensure accuracy and completeness, organizations using a bar-coding process will need to validate both that the software operates as expected and that the underlying database information is correct and reliable. A process will also need to be in place to immediately remediate problems if it is discovered that the hardware, software, or database are not operating properly.

Conclusion

Prudent use of bar-code scanning in inventory management, dose preparation and packaging, and dispensing of medications can enhance patient safety and the quality of care. Such scanning also provides the opportunity to accumulate and use statistics on the pharmacy distributive operation that can direct more appropriate staffing, identify sources of routine error, and generally permit better management of the drug distribution process.

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Suggested Reading

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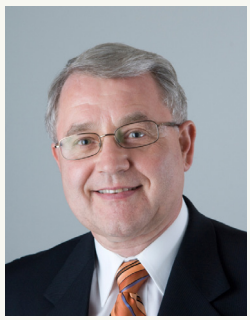

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Professional policies approved by the 2010 ASHP House of Delegates

Tampa, FL
June 8, 2010

Am J Health-Syst Pharm. 2010; 67:e50-4

The new professional policies approved by the ASHP House of Delegates at its June 2010 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/CouncilReports.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.

1001

Health Insurance Coverage for U.S. Residents

Source: Council on Public Policy

To advocate health insurance for all residents of the United States, including coverage of medications and related pharmacist patient-care services; further,

To advocate that the full range of available methods be used to (1) ensure the provision of appropriate, safe, and cost-effective health care services; (2) optimize treatment outcomes; and (3) minimize overall costs without compromising quality; further,

To advocate that health insurers seek to optimize continuity of care in their design of benefit plans.

This policy supersedes ASHP policy 0512.

1002

Risk Evaluation and Mitigation Strategies

Source: Council on Public Policy

To advocate for research on the impact of the Food and Drug Administration's Risk Evaluation and Mitigation Strategies (REMS) on patient safety, cost effectiveness, and pharmacy workflow; further,

To advocate pharmacist involvement in the development and implementation of REMS; further,

To urge computer software vendors to assist pharmacists in the identification of and compliance with REMS; further,

To advocate that any REMS that include constraint on traditional drug distribution systems be consistent with ASHP policy on restricted drug distribution.

1003

FDA Authority on Recalls

Source: Council on Public Policy

To strongly encourage the Food and Drug Administration (FDA) to develop a standard recall notification process and format to be used by all manufacturers to facilitate the timely removal of recalled drugs; further,

To advocate that such notification should (1) come from a single source, (2) clearly identify the recalled product, (3) explain why the product is being recalled, (4) provide a way to report having the recalled product, (5) give instructions on what to do with the recalled product, and (6) be provided concurrently to all entities in the supply chain; further,

To advocate that the FDA be given the authority to order mandatory recalls of medications; further,

To urge the FDA to require drug manufacturers and the computer software industry to provide bar codes and data fields for lot number, expiration date, and other necessary and appropriate information on all medication packaging, including unit dose, unit-of-use, and injectable drug packaging, in order to facilitate compliance with recalls or withdrawals and to prevent the administration of recalled products to patients; further,

To urge the FDA to encourage postmarketing reporting of adverse events and product quality issues to enhance the recall system.

1004

Postmarketing Comparative Clinical and Pharmacoeconomic Studies

Source: Council on Public Policy

To advocate expansion of comparative clinical and pharmacoeconomic studies on the effectiveness, safety, and cost comparison of marketed medications in order to improve therapeutic outcomes and promote cost-effective medication use; further,

To advocate that such studies compare a particular medication with (as appropriate) other medications, medical devices, or procedures used to treat specific diseases; further,

To advocate adequate funding for the Agency for Healthcare Research and Quality and other federal agencies to carry out such studies; further,

To encourage impartial private-sector entities to also conduct such studies.

This policy supersedes ASHP policy 0513.

1005

Medication Therapy Management

Source: Council on Public Policy

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

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

1006

Definition of Meaningful Use of Health Information Technology

Source: Council on Public Policy

To advocate to policymakers (public and private) that definitions of "meaningful use of health information technology" address interoperability of medication orders and prescriptions, medication decision support and continuous improvement, and quality reporting; further,

To advocate with respect to interoperability of medication orders and prescriptions that (1) a common medication vocabulary be mandated to promote the semantic interoperability of medication use across the continuum of care, because a common vocabulary is essential for comparative effectiveness research and for communicating medication information; and (2) communication of orders and electronic prescriptions must be demonstrated to be functional and semantically interoperable with pharmacy information systems; further,

To advocate with respect to medication decision support and continuous improvement that (1) medication decision support should include but not be limited to allergy, drug interaction (e.g., drug-lab or drug-disease interactions), duplicate therapy, and dose-range checking; and (2) that such a decision-support service must include an ongoing, continuous improvement process to attune the decision-support service to the needs of the providers who use it; further,

To advocate with respect to quality reporting that the ability to quantify improved patient safety, quality outcomes, and cost reductions in the medication-use process is essential, particularly in antimicrobial and adverse event surveillance.

1007

Regulation of Home Medical Equipment Medication Products and Devices

Source: Council on Public Policy

To advocate for consistent regulatory oversight of all home medical equipment, with the goals of continuity of care, patient safety, and appropriate pharmacist involvement whenever equipment is used for medication administration; further,

To monitor the impact of the Centers for Medicare & Medicaid Services quality standards on the accreditation of suppliers of medication-related durable medical equipment and supplies.

1008

Employment Classification and Duty Hours of Pharmacy Residents

Source: Council on Public Policy

To advocate that pharmacy residents should be classified as exempt employees; further,

To advocate that pharmacy residents be subject to duty hour limits (similar to resident physicians) with respect to all clinical and academic activities during their training program in accordance with the Accreditation Council on Graduate Medical Education (ACGME) standards and ASHP accreditation standards for pharmacy residency programs.

1009

Preservation of Antimicrobials for Medical Treatment

Source: Council on Therapeutics

To advocate that the Food and Drug Administration (FDA) eliminate future approval of antimicrobials for nontherapeutic uses in agricultural animals that represent a safety risk by contributing to antibiotic resistance; further,

To encourage efforts to phase out and eliminate the nontherapeutic uses of antimicrobials previously approved by the FDA; further,

To support the therapeutic use of antimicrobials in animals only under the supervision of a veterinarian; further,

To encourage the FDA, Centers for Disease Control and Prevention, and other stakeholders to monitor

and limit, when effective alternatives are available, the therapeutic use of antimicrobials that are essential to the treatment of critically ill human patients; further,

To advocate for the inclusion of pharmacists in antimicrobial surveillance and related public health efforts based on pharmacists' knowledge of antimicrobial drug products and antimicrobial resistance.

1010

Safety and Effectiveness of Ethanol for Treatment of Alcohol Withdrawal Syndrome

Source: Council on Therapeutics

To oppose the use of oral or intravenous ethanol for the prevention or treatment of alcohol withdrawal syndrome (AWS) because of its poor effectiveness and safety profile; further,

To support hospital and health-system efforts that restrict or prohibit the use of oral or intravenous ethanol therapies to treat AWS; further,

To educate clinicians about the availability of alternative therapies for AWS.

1011

Use of Surrogate Endpoints for FDA Approval of Drug Uses

Source: Council on Therapeutics

To support the continued use of qualified surrogate endpoints by the Food and Drug Administration (FDA) as a mechanism to evaluate the effectiveness and safety of new drugs and new indications for existing therapies, when measurement of definitive clinical outcomes is not feasible; further,

To support efforts by the FDA and other stakeholders to qualify surrogate endpoints; further,

To advocate that the FDA consistently enforce existing requirements that drug product manufacturers complete postmarketing studies for drugs approved based on qualified surrogate endpoints in order to confirm that the expected improvement in outcomes occurs, and to require that these studies be completed in a timely manner.

1012

Quality Consumer Medication Information

Source: Council on Therapeutics

To support efforts by the Food and Drug Administration (FDA) and other stakeholders to improve the quality, consistency, and simplicity of written consumer medication information (CMI); further,

To encourage the FDA to work in collaboration with patient advocates and other stakeholders to create evidence-based models and standards, including establishment of a universal literacy level, for CMI; further,

To advocate that research be conducted to validate these models in actual-use studies in pertinent patient populations; further,

To advocate that state boards of pharmacy require that pharmacies comply with FDA-established standards for content, format, and distribution of CMI.

1013

Research on Drug Use in Obese Patients

Source: Council on Therapeutics

To encourage drug product manufacturers to conduct pharmacokinetic and pharmacodynamic research in obese patients to facilitate safe and effective dosing of medications in this patient population, especially for medications most likely to be affected by obesity; further,

To encourage manufacturers to include in the Food and Drug Administration (FDA)-approved labeling detailed information on characteristics of individuals enrolled in drug dosing studies; further,

To advocate that the FDA develop guidance for the design and reporting of studies that support dosing recommendations in obese patients; further,

To advocate for increased enrollment of obese patients in preapproval clinical trials of new medications; further,

To encourage independent research on the clinical significance of obesity on drug use, as well as the reporting and dissemination of this information via published literature, patient registries, and other mechanisms.

1014

Interprofessional Education and Training

Source: Council on Education and Workforce Development

To support interprofessional education as a component of didactic and experiential education in Doctor of Pharmacy degree programs; further,

To support interprofessional education as a part of professional development for pharmacy practitioners and to collaborate with other disciplines to facilitate and promote programs that support this goal; further,

To encourage and support pharmacists' collaboration with other health professionals and health care executives in the development of team-based, patient-centered care models; further,

To foster documentation and dissemination of outcomes achieved as a result of interprofessional education of health care professionals.

This policy supersedes ASHP policy 0608.

1015

Minimum Hiring Standards for Pharmacy Technicians

Source: Council on Education and Workforce Development

To encourage employers to hire pharmacy technicians who have successfully completed an ASHP-accredited pharmacy technician

training program and are certified by the Pharmacy Technician Certification Board (PTCB); further,

To support employment practices that would permit hiring of pharmacy technician trainees only if those individuals (1) are required to both successfully complete an ASHP-accredited pharmacy technician training program and successfully complete PTCB certification within 24 months of employment, and (2) are limited to positions with lesser responsibilities until they successfully complete such training and certification; further,

To encourage employers to require ongoing PTCB certification as a condition of continued employment; further,

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

1016

Pharmaceutical Distribution Systems

Source: Council on Pharmacy Management

To support wholesaler/distribution business models that meet the requirements of hospitals and health systems with respect to timely delivery of products, minimizing short-term outages and long-term product shortages, managing and responding to product recalls, fostering product-handling and transaction efficiency, preserving the integrity of products as they move through the supply chain, and maintaining affordable service costs.

This policy supersedes ASHP policy 0605.

1017

Impact of Insurance Coverage Design on Patient Care Decisions

Source: Council on Pharmacy Management

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

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

To advocate for the exclusion of hospital and health-system outpatient settings from restrictive reimbursement requirements.

1018

Standardization of Device Connections to Avoid Wrong-Route Errors

Source: Council on Pharmacy Practice

To advocate for development and use of medication administration device connectors and fittings that are designed to prevent misconnections and wrong-route errors; further,

To support the use of oral syringes that are readily distinguishable from injectable syringes and connect only to oral or enteral adapters and fittings; further,

To oppose the use of injectable syringes for other than injectable routes of administration; further,

To identify and promote the implementation of best practices for preventing wrong-route errors.

1019

Medication Safety Officer Role

Source: Council on Pharmacy Practice

To advocate that accountability for development and maintenance of a medication safety program in hospitals and health systems be assigned to a qualified individual (i.e., a medication safety officer or leader of a medication safety team); further,

To advocate that individuals in these roles have the authority and autonomy to establish priorities for medication-use safety and make the necessary changes as authorized by the medical staff committee responsible for medication-use policy; further,

To affirm that pharmacists are uniquely prepared by education, experience, and knowledge to assume the role of medication safety officer or other leadership role in all activities that ensure the safety, effectiveness, and efficiency of the medication-use process; further,

To support all pharmacists in their leadership roles in organizational medication-use safety, reflecting their authority over and accountability for the performance of the medication-use process.

1020

Role of Pharmacists in Safe Technology Implementation

Source: Council on Pharmacy Practice

To affirm the essential role of the pharmacist in the evaluation, implementation, and ongoing assessment of all technology intended to ensure safety, effectiveness, and efficiency of the medication-use process.

1021

Just Culture and Reporting Medication Errors

Source: Council on Pharmacy Practice

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

To provide leadership in supporting a single, comprehensive, hospital- or health-system-specific medication error reporting program that (1) fosters a confidential, nonthreatening, and nonpunitive environment for the submission of medication error reports; (2) receives and analyzes

these confidential reports to identify system-based causes of medication errors or potential errors; and (3) recommends and disseminates error prevention strategies; further,

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

(*Note*: A just culture is one that has a clear and transparent process for evaluating errors and separating events arising from flawed system design or inadvertent human error from those caused by reckless behavior, defined as a behavioral choice to consciously disregard what is known to be a substantial or unjustifiable risk.)

This policy supersedes ASHP policy 0910.

1022

Patient Access to Pharmacy Services in Small and Rural Hospitals

Source: Council on Pharmacy Practice

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

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

This policy supersedes ASHP policy 0503.

1023

Scope and Hours of Pharmacy Services

Source: Council on Pharmacy Practice

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

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

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

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

This policy supersedes ASHP policy 0403.

1024

Use of Two Patient Identifiers in the Outpatient Setting

Source: Council on Pharmacy Practice

To encourage the use of two identifiers to confirm patient identity when transferring filled prescriptions to the possession of the patient or patient's agent in outpatient settings.

1025

ASHP Statement on Bar-code Verification During Inventory, Preparation, and Dispensing of Medications

Source: Section of Pharmacy Informatics and Technology

To approve the ASHP Statement on Bar-code Verification During Inventory, Preparation, and Dispensing of Medications.*

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

Inaugural address of the President-elect

The "University of ASHP": Teaching and learning in a new world of practice

DIANE B. GINSBURG

Am J Health-Syst Pharm. 2010; 67:1373-6

As I begin my formal remarks this morning, I'd like to take a few minutes to acknowledge some very special people who are here with us today. First, I want to recognize the ASHP staff. They are our crown jewel, and I never take them for granted. I know that our membership feels the same way.

Before I ever got into leadership positions at ASHP, I was fortunate to work with every single division. I know what an incredible group of people we have working tirelessly on our behalf. Thank you, ASHP staff, for your commitment to our Society and to the profession of pharmacy.

I'd also like to recognize and give special thanks to my colleagues at the University of Texas at Austin, some of whom are here with me today and some of whom are back home supporting me in my journey as ASHP president. I'd like to thank my students who are a constant source of energy for me and truly inspire me to do what I do on a daily basis. I'd also like to thank an individual who is not only my boss, but my mentor and very dear friend . . . my dean, M. Lynn Crismon.

We as members of ASHP are a radiating force, and our power to effect change is exponential. I urge you to keep learning, keep teaching, and keep advocating for your patients.

I was fortunate to be able to serve in the Texas Society of Health-System Pharmacists, and some special people afforded me opportunities along the way. Those individuals include Roland Patry, Lois Nash, Julie Nelson, Lourdes Cuellar, and Donna Burkett.

I have also had the privilege to serve with an incredible group of people during my tenure on the ASHP Board of Directors. Thank you, not only for your personal support of me but for your commitment to our Society and to our profession.

And then to a very special group of people that I refer to as "the brain trust." Everyone should be fortunate enough to have people in their lives who are there for them no matter what, to provide encouragement, to celebrate good times, and to be there when times are difficult. These people are a constant source of guidance for me. I would like to thank my very

DIANE B. GINSBURG, M.S., FASHP, is Assistant Dean for Student Affairs, Division of Pharmacy Practice and Administration, College of Pharmacy, University of Texas at Austin, Austin.

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

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The following ASHP Reports and information on 2010 ASHP award recipients appear in the online version of this issue (www.ajhp.org):

- "Keeping our focus during a difficult time": remarks of ASHP Executive Vice President and Chief Executive Officer Henri Manasse, Jr., Ph.D., Sc.D.
- "Recovery . . . Stability . . . Strength": 2010 Report of the Treasurer by ASHP Treasurer Paul W. Abramowitz
- Professional Policies approved by the 2010 ASHP House of Delegates
- ASHP Board of Directors, 2010–2011
- ASHP Honorary Membership

dear friends, leaders in their own right, who are a continuous source of inspiration and true beacons for our profession: Cindi Brennan, Jill Martin Boone, Toby Clark, Mick Hunt, Steve Sheaffer, Sara White, John Murphy, John Woon, Kathryn Schultz, my "board buddy" Lynnae Mahaney, Charles Jastram, Malcolm Broussard, Teresa Hudson, Janet Silvester, and Deb Devereaux.

Finally, I want to acknowledge my friends and family, many who have come very long distances to celebrate with me today. And I especially want to thank my husband, Dr. Jeffrey Josephs, for your love and support and understanding of my commitment to my profession.

Life as a teacher and student

Let me start by telling you who I am. I'm a teacher. I've dedicated my professional life to teaching students and practitioners what they need to know to become passionate and competent patient care providers and leaders in our profession. I am committed to developing the future of our profession. It is my calling.

But I'm also a lifelong student. My students are constantly teaching me, showing me new ways of thinking, challenging me at all times to stay on top of my game, and fueling my passion for lifelong learning. And even now, as I've reached the halfway point of my Ph.D., I know there is always more to learn.

Indeed, all of us in this room are teachers. We mentor new practitioners. We educate and train residents. And we even reach outside of our profession to advise physicians, nurses, and administrators on the best and most effective ways to use medicine. But all of us in this room and in this profession are also lifelong students.

We come together at meetings like this one and other professional venues to share knowledge with each other and ASHP so that we can always be on the cutting edge of patient care. We are constantly learning and seeking out the best institutions through which to learn.

So, if you think about it, ASHP is really our classroom: the "University of ASHP," if you will. And, really, what is a university? I know that might seem like a very basic question, but I think it is really important to define.

According to *Webster's Dictionary*, a *university* is "an institution of learning at the highest level; an institution like no other." ASHP fits that definition. We are always teaching and learning. We are always sharing and connecting, and that is truly what ASHP does best. But the heavy lifting, what happens on a daily basis, the direct patient care, the patient advocacy, the creation of practice models that work well in this new world we find ourselves in, that is up to all of us.

A fundamental misalignment

You know, there is something that has been on my heart for a very long time—something that is truly worrying me with every passing day. We have a fundamental misalignment with those educated in the profession and current practice. Our colleges and schools are producing highly educated and trained graduates, but the way our practice sites are run and how we practice pharmacy are not changing fundamentally. We promise students the chance to practice their art of patient care, but most will not get that opportunity with our current practice model.

We need to look to the next generation to see the possibilities, and the Millennial generation is filled with possibilities. If you have done any reading about the traits and characteristics common to this generation, you will find that they have always been treated as special and important. They feel that they are here to solve the world's problems, especially those problems that older generations have failed to solve. They work well in teams. They are motivated, goal oriented, and confident in not only themselves but the future. And the best part of all is that they are incredibly optimistic.

But we take these unbelievable students who are motivated to make a difference, and using the current practice model, we crush their spirits within two to three years. These bright new professionals lose their passion and stop questioning the status quo. That is everyone's loss.

A broken practice model

I'd like to share a story I heard from a dear friend and colleague of mine from another college of pharmacy. He was talking to an employer about why there had been a decline in student recruitment from their organization. The employer said that they like to hire students after they have been in practice for a few years, after their idealism was gone. This way, new hires would be compliant and not challenge the system.

This seriously disturbed me. It should disturb all of us. What are we going to do about this disconnect between students' expectations and the way some practice environments view the involvement of pharmacists? What are we going to do about this disparity between what we are teaching students in our curricula and what many practice sites in the real world offer them?

We clearly have a broken practice model. But the news is not all bad. We have an incredible opportunity to create a new vision for pharmacy practice. We need, in some ways, to start over. And there are some important questions that we need to ask ourselves to get back to our core mission.

What is the purpose of our profession? How can we re-imagine it? How can we reframe the future so that we better reflect the legal, ethical, and moral obligations we all have to care for patients?

One thing I know for sure is this: If we continue to do things the way we've always done them, we will continue to get what we have always gotten. We need to get back to our core mission.

One degree of separation

You know, one of my best teachers was my mother. She taught me never to be more than one degree of separation away from patients, to always remember that every patient is someone's parent, spouse, sibling, or child. She made sure I understood that everyone is significant to someone. It was a lesson she had learned while managing my uncle's surgery practice at the University of Pittsburgh. In my uncle's practice, clients weren't just a "gall bladder removal" or "colon resection." They were patients.

When my mother was diagnosed with pancreatic cancer 13 years ago, I came to really feel and understand the truth in that lesson. The weekend that Princess Diana was killed, my mother was admitted to Seton Hospital in Austin, Texas. Shortly after we arrived at the hospital, the following words appeared on her chart: "PG is a 60-year-old white female presenting with severe abdominal pain, nausea, and vomiting. CT scan showed a large mass in her pancreas with mets throughout her body."

As you can imagine, these were incredibly chilling words because this was my mother. So, I did what most clinicians would do. I went back to where it was safe, my clinical knowledge. I set up a war room by her hospital bed, with references, cell phone, and other resources.

Because my mom had metastases everywhere, including throughout her liver, managing her pain was becoming very difficult. One of my former students, a newly licensed pharmacist, came to me one day and said, "We figured out what's going to work to manage your mother's pain, Diane. Don't worry. She's going to get some relief. I'm going to take care of her."

I looked up at this kid and asked, "Why are you being so kind to us?" And he replied very simply, "I know you're not in your right mind right now because if you were, you'd realize that all I'm doing is what you told me to do that very first day of pharmacy school. Your mother is *my* 'every patient.' "

I remember thinking in that moment that it would never matter what I did for the remainder of my professional life. I got through to one student who took care of my "every patient."

Getting to the core mission

As pharmacists, we have to learn to be the voice for these patients. We have to teach other pharmacists how to be that voice, too. For me, ASHP was never more than one degree of separation away from my mother's care in terms of providing me information and supporting my practice, even in that most difficult time. And that is how it should be.

This lesson, understanding the very humanity of my patients, is top of mind for me at all times. It is reinforced for me on a daily basis as I watch my husband provide care for his psychiatric patients. It is one of the first things I teach to my students, and I hope it is the last thing they remember as they exit my classroom. It is part of my core mission, and it is part of ASHP's, too.

Most of you know that I don't practice in a hospital anymore. Although I loved being an institutional practitioner, I feel so privileged to be a professor and dean of student affairs at one of the top colleges of pharmacy in the country. I prepare the practitioners who will be coming to all of you for practice opportunities some day.

But, even though I'm in a classroom every day, I am only one degree of separation away from patients. I never forget the mission we all have for patient care. Let me give you an example of what I mean.

On the very first day of class, I often walk to the blackboard and put the following number up on the blackboard: 28011. I ask my class if they know what the number is. I offer them a free Starbucks card, Jamba Juice, whatever. Of course, I always get that "deer in the headlights" look. And that's when I hit them with it.

This is my pharmacist's license number. I earned it. I own it. No one has it but me. My board of pharmacy does care about it, but quite frankly, it is my BFF (best friend forever). I am granted the privilege and gift of practicing pharmacy. So what am I going to do with this gift? Am I going to challenge the status quo, be that squeaky wheel that pushes for change?

I'd like to share with you a quote that gets to the essence of this philosophy from a very famous pharmacist: Hubert Humphrey. "If there is dissatisfaction with the status quo, good. If there is foment, so much the better. If there is restlessness, I am pleased. Then let there be ideas and hard thought and hard work."

You know, I've been fortunate to practice with individuals who remind

me to always do the right thing and think about the people we serve no matter what our practice environment. These people always challenge the status quo and are never afraid to ask the hard questions.

One of these people is my dean, Lynn Crismon. When Lynn was interim dean at our college, he made some decisions that could have easily jeopardized his chances of being selected as our permanent dean. But people saw beyond that and realized he was serving the best interests of the college.

He leads by example. He always keeps the college, our students, faculty, and staff front and center. He is an incredible role model, somebody whom I am privileged to work with every day. Lynn has taught me that everything we do, especially as practitioners, is about the people we serve.

The University of ASHP

I got involved in ASHP early in my career because some inspirational people instilled in me the importance of supporting our profession. ASHP has been a magnificent teacher for me, and I suspect that it has been for each of you as well. This University of ASHP, as I like to call it, is an institution of higher education like no other.

Institutions of higher education were created to educate people to be able to know the truth and to study the best that has been thought and said in the world. We know the truth. We have a relationship with those we serve. Our mission and purpose are clear—to provide the best patient care that we can to those special, significant people, to our "every patient."

And our alma mater is there for us. ASHP supports all of us in our work to provide the highest level of patient care. Through the development of practice standards, in its advocacy to enact a legislative and regulatory framework that improves both pharmacy practice and patient care, and through its work to develop cutting-edge professional education and resources, ASHP is changing practice and patient care, both in this country and around the world. But these are not the only reasons to join ASHP and get involved.

As one of my former professors, Dr. Terry Schwinghammer, department chair for pharmacy practice at the University of West Virginia, said, "Join a professional organization. It is the rent you pay on the space you take up in the profession."

Well, let me tell you, I'm paying my rent gladly.

This is pharmacy's time

How are we going to take the lessons we learn every day in our institutions and in our interactions with each other and make them real in our own practice environments? One phrase captures it for me: Let's get it started.

On March 21, 2010, history was made in this country with the passage of new health care reform legislation. The time is now to make changes in our practice model to better serve our patients. The planets, moons, and stars are in alignment like no other time. This is pharmacy's time.

ASHP's Pharmacy Practice Model Initiative and the summit in November 2010 will get us started toward creating this new practice model. As my residency preceptor Darrell Newcomer taught me, "There are no problems, only opportunities." We have incredible opportunities right now.

Everyone has talents that they can contribute. And we are going to need everyone as we move forward. As pharmacists, we have knowledge that no other health care professional has. Never forget that we are medication experts.

When I was a kid, I used to watch Saturday morning cartoons, and one of my favorites was *School House Rock*. Some of you might remember that, including songs like "Conjunction Junction, What's Your Function?," "I'm Just a Bill," and "Three is a Magic Number."

You may also remember the words to the opening song for every episode: "As your body grows bigger, your mind will flower. It's great to learn, 'cause knowledge is power."

Knowledge is power. This is what I believe. What are you doing to learn all you can to provide the best care for your patients every day? What are you doing to teach others so that they can provide the best care for *their* patients every day? What are you going to do with this amazing gift of knowledge? Are you going to use this power for good?

Conclusion

I'd like to conclude with a quote from my dear friend, colleague, and mentor Billy Woodward's great Whitney Award lecture. He said, "Being a pharmacist is a privilege and blessing bestowed by society on a relative few. With such privilege also comes a responsibility . . . a sacred professional duty . . . to continually define quality by our actions and never, never be content with anything less."

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. We as members of ASHP are a radiating force, and our power to effect change is exponential. I urge you to keep learning, keep teaching, and keep advocating for your patients. I promise you that ASHP will do the same and that the "University of ASHP" will always be there to support you.

The time is now to "get it started!" I look forward to working with you and ASHP to not only influence our profession but do the very best we can to care for our "every patient."

Thank you again for this honor.

ASHP: Leading the way to better patient care

LYNNAE MAHANEY

Thank you and good afternoon!

I'm very happy to be here today, speaking to you as chair of the Board of Directors. As I conclude my term as president, I want you to know what a privilege it has been to serve ASHP. Despite a very challenging year, which saw ASHP caught in the economic storm that affected all of us, we maintained our strength as an organization and our unity as a community. Today, I'm happy to report to you that ASHP continues to thrive, and I'd like to share some news about ASHP initiatives that really affected members over the past year and will continue to affect them in the year to come.

I'll be talking about four topics:

- The new Leadership Agenda that was just approved by the Board,
- Dr. Manasse's upcoming retirement and the search committee's work to find a suitable replacement,
- The Pharmacy Practice Model Initiative, and
- The current state of residency accreditation work at ASHP.

Despite a very challenging year . . . we maintained our strength as an organization and our unity as a community.

Leadership Agenda

The Board's work this year on the Leadership Agenda focused on revising current planks and adding news ones to ensure that they fully reflect the contemporary and special challenges we all face in our day-to-day work and where we want to go in the future.

The first plank—*Ensure that pharmacists are leaders in implementing all medication-related changes to the health care delivery system*—is new and reflects the opportunities pharmacists have before them through the passage into law of health care reform.

The second plank—*Foster optimal models for team-based, patient-centered care that includes the pharmacist as the expert in medication therapy management*—moves ASHP to a more specific statement about the importance of interdisciplinary, patient-oriented care. This plank really highlights our niche. It captures the direction in which we're going with the Pharmacy Practice Model Initiative as a force in ASHP activities.

The third plank—*Influence the development and implementation of health information technologies and standards that help improve patient-care outcomes through the leadership of pharmacists*—focuses on patient care. It also reflects the new realities of quality and outcomes and points to the important leadership of pharmacists in ensuring that health information technology systems are safe and effective for patients. Further, it

LYNNAE MAHANEY, MBA, FASHP, is Immediate Past-President, American Society of Health-System Pharmacists, 7272 Wisconsin Avenue, Bethesda, MD 20814.

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emphasizes the need for standards that ensure the interoperability of systems throughout the continuum of care.

The fourth plank—*Increase the influence of pharmacy leaders in hospitals and health systems*—uses clear, strong language to indicate that in order for pharmacists to ensure that the medication-use process is safe and effective for patients, they must be influential with the C-suite.

The fifth plank—*Promote pharmacists as the health care professional who is accountable for the medication-therapy outcomes of patients*—continues this rationale of pharmacists as leaders in medication use. As pharmacists, we must hold ourselves accountable for the medication therapy outcomes of patients, and other health care practitioners must know and trust that pharmacists consider this responsibility fundamental to pharmacy practice.

Search for a new Executive Vice President/Chief Executive Officer

You know, it's never fun to lose a good friend and mentor to retirement. I think I can speak for current and past Board members in saying that ASHP has been very lucky to have such a uniquely skilled, creative, forward-thinking leader as Dr. Manasse. As Henri contemplates his retirement next year, it is very clear that his leadership has changed ASHP in a thousand large and small ways. His clear-eyed vision of what pharmacy can achieve for both patients and practitioners is a chief reason behind ASHP's gains in national and international stature, in our improved ability to influence regulatory and legislative policy, and in our expansion and improvement of the services and resources that we offer to hospital and health-system pharmacists.

Thank you, Henri, for all you have done and continue to do on behalf of members and patients!

As you may know, former ASHP President Janet Silvester is chairing the search committee for a new Executive Vice President (EVP). The committee is looking at a broad range of issues in setting candidate requirements, including examining the implications of key issues that ASHP is likely to face in the next 5–10 years.

We are considering four general domains in assessing what is needed in the next ASHP EVP/Chief Executive Officer (CEO). These include current and future events that affect ASHP membership; contemporary pharmacy practice issues; ASHP programs, services, and governance; and ASHP's business model.

For example, we know that ASHP's business model will be driven by the need to continuously demonstrate the value of membership, a volatile economy, the changes brought about by globalization, the imperative to improve the delivery of health care, and the need to electronify ASHP's vast library of drug information resources.

The person we are seeking will have a number of attributes, including:

- Unquestioned honesty, integrity, and ethics;
- A passion for pharmacy, health-system practice, and ASHP;
- An ability to build relationships;
- And a forward-thinking perspective that offers inspiration to the organization and to the profession as a whole.

We are currently working with a search firm to create a fitting job description and are beginning to accept curricula vitae. In February 2011, the search committee will interview candidates. Candidates will then be presented to the Board for interview in the spring, and, next June, you will meet the new EVP/CEO designate.

If you would like to nominate a candidate, please go to www.ashp.org/evpsearch for more information. All nominations must be submitted by November 1, 2010.

Pharmacy Practice Model Initiative

Hopefully, you've been following the latest developments with ASHP's exciting Pharmacy Practice Model Initiative (PPMI). We now have a summit date set for November 7–9 in Dallas. We've received many nominations for participants and are working to ensure that attendees represent diverse practice settings and areas of expertise.

We are also getting ready to launch a survey of ASHP members to find out how they feel about the state of pharmacy practice and about the prospects of practice change. We'll be sharing survey results with members and will use them to help kick off discussions at the PPMI summit.

The PPMI couldn't come at a more opportune time. The health care reform legislation that passed this year reflects the driving need for high-quality, effective, and efficient patient care. As pharmacists who practice in hospitals and health systems, we have a key voice in how our medication-use systems are managed and what they will look like in the future.

The PPMI Summit has a number of objectives. At the end of the process, we want to be able to describe optimal pharmacy practice models that ensure the provision of safe, effective, efficient, and accountable medication-related care for hospital and health-system patients.

We assume that these new models will fully utilize the education and training of pharmacists, enhance the roles of pharmacy technicians, and incorporate current and future technologies. We will identify core patient-care-related services that should be consistently provided by departments of pharmacy in hospitals and health systems.

As you know, ASHP and the ASHP Research and Education Foundation have always been at the forefront of practice change. We were there 25 years ago when the Hilton Head con-

ference successfully laid the groundwork for the entry-level Pharm.D. degree and many of the professional opportunities that pharmacists now enjoy. And we've been spearheading change ever since, at the "Pharmacy for the 21st Century" Conference in 1989 and at the 1993 San Antonio conference that focused on implementing pharmaceutical care.

I'm very excited to be part of this effort, and I hope that you are, too. It will take all of us working together to figure out the right paths to the future. The PPMI is an investment on behalf of all members . . . we are *all* responsible for changing what is possible in pharmacy practice.

But we especially look to you, as members of the body that approves all professional policy and as practice leaders, to help jump-start practice change. I feel confident that all of us here today will be the early adopters of new practice models that fully utilize pharmacists' medication expertise.

Work-force Issues

ASHP hit an exciting milestone n April. We completed our 1000th residency program accreditation, at the Jesse Brown VA Medical Center Department of Pharmacy in Chicago. The postgraduate year 2 program in health-system pharmacy practice administration at the center is under the leadership of Richard J. Rooney.

Yet even with a record number of new residency programs in the United States, pharmacy continues as a profession, to face real capacity challenges. For the past 20 years, the number of residency applicants has consistently outpaced the number of positions available.

We must change that. Given the complexity of medication therapies and the growing number of patients who have both critical and long-term health care needs, we must have more residency-trained pharmacists who can manage complex medication therapies.

ASHP is well aware of the gap. And it has taken the position that by 2020—in just 10 years—all new pharmacy college graduates who will provide direct patient care should have completed an ASHP-accredited postgraduate year 1 residency.

So, I'm standing here today to ask every one of the leaders in this House . . . if your institution does not offer residencies, please take a good, hard look at whether you can start a program. If your institution does provide residencies, consider expanding the number offered.

We all know that residents help hospitals and health systems expand their scope of services. They help train pharmacy students, which helps address the need for more student experiential sites.

Institutions that host residents find that their recruitment and retention efforts are improved. Residents have passion for the profession, and they push the progression of pharmacy staff and services. They also take on special projects for which many pharmacy departments don't typically have time.

If you're interested in starting a new residency program, I urge you to take the time to come to ASHP's National Residency Preceptors Conference August 19-20 in Washington, D.C. We promise you'll come away from that meeting with great ideas on everything from funding a residency program . . . to actual program design . . . to preceptor development.

Conclusion

As I conclude, I hope you'll agree that ASHP is highly focused on the strategic and tactical priorities that matter most to members. Everything we do, from our Leadership Agenda on down to our day-to-day operations, reflects our mission to support the critical work that hospital and health-system pharmacists do on behalf of patients.

As the world of health care continues to evolve, we are poised and ready to help pharmacists take advantage of every opportunity to improve medication use, exhibit leadership within our institutions, and become evermore valuable members of the health care team.

I thank you for all of the support and goodwill you've shown me during this year of my presidency. My relationship with both ASHP and with each of you is something that I cherish every day.

Thank you!

2010 Report of the Executive Vice President and Chief Executive Officer

Keeping our focus during a difficult time

HENRI R. MANASSE, JR.

Am J Health-Syst Pharm. 2010; 67:e43-6

Let me begin my remarks today by talking about ASHP's efforts related to health care reform, a major piece of social and political legislation that will change the face of health care in the United States over the coming decades. The Patient Protection and Affordable Care Act creates a number of opportunities for hospital and health-system pharmacists to lead improvements in the quality of care and to create a more coordinated, integrated, and outcomes-oriented health care system.

The [new health care reform] law allows us to continue the national conversation about pharmacy's important role in establishing rational, safe, and accountable medication use in the United States.

Everything that ASHP advocated for during the recent reform debate was expressed in policy adopted by our House of Delegates. The policies that the House adopted gave us the tools and information we needed to educate congressional representatives, White House staffers, and a number of individuals who were engaged in crafting the legislation that the President signed on March 23, 2010.

We are very excited about the possibilities contained within the legislation to increase patient access and lay the groundwork for designating pharmacists as health care providers. The law allows us to continue the national conversation about pharmacy's important role in establishing rational, safe, and accountable medication use in the United States.

Under the Patient Protection and Affordable Care Act, pharmacists will be able to become part of medical home teams and help improve the health of high-risk patients as well as patients with chronic conditions in primary care settings.

Hospitals also will have financial incentives to improve health care quality, lower health care costs, and reduce the number of hospital-acquired conditions. Pharmacists can help hospitals achieve these imperatives by applying their medication therapy management expertise and by helping to convince the hospital enterprise to effectively use medications.

As we move forward, it is important that pharmacists promote their clinical and economic value within their own organizations. This will ensure that pharmacists are, in fact, members of patient care teams in all varieties of delivery models and that they can push innovation within those settings. Also, by including pharmacists in health care reform implementation efforts from the very beginning, health systems will ensure

HENRI R. MANASSE, JR, PH.D., SC.D., is Executive Vice President and Chief Executive Officer, American Society of Health-System Pharmacists, 7272 Wisconsin Avenue, Bethesda, MD 20814 (evp@ashp.org).

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their own success in improving patient care and reducing costs.

Pharmacy Practice Model Initiative

As you may know, ASHP has been very strongly engaged in a Pharmacy Practice Model Initiative (PPMI). This particular initiative reflects a long and distinguished history of collaborating with other pharmacy organizations on issues of mutual importance to pharmacists and patients.

As a founding member of the Joint Commission of Pharmacy Practitioners (JCPP), ASHP fully supports JCPP's 2015 vision. In fact, ASHP's own Pharmacy Practice Model Initiative aligns strongly with the JCPP vision, particularly as it relates to pharmacy practice models of the future. Specifically, the vision highlights the importance of communicating about the patient care role of the pharmacist and the need for new, appropriate payment models.

The JCPP vision also calls for pharmacists to be the health care professionals who are responsible for providing optimal medication therapy. The vision supports new pharmacy practice models that describe the desired patient care services provided by pharmacists and ensures that such services are widely and consistently available in all patient care settings in an accountable fashion.

The vision also supports transitioning from a payment system based mainly on product-based reimbursement to one that includes appropriate payment for professional services and management of the medication-use system. Finally, the vision supports a communication strategy that helps transform the profession by educating the public about pharmacists' patient care and medication management roles.

ASHP's PPMI reflects all of the best thinking that is currently happening in the profession about the next steps for a viable profession of the future. But we know that it can often take 40 years from innovation to actual adoption. That's a long curve.

So, I ask everyone here today: Is 40 years a reasonable and acceptable innovation curve? Can we wait that long, or will pharmacy as a profession of medication experts be lost long before that period is over? There is an urgency surrounding the PPMI. Essentially, we must find a stronger relationship between quality and cost, and pharmacy clearly has a critical role to play in demonstrating that relationship. We will continue to seek areas of common ground with our pharmacy organization colleagues.

One area where we are presently planning to work with the American Pharmacists Association (APhA) is continuity in transitions of care. We need to figure out how to connect the dots to get patients home from the hospital and vice versa with a continuous focus on appropriate medication use and effective communication among the pharmacist, patient, and prescriber.

New credentialing framework

ASHP continues to collaborate as a founding member of the Council on Credentialing in Pharmacy to ensure that all credentialing programs in pharmacy meet established standards of quality and contribute to improving patient care and overall public health. Moreover, this group is the professionwide table at which the matter of credentialing for pharmacists and technicians is being discussed.

In August 2009, this coalition of national organizations published the "Pharmacy Technician Credentialing Framework." This framework recommends that the profession establish national standards of quality for education, training, certification, and regulation of pharmacy technicians in all practice settings. This framework closely aligns with ASHP's policies regarding the technician work force and lends further support to our efforts to stimulate the adoption of consistent laws and regulations at the state level.

This year, the council is undertaking a similar effort to establish an agreed-upon framework for credentialing pharmacists. The need has never been greater for the profession to establish a clear vision regarding the appropriate use of credentialing and its validity. This effort will ensure that pharmacists are prepared and capable of providing care in increasingly complex health care environments. ASHP's staff and our President Lynnae Mahaney have been busy at this table all year.

Pharmacy Technician Initiative

As you know, ASHP has been actively working to encourage states to require standardized accredited education, registration, and Pharmacy Technician Certification Board (PTCB) certification of pharmacy technicians. As of June 2010, 19 states have agreed to partner with us in ASHP's Pharmacy Technician Initiative. Now, we have widened our approach to include technicians themselves.

We are launching a new website this summer that will provide important information to current and future technicians about their role, the value of the PTCB certification, and where to find accredited training programs. Finally, to help boost the availability of accredited training programs, we are reaching out to existing unaccredited training programs and encouraging them to become accredited.

I also have two announcements to make about pharmacy technician issues. One was the announcement by the Department of Veterans Affairs (VA) requiring PTCB certification for pharmacy technician employment. So, we thank our VA colleagues for moving this through the bureaucracy.

In addition, the National Association of Boards of Pharmacy (NABP), soon to be led by ASHP member Malcolm Broussard as their incom-

ing president, this past week passed an important resolution. The resolution said, "Be it resolved that NABP continue to encourage states to adopt uniform standards for pharmacy technician education and training programs." ASHP is very grateful for this important action. The puzzle pieces of technician education, certification, and training are starting to come together.

Board of Pharmaceutical Specialties ambulatory care credential

As the complexities of patient care multiply, the need for new, focused pharmacy skills is growing as well. The Board of Pharmaceutical Specialties (BPS) in 2009 unanimously approved a joint petition from ASHP, the American College of Clinical Pharmacy, and APhA requesting recognition of ambulatory care pharmacy practice.

Ambulatory care practice, defined as a specialty in medication use for preventive and chronic care, is now the sixth specialty in which pharmacists can be board certified. This is such an important event because, as health care reform begins to take shape, pharmacists who are specialty certified will likely be in tremendous demand.

BPS has established a specialty council for this new credential. The council has been defining the details of the certification process for this new specialty and preparing content for the certification examination. It should be noted that about 50% of the examination content focuses on direct patient care.

Former ASHP President Cindy Brennan serves on the council, and we have heard from a variety of people about the importance of her role.

Specialists in ambulatory care pharmacy practice should be able to take the first certification exam in the fall of 2011. To help pharmacists prepare, we are pleased to announce that ASHP and APhA are partnering to offer both live and online review courses in preparation for taking the exam. The first offering of the live review course will be held immediately before ASHP's Midyear Clinical Meeting in Anaheim in December. It will also be offered in conjunction with the APhA annual meeting in 2011.

American Medical Association's scope of practice controversy

In this era of advanced pharmacy practice and enhanced public focus on medication safety and efficacy, it is more than a little surprising that the American Medical Association (AMA) recently published a scope of practice data series on pharmacists that inaccurately portrays how pharmacists are educated and what pharmacists do and that seeks to establish a political base for limiting pharmacists' scope of practice.

ASHP responded aggressively to the document, pointing out the use of erroneous information, false statements, and, frankly, pure errors of fact about pharmacists' education, training, and practice.

In our view, the AMA's point of view is out of the mainstream of practice and contemporary thinking. The scope of practice document is devoid of what prominent national boards and regulatory bodies such as the Institute of Medicine, the National Quality Forum, the American Board of Internal Medicine, and seven other medical specialty organizations are saying about the importance of collaborative care and the inclusion of pharmacists in team-based care.

It is clear from the AMA document that the organization is concerned about the way that medication therapy management and collaborative practice agreements have evolved and continue to evolve. But there has never been a time of greater need for the medication expertise of pharmacists on health care teams, and I think the new health care reform legislation recognizes that importance.

We continue to witness very strong collaboration between pharmacists and physicians, both in ambulatory and in inpatient care settings. That is why we felt that we had to take a forceful stand. ASHP sent a strongly worded letter to AMA's Chief Executive Officer Dr. Michael Maves that detailed the inaccuracies and untrue representations.

We believe that it will take every health profession working together to ensure that patients receive the safest and most effective care. Pharmacists are a critical component of that delivery model.

Dealing with a difficult economy

ASHP continues to deal with the aftermath of the economic meltdown of last year. We are holding our own due to a number of factors, including the hard work by our staff to keep expenses down, some good news about recovery in the marketplace in our investments, and the personal sacrifices that staff have made in terms of salary and benefit reductions.

ASHP's experienced and talented staff are one of the greatest assets that the Society has. I am happy to report that the Board approved in early 2010 a partial reinstatement of the salary levels that were cut during the worst of the recession. We are also examining some pension plan options that provide an important safety net to our employees while ensuring a reasonable pension liability for the Society.

But we are not out of the woods yet. Our approach to doing business, namely to do it more efficiently and more effectively, will remain the same even as the economy recovers. We are committed to staying lean while also looking for new and innovative opportunities to improve our income base. Overall, ASHP will continue to provide services and resources that members need while staying committed to a strong fiscal foundation.

Conclusion

I would like to express my heartfelt and sincere gratitude to the members of the House and the Board of Directors for all of the hard work they do on behalf of ASHP and the profession as a whole. I also want to extend a personal thank you to the ASHP staff and the Board members who have exhibited a steadfast spirit and positive outlook as we've managed through a very difficult time. We are starting to see the green sprouts of a recovery, and that is an exciting development.

As we collectively work to transform our health care system and recover from a very difficult economic crisis, I want to encourage you to keep looking forward. ASHP is here to support you and to reflect the very best that pharmacists can bring to patient care throughout our nation. It will take all of us working together to ensure that our profession continues to bring real value to our nation's patients. Together, we really do make a great team!

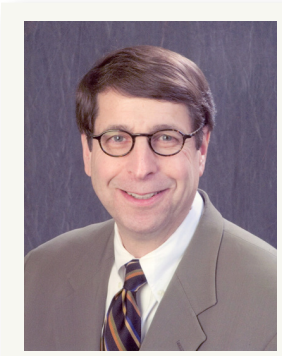
Thank you.

2010 Report of the ASHP Treasurer

Recovery . . . Stability . . . Strength

Paul W. Abramowitz

Am J Health-Syst Pharm. 2010; 67:e47-9



The Society's financial year is from June 1 through May 31, coinciding with its policy development year. This year I will report on (1) the final audited prior-year numbers (for the fiscal year 2009), (2) the current year (2010) projected performance, and (3) the budget for the fiscal year ending May 31, 2011.

The audit of the May 31, 2009, financial statements of the Society and the Society's subsidiary, the 7272 Wisconsin Building Corp., resulted in an unqualified opinion. Copies of the audited statements are available by contacting the ASHP Executive Office.

Fiscal Year Ending May 31, 2009–Actual

Last year I reported to you that falling market values in the Society's reserve portfolio, falling core revenue, and an anticipated pension adjustment would combine to produce a projected $23.398 million loss. We did in fact end the year with a deficit, but thanks to an improvement in the financial markets just before year's end, our loss for the 2009 fiscal year was $18.368 million (Figure 1). Net worth, which was projected to decrease to $12.005 million, 22% of total annual expense, actually ended the fiscal year at $17.035 million, 33% of total annual expense.

Like all corporate balance sheets, the Society's May 31, 2009, year-end balance sheet (Figure 2) was not immune from the effects of the financial crisis that impacted our nation. Assets decreased by $16.735 million (28%), while liabilities increased $1.633 million (6%). The asset-to-liability ratio, which had been $2.40:$1.00 at May 31, 2008, fell to a still-respectable (by 2009 standards) $1.63:$1.00 at May 31, 2009.

Fiscal Year Ending May 31, 2010–Projected

This year, a recovery in the market value of the Society's reserve portfolio is bringing positive results to both the statement of income and expense and to the balance sheet's net worth. A projected $1.117 million surplus in the core, coupled with a $3.425 million surplus projected in the program development budget (funded by investment income), produces a projected corporate net income of $4.542 million for the fiscal year ended May 31, 2010 (Figure 1). The surplus is anticipated to grow net worth to $21.577 million at May 31, 2010, 45% of total expense.

Fiscal Year Ending May 31, 2011–Budget

Like many for-profit, non-profit, and governmental entities, the Society continued to struggle to maintain its core strategic operations in the face of declining revenues and falling asset values. The 2011 budget was certainly a challenge to prepare, but it is a balanced budget, with a surplus of $171,000 in the program development budget offsetting a $171,000 deficit in the core (Figure 1). Investment income has been included in the 2011 program development budget at a modest 4.16% return. Although the 2011 budget represents a smaller ASHP (the 2010 budget included a 15% workforce reduction, implemented across all offices and divisions of the organization) with less revenue and less spending, we believe it provides the resources necessary to maintain the services critically important to our members.

7272 Wisconsin Building Corporation

The Society's subsidiary, the 7272 Wisconsin Building Corporation, finished the 2009 fiscal year on a positive note, producing a $1.484 million net income before owner's distribution (Figure 3). The subsidiary owns the headquarters building and derives income from leased commercial and office space.

Conclusion

Working together, the Board, the membership, and the staff have kept ASHP a strong and vibrant organization during the last 24 months of economic turmoil. Today ASHP is smaller than before, but with the prudent use of resources, the Society is well positioned to meet the needs of its membership.

DOI 10.2146/sp100009

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

	Actual Fiscal Year Ended May 31, 2009	Projected Fiscal Year Ended May 31, 2010	Budget Fiscal Year Ended May 31, 2011
CORE OPERATIONS			
Gross revenue	$ 42,207	$ 41,239	$ 42,280
Total expense	(45,158)	(40,872)	(43,201)
Earnings from subsidiary	1,484	750	750
Core Net Income	$ (1,467)	$ 1,117	$ (171)
PROGRAM DEVELOPMENT			
Investment income	$ (12,412)	$ 4,968	$ 1,493
Program expenses	(2,217)	(1,543)	(1,322)
Program Development Net Income	$ (14,629)	$ 3,425	$ 171
PROGRAMS - NET WORTH			
Programs funded from Net Worth	$ (744)	$ —	$ —
ASHP Net Income	$ (16,840)	$ 4,542	$ —
Pension Plan Adjustment	(1,528)	—	—
ASHP Net Income	$ (18,368)	$ 4,542	$ —
Net Worth Beginning of Year	$ 35,403	$ 17,035	$ 21,577
ASHP Net Income	(18,368)	4,542	—
Net Worth End of Year	$ 17,035	$ 21,577	$ 21,577
% of Total Expense	33%	45%	44%

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

	Actual as of May 31, 2009	Actual as of May 31, 2008
ASSETS		
Current assets	$ 6,122	$ 8,040
Fixed assets	2,342	3,106
Long-term investments (at market)	32,579	46,861
Investment in subsidiary	2,708	2,460
Other assets	250	269
Total Assets	$ 44,001	$ 60,736
LIABILITIES		
Current liabilities	$ 17,909	$ 19,049
Long-term liabilities	9,057	6,284
Total Liabilities	$ 26,966	$ 25,333
NET ASSETS		
Net assets	$ 17,035	$ 35,403
Total Net Assets	$ 17,035	$ 35,403
Total Liabilities and Net Assets	$ 44,001	$ 60,736

Figure 3. 7272 Wisconsin Building Corp. (ASHP subsidiary) statement of financial position and statement of activites for fiscal year 2009 (in thousands).

	Fiscal Year Ended May 31, 2009
REVENUE AND EXPENSE	
Gross revenue	$ 6,352
Operating expense	(4,246)
Operating Income	$ 2,106
Provision for income taxes	$ (622)
Increase in Net Assets	$ 1,484
Owner's distribution and capital contributions	$ (1,236)
Net Increase in Net Assets	248

	Actual as of May 31, 2009
ASSETS	
Current assets	$ 1,508
Property and plant (net)	18,115
Other assets	1,231
Total Assets	$ 20,854
LIABILITIES	
Current liabilities	$ 860
Mortgage payable	16,995
Other liabilities	291
Total Liabilities	$ 18,146
NET ASSETS	
Net assets	$ 2,708
Total Net Assets	$ 2,708
Total Liabilities and Net Assets	$ 20,854

House of Delegates Session—2010

Board of Directors Reports on Councils

ASHP councils met in Bethesda, Maryland, September 22–23, 2009.

Each report has three sections:

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

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

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

Policy Recommendations

1 Council on Public Policy

A. Full Health Insurance Coverage
B. Risk Evaluation and Mitigation Strategies
C. FDA Authority on Recalls
D. Postmarketing Comparative Clinical and Pharmacoeconomic Studies
E. Medication Therapy Management
F. Definition of Meaningful Use of Health Information Technology
G. Regulation of Home Medical Equipment Medication Products and Devices
H. Employment Classification of Pharmacy Residents

7 Council on Therapeutics

A. Preservation of Antimicrobials for Medical Treatment
B. Safety and Effectiveness of Ethanol for Treatment of Alcohol Withdrawal Syndrome
C. Use of Surrogate Endpoints for FDA Approval of Drug Uses
D. Quality Consumer Medication Information
E. Research on Drug Use in Obese Patients

14 Council on Education and Workforce Development

A. Interprofessional Education and Training
B. Minimum Hiring Standards for Pharmacy Technicians
C. Professional Development

18 Council on Pharmacy Management

A. Pharmaceutical Distribution Systems
B. Impact of Insurance Coverage Design on Patient Care Decisions
C. Prudent Purchasing of Pharmaceuticals

23 Council on Pharmacy Practice

A. Standardization of Device Connections to Avoid Wrong-Route Errors
B. Medication Safety Officer Role
C. Role of Pharmacists in Safe Technology Implementation
D. Just Culture and Reporting Medication Errors
E. Patient Access to Pharmacy Services in Small and Rural Hospitals
F. Scope and Hours of Pharmacy Services
G. Use of Two Patient Identifiers in the Outpatient Setting

House of Delegates Session—2010

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.

John A. Armitstead, Board Liaison

Policy Recommendations

A. Full Health Insurance Coverage

To advocate health insurance for all legal residents of the United States, including coverage of medications and related pharmacist patient-care services; further,

To advocate that the full range of available methods be used to (1) ensure the provision of appropriate, safe, and cost-effective health care services, (2) optimize treatment outcomes, and (3) minimize overall costs without compromising quality; further,

To advocate that health insurers seek to optimize continuity of care in their design of benefit plans.

(Note: This policy would supersede ASHP policy 0512.)

Rationale

This policy expresses ASHP's stance on coverage for the uninsured in the United States. The policy emanated from ASHP policies dealing with affordability and accessibility of pharmaceuticals. The Council believed and the Board agreed that it is important to address the larger issue of coverage for the uninsured, particularly due to the impact of the cost of medications on the nation's overall health care budget as well as pharmacy budgets in hospitals and health systems.

Background

The Council voted and the Board agreed to recommend amending ASHP policy 0512 as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

To advocate ~~full~~ health insurance ~~coverage~~ for all legal residents of ~~persons living in~~ the United States, including coverage of ~~prescription~~ medications and related pharmacist patient-care services; further,

To advocate that ~~all health insurers, both public and private, use~~ the full range of available methods be used to (1) ensure the provision of appropriate, safe, and cost-effective health care services ~~for their beneficiaries~~, (2) optimize ~~the~~ treatment outcomes ~~of the insured population~~, and (3) minimize overall ~~program~~ costs without compromising quality; further,

To advocate that health insurers seek to optimize continuity of care in their design of benefit plans.

ASHP policy 0512 expressed ASHP's stance on coverage for the uninsured in the United States. The Council revised policy 0512 in light of current congressional proposals on health care reform.

In the first clause the Council agreed and the Board concurred to delete the term "full" in describing health insurance coverage, since it was subject to interpretation. Council members noted that further debate and interpretation could ensue on what is meant by various levels of coverage (e.g., basic, enhanced, etc.) and whether they could be considered "full." The Council proposed and the Board concurred to add the term "legal residents of" and delete "persons living in" [the United States] to address the concern about providing coverage for persons residing illegally in the United States. The Council also proposed and the Board concurred in deleting the term "prescriptions" to note that coverage should be for medications, since nonprescription medications should be covered under certain circumstances.

In the second clause, the Council (with the Board's concurrence) deleted three phrases: (1) "all health insurers, both public and private, use"; (2) "for their beneficiaries"; and (3) "of the insured popula-

tion," in order to broaden the emphasis on the overall health care system and its many stakeholders (including insurers) while still acknowledging the need to address cost and quality.

B. Risk Evaluation and Mitigation Strategies

To advocate for research on the impact of the Food and Drug Administration's Risk Evaluation and Mitigation Strategies (REMS) on patient safety, cost effectiveness, and pharmacy workflow; further,

To advocate pharmacist involvement in the development and implementation of REMS; further,

To urge computer software vendors to assist pharmacists in the identification of and compliance with REMS; further,

To advocate that any REMS that include constraint on traditional drug distribution systems be consistent with ASHP policy on restricted drug distribution.

Rationale

Risk Evaluation and Mitigation Strategies (REMS) are part of new authority granted to the Food and Drug Administration (FDA) to ensure that a drug's benefits outweigh its risks. An increasing number of drug products require REMS in order to be marketed, and some REMS require Medication Guides as well as other "elements to assure safe use." These elements beyond a Medication Guide have included prescriber and pharmacist training, patient registry, and additional patient monitoring. The Council believed and the Board agreed that more research should be conducted by either the FDA or drug manufacturers to determine the effectiveness of and need for REMS.

Health-system pharmacists have encountered problems with REMS that were developed without input from health-system pharmacy. Pharmacist input in the development of REMS is essential to avoid unnecessary barriers to patients and burdensome interruptions to pharmacy workflow that could impact patient care and safety.

Drug information and knowledge vendors providing information technology and decision support systems will need to include gateways to specific information about REMS so that pharmacists and other health professionals have access to information about all REMS-required products and the specific requirements for a particular REMS that includes elements to assure safe use.

The Council and Board agreed that REMS that include constraints on traditional drug distribution systems should be consistent with existing ASHP policy on restricted drug distribution.

Background

This policy stemmed from staff recommendation and current FDA consideration of proposals for REMS for opioid analgesics. In addition, ASHP member experience with Medication Guides and RiskMaps (a precursor to REMS) suggested a need to advocate for standardization of REMS elements and input by pharmacists.

The Council believed and the Board concurred that it was important to have a distinct policy that addresses REMS. The Council noted the increase in drug products that require REMS in order to be marketed and that some REMS require Medication Guides as well as other "elements to assure safe use" (e.g., prescriber and pharmacist training, patient registry, or additional patient monitoring). The Council felt and the Board agreed that research should be conducted by either the FDA or the manufacturer to determine the effectiveness of and need for REMS.

The Council discussed and the Board reviewed the experience of practitioners with REMS that were developed without input from health-system pharmacy. They recognized the need to advocate for pharmacist input in the development of REMS to avoid unnecessary barriers to patients and burdensome interruptions to pharmacy workflow that could impact patient care and safety.

The Council also noted and the Board agreed that drug information and knowledge vendors providing information technology and decision support systems will need to include gateways to specific information about REMS to enable pharmacists and others to access information about all REMS-required products and the specific requirements for a particular REMS that includes elements to assure safe use.

In developing this policy, the Council referred to existing ASHP policy 0714, Restricted Drug Distribution, and reiterated ASHP support for granting the FDA authority to require that manufacturers disclose all of the considerations that led to the establishment of a restricted distribution system for a specific product. The goal of such a requirement is to allow the existing distribution system to provide patient access and pharmacist patient care services.

C. FDA Authority on Recalls

To strongly encourage the Food and Drug Administration (FDA) to develop a standard recall notification to be used by all manufacturers; further,

To advocate that such notification should (1) come from a single source, (2) clearly identify the recalled product, (3) explain why the product is being recalled, (4) provide a way to report having the recalled product, and (5) give instructions on what to do with the recalled product; further,

To advocate that the FDA be given the authority to order mandatory recalls of medications; further,

To urge the FDA to require drug manufacturers and the computer software industry to provide bar codes and data fields for lot number, expiration date, and other necessary and appropriate information on all medication packaging, including unit dose, unit-of-use, and injectable drug packaging, in order to facilitate compliance with recalls or withdrawals; further,

To urge the FDA to encourage postmarketing reporting of adverse events and product quality issues to enhance the recall system.

Rationale

The Council and Board agreed that the FDA must have the authority to clearly communicate with stakeholders about recalls of marketed products. Inconsistent, unclear, and confusing information has been communicated during past recalls. A standardized recall notification should be used by manufacturers because it would enable practitioners and others in the drug distribution chain to readily identify and respond to a recall. Such a notification should contain the following elements: a single source to designate a point of contact and control communication, clear identification of the recalled product to assist in removing the product from stock, an explanation of why the product is being recalled in order to understand the nature of the recall and communicate with patients and other stakeholders, a feedback mechanism (a reporting loop) so manufacturers and the FDA know where recalled product is located, and instructions on how to return or dispose of the recalled product.

The Council and Board also agreed that the FDA should be given the authority to order a mandatory recall of a product to avoid the miscommunication that has occurred in past voluntary recalls. In addition, ASHP policy encourages the FDA to require lot number, expiration date, and other necessary information be provided electronically (e.g., by bar code or radio frequency identification) as part of the manufacturer's information on all unit dose, unit-of-use, and injectable drug packaging.

Finally, the Council and Board suggested that postmarketing reporting of adverse events and product quality issues must be encouraged. Voluntary reporting will provide information for FDA

to analyze to determine with the manufacturer the correct course of action.

Background

The Council developed this policy in response to a recommendation from the ASHP House of Delegates. In addition, staff review of the recent experience with recalls of heparin and other drug products prompted the development of policy regarding the current authority of the FDA and the communication process for recalls.

The Council and the Board recognized the need for FDA to have the authority to clearly communicate with stakeholders about recalls of marketed products, since inconsistent, unclear, and confusing information has been communicated during past recalls. The Council noted the need for a standardized recall notification that should be used by manufacturers to enable practitioners and others in the distribution chain to readily identify and respond to a recall. The Council and the Board agreed that such a notification should contain the elements listed in the policy. The Council believed and the Board concurred that FDA should be given the authority to order a mandatory recall of a product to avoid the miscommunication that has occurred in past voluntary recalls.

The Council and the Board noted the relevance of existing ASHP policy regarding manufacturers providing necessary information electronically on all unit dose, unit-of-use, and injectable drug packaging. ASHP policy encourages the FDA to require that lot number, expiration date, and other necessary information be provided electronically (e.g., by bar code or radio frequency identification) as part of the manufacturer's information on all unit dose, unit-of-use, and injectable drug packaging (ASHP Statement on Bar-Code-Enabled Medication Administration Technology). The Council also noted that improvements are needed in existing bar codes, which are not always functional and can require unnecessary repackaging of medications.

Finally, the Council and Board recognized the importance of increasing postmarketing reporting of adverse events and product quality issues, because voluntary reporting will provide information for FDA to analyze to determine with the manufacturer the correct course of action.

D. Postmarketing Comparative Clinical and Pharmacoeconomic Studies

To advocate expansion of comparative clinical and pharmacoeconomic studies on the effectiveness, safety, and cost comparison of marketed medications in order to improve therapeutic outcomes and promote cost-effective medication use; further,

To advocate that such studies compare a particular medication with (as appropriate) other medications, medical devices, or procedures used to treat specific diseases; further,

To advocate adequate funding for the Agency for Healthcare Research and Quality and other federal agencies to carry out such studies; further,

To encourage impartial private-sector entities to also conduct such studies.

(Note: This policy would supersede ASHP policy 0513.)

Rationale

Pharmacists, other members of the health care team, patients, and private and public payers need objective, authoritative, reliable evidence in order to make the best treatment decisions. Since the passage of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the Agency for Healthcare Research and Quality (AHRQ) has been tasked with studying the outcomes, comparative clinical effectiveness, and appropriateness of health care items and services. For such research to contribute to the practice of evidence-based patient care, good clinical decision-making, and rational drug use, AHRQ must evaluate devices, invasive procedures, and prescription and nonprescription medications, including both labeled and unlabeled uses of prescription drugs. Since prescription drugs represent a significant and growing portion of health care costs, the need for such research is increasingly important. Although impartial private sector entities can supplement the research efforts of government agencies such as AHRQ, only the federal government has the ability to support such independent research, provide oversight to safeguard the integrity of the research process, and disseminate the findings.

Background

The Council voted and the Board agreed to recommend amending ASHP policy 0513 as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To advocate ~~an~~ expansion of comparative clinical and pharmacoeconomic studies ~~of~~ on the effectiveness, ~~and~~ safety, and cost comparison of marketed medications in order to improve therapeutic outcomes and promote cost-effective medication use; further,
>
> To advocate that such studies compare a particular medication with (as appropriate) other medications, medical devices, or procedures used to treat specific diseases; further,
>
> To advocate adequate funding for the Agency for Healthcare Research and Quality and other federal agencies to carry out such studies; further,
>
> To encourage impartial private-sector entities to also conduct such studies.

The Council continued its discussion from 2008 concerning the issue of including comparative effectiveness research as factors in coverage decisions for medications. It revised ASHP policy 0513 to add in the first clause the terms "pharmacoeconomic" studies and "cost comparisons" as factors in evaluating a medication's use. The Council felt and the Board agreed about the need to be explicit in adding these terms in light of recent consideration of the terms in the American Recovery and Reinvestment Act (ARRA).

In addition, priorities for comparative effectiveness research and the federal infrastructure to support it will continue to receive attention from federal agencies and policymakers. The Council proposed and the Board concurred in revising the third clause to acknowledge this continued evolution beyond the AHRQ and the need for continued ASHP advocacy for funding of this effort.

E. Medication Therapy Management

To support medication therapy management (MTM) as a partnership of the patient (or a caregiver), pharmacist, and other health care professionals that promotes the safe and effective use of medications, as defined in the 2004 consensus definition of MTM services by national pharmacy organizations, including ASHP; further,

To advocate that collaborative drug therapy management practices fall under the scope of MTM.

Rationale

The term "medication therapy management" (MTM) has received widespread use within the pharmacy profession and among health policymakers. The definition of MTM under Part D of the Medicare program is significantly different from the consensus definition developed by national pharmacy organizations, including ASHP, in 2004 (Appendix). Provisions dealing with MTM grant programs contained in current health care reform proposals broaden and

enhance MTM beyond the Part D definition. Those provisions also refer to collaborative practice agreements as allowed by state practice acts, referred to in ASHP policy and elsewhere as "collaborative drug therapy management" (CDTM). As health care reform evolves and is implemented, it is important to recognize the difference between these two terms: MTM is a broad umbrella term, and CDTM services fall under that broad concept.

Background

This policy resulted from the Council's discussion about various provisions in health care reform legislation and ASHP's experience with the use of MTM and CDTM terminology since passage of Part D under Medicare. To clarify the use of terms and make a distinction between MTM and CDTM, the Council developed and the Board concurred with this policy to refer to the consensus definition developed in 2004 and other existing ASHP policies (9801, 9812, and 0905) that describe CDTM.

F. Definition of Meaningful Use of Health Information Technology

To advocate to policymakers (public and private) that definitions of "meaningful use of health information technology" address interoperability of medication orders and prescriptions, medication decision support and continuous improvement, and quality reporting; further,

To advocate with respect to interoperability of medication orders and prescriptions that (1) a common medication vocabulary be mandated to promote the semantic interoperability of medication use across the continuum of care, because a common vocabulary is essential for comparative effectiveness research and for communicating medication information; and (2) communication of orders and electronic prescriptions must be demonstrated to be functional and semantically interoperable with pharmacy information systems; further,

To advocate with respect to medication decision support and continuous improvement that (1) medication decision support should include but not be limited to allergy, drug interaction (e.g., drug-lab, or drug-disease interactions), duplicate therapy, and dose-range checking; and (2) that such a decision-support service must include an ongoing, continuous improvement process to attune the decision-support service to the needs of the providers who use it; further,

To advocate with respect to quality reporting that the ability to quantify improved patient safety, quality outcomes, and cost reductions in the medication-use process is essential, particularly in antimicrobial and adverse event surveillance.

Rationale

The Council and Board recognize the growing influence of health information technology (HIT) on health-system pharmacy practice. Provisions in ARRA direct federal policymakers to develop definitions of and standards regarding the term "meaningful use" and the implementation of HIT by hospitals and health systems in order to receive incentive payments from Medicare and Medicaid.

Since the medication-use process is pervasive in health systems and throughout the continuum of care, the definition of "meaningful use" needs to address the concept of interoperability, the criticality of decision support systems, and the use of quality reporting to improve patient safety.

Background

This policy was developed in response to a New Business Item from the ASHP House of Delegates related to ongoing proposals by the Office of the National Coordinator for Health Information Technology (ONCHIT) within the Department of Health and Human Services. ASHP and its Section of Pharmacy Informatics and Technology have also been engaged with ONCHIT as it implements provisions in ARRA.

The Council noted the growing influence of HIT on health-system pharmacy practice. In particular, it examined the provisions in ARRA that direct federal policymakers to develop definitions of and standards regarding the term "meaningful use" and the implementation of HIT by hospitals and health systems in order to receive incentive payments from Medicare and Medicaid.

The Council and the Board recognized the need to develop policy on the medication-use aspects of meaningful use as it is defined and implemented. The policy addresses the concept of interoperability, the criticality of decision support systems, and the use of quality reporting to improve patient safety. The Council believed and the Board concurred that this policy would demonstrate health-system pharmacy's interest in the broad issue of HIT and enable advocacy on its medication-use aspects during consideration of that broader issue.

G. Regulation of Home Medical Equipment Medication Products and Devices

To advocate that state boards of pharmacy or other regulatory agencies develop regulations concerning the medication-related aspects of suppliers of legend home medical equipment medication products and devices (e.g., oxygen, implantable pumps, respiratory, and wound care) to ensure patient safety and improve the continuity of care; further,

To monitor the impact of the Centers for Medicare & Medicaid Services quality standards on the accreditation of suppliers of medication-related durable medical equipment, prosthetics, orthotics, and supplies.

Rationale

Federal and state regulation of home medical equipment (HME) and durable medical equipment (DME) suppliers creates a gap in pharmacist review and input in medication-related aspects of the services these suppliers provide to patients, particularly when a patient is discharged from the hospital to the home. The Centers for Medicare & Medicaid Services (CMS) provides conditions of participation for home health services, and states may regulate HME and DME suppliers, home health agencies, and suppliers of medical gases. Furthermore, CMS has proposed surety bond requirements for pharmacies that are also DME suppliers. The Council recommended and the Board agreed that ASHP should advocate for regulation of these medication-related aspects by state boards of pharmacy or other regulatory agencies so that this medication-use process ensures patient safety and improves continuity of care.

Background

This policy was discussed based upon a recommendation from the ASHP House of Delegates. The Council examined the current regulatory scheme for home HME and DME suppliers at the federal and state levels. The Council developed and the Board concurred with new proposed policy to advocate for regulation of these medication-related aspects by state boards of pharmacy or other regulatory agencies so that the medication-use process is designed to ensure patient safety and improve continuity of care.

H. Employment Classification of Pharmacy Residents

To advocate that pharmacy residents, as part of the organization's graduate medical education program, should be classified as exempt employees; further,

To advocate that pharmacy residents be subject to duty hour limits (similar to resident physicians) with respect to all clinical and academic activities during their training program in accordance with the Accreditation Council on Graduate Medical Education (ACGME) standards and ASHP accreditation standards for pharmacy residency programs.

Rationale
In some states, pharmacy residents are classified as non-exempt employees (eligible for overtime pay) in accordance with guidance from state employment offices. The Council and Board agreed that there is an important job classification distinction between pharmacists employed by a hospital or health system and pharmacy residents who are part of an organization's residency program. Specifically, pharmacy residents are in an organized, directed, and accredited postgraduate training program that builds upon knowledge, skills, attitudes, and abilities gained from an accredited professional pharmacy-degree program. Pharmacy residents receive a salary and are subject to the same duty hours as physicians. Classifying residents as non-exempt employees is overly burdensome and counterproductive to the residency experience and objectives of the training program. Moreover, it could inhibit the development of an important component of the pharmacy workforce at a time of increased demand for pharmacist services as health care reform is implemented.

Background
This policy was discussed based upon a recommendation from the ASHP House of Delegates. The Council discussed the important job classification distinction between pharmacists employed by a hospital or health system and pharmacy residents. The Council believed and the Board concurred that classifying residents as non-exempt employees would be overly burdensome and counterproductive to the residency experience and objectives of the training program and could inhibit the development of an important component of the pharmacy workforce at a time of increased demand for pharmacist services.

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 still be appropriate. (No action by the House of Delegates is needed to continue these policies.)

- Dispensing by Nonpharmacists and Nonprescribers (0010)
- Statutory Protection for Medication-Error Reporting (0011)
- FDA's Public Health Mission (0012)
- Patient's Right to Choose (0013)
- Premarketing Comparative Clinical Studies (0514)
- Postmarketing Safety Studies (0515)
- Mandatory Registry of Clinical Trials (0516)
- Funding, Expertise, and Oversight of State Boards of Pharmacy (0518)
- Opposition to Creation of New Categories of Licensed Personnel (0521)

Other Council Activity

FDA Regulation of Tobacco. The Council noted new authority for the FDA to establish a Center for Tobacco Products to regulate the marketing and promotion of these products as well as set performance standards. The Council suggested that the activities of the new FDA center be monitored as it accomplishes certain deadlines set forth in the new law over the next few years. It noted that the Council should review the progress and work of the Center at its meeting next year.

Medical Use of Marijuana. A growing number of states are permitting the medical use of marijuana within certain requirements. These include patient registration with the state, approved medical conditions to allow possession and cultivation of small quantities, and in some cases, registration of dispensaries. The Council concluded that more research on the evidence, including side effects, was needed before a policy could be developed. It recommended continued monitoring of state legislation and enforcement as well as new research on this issue.

State Regulatory Approach to Reporting Medication Errors. A recent conviction and prison sentence for a pharmacist in Ohio who was involved in a medication error involving the death of a pediatric patient was discussed. The Council remained concerned about the proper instances of criminal prosecution involving pharmacists. In particular, it was concerned about the impact of this type of case on overall reporting of medication errors, the ability to learn from those reports, and opportunities to institute changes to the medication-use system. The Council noted that state boards of pharmacy have the authority to protect the public through licensure sanctions in cases involving medication errors if warranted, and acknowledged the use of the civil court to address professional liability issues. However, it remained concerned about instances in which medication errors were being adjudicated in the criminal courts.

The Council noted that the Council on Pharmacy Practice discussed additional explanation of the term "just culture" in ASHP policy 0910. It also noted the need to incorporate the concepts of just culture into the ASHP Statement on Reporting Medication Errors. The Council decided to closely monitor the situation and revisit this topic as needed.

Extending 340B Discounts to Inpatients. The Council discussed provisions in health care reform proposals that would extend discounts to a hospital's inpatient operation if the institution was eligible for the drug discount (340B) program administered by the Office of Pharmacy Affairs of the Health Resources and Services Administration (HRSA). Members acknowledged ASHP policy 0506 that advocates for inpatient inclusion in the 340B program. They noted the potential for cost-shifting to non-340B entities and suggested further research on the ramifications of further expansion.

U.S. Hospital Use of Drugs Manufactured and Approved by Foreign Countries. ASHP members recommended discussion of the use by patients in hospitals of drugs manufactured and approved by foreign countries but brought into the United States for personal use. The Council examined relevant federal laws and enforcement of this issue, including guidance by the FDA, "Coverage of Personal Importations." The Council felt that this issue did not warrant policy but suggested that the membership be informed about practice considerations and suggestions for use via ASHP communications vehicles.

CMS Conditions of Participation on Standing Orders. Interpretation by CMS of its Conditions of Participation with respect to prescriber signature of standing orders has received attention from and generated concern among pharmacists. Council members noted the need for additional clarification by CMS with respect to this issue,

particularly in non-emergency situations. The Council did not feel the need for ASHP policy but noted ongoing advocacy with CMS to obtain additional guidance.

Pharmacy Technician Scope of Practice. The use of pharmacy technicians to collect medication histories as part of required patient medication reconciliation has prompted questions concerning a technician's defined role and responsibilities. The Council noted technicians' ability to assist in collecting medication histories and the role of the pharmacist in reviewing it prior to inclusion in the patient's medical record. The Council did not think specific policy was needed and suggested that the issue be monitored and more information be gathered to determine the extent to which technicians are used in the medication reconciliation process.

Pharmacist Right of Conscience. The Council reviewed a recent federal Appeals Court decision involving Washington State Board of Pharmacy rules for dispensing Plan B products. It assessed existing ASHP policy in light of the Court's decision to allow the Board's rules to be implemented, noting the balance in ASHP policy 0610 that acknowledges a pharmacist's right of conscience as well as a patient's right to access therapy. The Council suggested monitoring the case in the event it is appealed.

Accreditation of Community Pharmacies. A recent National Association of Boards of Pharmacy task force explored the development and implementation of a pharmacy accreditation program to ensure pharmacies are operating in a manner consistent with continuous quality improvement standards. The Council noted that ASHP policy 0617 addressed accreditation of compounding facilities where extemporaneous compounding occurs. It further noted that hospitals and health systems were accredited by The Joint Commission or inspected by states to comply with CMS Conditions of Participation. The Council did not recommend policy but supported the concept that accreditation of all pharmacies (as appropriate) would ensure consistency and quality throughout practice and help lead to quality improvement.

State Requirements for Point-of-Care Testing. The Council noted that certain states create barriers or do not allow pharmacists to conduct laboratory tests as part of collaborative practice agreements. The Council also noted that ASHP policy 9801, which describes collaborative practice, includes performing laboratory tests. The Council recommended conducting a survey in conjunction with the Section of Home, Ambulatory and Chronic Care Practitioners that would identify where and to what extent these barriers exist.

Worker Representation and Collective Bargaining. Recent legislative proposals to allow for open (non-secret) balloting for worker selection of a collective bargaining agent prompted the Council to assess its impact on health-system pharmacy organizations. Council members related how pharmacists are grouped with other hospital personnel (including technicians and clerical workers) to form a bargaining unit. The Council concluded that more research is needed on how employers classify pharmacists and how those classifications compare with those of other hospital workers (e.g., nurses and physicians). In addition, the Council suggested monitoring the impact of these proposals on pharmacy practice in hospitals and health systems.

Appendix—Medication Therapy Management Services Definition and Program Criteria

Approved July 27, 2004, by the Academy of Managed Care Pharmacy, the American Association of Colleges of Pharmacy, the American College of Apothecaries, the American College of Clinical Pharmacy, the American Society of Consultant Pharmacists, the American Pharmacists Association, the American Society of Health-System Pharmacists, National Association of Boards of Pharmacy, National Association of Chain Drug Stores, National Community Pharmacists Association and the National Council of State Pharmacy Association Executives.

Medication Therapy Management is a distinct service or group of services that optimize therapeutic outcomes for individual patients. Medication Therapy Management Services are independent of, but can occur in conjunction with, the provision of a medication product.

Medication Therapy Management encompasses a broad range of professional activities and responsibilities within the licensed pharmacist's, or other qualified health care provider's, scope of practice. These services include but are not limited to the following, according to the individual needs of the patient:

a. Performing or obtaining necessary assessments of the patient's health status;
b. Formulating a medication treatment plan;
c. Selecting, initiating, modifying, or administering medication therapy;
d. Monitoring and evaluating the patient's response to therapy, including safety and effectiveness;
e. Performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;
f. Documenting the care delivered and communicating essential information to the patient's other primary care providers;
g. Providing verbal education and training designed to enhance patient understanding and appropriate use of his/her medications;
h. Providing information, support services and resources designed to enhance patient adherence with his/her therapeutic regimens;
i. Coordinating and integrating medication therapy management services within the broader health care-management services being provided to the patient.

A program that provides coverage for Medication Therapy Management services shall include:

a. Patient-specific and individualized services or sets of services provided directly by a pharmacist to the patient*. These services are distinct from formulary development and use, generalized patient education and information activities, and other population-focused quality assurance measures for medication use.
b. Face-to-face interaction between the patient* and the pharmacist as the preferred method of delivery. When patient-specific barriers to face-to-face communication exist, patients shall have equal access to appropriate alternative delivery methods. Medication Therapy Management programs shall include structures supporting the establishment and maintenance of the patient*- pharmacist relationship.
c. Opportunities for pharmacists and other qualified health care providers to identify patients who should receive medication therapy management services.
d. Payment for Medication Therapy Management Services consistent with contemporary provider payment rates that are based on the time, clinical intensity, and resources required to provide services (e.g., Medicare Part A and/or Part B for CPT & RBRVS).
e. Processes to improve continuity of care, outcomes, and outcome measures.

*In some situations, Medication Therapy Management Services may be provided to the caregiver or other persons involved in the care of the patient.

Source: American Association of Colleges of Pharmacy. Historical Documents. Medication Therapy Management (MTM) Services definition and program criteria. Available at: www.aacp.org/resources/historicaldocuments/Documents/MTMServicesDefinitionandProgramCriteria04.pdf (accessed 01 Mar 2010).

House of Delegates Session—2010

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.

Janet A. Silvester, Board Liaison

Council Members

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Kimberley W. Benner, Vice Chair (Alabama)
Jill S. Bates (North Carolina)
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Laura L. Ng, Student (California)
Kenneth M. Shermock, Jr. (Maryland)
Michelle L. Wiest (Ohio)
Kelly M. Smith, Section of Clinical Specialists and Scientists Liaison (Kentucky)
Cynthia Reilly, Secretary

Policy Recommendations

A. Preservation of Antimicrobials for Medical Treatment

To advocate that the Food and Drug Administration (FDA) eliminate future approval of antimicrobials for nontherapeutic uses in agricultural animals that represent a safety risk by contributing to antibiotic resistance; further,

To encourage efforts to phase out and eliminate the nontherapeutic uses of antimicrobials previously approved by the FDA; further,

To support the therapeutic use of antimicrobials in animals only by prescription and under the supervision of a veterinarian; further,

To encourage the FDA, Centers for Disease Control and Prevention, and other stakeholders to monitor and limit, when effective alternatives are available, the therapeutic use of antimicrobials that are essential to the treatment of critically ill human patients; further,

To advocate for the inclusion of pharmacists in antimicrobial surveillance and related public health efforts based on pharmacists' knowledge of antimicrobial drug products and antimicrobial resistance.

Rationale

The Council expressed strong support for the public health approach to antimicrobial use in agricultural animals outlined in the July 2009 Food and Drug Administration (FDA) testimony to Congress, and the Board concurred. The goal of this approach is to minimize the development of antimicrobial resistance, preserving the effectiveness of antimicrobial therapies that are critical in human medicine. According to the FDA, an enhanced action plan would seek to phase out the use of antimicrobials for nontherapeutic purposes (e.g., animal growth promotion, food efficiency) by eliminating future approvals for new nontherapeutic indications. The Council and Board also supported the FDA's request for increased statutory authority that would facilitate removal of previously approved nontherapeutic uses of antimicrobials. This two-pronged approach is critical to preserving the effectiveness of existing antimicrobials as well as those in development. While the Council and Board opposed nontherapeutic uses, they expressed support for animal use of antimicrobials for therapeutic purposes (e.g., treatment of disease or prevention of disease in animals within a population that has documented disease) when this use occurs under the supervision of a veterinarian. In addition, the Council and Board agreed that FDA approval and subsequent use of antimicrobials should take into consideration the public health impact of the drugs' use. Pharmacists' knowledge of antimicrobial drugs and antimicrobial resistance will be critical to these efforts, including the identification of antibiotic classes for which animal treatment use should be minimized in order to retain the effectiveness of these drugs for the treatment of critically ill human patients.

Background

The Council reviewed uses of antimicrobial therapies in agricultural animals. These uses include (1) treatment of actual infection, (2) prophylactic treatment of an animal population when infection is likely or present in that population, (3) as a precautionary measure prior to initiating a stressful situation (e.g., animal transport or weaning), and (4) growth or feed efficiency, which is intended to increase the size and rate of growth of animals bred for human consumption. Nontherapeutic uses (e.g., animal growth promotion,

food efficiency) have been estimated to account for approximately 70% of all antibiotics produced. These uses, which frequently occur without the supervision of a veterinarian or other individual with clinical or drug therapy expertise, are the most controversial.

The Council concluded and the Board agreed that there is evidence of human benefit from antimicrobial use in agricultural animals, such as that derived from minimization of foodborne pathogens (e.g., *Salmonella*). However, the Council believed and the Board concurred that there is significant evidence that unrestricted use in this setting contributes to antimicrobial resistance in humans. Resistance has been shown to arise through selection of resistant organisms in animals who receive antibiotics and subsequent exposure and colonization in humans following consumption. Further, exposed pathogens can develop multi-drug-resistant traits, such as efflux pumps, that confer resistance to antibiotics that were not administered. Antibiotic runoff in soil and water supplies has also been cited as contributing to antibiotic resistance in humans. Many European countries have already taken steps to reduce nontherapeutic antibiotic use in agricultural animals and subsequently seen reduction in resistant pathogens.

The Council and Board strongly supported efforts to phase out nontherapeutic uses of antimicrobials, including the FDA's request for increased statutory authority to remove existing approved indications for nontherapeutic uses in agricultural animals. This approach was seen as critical to preserving the effectiveness of existing antimicrobials, not just those in development.

The Council and Board generally supported therapeutic uses of antimicrobials in animals when this treatment occurs under the supervision of a veterinarian. However, both expressed heightened concern about extensive and potentially inappropriate use of essential antibiotics, such as fluoroquinolones, glycopeptides, and beta-lactams, which are among the limited armamentarium of drugs used in the treatment of critically ill human patients. To minimize the development of resistance, the Council advocated and the Board agreed that the FDA, Centers for Disease Control and Prevention, and other stakeholders should monitor the therapeutic use of antimicrobials and where possible limit the use of therapies that are essential to the treatment of critically ill human patients (e.g., preferential use of narrow-spectrum therapies such as tetracyclines that would effectively treat infected animals while reserving life-saving therapies for critically ill human patients). The Council and Board noted that these essential therapies would evolve over time and therefore emphasized that pharmacists' input on this and other issues to be addressed in national and regional surveillance activities is crucial.

B. Safety and Effectiveness of Ethanol for Treatment of Alcohol Withdrawal Syndrome

To oppose the use of oral or intravenous ethanol for the prevention or treatment of alcohol withdrawal syndrome (AWS) because of its poor effectiveness and safety profile; further,

To support hospital and health-system efforts that restrict or prohibit the use of oral or intravenous ethanol therapies to treat AWS; further,

To educate clinicians about the availability of alternative therapies for AWS.

Rationale

Alcohol withdrawal syndrome (AWS), which can delay patient recovery and interfere with response to therapy, is often prevented or treated using oral or intravenous ethanol. Based on a review of the available evidence, including treatment guidelines from the American Society of Addiction Medicine (ASAM), the Council expressed strong opposition to the use of these therapies to prevent or treat AWS, and the Board agreed. Limited and conflicting evidence of effectiveness, inability to achieve accurate and consistent dosing and blood levels, and the availability of more effective and safer therapies are among the reasons to oppose use of ethanol to prevent or treat AWS symptoms. For these reasons, the Council and Board expressed support for hospital and health-system efforts to restrict or prohibit use of these therapies for AWS and recommended education to multidisciplinary audiences to increase awareness of appropriate alternative therapies. The Council and Board continue to support the use of ethanol for the treatment of acute alcohol poisoning, which is described in evidence-based guidelines.

Background

The Council reviewed information about the extent of alcohol use by hospitalized patients and the effect that such use has on patient morbidity and mortality. Unhealthy alcohol use by hospitalized patients is prevalent. A 2006 survey of medical inpatients found that 97% of patients exceeded recommended alcohol intake on occasion, and up to 17% reported chronic use that was risky or excessive. Oral or intravenous ethanol is frequently used in the inpatient setting to prevent or treat AWS, which can occur when patients reduce or stop a pattern of excessive alcohol consumption. Symptoms of AWS, which range from mild (sleep disturbances, mild anxiety) to severe (delirium tremens, seizures), have been reported to occur in up to 25% of inpatients who abstain from chronic alchohol use during a hospitalization. AWS can worsen comorbid conditions (e.g., exacerbate congestive heart failure, delay wound healing) and result in increased morbidity and mortality.

The Council opposed the use of ethanol to prevent or treat AWS based on insufficient evidence to support its effectiveness and the potential for patient harm, and the Board concurred. Although intravenous ethanol is frequently used to prevent AWS in surgical or trauma patients, the Council concluded that evidence evaluating the effectiveness and safety of this therapy is conflicting. AWS treatment guidelines published by ASAM in 2004 recommend the use of sedative hypnotics (Grade A recommendation; supported by high-quality randomized trials). Ethanol use was given a Grade C recommendation because of the lack of controlled trials evaluating its use and the potential for adverse effects (e.g., hepatic, gastrointestinal, hematologic, and neurologic effects). The Council believed that although the ASAM guidelines were outdated, revision to include more recent studies would not result in a stronger recommendation for the use of ethanol. The Council recommended and the Board agreed that ASHP should educate pharmacists about the availability of more effective and safer alternative therapies and that pharmacists should educate other clinicians, including surgeons, about effective therapies for AWS.

The Council also discussed use of oral ethanol therapies (e.g., beer, wine) to create a home environment. When it is used for this purpose, oral ethanol is usually managed by the pharmacy department or dietary services. The Council did not reach consensus on whether this use is appropriate. Some members were concerned that opposing such use would detract from quality of life for patients receiving hospice or end-of-life treatment, while others believed this was not an appropriate therapy for use by facilities involved in the profession of healing. The Council and Board supported the use of ethanol for the treatment of acute alcohol poisoning, which is described in evidence-based guidelines, the American Academy of Clinical Toxicology Guidelines on the Treatment of Methanol Poisoning (*J Toxicol Clin Toxicol*. 2002;40(4):415-46).

C. Use of Surrogate Endpoints for FDA Approval of Drug Uses

To support the continued use of surrogate endpoints by the Food and Drug Administration (FDA) as a mechanism to evaluate the effectiveness and safety of new drugs and new indications for existing therapies; further,

To support efforts by the FDA and other stakeholders to validate surrogate endpoints; further,

To advocate that the FDA consistently enforce existing requirements that drug product manufacturers complete postmarketing studies for drugs approved based on surrogate endpoints in order to confirm that the expected improvement in outcomes occurs, and to require that these studies be completed in a timely manner.

Rationale

The Council and Board expressed support for the use of surrogate endpoints, when appropriate, for approval of new drugs or new indications for existing therapies because the use of surrogate endpoints can shorten the time to availability for life-saving therapies, including those used to treat human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS). To support this goal, the Council and Board encouraged the FDA and other stakeholders to collaborate to prevalidate surrogate measures that could be used in clinical studies, because such validation would standardize and improve the applicability of surrogate endpoints. In addition, they encouraged the FDA to utilize its current authority to require postmarketing studies for drugs approved using surrogate endpoints to ensure that these drugs demonstrate the effectiveness and safety anticipated when the drugs were approved.

Background

The Council discussed surrogate endpoints—proposed correlates for clinical outcomes—which have been used to expedite FDA approval of drugs for the treatment of chronic diseases associated with significant morbidity and mortality. This concept, with a requirement for postapproval validation studies, has been applied by the FDA since the early 1990s. The Council and Board supported this approach as an option for drug approval, noting that its use had improved patient outcomes for conditions including HIV, AIDS, cancer, and heart disease. There are several limitations to the use of surrogate endpoints, however, including uncertainty as to whether all surrogate endpoints correlate with improved patient outcomes over time and whether they are applicable to broader patient populations. Many surrogate endpoints, such as CD4 counts and cholesterol levels, have been widely validated to correlate with patient outcomes, while other measures, such as mean arterial thickness, were developed by drug product manufacturers to support drug-specific studies and have not yet been validated. The Council and Board encouraged the FDA, drug manufacturers, and other stakeholders to standardize and validate surrogate endpoints that could become the accepted standard, or one of several acceptable standards, for assessing drugs to treat specific conditions. However, the Council and Board believed prevalidation efforts should also allow flexibility for the development and validation of emerging surrogate endpoints.

The Council also discussed the existing FDA requirement that drug product manufacturers complete postapproval studies to demonstrate achievement of proposed outcomes for drugs approved using surrogate endpoints. The importance of this step is illustrated by instances in which estimates of improved patient outcomes do not materialize, or use of the medication results in patient harm. The Council noted that these postapproval studies are not frequently completed, however. The Council and Board called for the FDA and drug product manufacturers to assume greater responsibility for ensuring that this critical step is completed within a reasonable time frame. ASHP was also encouraged to provide education to pharmacists on the benefits, limitations, and clinical significance of surrogate endpoints.

D. Quality Consumer Medication Information

To support efforts by the Food and Drug Administration (FDA) and other stakeholders to improve the quality, consistency, and simplicity of written consumer medication information (CMI); further,

To encourage the FDA to work in collaboration with stakeholders to create evidence-based models and standards for CMI; further,

To advocate that research be conducted to validate these models in actual-use studies in pertinent patient populations; further,

To advocate that state boards of pharmacy require that pharmacies comply with FDA-established standards for content, format, and distribution of CMI.

Rationale

The Council and Board expressed their support for the intent of efforts to improve the quality, consistency, and simplicity of consumer medication information (CMI), which the FDA defines as written information about prescription drugs developed by organizations or individuals other than a drug's manufacturer that is intended for distribution to consumers at the time of drug dispensing. Those efforts included the *Action Plan for Provision of Useful Prescription Medicine Information* (also known as the "Keystone Guidelines")—criteria developed by private-sector stakeholders that are intended to standardize the content and format of this information. However, because the Keystone Guidelines were largely developed based on consensus of expert opinion, rather than quantitative and well-documented evidence, and because subsequent studies that evaluated CMI based on the Keystone Guidelines were conducted using expert-based focus groups and other study designs that do not reflect typical patients, the Council recommended and the Board agreed that ASHP should strongly encourage the development of evidence-based models for CMI that are designed to support desired outcomes (e.g., better medication use, improved patient safety). In addition, the Council and Board agreed that research to validate the effectiveness of existing and new CMI models under real-use conditions by actual patients should be encouraged. Although drug information publishers have made significant progress in improving the quality of CMI, this content is often truncated or provided in illegible formats to accommodate size restrictions or marketing information on patient drug information leaflets that are stapled to prescription packaging. The Council recommended and the Board agreed that ASHP should strongly advocate that state boards of pharmacy require that pharmacies distribute CMI according to FDA-established standards and be held accountable if CMI content or format is modified in a manner that results in this information not conforming to those standards.

Background

The Council reviewed the history of efforts to improve the quality of CMI. These efforts include development of the Keystone Guidelines—criteria developed by drug information providers, patient safety advocates and other private-sector stakeholders in 1996 that are intended to improve CMI by standardizing the content and format of this information. The Council did not disagree with the recommendations in the Keystone Guidelines, but it noted that the criteria were based on expert opinion of stakeholders, not evidence of effectiveness. The Council also reviewed results of two FDA-requested studies that evaluated whether CMI developed after the guidelines were issued met the defined criteria. The studies demonstrated improved adherence to the criteria (as determined by experts). However, the Council noted that consumer use of this information, as well as their expectations and desires, was not evaluated. The Council strongly believed and the Board concurred that evaluation of CMI models based on the Keystone Guidelines or other criteria should assess actual patient understanding and use of this information. It was noted that the FDA and other stakeholders are currently meeting to determine best approaches for providing CMI. The intent of the Council's discussion was to provide the member clinician's perspective, which could inform ASHP staff members' participation in those efforts.

The Council reviewed a one-document approach, which has been proposed in a citizens' petition submitted to the FDA by the

National Association of Chain Drugstores, the National Community Pharmacists Association, and other stakeholder organizations that represent industry and consumers. The Council agreed with the intent to simplify the array of documents patients now receive with a new prescription. However, the Council opposed suggestions voiced by some stakeholders that would limit this information to one page, noting that desire to reduce page count should not override the need to provide accurate and complete drug information.

The Council also reviewed published evaluations of a drug facts box—an approach similar to nutrition labels on food products—which has been proposed to simplify the provision of CMI. The drug facts box would also provide information from clinical studies, with the intent of assisting patients in assessing the risks and benefits of using a drug product. The Council stated that the drug facts box's simplicity was beneficial, but did not believe it provided sufficient information to be used as a stand-alone CMI tool. In addition, the Council believed that the risk-benefit information would be better provided and discussed with patients at the time when the prescribing decision is made, not at the dispensing phase. The Council also expressed concern about how the proposed drug facts box would accommodate drugs with more than one therapeutic use. Strategies for determining which studies to include and difficulties in maintaining the currency of this information as new evidence arises were noted as limitations of the drug facts box. Limited availability of high-quality comparative effectiveness studies that would provide sufficient information for consumers to compare alternative therapies was also noted. Cultural sensitivity, patient reading level and health literacy, including the extent to which consumers would understand and correctly interpret the statistical analyses, were significant concerns. The Council believed this format would be useful only in the context of counseling provided by pharmacists and physicians.

Distribution of written CMI at the point of dispensing was also discussed. The Council and Board agreed that CMI publishers had made significant improvements in the content and format of this information. However, these improvements are often negated at the point of dispensing because pharmacies frequently truncate or reformat this information to accommodate space limitations on patient leaflets that are stapled to prescription packaging. In addition, this information is often crowded by advertisements, coupons, and other extraneous information. The Omnibus Budget Reconciliation Act of 1990 and state board of pharmacy practice acts require patient counseling, but the Council and Board were not aware of any state requirements related to distribution of CMI, which was a significant concern. The Board and Council agreed that ASHP should advocate that state boards of pharmacy require that pharmacies distribute CMI according to FDA-established standards and be held accountable if CMI content or format is modified in a manner that results in this information not conforming to those standards.

E. Research on Drug Use in Obese Patients

To encourage drug product manufacturers to conduct pharmacokinetic and pharmacodynamic research in obese patients to facilitate safe and effective dosing of medications in this patient population, especially for medications most likely to be affected by obesity; further,

To encourage manufacturers to include in the Food and Drug Administration (FDA)-approved labeling detailed information on characteristics of individuals enrolled in drug dosing studies; further,

To advocate that the FDA develop guidance for the design and reporting of studies that support dosing recommendations in obese patients; further,

To advocate for increased enrollment of obese patients in preapproval clinical trials of new medications; further,

To encourage independent research on the clinical significance of obesity on drug use, as well as the reporting and dissemination of this information via published literature, patient registries, and other mechanisms.

Rationale

The Council discussed the growing rate of obesity in the United States, with a focus on uncertainty surrounding how obesity affects drug dosing, effectiveness, and safety. The Council believed and the Board agreed that ASHP should advocate for increased research in obese patients, similar to existing policy that advocates for research in other special patient populations. Drug product manufacturers should be encouraged to complete pharmacokinetic and pharmacodynamic dosing studies in obese patients, especially for drugs for which obesity is expected to have significant clinical impact (e.g., antimicrobials, highly lipophilic drugs, etc.). If these voluntary studies are not completed, then manufacturers should include in the FDA-approved labeling complete information on the population enrolled in dosing studies and the methods used to determine dosing so that clinicians can assess the extent to which that population reflects patients being treated by the clinician. The Council strongly recommended and the Board concurred that the FDA develop guidance for voluntary drug dosing studies in obese patients that would define study design and reporting with the intent of standardizing this research to the extent possible. The need for this guidance is supported by the complexity of drug dosing in obese patients, which varies based on drug and patient characteristics. A paucity of research in this patient population was noted, which was described as parallel to the lack of preapproval studies in geriatric and pediatric patients. The Council and Board also encouraged independent clinical and practice-based research to further define clinical use of drugs in obese patients, as well as clinician reporting of patient experience via published articles and clinical registries.

Background

The extent of people in the United States who are obese (an excessively high amount of body fat in relation to lean body weight) or overweight (increased body weight in relation to height) continues to rise, with two-thirds of adults and nearly one-third of children and adolescents now considered overweight or obese. It was noted that 10% of all health care costs result from conditions associated with or affected by obesity, including diabetes, hypertension, and chronic airway obstructive diseases. Some drugs, including those used to treat psychiatric conditions, also cause or contribute to obesity.

Numerous factors contribute to the complexity of drug dosing in obese patients, including drug characteristics (e.g., lipophilic versus hydrophilic, extent of protein binding) and organ function (e.g., renal clearance). Under- or overdosing of obese patients is a significant concern, especially with drugs associated with high toxicity (chemotherapy) or minimum effective doses (antibiotics). There is published information about drug dosing in obese patients for some medications, including antibiotics, chemotherapeutic agents, and low-molecular-weight heparins. However, this information is frequently based on small studies and is often contradictory among postmarketing studies completed by independent researchers. Variability in the weight used to determine drug dosing (e.g., ideal body weight, actual body weight, body mass index) further compounds the complexity of drug dosing. In addition, maximum dosing recommendations are not available for most drugs.

The Council reviewed ASHP policy 0229, which encourages pharmacokinetic, pharmacodynamic, and clinical research in geriatric and pediatric patients. The Council appreciated the intent of such research to address special patient populations and noted that the number of obese patients may exceed those other patient populations. The Council believed this prevalence supports the need for additional research in this patient population.

The Council believed that preapproval pharmacokinetic and pharmacodynamic studies completed by drug manufacturers to determine drug dosing have limitations in their application to obese patients. These patients are generally excluded from studies either by weight-based criteria, or more frequently because these

patients may have co-morbid conditions, such as diabetes or hypertension. While these conditions can affect drug disposition, knowledge of drug disposition in obese patients is important for determining the effectiveness and safety of some drugs. Therefore, drug manufacturers should be encouraged to include these patients as a component of these studies, or in a distinct study, for those drugs most likely to be affected by weight or body composition. It was also noted that detailed information on manufacturer-conducted drug dosing studies is frequently not included in the FDA-approved labeling or otherwise readily available to clinicians. The Council strongly believed, and the Board agreed, that the FDA should issue guidance for drug product manufacturers that define best practices for designing, completing, and reporting dosing studies in obese patients. This guidance should provide recommendations based on drug characteristics, definitive parameters for determining obesity, and appropriate use of weight-based dosing formulas.

The Council and Board believed that preapproval studies to determine dosing and clinical effect in obese patients would provide significant benefit, but also recognized that this approach would be hampered by limitations inherent in all preapproval studies (e.g., small patient population compared to the extent of patient exposure postapproval). The Council and Board therefore encouraged independent researchers and individual clinicians to study and report experience in dosing obese patients and subsequent observed effect on clinical effectiveness and safety. ASHP was encouraged to collaborate with stakeholders, such as the Agency for Healthcare Research and Quality and the Center for Medical Technology Policy, to promote and support this research. In addition, ASHP should provide mechanisms for disseminating this information via the *American Journal of Health-System Pharmacy* (*AJHP*), educational programming, and drug information and other publications. An *AJHP* primer on drug characteristics that affect dosing in obese patients, as well as a review of therapeutic classes most affected, was also suggested.

Board Actions

ASHP Therapeutic Position Statement on Use of Low-Molecular-Weight Heparins for Adult Outpatient Treatment of Acute Deep-Vein Thrombosis. The Council recommended and the Board voted

> To discontinue the ASHP Therapeutic Position Statement on Use of Low-Molecular-Weight Heparins for Adult Outpatient Treatment of Acute Deep-Vein Thrombosis.

The Council discussed the ASHP Therapeutic Position Statement on Use of Low-Molecular-Weight Heparins for Adult Outpatient Treatment of Acute Deep-Vein Thrombosis as part of sunset review. The Council supported the intent of the therapeutic position statement (encouraging the use of outpatient low-molecular-weight heparin [LMWH] therapies as an alternative to inpatient treatment with unfractionated heparin), but noted that use of LMWH therapy has largely become the standard of practice. Therefore, the need for this document has decreased substantially. The Council also noted that the document was outdated. Rather than revising the current document, the Council believed that ASHP member needs could be better met through development of guidelines or tools that facilitate appropriate use of these therapies by describing a process for pharmacy management of LMWH therapies in inpatient and outpatient settings. It was noted that ASHP has a number of resources on this topic, including an anticoagulation Web resource center. ASHP staff will review and seek input from the appropriate council as to whether additional resources are needed.

Guidance on Managing LMWH Therapies. The Council recommended and the Board voted

> To review existing ASHP guidance documents, tools, and resources to determine if member needs related to management of LMWH therapies in the inpatient and outpatient settings are being met.

The Council reviewed the ASHP Therapeutic Position Statement on Use of Low-Molecular-Weight-Heparin for Adult Outpatient Treatment of Acute Deep-Vein Thrombosis as part of sunset review. The Council voted to discontinue that guidance document, which reviews the clinical evidence supporting the safety and effectiveness of these therapies in the outpatient setting. The Council believed that the gap in practice that this therapeutic position statement was intended to address had been resolved. However, the Council recommended that ASHP consider development of a guidance document or other tools to guide practice-related aspects of managing LMWH therapies in inpatient and outpatient settings.

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 still be appropriate. (No action by the House of Delegates is needed to continue these policies.)

- Pharmacogenetics (0016)
- ASHP Statement on the Over-the-Counter Availability of Statins

Other Council Activity

Use of the CONSORT Statement for Reporting Harms. The Council voted

> To consider for endorsement by the *American Journal of Health-System Pharmacy* (*AJHP*) the Consolidated Standards of Reporting Trials [CONSORT] group recommendations, Better reporting of harms in randomized trials: an extension of the CONSORT statement; further,
>
> To educate ASHP members and *AJHP* contributors and reviewers about this CONSORT extension and other efforts to improve reporting of adverse drug events that occur in pre- and postapproval studies.

The Council reviewed information about the CONSORT group and a list of scientific journals that have endorsed the initial CONSORT statement and its extensions. This discussion was a follow-up to a 2008 agenda item on drug safety for which the Council reviewed the 2004 publication, "Better reporting of harms in randomized trials: an extension of the CONSORT statement." At that time, the Council viewed favorably the CONSORT group's recommendations to improve reporting of adverse drug events (e.g., use of standardized terminology, inclusion of harms information in the abstract) and requested that ASHP complete an assessment of the extent to which this CONSORT model has been adopted. The Council was pleased with the number of medical journals that have endorsed this CONSORT extension, but noted that no pharmacy journal had officially supported the document. The Council recommended that the editorial board of *AJHP* review the extension for possible endorsement and, further, that ASHP educate members and *AJHP* contributors and reviewers about this and other efforts to improve reporting of adverse drug events that occur in pre- and postapproval studies.

Safety and Effectiveness of Meperidine. The Council discussed the clinical use of meperidine, an opiate agonist indicated for the treatment of moderate to severe pain and as adjunctive therapy for anesthesia and sedation. Meperidine has evidence demonstrating effectiveness for those indications, but the Council identified safety concerns with use of the drug, including significant drug interactions and the potential for toxicity associated with accumulation of normeperidine (a metabolite that exhibits approximately half the analgesic affect but twice the stimulant effect of meperidine). It was noted that some health care facilities have eliminated or restricted the use of meperidine based on these concerns. The American Pain Society and the Agency for Healthcare Research and Quality have recommended limiting the use of meperidine, and the American Academy of Pediatrics has recommended against use of the drug in children. The Council was supportive of these recommendations, as well as health-system efforts to restrict use of this therapy to ensure appropriate use. There was not unanimous support for excluding meperidine from health-system formularies because there are several unlabeled uses for meperidine, including treatment of postoperative shivering, migraine headache, management of pain in patients with sickle cell disease, and rigors associated with blood transfusions or amphotericin use. However, the Council noted that there is less evidence supporting the effectiveness of meperidine for these uses. In addition, meperidine is not the recommended first-line treatment for these conditions, and more effective and safer treatment alternatives are available for most patients.

The Council suggested that ASHP assess current practice related to meperidine use through completion of a member survey or other mechanism. If need is documented, it was suggested that ASHP develop a guidance document that describes appropriate use of the drug, including appropriate patient selection and dose and duration limits.

Therapeutic Use of Gastrointestinal Cocktail. The Council discussed gastrointestinal (GI) cocktail, a treatment that has been used in the emergency department to rule out cardiac events. GI cocktail is usually extemporaneously compounded using a liquid antacid, viscous lidocaine, and an anticholinergic agent; a very popular mixture is aluminum and magnesium hydroxide (Maalox), lidocaine, and belladonna alkaloids and phenobarbital (Donnatal), in equal parts. Of note, the FDA has described the effectiveness of belladonna alkaloids and phenobarbital as "questionable" for all indications. Use of this therapy has decreased based on advances in diagnostics and recent evidence questioning its clinical value, including a 2003 study in the *Journal of Emergency Medicine* that demonstrated that the compounded product is no more effective than the individual components. However, use of GI cocktail continues in some settings. The Council discussed concerns about this therapy, including that its use may produce a placebo effect that masks symptoms of a myocardial infarction. The Council suggested that ASHP pursue development of an article for *AJHP* that would address the use of GI cocktail. It was also suggested that all compounded products, including GI cocktail, should be vetted via facilities' Pharmacy and Therapeutics Committee process to ensure effectiveness, safety, bioavailability, and stability.

Use of Proton Pump Inhibitors for Chronic Acid Suppression. The Council discussed safety concerns with long-term use of proton pump inhibitors (PPIs), with a focus on the use of PPIs for treatment of patients with gastrointestinal (GI) ulcerations or gastroesophageal reflux disease (GERD) and as a gastroprotective therapy for patients receiving long-term nonsteroidal anti-inflammatory drug (NSAID) or aspirin therapy. The Council supported the clinical benefit of PPIs for these conditions but believed these therapies are overused. PPIs have generally been viewed as safe, but there is growing evidence to suggest potential harm, including an increased risk of pneumonia, *Clostridium difficile*–associated disease, and osteoporosis with associated bone fractures. Drug interactions are an additional concern, as well as altered absorption of other therapies because of decreased acidity of the GI tract.

The Council reviewed evidence demonstrating that PPIs are often prescribed to prevent stress ulcers in hospitalized patients who are not appropriate candidates for the drug's use based on evidence. Further, almost half of those patients receive prescriptions to continue oral therapy once discharged. The Council strongly believed that health-system pharmacists should play a central role in ensuring that initiation of PPI therapy occurs only for those patients with appropriate indications defined by treatment guidelines and that PPI therapy is discontinued as soon as appropriate. It was noted that ASHP is collaborating with the Society of Critical Care Medicine to revise guidelines on stress ulcer prophylaxis.

Medication reconciliation was recommended as a core activity through which pharmacists can reduce and eliminate inappropriate PPI use. The Council suggested that ASHP develop an *AJHP* commentary, education, or other resources to inform pharmacists about their important role in ensuring appropriate PPI use across the continuum of care. In turn, pharmacists should educate and collaborate with other health care professionals to ensure appropriate use.

Application of Noninferiority and Equivalence Trials to Clinical Practice. The Council discussed the increasing use of noninferiority and equivalence trials—studies designed to demonstrate that an intervention achieves outcomes that are either not clinically worse or are similar to those achieved with the comparator treatment. The Council stated that use of this study design is appropriate but encouraged clinicians to be cautious in their interpretation of study results. Inappropriate study design, including incorrect comparator selection or errors in statistical analysis, can bias study results and lead to confusion in their interpretation by clinicians. The Council encouraged ASHP to educate pharmacists about interpretation of noninferiority trials via *AJHP*, educational programming, and other resources. The Council also encouraged *AJHP* and other medical publishers to mandate that researchers determine the margin of noninferiority prior to initiating the study and provide a through description of that determination and the statistical analysis in the published report.

Patient Access to Investigational Drugs. The Council reviewed regulations issued by the FDA in August 2009 that are intended to clarify a process that would allow individual patients access to investigational drugs. This discussion was in follow-up to a 2007 Council on Therapeutics discussion that reviewed litigation brought by a patient advocacy group, the Abigail Alliance for Better Access to Developmental Drugs. At that time, the Council supported efforts to expand access to investigational drugs for patients who had exhausted other treatment options. However, safe use of the therapies was a significant concern. The Council was pleased with elements of the new regulations that require patient education on risk versus benefit and documentation of patient experience. However, the Council was concerned that informed consent may be impeded by the patient's emotional state. The Council also questioned whether the new regulations would result in significant expansion of patient access, noting that drug manufacturers may be reluctant to grant access to patients whose poor clinical prognosis would reflect unfavorably on overall patient outcomes in the intended study population. The Council encouraged ASHP to monitor implementation of the new regulation to determine the true effect on patient access and safety.

Clinical Decision Support in Electronic Health Care Records. The Council reviewed draft criteria from the Office of the National Coordinator for Health Information Technology (ONCHIT) to assess "meaningful use" of electronic health records (EHRs). Health care facilities that meet the final criteria will be eligible for Medicare and Medicaid incentive payments under the American Recovery and Reinvestment Act of 2009. The Council's discussion focused on aspects of the criteria that describe clinical decision support functions within EHRs (e.g., drug allergy, drug interaction, duplicate therapy, and dose-range checking) and documentation and reporting of quality measure data. The Council desired to review the full details of each quality measure, which were not available at the time of the Council's discussion. The Council deferred additional discussion of this topic and requested that ASHP obtain this information for review at a future meeting.

Bioequivalence Testing and Postmarketing Surveillance for Generic Drugs. The Council discussed calls to reevaluate existing approaches to bioequivalence testing for generic drug products and to enhance postmarketing safety surveillance for these products. Such changes were proposed in an editorial authored by a former FDA Commissioner. The Council agreed that there are case reports of patients experiencing an adverse drug reaction (ADR) or therapeutic failure with a generic drug, including generic formulations of narrow therapeutic index drugs (e.g., antiepileptic therapies and sustained-release products). However, the Council stated that ADEs and failures also occur with branded drug products. It was noted that there is limited or no high-quality evidence that refutes the safety and effectiveness of generic drugs. Existing ASHP policies support current processes for generic bioequivalence testing. However, the Council was supportive of the call to re-evaluate existing processes, which was considered an appropriate continuous quality improvement process. The Council requested that ASHP monitor developments in this area.

House of Delegates Session—2010

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.

Janet L. Mighty, Board Liaison

Council Members

Miriam Mobley-Smith, Chair (Illinois)
Dianna L. Gatto, Vice Chair (Washington)
Kathleen H. Besinque (California)
Dianna Borowski-Wright (Arizona)
Manouchkathe Cassagnol, New Practitioner (New York)
Kathryn M. Clark (Ohio)
Jordan R. Covvey, Student (Kentucky)
Lisa L. Deal (Virginia)
William L. Greene (Tennessee)
Russell K. Hulse (Utah)
Beverly A. Kroner (Colorado)
Natasha C. Nicol (South Carolina)
Douglas J. Scheckelhoff, Secretary

Policy Recommendations

A. Interprofessional Education and Training

To support interprofessional education as a component of didactic and experiential education in Doctor of Pharmacy degree programs; further,

To support interprofessional education as a part of professional development for pharmacy practitioners and to collaborate with other disciplines to facilitate and promote programs that support this goal; further,

To encourage and support pharmacists' collaboration with other health professionals and health care executives in the development of team-based, patient-centered care models; further,

To foster documentation and dissemination of outcomes achieved as a result of interprofessional education of health care professionals.

(Note: This policy would supersede ASHP policy 0608.)

Rationale

Pharmacist involvement in team-based patient care improves medication-use safety and quality and reduces health care costs. For patient-care teams to be effective, they must possess unique skills that facilitate effective team-based interactions. Some pharmacists are exposed to team-based care models through interprofessional education and interaction with students of other disciplines when they are pharmacy students. Some colleges and schools of pharmacy have very effective interprofessional didactic courses that include medical, pharmacy, nursing, and other health professional students. Additionally, most experiential rotations involve interaction with other members of the health care team and help students of all disciplines learn about the expertise of other team members. However, not all colleges and schools are effective in providing interprofessional education that facilitates team-based patient care. The reasons vary, but may include differences in teaching philosophies or a lack of access to other health professional schools at the university or campus.

The Hospital Care Collaborative (HCC) recently released common principles for team-based care. The HCC includes ASHP, the Society of Hospital Medicine, the American Association of Critical-Care Nurses, the Case Management Society of America, the American Association for Respiratory Care, and the Society for Social Work Leadership in Health Care. The HCC principles recognize the knowledge, talent, and professionalism of all team members and support role delineation, collaboration, communication, and the accountability of individual team members and the entire team. The HCC principles note that collaboration of the health care team can lead to improved systems and processes that provide care more efficiently and result in better patient outcomes. The HCC states that current undergraduate and postgraduate professional education of team members is inadequate to promote true team functions. The Council was supportive of the principles and suggested that ASHP make members aware of their existence and seek ways to promote the adoption of team-based care by all hospitals.

The Council concluded and the Board agreed that interprofessional education is important not only for pharmacy students but also throughout one's professional career. Similarly, it is important for other disciplines on the team so that collaboration and a synergistic relationship might result. Failure to establish these collaborative working relationships early in one's career can result in poor interactions in years to come. A positive working relationship with physicians and nurses is productive, while a bad working relationship can be counterproductive and devastating to all parties.

Background
The Council reviewed existing ASHP policies related to interprofessional education and training, and the Council voted and the Board agreed to recommend revising policy 0608, Interdisciplinary Health Professions Education, as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To support interprofessional education as a component of didactic and experiential education in Doctor of Pharmacy degree programs; further,
>
> ~~To encourage colleges of pharmacy and other health professions schools to teach students the skills necessary for working with other health care professionals and health care executives to provide patient care; further,~~
>
> To support interprofessional education as a part of professional development for pharmacy practitioners and to collaborate with other disciplines to facilitate and promote programs that support this goal; further,
>
> ~~To encourage the Accreditation Council for Pharmacy Education to include interdisciplinary patient care in its standards and guidelines for accreditation of Doctor of Pharmacy degree programs; further,~~
>
> To encourage and support pharmacists' collaboration with other health professionals and health care executives in the development of ~~interdisciplinary practice~~ team-based, patient-centered care models; further,
>
> ~~To urge colleges of pharmacy and other health professions schools to include instruction, in an interdisciplinary fashion, about the principles of performance improvement and patient safety and to train students in how to apply these principles in practice; further,~~
>
> To foster documentation and dissemination of outcomes achieved as a result of ~~interdisciplinary~~ interprofessional education of health care professionals.

The Council suggested that ASHP develop tools and education that help pharmacists develop collaborative, effective relationships with physicians, nurses, and other key members of the health care team. Sites providing experiential education to pharmacy students would also benefit from resources that aid their ability to provide interprofessional interaction on rotations.

The Council and Board agreed that each health discipline would benefit from education that leads to improved communication among providers, methods for shared decision-making and goal-setting responsibilities, effective collaboration, and smooth handoffs.

B. Minimum Hiring Standards for Pharmacy Technicians

To encourage employers to require individuals who are hired as pharmacy technicians to have successfully completed an ASHP-accredited pharmacy technician training program and be certified by the Pharmacy Technician Certification Board (PTCB); further,

To support employment practices that would permit hiring of pharmacy technician trainees only if those individuals (1) are required to successfully complete an ASHP-accredited pharmacy technician training program followed by PTCB certification within 12 months of employment, and (2) are limited to positions with lesser responsibilities until they successfully complete such training and certification; further,

To encourage employers to require ongoing PTCB certification as a condition of continued employment.

(Note: This policy would supersede ASHP policy 0702.)

Rationale
The Council on Credentialing in Pharmacy (CCP), made up of 11 pharmacy organizations including ASHP, recently released its *Pharmacy Technician Credentialing Framework*. The Framework calls for all technicians to have accredited training, certification, and be registered by state boards of pharmacy. In addition, ASHP has well-established policy on education, certification, and registration requirements for pharmacy technicians. Despite these policies and a concerted legislative effort through the Pharmacy Technician Initiative, these requirements are not routinely used by employers as a condition of hiring or employment. Adoption of these requirements by employers would result in improved patient safety, standardization, and expansion of the role of pharmacists as patient-care providers. Consistent with existing ASHP policies, hospitals and health systems should only hire technicians who have completed an ASHP-accredited training program, or individuals who are able to complete such a program in a specified period of time.

Background
The Council reviewed existing ASHP policies related to pharmacy technician qualifications, and the Council voted and the Board agreed to recommend completely revising policy 0702, Pharmacy Technician Training. For ease of comparison, policy 0702 reads as follows:

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

C. Professional Development

To discontinue ASHP policy 0511, which reads:

To recognize that providing professional development opportunities for health-system pharmacy practitioners is an essential component of staff recruitment and retention as well as quality of work life; further,

To strongly encourage health-system pharmacy directors and administrators to support professional development programs as an employee benefit that ultimately improves patient care and aids in recruiting and retaining qualified practitioners; further,

To recognize that professional development encompasses more than staff development programming and includes informal learning among colleagues, mentoring, and other types of learning; further,

To develop educational programs, services, and resources to assist health-system pharmacies in supporting professional development.

Background
As part of sunset review, the Council reviewed policy 0511 and concluded that it is duplicative of policy 0916, Continuing Professional Development, which reads:

> To endorse and promote the concept of continuing professional development (CPD), which involves personal self-appraisal, edu-

cational plan development, plan implementation, documentation, and evaluation; further,

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

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

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

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

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

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

The Council voted and the Board agreed to recommend discontinuing policy 0511.

Board Actions

Pharmacists' Role in Immunization. The Council recommended and the Board voted

To promote ASHP guidelines and other best practices highlighting the pharmacist's role in health-system-based vaccination programs; further,

To promote ASHP policies on the pharmacist's role in immunization and vaccination programs, including the inclusion of immunization training in the pharmacy curriculum.

All states have approved legislation to allow pharmacists to administer vaccines and, in some cases, prescribe them. As pharmacy students prepare for practice, it is important that they have specific training and education in this area. Hands-on vaccination administration programs also serve as a way to give students early patient contact. The Council discussed the inclusion of vaccination training and education in the current Doctor of Pharmacy curriculum. It was noted that a high percentage of colleges and schools of pharmacy currently use the American Pharmacists Association Immunization Training Program as a means of teaching pharmacy students about vaccines and how to administer them. Council members described different formats being used by colleges and schools of pharmacy, some teaching students how to administer vaccines early in the curriculum, others waiting until experiential rotations.

The Council also reviewed the ASHP Guidelines on the Pharmacist's Role in Immunization and existing ASHP policies 0213 and 0615. Current ASHP policies address all of the issues brought up by the Council, but it was felt that there needs to be an emphasis on advancing the pharmacist's role, making sure that pharmacists are adequately trained, and a promotion of best practices specifically in health-system settings. Since inclusion of vaccination training is already stated in ASHP policy and since most colleges and schools of pharmacy currently have it in their curricula, the Council did not recommend new ASHP policy.

Council members discussed the three roles pharmacists can have in immunization: administering vaccines, prescribing vaccines or managing compliance with an immunization schedule, and advocating the value of vaccination with the public. The Council discussed the need for pharmacists to do more than just administer vaccines, specifically stating that pharmacists should play more of a role in prescribing vaccines and managing vaccination schedules. This role could be an important one for pharmacists, serving an important public health role, beyond the technical role of administering vaccines.

New Models for Workforce Development. The Council recommended and the Board voted

To explore the development of an electronic tool that would facilitate and enable practitioner use of continuing professional development, including self-assessment, educational plan development, documentation, and evaluation.

Traditional pharmacy education followed by residency training continues to be the predominant model for preparing many pharmacy graduates for the needs of today's pharmacy workforce. However, for those individuals who are established in practice, there are fewer options for maintaining competence or developing new knowledge. Practical issues such as scheduling and cost are also factors for many. The Council discussed the options available to practitioners, such as traineeships, mini-sabbaticals, non-traditional residencies, and how they compare to an individualized model of continuing professional development.

The Council reaffirmed that the CPD process is valuable and important but noted that it continues to be difficult to achieve widespread adoption because CPD is largely a manual process. Having a simple, electronic tool would be helpful in assisting practitioners in their quest to identify their own professional development needs, search for available programs and resources, and document their learning. This type of tool would also be helpful for documenting competencies in the workplace, for the supervisor and for outside groups such as The Joint Commission. It could also build on the profile requirements now being used for pharmacy students and residents.

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.)

- Communication Among Health-System Pharmacy Practitioners, Patients, and Other Health Care Providers (0510)
- Residency Training for Pharmacists Who Provide Direct Patient Care (0005)
- Pharmacist Credentialing (0006)
- Financial Management Skills (0508)
- Developing Leadership and Management Competencies (0509)

Other Council Activity

Pharmacist Education and Training on New and Emerging Therapies. The Council discussed pharmacists obtaining knowledge on new drug therapies and maintaining their competence in order to manage these therapies during the course of their career, especially with many new and unique therapeutic modalities expected in the future. They also discussed the need for students to learn about these therapies as well as develop a philosophy of lifelong learning, since many of the therapies will emerge years from now. Developing the needed skills so that they know how to find information was also a consideration.

While there will be a need for general knowledge about these products that should be understood by all pharmacists, there will also be a need for specialists in these areas. Pharmacists will need to recognize the need and be committed to remaining current on new therapeutic information. It was suggested that one way to ensure that practitioners stay current on these new therapies is to require it through an accreditation standard, through a licensure requirement, or as a requirement for continued employment.

Pharmacy Technician Credentialing Framework. The Council discussed current ASHP policy regarding pharmacy technicians in light of the recently approved CCP *Pharmacy Technician Credentialing Framework*. CCP is made up of 11 organizations, including ASHP, and through the Framework reached a consensus on minimum requirements on pharmacy technician education, training, certification, and registration. It was noted, though, that significant sectors of pharmacy, such as the chain drug stores and community pharmacies, were not part of the consensus process and chose not to participate in the development of the CCP Framework.

The Council supported the principles of the CCP Framework. There was concern that there is little awareness of the Framework within the profession, and ASHP was asked to use whatever means it has available to promote the document.

Pharmacist Credentialing. The Council discussed a credentialing framework for pharmacists at its meeting in 2008. Since then, the CCP has developed a resource paper, *The Scope of Contemporary Pharmacy Practice*, describing the relationship between scope of practice and credentials. CCP has also formed a Pharmacist Credentialing Integration Work Group, charged with developing a specific CPP position on the desired framework for the effective integration of pharmacist education, licensure, residency training, and board certification. The Council discussed what elements should be included in this eventual framework expected from CCP.

The importance of having a widely accepted credentialing framework was stressed by members of the Council, especially since it is likely to be tied to payment for services.

Development of a Teaching Certificate Program. The Council discussed the growth in the number of colleges and schools of pharmacy and the resulting shortage of qualified faculty. There continues to be a great deal of discussion about how to best prepare clinical faculty for these critical roles. Similarly, the growth in residency training has resulted in the need for qualified preceptors. The Council discussed the role of postgraduate year one (PGY1), two (PGY2), and certificate-type programs in developing clinical faculty.

The role of residency training in faculty development was also discussed. The goals and objectives of PGY1 and PGY2 residency training programs were rewritten two years ago and include goals around teaching as electives. The elective was designed so that the AACP Education Scholar program, which currently exists and is used by many schools, could be used to meet the goal. PGY1 goals only focus on teaching skills in a broad manner, whereas the PGY2 residency standard is more focused on a higher level.

Most training programs currently are developed by colleges or schools of pharmacy for their own new faculty. Some are live programs, others are distance-based education, that help new faculty understand teaching principles and philosophy. There is little standardization, and programs vary greatly in length and depth of knowledge gained by participants.

The Council concluded that the current focus of PGY1 residency training (developing teaching skills from a broad perspective) and PGY2 residency training (developing teaching skills at a higher level, as an elective) is appropriate. They recommended that ASHP continue to develop resources for preceptor development, focusing on experiential students and residents, in the health-system environment.

National Health Care Workforce Commission. The Council provided advice on key considerations that ASHP should advocate for with a new national health care workforce commission proposed in pending health care reform legislation. Congress is calling for a workforce commission that will address the current and projected health care workforce supply and demand, education and training capacity, and integration of a workforce that supports high-quality health care delivery and meets the long-range needs of the U.S. population.

Pharmacy technician education and certification should be one issue raised with the proposed commission. Interprofessional relationships and a long-range plan for an interactive health care workforce should be another area of consideration. The evolving pharmacy practice model and the corresponding workforce needs should also be considered.

House of Delegates Session—2010

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.

Lisa Gersema, Board Liaison

Council Members

Eugene A. Handza, Chair (Tenessee)
Thomas E. Kirschling, Vice Chair (Pennsylvania)
Paul J. Barrett (Maine)
Dominick A. Caselnova (Montana)
Robert DeChristoforo (Maryland)
Leigh DeMarco, New Practitioner (Utah)
Nancy A. Konieczny (Missouri)
Donald H. Lynx (Texas)
Judith K. Schneider (Minnesota)
Beju Shah, Student (South Carolina)
Linda S. Tyler (Utah)
Kathleen S. Pawlicki, Section of Pharmacy Practice Managers Liaison (Michigan)
David R. Witmer, Secretary

Policy Recommendations

A. Pharmaceutical Distribution Systems

To support wholesaler/distribution business models that meet the requirements of hospitals and health systems with respect to timely delivery of products, minimizing short-term outages and long-term product shortages, managing and responding to product recalls, fostering product-handling and transaction efficiency, preserving the integrity of products as they move through the supply chain, and maintaining affordable service costs.

(Note: This policy would supersede ASHP policy 0605.)

Rationale

A recall is a manufacturer or distributor's voluntary removal or correction of a marketed product. The Food and Drug Administration (FDA) may request a recall in "urgent situations." For each recall, the manufacturer or distributor develops a recall strategy based upon guidance from the FDA; there is no standard format for recall notices, and communication timelines, format, content, and distribution vary.

Managing product recalls within hospitals and health systems is a complex process. Recent recall events have highlighted the complexity of the process and demonstrate the need for improvements to ensure that recalled product can be removed effectively and efficiently to protect patients from inadvertent administration. During the recent recall of heparin, for example, 94 hospitals were found to have recalled product remaining on their shelves. Further evaluation of how the recall was implemented revealed flaws in the system. Some pharmacy departments reported that they never received the recall notice; in other cases, recalled product was shipped to the pharmacy after the hospital had completed its review of supplies and quarantined all recalled product.

The Council discussed the need for improvements to the product recall system and provided the following suggestions to the Council on Public Policy for consideration as it develops policy related to product recalls:

- Advocate for standardized format for recall notices and standardized processes for communication to stakeholders.
- Advocate for timely removal of product throughout the entire supply chain.
- Encourage the inclusion of lot and expiration data in product labeling (e.g., package bar codes) to facilitate implementation of product recalls and to permit the development of computer fail-safes to ensure that recalled products are not administered to patients.
- Reassess the voluntary nature of recalls and consider advocating for FDA authority to initiate recalls.
- Advocate for a central repository of all recall notices with a mechanism to receive alerts.
- Consider revision of ASHP policy 9919 to include all drug products.

Background

The Council reviewed ASHP policies regarding medication distribution and control and believed that ASHP policy 0605, Pharmaceutical Distribution Systems, should be amended to include managing and responding to product recalls. The Council voted and the Board agreed to recommend amending ASHP policy 0605 as follows (underscore indicates new text):

> To support wholesaler/distribution business models that meet the requirements of hospitals and health systems with respect

to timely delivery of products, minimizing short-term outages and long-term product shortages, managing and responding to product recalls, fostering product-handling and transaction efficiency, preserving the integrity of products as they move through the supply chain, and maintaining affordable service costs.

This policy was discussed based upon a recommendation from the ASHP House of Delegates. The Council also voted to develop guidelines on the management of product recalls (see "Other Council Activity" below).

B. Impact of Insurance Coverage Design on Patient Care Decisions

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

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

To advocate for the exclusion of hospital outpatient settings from restrictive reimbursement requirements.

Rationale

Evolving practices by health insurers are affecting patient care decisions in hospitals and health systems. One increasingly common health insurance practice restricts management of and access to certain drugs to specialty suppliers, which may coincide with a particular drug being shifted from a medical benefit to a prescription benefit. Another problematic practice is that certain drugs are not reimbursed by the insurer when used as part of the patient's hospital or health-system care. Medicare, for example, deems certain drugs as "self-administered drugs" (SADs), which are not reimbursed when provided to a patient because they are not considered integral to the reason for admission.

These practices increase the number of patients that "brown bag" medications when they are admitted to a hospital to avoid being charged personally for the uncovered medications. In turn, hospitals often make determinations differently on how to manage billing for these drugs, causing compliance concerns and customer service challenges. Pharmacy leaders are charged with ensuring the safe use of medications, regulatory compliance, and customer satisfaction in an environment that is increasingly making insurance coverage decisions that do not take into consideration the hospital and health-system patient care environment. Billing patients for these medications can result in public relations challenges, especially when other facilities in the same service area elect not to charge for SADs. Failing to bill can result in compliance concerns, and verifying and documenting the integrity of patients' medications can be time consuming and is particularly challenging when treating patients in emergency departments and observation units.

The Council identified a number of concerns about these practices, including impact on continuity of care, integrity of the drug supply, and impacts on patient satisfaction and public perception of hospitals and health systems. In the case of high-cost injectable medications, which can be difficult to identify, providers and patients may face difficult decisions about delivering care.

The Council reviewed ASHP policy 0806, Health-System Use of Medications and Administration Devices Supplied Directly to Patients, and believed that the policy is still appropriate. The Council believed that it is the responsibility of the pharmacist to ensure the integrity of drugs used in the care of patients in the health care facility in which he or she practices. Patients bringing their own medications from multiple suppliers that require verification disrupts the care process. Having patients go unreimbursed for product because it was administered in and supplied by the hospital or health system is confusing to the patient and damaging to the patient–provider relationship. More broadly, lack of understanding of the differing payment systems in different care settings leads to public relations challenges.

The Council believed that ASHP should proactively advocate for reforms to these insurance practices. Coverage of medications should not interfere with the safe and effective provision of care and should recognize the responsibility of pharmacists to ensure product integrity for care provided at hospitals and health systems. The Council also believed that ASHP should advocate with the Centers for Medicare & Medicaid Services (CMS) and others for the exclusion of hospital outpatient settings from SAD and other restrictive reimbursement requirements.

Background

This topic was discussed based upon a recommendation from the ASHP House of Delegates. The Council voted and the Board agreed to recommend the new policy as defined above.

C. Prudent Purchasing of Pharmaceuticals

To discontinue ASHP policy 0524, which reads:

To support existing laws and legitimate practices that ensure product integrity and allow organized health care settings to purchase drug products and related supplies at prices that minimize health care costs; further,

To support the principle of purchase of pharmaceutical products and related supplies by public and private entities using appropriate professional practices to achieve that end; further,

To encourage government acknowledgement of existing local professional activities (e.g., drug-use review, formulary systems, pharmacy and therapeutics committees, and patient counseling) already practiced in organized health care settings that are methods of promoting quality and cost-effective pharmacist patient-care services.

Rationale

The Council discussed this policy as a part of sunset review and believed that the policy was redundant with a number of existing ASHP policies and that these concepts were adequately addressed. The following policies address one or more of the concepts reflected in ASHP policy 0524:

- ASHP policy 0907, Pharmaceutical Product and Supply Chain Integrity
- ASHP Technical Assistance Bulletin on Hospital Drug Distribution and Control
- ASHP Guidelines on Managing Drug Product Shortages in Hospitals and Health Systems

The Council also believed that the intent of the policy statement was not clear and that it was dangerous to have policy that broadly states ASHP support for "existing laws and legitimate practices" since these may change over time and ASHP may not be supportive of all changes that may occur. The Council voted and the Board agreed to recommend discontinuing policy 0524.

Board Actions

Pharmacist Professional Leadership Obligation. The Council recommended amending ASHP policy 9901 to read:

> To affirm that all pharmacists have a professional obligation to serve as leaders in the safe and effective use of medicines; further,
>
> To encourage all pharmacists to serve as mentors to pharmacy students, pharmacy residents, peers, and pharmacy technicians; further,
>
> To encourage pharmacists in positions of formal leadership to foster the development of leadership skills of pharmacists; further,
>
> To encourage hospital and health-system executives to support the development of leadership skills of all health care professionals; further,
>
> To encourage colleges and schools of pharmacy to go beyond management coursework and integrate education on leadership as a practice philosophy throughout the entire pharmacy curriculum.

The Board was supportive of the concepts in the proposed policy language but believed that ASHP policy on this issue would be more effectively conveyed in a formal ASHP statement on the professional leadership obligation of pharmacists. The Board voted

> To refer the proposed policy back to the Council with the recommendation that the Council consider incorporating the concepts in the proposed policy language into an ASHP statement.

The Council discussed ASHP policy 9901 on fostering pharmacy leadership and recommended amendments to the policy. ASHP policy 9901 encourages only pharmacy managers to mentor other members of the staff, students, and residents to foster the development of leaders. The policy implies that fostering leadership is the exclusive responsibility of pharmacy managers. The ASHP Statement on Professionalism defines leadership as one of ten characteristics of a professional. The ASHP Statement on the Roles and Responsibilities of the Pharmacy Executive focuses on the formal leadership roles of the pharmacy executive. Other ASHP policies that relate to leadership all speak to both development of leadership and management skills, further leading to the perception that leadership is an obligation of pharmacy managers but not necessarily a core professional responsibility of all pharmacists. The Council believed that there is a need for ASHP policy on leadership that is distinct from its many policies dealing with management. The Council believed that leadership is not the sole responsibility of pharmacy managers and noted that much of our profession's progress towards achieving the vision of pharmacy as a clinical profession can be attributed to the leadership of strong clinical leaders who did not hold formal management titles. The Council supported the concept that leadership is a professional obligation of all pharmacists and believed ASHP policy should clearly articulate this concept.

The Council encouraged ASHP, through the Section of Pharmacy Practice Managers and the Center for Health-System Pharmacy Leadership, to continue efforts to provide opportunities for mentorship and leadership training and development. The Council acknowledged many high-quality programs currently available but noted that many of these programs emphasize formal leadership roles and require significant time commitment and travel. In particular, the Council suggested the need for more didactic leadership training, distance learning programs, the use of social media for networking and mentorship, and an increased focus on the full spectrum of leadership.

Pharmacists Staffing and Error Assessment. The Council recommended the following new policy:

> To advocate that staffing effectiveness assessments be part of the root cause analysis following a medical error; further,
>
> To promote inclusion of all members of the health care team in such staffing effectiveness assessments, including pharmacists; further,
>
> To foster research and development of validated staffing effectiveness performance measures.

The Board believed that this topic was an important issue but believed that further study by the Council would be valuable prior to approval of policy. The Board voted

> To refer the proposed policy back to the Council for further analysis and refinement.

The Council discussed staffing effectiveness standards for hospital and long-term care that have been undergoing field-testing by The Joint Commission (TJC). The focus is on staffing effectiveness related to the units or divisions providing patient care, such as medical-surgical, intensive care, and pediatric units. Data collection is currently only specifically required for nursing staff (registered nurses, licensed practical nurses, nursing assistants, or aides). Organizations may choose to include other staff, such as therapists, laboratory staff, pharmacists, or others. Data is not required to be collected for staff that work outside patient care areas, such as in accounts payable or marketing.

The Council believed that inadequate staffing can contribute to medical errors and that ASHP should advocate for assessment of staffing as a part of the investigation of any error or incident affecting patient care. In increasingly team-based care delivery models, adequate staffing of all health professionals can affect outcomes of care. Therefore, the Council believed that staffing levels of all health professionals should be part of any root cause analysis of errors or near misses. The Council recognized that there is currently a lack of well-validated models for assessment of staffing effectiveness and encouraged ASHP to support research and development efforts to create these tools.

The Council also recommended that ASHP monitor changes to medication reconciliation and keep members informed of pending changes and suggested that ASHP encourage networking among members to share solutions to TJC standards with low compliance. Further, the Council noted that the ASHP Guidelines on Preventing Medication Errors in Hospitals were scheduled for revision and suggested that revisions should include the concept of root cause analysis.

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.)

- Pharmacy Staff Fatigue and Medication Errors (0504)
- Health-System Facility Design (0505)

Other Council Activity

Guidelines on the Management of Product Recalls. The Council discussed pharmaceutical supply chain management and drug product recalls and voted to develop guidelines on the management of product recalls. The Council believed that ASHP guidelines and technical assistance bulletins contained limited references to managing drug product recalls. However, this advice was general in nature and the Council believed that the management of product recalls in today's practice environment is sufficiently complex that further advice should be developed. The Council also suggested that ASHP and the Section of Pharmacy Practice Managers seek to educate members about this issue and to develop and disseminate best practices.

Expansion of Standard-Setting Bodies. The conclusion of the ASHP Statement on the Health-System Pharmacist's Role in National Health Care Quality Initiatives states "The number of mandatory and voluntary health care quality measures related to the use of medications is large and growing." At the same time, regulatory agencies are facing greater public scrutiny and becoming more active. Regulatory agencies, including state boards of pharmacy, state boards of health, the FDA, U.S. Environmental Protection Agency, U.S. Drug Enforcement Administration, Occupational Safety and Health Administration, CMS, and others are all increasingly active. Organizations such as TJC and the United States Pharmacopeia (USP) also create standards that are enforceable. A wide array of quality improvement organizations—Leapfrog, National Quality Forum (NQF), Hospital Quality Alliance, Institute of Medicine, National Patient Safety Foundation, etc.—also develop standards that are often incorporated into the priorities and plans of health care organizations.

Pharmacy directors are facing an increasingly complex array of competing and conflicting priorities, which is especially challenging in an era of diminished resources. Examples that were discussed include Medicaid requirements for inclusion of National Drug Code, CMS requirements that conflict with those of TJC, USP 797, and others. The Council stressed that monitoring and collecting data to ensure compliance is becoming increasingly burdensome. Council members noted that some pharmacy departments have devoted entire staff positions to compliance. The Council believed that the ASHP 2015 initiative is helpful in aligning some national priorities in a crosswalk, but believed that more efforts of this kind would be helpful. The Council suggested that ASHP consider expanding the crosswalk in the 2015 Initiative into a more comprehensive crosswalk of national priorities. The Council also suggested that to be truly useful this document would need to be regularly updated and maintained.

Duty Hours of Pharmacy Residents. Based on a recommendation from the House of Delegates, the Council discussed the workload of pharmacy residents and principles for managing that workload. Standards for medical residents limit "duty" hours. Duty hours are specifically defined and do not include hours spent studying or preparing for presentations. ASHP residency standards require compliance with the duty hour standards of the Accreditation Council for Graduate Medical Education (ACGME). The state of California has designated all pharmacists as nonexempt employees, including pharmacy residents. This severely restricts not only the hours that a resident may "work" in a given week, but also the study assignments and projects that can be assigned to the resident.

The Council believed that ASHP residency accreditation standards policies addressing staffing levels of the pharmacy were appropriate. The Council also discussed California Senate Bill 651, which states "No person employed in the practice of pharmacy may be subject to an exemption from coverage under the orders of the Industrial Welfare Commission established for professional employees." This law applies to all pharmacists, including residents. The Council believed that ASHP has adequate policies and position statements that clearly establish ASHP's belief that pharmacists are professionals. The Council also noted that many institutions treat pharmacists as non-exempt employees, and while this may not be optimal, the Council agreed that it was possible to manage pharmacists and abide by labor laws in this circumstance.

The Council did not believe that it was possible to provide a high-quality residency experience if residents were classified as non-exempt employees. Classifying residents as non-exempt would greatly limit the number and nature of study and project assignments that could be assigned to residents and limit their ability to participate in leadership or management functions. The Council believed that ASHP's adoption of the ACGME guidelines demonstrates that the residency training experience is expected to be a robust learning experience in excess of the limits conferred by non-exempt employment status. Although to date this has only been an issue in California, the Council noted that there are a large number of residencies in California and that the classification of residents as non-exempt could hinder ASHP efforts to secure funding for second-year residencies. The Council suggested that ASHP assist California in advocacy to reclassify resident positions, and that the Council on Public Policy develop policy regarding the employment status of residents.

Quality Measures for Medication Management. The Council discussed the need for quality measures for medication management. The Council agreed that there is currently a lack of agreed-upon, validated measures for quality of medication management. Some Council members had difficulty distinguishing quality measures from measures of workload and productivity. Others believed these were distinct but related measures. Some Council members advocated that pharmacy should only measure quality and that pharmacy should not be required to justify staffing based on workload data. The Council discussed the challenges of developing valid measures and convincing administrators of their validity.

The Council suggested that ASHP review current quality measures. Hospitals are already expending considerable resources to track a variety of measures. A good strategy may be to evaluate which of these existing measures most closely reflect the quality of pharmacy services. ASHP documents such as the goals of the 2015 Initiative should also be explored. It was noted that pharmacy in the Department of Veterans Affairs (VA) has done considerable work in this area and ASHP should consider convening a group of quality leaders from the VA and other organizations that have made substantial progress to gather information that could be shared with members. ASHP should also consider collaboration with other outside experts in quality measurement to see if any outside expertise can be leveraged.

Workload and Productivity Measures. The Council discussed workload and productivity measurement. As noted above, the Council had some difficulty distinguishing these measures from the concept of quality measurement. Council members noted that unlike many clinical departments in hospitals, pharmacy is a hybrid that requires monitoring workload associated with managing the medication distribution system and monitoring workload associated with the delivery of direct patient care. Measures of both areas of productivity are needed to monitor the adequacy of staffing. Council members discussed problems with use of interventions or with measures of doses dispensed or billed.

The Council believed that quality measurement and workload and productivity measurement were critical issues for members and that ASHP should place a high priority on developing tools and resources to assist pharmacy managers. The Council encouraged ASHP to expedite publication of a white paper on workload and productivity that is currently under review. The Council also suggested that ASHP foster networking and education on these concepts to build better understanding and develop managers' skills in these areas. ASHP should also aggressively pursue the development of workload/productivity (and quality measurement) tools. Council members noted that they would greatly value such a tool if available from ASHP, even if it were imperfect.

Verification of Discontinued Orders. The Council discussed verification of discontinued orders based on a recommendation from

the House of Delegates. The delegate recommended that "…ASHP support research and make evidenced-based guidelines on when it is appropriate for pharmacist review of discontinued orders in CPOE [computerized provider order entry] environments." The Council noted that procedures for reviewing discontinued orders varied widely and that the functionality of computer systems to support discontinued order review also varied. Practices differ in hospitals with and without CPOE. Council members believed that there may be benefit in reviewing discontinued orders, and some Council members routinely reviewed these in their practice sites. It was noted that review of discontinued orders may be useful in identifying errors of omission. The Council supported more research in this area but did not believe it was necessary to develop specific policy on this issue. The Council noted that ASHP's support for further research in the safe and effective application of technology to support pharmacy practice is embodied in the ASHP Leadership Agenda. The Council also thought that it was premature to develop evidence-based guidelines, since further research is necessary to establish the evidence.

Impact of Economic Downturn on Pharmacy Operations. The Council discussed the impact of the economic downturn on pharmacy operations in hospitals and health systems and provided examples of specific impacts from their own experience. Negative impacts included reduced travel budgets, capital requests delayed, reductions in staffing, pay and benefit reductions, hiring freezes, renewed interest in collective bargaining, elimination of clinical programs, increased use of consultants, and others. Positive impacts included better-qualified applicants, fewer disciplinary actions, and more support for pharmacy programs that reduce expenses. Some Council members did note that they have observed an increase in drug diversion among both hospital staff and patients.

Council members applauded ASHP for prompt action in addressing this issue. The Council believed that the current economic situation underscores the need for tools and resources to assist in quantifying workload and productivity. The Council believed that residency and student rotations are particularly at risk in the current downturn. The Council encouraged ASHP to continue to create networking opportunities. The Council also believed that reviewing the history of past economic downturns may provide some new insights.

National Quality Forum Best Practice. The Council was asked to provide advice on actions ASHP should consider in response to NQF Safe Practice 18: Pharmacist Leadership Structures and Systems. The Council believed that this document could be used as a foundation for the development of quality measures discussed earlier. The Council also encouraged ASHP to communicate broadly with members about the content of this document and consider publishing an editorial or commentary on this topic. ASHP should also communicate with groups such as the American College of Healthcare Executives (ACHE) regarding the Safe Practice. ASHP may also wish to explore the feasibility of co-marketing the Safe Practice.

House of Delegates Session—2010

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.

Kathryn R. Schultz, Board Liaison

Policy Recommendations

A. Standardization of Device Connections to Avoid Wrong-Route Errors

To advocate for development and use of medication administration device connectors and fittings that are designed to prevent misconnections and wrong-route errors; further,

To support the use of oral syringes that are readily distinguishable from hypodermic syringes and connect only to oral or enteral adapters and fittings; further,

To strongly discourage the use of hypodermic syringes for other than parenteral routes of administration; further,

To identify and promote the implementation of best practices for preventing wrong-route errors.

Rationale

Interconnectivity among drug delivery devices and their fittings is a significant and preventable cause of serious or fatal wrong-route errors. Connector and tubing design unique to the route of administration that cannot be linked to a device used for a different route is the strongest type of control for these errors. However, few devices feature such connectors, and some can still be joined using tubing adapters.

Interconnectivity-related errors were recently addressed by two different consensus-development conferences. A multidisciplinary group of health care providers and safety experts at ASHP's IV Safety Summit in July 2008 recommended that standards-setting organizations should "encourage manufacturers of intravenous (IV) administration devices to design fail-safe tubing connections that preclude opportunities for misconnections." In addition, the following statements were issued from the 2008 Global Conference on the Future of Hospital Pharmacy in Basel, Switzerland:

> Pharmacists should ensure that strategies and policies are implemented to prevent wrong route errors, including, for example, labeling of intravenous tubing near insertion site to prevent misconnections, and use of enteral feeding catheters that cannot be connected with intravenous or other parenteral lines.
>
> Oral syringes that are distinctly different from hypodermic syringes should be used to prevent injection of enteral or oral medicines, especially in pediatric patients.

Background

The Council believed and the Board concurred that ASHP policy corresponding to the Global Conference statements is needed to confirm the importance of these safety recommendations and address a gap in official guidance on the risks of wrong-route errors.

B. Medication Safety Officer Role

To advocate that accountability for development and maintenance of a medication safety program in hospitals and health systems be assigned to a qualified individual (i.e., a medication safety officer or leader of a medication safety team); further,

To advocate that individuals in these roles have the authority and autonomy to establish priorities for

medication-use safety and make the necessary changes as authorized by the medical staff committee responsible for medication-use policy; further,

To affirm that pharmacists are uniquely prepared by education, experience, and knowledge to assume the role of medication safety officer or other leadership role in all activities that ensure the safety, effectiveness, and efficiency of the medication-use process; further,

To support all pharmacists in their leadership roles in organizational medication-use safety, reflecting their authority over and accountability for the performance of the medication-use process.

Rationale

Although multiple disciplines interact with the medication-use process, pharmacists are generally acknowledged to have the most knowledge of and responsibility for process performance. While all pharmacists are professionally obligated to provide care as safely as possible, the complexity of the medication-use process, as well as its critical importance to the quality of care, warrants assigning responsibility for coordination of a hospital-wide medication safety program to an individual.

The newly revised National Quality Forum Safe Practice for Better Healthcare 18, Pharmacy Leadership Structures and Systems, states that "pharmacy leaders should have an active role on the administrative leadership team that reflects their authority and accountability for medication management systems performance across the organization." The specifications of the Safe Practice affirm the qualifications and leadership role for pharmacists as the medication safety leaders in health care.

Background

The Council and the Board agreed that pharmacists should be the leaders in ensuring safe medication use. The Council discussed ASHP's historical role in providing definitive guidance on medication-use safety and its role in influencing key organizations to raise the standard of practice in this area. The Council believed that ASHP, rather than another organization, should provide definitive guidance for this important role as well. The concept for this proposed policy originates from a recommendation in the ASHP House of Delegates on behalf of the Section Advisory Group on Medication Safety, Section of Inpatient Care Practitioners, which urged ASHP to "define the role of the pharmacist as medication safety officer and provide increased educational opportunities and resources for medication safety officers and the development of such positions."

C. Role of Pharmacists in Safe Technology Implementation

To affirm the essential role of the pharmacist in the evaluation and implementation of all technology intended to ensure safety, effectiveness, and efficiency of the medication-use process.

Rationale

Effective use of automation and technology solutions improves efficiency, allows more time for direct patient care, and ensures safe medication management. The Joint Commission Sentinel Event Alert published in December 2008 outlined patient safety concerns specific to technology implementation and recommended specific actions to reduce error and patient harm. The Institute for Safe Medication Practices (ISMP) has published related recommendations for specific technologies and noted recently that one drug delivery device was marketed to promote physician autonomy as a benefit of its use.

Background

The Council believed and the Board agreed that, although ASHP has developed a number of technology-specific policies and guidelines that stipulate the essential role of pharmacists in planning and implementation, there was no overarching general statement on the pharmacist's role in safe implementation of technology. The Council and the Board agreed that such a statement is required to better support advocacy efforts. The Council requested that the Council on Pharmacy Management examine and possibly merge technology policies in order to remove redundancies and make the language consistent.

The concept for this proposed policy is the result of a recommendation from the House of Delegates, which suggested that ASHP "define and advocate for the pharmacist's role in safe implementation of technologies used in medication procurement, prescribing, preparation, dispensing, administration, and monitoring."

D. Just Culture and Reporting Medication Errors

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

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

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

(Note: A just culture is one that has a clear and transparent process for evaluating errors and separating events arising from flawed system design or inadvertent human error from those caused by willful disregard for safety.)

(Note: This policy would supersede ASHP policy 0910.)

Rationale

"Just culture" is an approach to medical error management that recognizes individual accountability for behavioral choices that compromise safety. The concept of "just culture" was first introduced by Sidney Dekker, a pilot and systems engineer, who recommended a different approach to the view that management of medical error should take a strict systems approach with a "no blame" attitude regarding individual accountability. David Marx, a lawyer and engineer, added additional background and recommendations, including criteria for determining whether error is "human" (i.e., inadvertent and unintended) or the result of behavioral choices that introduce risk.

"Just culture" differs from the "no blame" approach in two ways: (1) intentional actions that introduce risk or lead to error are acknowledged, and (2) an algorithm or criteria are used to determine the type of corrective action that should be taken (e.g., coaching or disciplinary action). Just culture has come to be accepted over the "no blame" approach because it allows the safety and health care community to address what Dekker and Marx characterize as at-risk and reckless behavior as causes of error.

Background
The Council voted and the Board agreed to recommend amending ASHP policy 0910, Reporting Medication Errors, as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To encourage pharmacists to exert leadership in establishing a just culture in their workplaces and a nonpunitive systems approach to addressing medication errors while supporting a nonthreatening reporting environment to encourage pharmacy staff and others to report actual and potential medication errors in a timely manner; further,
>
> To provide leadership in supporting a single, comprehensive medication error reporting program that (1) fosters a confidential, nonthreatening, and nonpunitive environment for the submission of medication error reports; (2) receives and analyzes these confidential reports to identify system-based causes of medication errors or potential errors; and (3) recommends and disseminates error prevention strategies; further,
>
> To provide leadership in encouraging the participation of all stakeholders in the reporting of medication errors to this program.
>
> (Note: ~~A just culture recognizes that individual practitioners should not be held accountable for system failings over which they have no control, and that many individual or "active" errors represent predictable interactions between human operators and the systems in which they work. However, a just culture does not tolerate conscious disregard of clear risks to patients or gross misconduct.~~ A just culture is one that has a clear and transparent process for evaluating errors and separating events arising from flawed system design or inadvertent human error from those caused by willful disregard for safety.)

The revisions are intended to improve clarity on the concept of "just culture," an approach to medical error management that uses a decision-making algorithm to determine whether error is "human" (i.e., inadvertent and unintended) or the result of behavioral choices that introduce risk. The Board believed that "inadvertent human error" also needed to be addressed and therefore amended the note to include this issue.

E. Patient Access to Pharmacy Services in Small and Rural Hospitals

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

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

(Note: This policy would supersede ASHP policy 0503.)

F. Scope and Hours of Pharmacy Services

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

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

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

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

(Note: This policy would supersede ASHP policy 0403.)

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

Background
The Council voted and the Board agreed to recommend amending ASHP policy 0503, Critical-Access, Small, and Rural Hospitals, as follows (underscore indicates new text):

> To advocate that critical-access hospitals (CAHs) and small and rural hospitals meet national medication management and patient safety standards, regardless of ~~hospital~~ size or location; further, *
>
> To provide resources and tools to assist pharmacists who provide services to CAHs and small and rural hospitals in meeting standards related to safe medication use.

The Council also voted and the Board agreed to recommend amending ASHP policy 0403, Scope and Hours of Pharmacy Services, as follows (underscore indicates new text):

> To support the principle that all patients should have 24-hour access to a pharmacist responsible for their care, regardless of hospital size or location; further,
>
> To advocate alternative methods of pharmacist review of medication orders (such as remote review) before drug administration when onsite pharmacist review is not available; further,
>
> To support the use of remote medication order review systems that communicate pharmacist approval of orders electronically to the hospital's automated medication distribution system; further,
>
> To promote the importance of pharmacist access to pertinent information, regardless of proximity to patient.

These policy revisions are the result of a recommendation from the House of Delegates, which urges ASHP to support access to a pharmacist to provide prospective medication review for hospitalized patients and other functions that improve the safe medication-use process in facilities regardless of hospital size or location. The Council confirmed the need for policy that specifically states that prospective review of orders by a pharmacist and 24-hour access to a pharmacist responsible for their care should be provided to all hospitalized patients.

*Please note that the word "hospital" was inadvertently added to the blacklined version of Policy Recommendation E in the Background above. The text of Policy Recommendation E (without the word "hospital") is accurate and is the text delegates will vote on. [Note added May 10, 2010.]

G. Use of Two Patient Identifiers in the Outpatient Setting

To encourage the use of two identifiers to confirm patient identity when transferring filled prescriptions to the patient's possession in outpatient settings.

Rationale
Errors caused by dispensing medications to the wrong patient are largely preventable. The Joint Commission's National Patient Safety Goal 1A requires using at least two patient identifiers when administering medications within the health care system. However, there is no similar requirement to confirm patient identity in the outpatient setting at the time the patients pick up their filled prescriptions.

Background
The Council and the Board agreed that errors due to providing prescription medications to the wrong patient in the ambulatory setting are largely preventable. The Council and Board support The Joint Commission's National Patient Safety Goal 1A and believe that this safety strategy should be used to confirm patient identity in the outpatient setting at the time the patients pick up their filled prescriptions.

Board Actions

Medication Safety Officer Education. The Council recommended and the Board voted

> To establish guidelines on the essential components, minimum competencies, and recommended training for the role of medication safety officer; further,
>
> To provide increased educational and training opportunities for medication safety officers.

The Council noted that medication safety officers (MSOs) must possess leadership skills as well as expertise in the tools of medication safety: systems analysis, performance improvement, risk management, conflict resolution, and other skills that may not be part of their professional education.

While ASHP has established standards for medication safety residency training, and other organizations have general policies supporting the pharmacist's role in safe medication use, no standard of practice has been established for training, minimum competencies, or position responsibilities for MSOs. Assigned responsibilities vary widely from organization to organization and are often combined with a regulatory, quality improvement, or pharmacy management role. Despite the minimal academic or experiential training opportunities available for the MSO role, a growing component of ASHP membership have either assumed MSO positions or have expressed interest in pursuing a professional career in medication safety. Establishing qualifications and minimum competencies as well as job responsibilities and educational requirements is necessary to assure that individuals who practice or wish to practice as MSOs have the necessary guidance to manage a high-risk, critical system appropriately.

A.S.P.E.N. Safe Practices for Enteral Nutrition. The Council recommended and the Board voted

> To endorse Safe Practices for Enteral Nutrition from the American Society of Parenteral and Enteral Nutrition (A.S.P.E.N.).

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

- Drug Shortages (0002)
- Drug Names, Labeling, and Packaging Associated with Medication Errors (0020)
- Medication Errors and Risk Management (0021)
- Mandatory Labeling of the Presence of Latex (0501)
- Health Care Quality Standards and Pharmacy Services (0502)
- Accessibility and Affordability of Pharmaceuticals (0506)
- Electronic Information Systems (0507)
- New and Emerging Medication Ordering and Distribution Systems (0522)
- Online Pharmacy and Internet Prescribing (0523)
- Mandatory Tablet Splitting for Cost Containment (0525)
- Standardization of Medication Formulary Systems (9601)
- Human Factors Concepts (9609)
- ASHP Statement on the Use of Dietary Supplements
- ASHP Guidelines on the Pharmacist's Role in the Development, Implementation, and Assessment of Critical Pathways

Other Council Activity

Use of Placebos. The Council voted

> To conduct a review of relevant scientific literature related to the use of placebos as well as current ASHP policy to determine whether revision is required for ASHP policy 0517, Ethical Use of Placebos, which states:
>
> > To affirm that the use of placebos in clinical practice is acceptable ethically only when patients grant informed consent for the use of placebos as a component of treatment; further,
> >
> > To encourage each health care facility to develop a policy and procedure to guide its clinicians in making informed decisions regarding the use of placebos.

The Council believed that the current statement misuses the term "informed consent." Requiring informed consent limits the use of placebos to clinical trials or to therapies with a consent process similar to that of a clinical trial, and the intent of that limitation is not clear to the Council. In comparison, the policy statement of the American Medical Association is less restrictive. The Council requested that more study be given to this issue during the 2009–2010 policy cycle and the issue reconsidered by next year's Council.

Just Culture and Reporting Medication Errors. The Council discussed the "just culture" in conjunction with its consideration of the recommended revision of ASHP policy 0910. They commented that the concept is clear when addressing events where the intent to do the right thing failed (human error) or the other end of the spectrum, intentional harm or reckless disregard for safety. How-

ever, the concept is challenging to apply in events where behavior is "at-risk," such as "bending the rules" when workload is heavy or due to a perceived urgency to deliver care to a patient. The Council suggested that the just culture concept should be considered as an agenda item by all the policy councils to determine whether there is anything ASHP should do for members.

Clinical Decision Support as an Alternative to Near-Universal Pharmacist Order Review. Council members reviewed the minutes from the discussion of this topic by the Council on Pharmacy Management in 2008, which included support of research as requested but not support for the use of clinical decision support systems to take the place of a pharmacist. Council members agreed with these and other conclusions from the previous Council's discussion and had no further comments to add. However, the Council suggested that ASHP should continue to monitor the development of clinical decision support systems that can auto-verify medication orders and that the Section of Pharmacy Informatics and Technology continue to deliberate this topic. The Council also suggested that the concept of auto-verification and how it affects practice might be considered in the Pharmacy Practice Model Initiative. ASHP should continue to monitor development of auto-verification systems, as this new technology has important implications for practice model, regulatory, and accreditation issues.

Practice Implications of Controlled Substance Status for Propofol and Fospropofol. The Council reviewed literature on abuse potential of propofol and fospropofol in order to identify key issues that ASHP should consider in its advocacy on this issue to the Drug Enforcement Agency. The Council recommended support of controlled substance status for propofol and fospropofol, and that ASHP should collaborate with the appropriate stakeholder groups to identify best medication management practices for these agents. They also suggested that pharmacists should be educated about the risks of diversion and abuse of propofol by publishing a review of biomedical literature on this topic in the *American Journal of Health-System Pharmacy*.

Documentation of Dose Volumes in the Medical Record. The Council considered a proposal by Katherine Francis, RN, for a new Joint Commission National Patient Safety Goal. The proposal recommended documentation of strength and volume administered for the dose in the medical record, and use of electronic clinical decision support at the bedside to perform the necessary calculations. The Council expressed support for the recommended documentation and agreed that it would better support quality audits. However, the Council declined to recommend the requirement for electronic clinical decision support, stating that there are other methods to meet the documentation requirement and that all organizations may not have the resources or capacity for this technology. In addition, the Council believed that such an action might be misinterpreted as product endorsement.

ASHP Statement on the Pharmacist's Role in Primary Care. The Council reviewed the revised statement and had no revisions to recommend. The Council felt that the statement is broad in scope, yet specific enough to support the primary care role for pharmacists and provide a basis for advocacy. The Council recommended that ASHP (1) consider the role of the pharmacist in primary care while defining the practice model of the future; (2) identify and recognize successful models of primary care delivery by pharmacists; (3) explore creative methods to place pharmacists in visible positions of patient care, such as marketing pharmacist services in a manner that increases consumer demand; (4) encourage the participation of pharmacists in health care teams practicing primary care; (5) explore expanding routine pharmacist responsibilities to include physical assessment; and (6) advocate that boards of pharmacy eliminate scope of practice regulations that prohibit pharmacists from assuming expanded roles as health care providers.

Recommendations for Guidelines for Industry Relations and Pharmacist Conflict of Interest. The Council believed that greater transparency is indicated in the pharmacy profession regarding industry support, including ASHP's own policy. Council members suggested that ASHP explore the implications of publicly reported industry support to pharmacists, including disclosure of the amount of funding or honoraria. In addition, they recommended education of ASHP members on ASHP policies for avoiding, minimizing, and resolving conflicts of interest in obtaining, maintaining, and using industry funding. The Council believed that less intrusive means of acknowledging industry should be sought to take the place of highly visible logos, trademarks, large print, and corporate colors on backpacks and lanyards.

House of Delegates Session—2010

Reports on Sections and Forums

ASHP sections consist of members within five well-defined areas of health-system pharmacy who collaborate to advance professional practice in their respective areas. ASHP members may enroll in as many sections as they wish; practitioner members are asked to select one section as their primary "home," which allows them to vote for the chair and members of the executive committee of that section.

The ASHP Student Forum consists of all student members. The New Practitioners Forum consists of all practitioner members who are within five years of graduation from a 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 12 and 13, 2009, to review the past year's activities and plan for the coming year. The committees met again on December 5, 2009, and by telephone periodically during the year to assess progress on initiatives and discuss new trends or events that warrant section or forum activity. Each section and forum has its own mission, vision, goals, and objectives.

1 ASHP Section of Clinical Specialists and Scientists
3 ASHP Section of Home, Ambulatory, and Chronic Care Practitioners
5 ASHP Section of Inpatient Care Practitioners
8 ASHP Section of Pharmacy Informatics and Technology
11 ASHP Section of Pharmacy Practice Managers
13 ASHP New Practitioners Forum
16 ASHP Pharmacy Student Forum

ASHP 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; and (4) communicate 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.

2009–2010 Section Highlights. Section membership increased by 10.6 % during 2009, to almost 13,000 members. Approximately 49% 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 Dr. Hess as Chair and Dr. Jennings as a Director-at-Large; both will be installed at the June 2010 ASHP Summer Meeting.

The Section selected Carol J. Rollins 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 2009 Midyear Clinical Meeting (MCM).

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. The 2008–2009 Committee developed more than 32 hours of educational programming on current issues in infectious diseases, critical care, pharmacogenomics, alcohol withdrawal, and nutraceuticals. 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 Section's electronic NewsLink is distributed once a month to almost 9000 ASHP members, providing news and current information on medical research, regulatory and health policy issues, health care, and therapeutics. The Section Chair's message is also distributed once a month to NewsLink subscribers and provides news on Section and ASHP programs and initiatives. The Section's electronic discussion group provides a forum for Section members to exchange information and ideas on a wide variety of topics related to clinical practice; currently, more than 3350 members participate. In addition, the Section provides an electronic discussion group in emergency care with over 1600 subscribers. The discussion groups are also used to communicate urgent information on clinical specialty practice.

The Section has 15 specialty networks encompassing most areas of specialty pharmacy practice. The networks meet regularly at the MCM, with almost 850 meeting attendees participating. Facilitators are appointed for 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.

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. This column covers therapeutic controversies and provides recommendations for handling specific pharmacotherapeutic problems. The Section continues to host the anticoagulation resource center, the ASHP Anticoagulation Initiative: Promoting Patient Safety through Education, Practice, Policy, and Advocacy, on the ASHP Web site. The resource center is a compilation of educational materials, policies, best practices, and links to other organizations for practitioners looking for resources in the area of anticoagulation management.

The Section also coordinated 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.

Two new advisory groups were established on preceptor skills development and clinical leadership to focus on the development of programs and resources in the specific areas of practice for Section and ASHP members. The Section also developed the Clinical Leaders Boot Camp: Practical Tools for Promoting and Establishing Services Workshop held on Sunday, December 6, prior to the MCM. This workshop was developed based on member needs identified through the Section Needs Assessment Survey and listserver postings and was well received by attendees.

Task Force on Science. The Section was involved with planning the ASHP Task Force on Science, held at ASHP on September 17, 2008, with participation from national experts in informatics/technology, pharmacogenomics, personalized medicine, gene therapy, and nanomedicine. The Task Force made 12 recommendations, which can be categorized into three areas: education and research, practice and policy development, and advocacy efforts. The recommendations from this meeting will help guide future activities of the Section and ASHP in the emerging sciences and the incorporation of informatics/technology into pharmacy practice. The full report was published in the June 15, 2009, issue of *AJHP*. A section advisory group was established on the emerging sciences, to include representation from, but not limited to, genomics, nanomedicine, biotechnology, and gene therapy. Activities of the Section Advisory Group on Gene Therapy are incorporated into the Section Advisory Group on Emerging Sciences. A Web resource center will be devel-

oped on the emerging sciences, and the newly formed advisory group would be charged with advising the Section and ASHP on the emerging sciences and implementing recommendations of the 2008 Task Force on Science.

Advisory Group on Emergency Care. As a follow-up to the ASHP Statement on Pharmacy Services to the Emergency Department, this advisory group is drafting guidelines on the pharmacist's role in the emergency department. The group also hosted a successful emergency medicine networking session at the MCM that drew more than 35 participants. Practitioners in this field also network through the ASHP Emergency Care electronic discussion group, which has close to 1600 subscribers.

Advisory Group on Gene Therapy. The Section Advisory Group on Gene Therapy was established in 2008. A gene therapy survey was developed and launched in November 2008. The purpose of the survey was to identify educational and practice gaps in gene therapy. Survey results identified a number of practitioner needs in this area. The group planned a two-hour educational program at the 2009 MCM, where results of the survey were presented in addition to therapeutic advances in gene therapy. This advisory group has been incorporated into the new advisory group on emerging sciences.

Advocacy. The Section has been heavily involved in emphasizing the evidence-based nature of pharmacy practice and has worked to incorporate evidence-based medicine concepts into the ASHP Health-System Pharmacy 2015 Initiative. The Section will continue to stress that the responsibility for incorporating evidence-based therapeutic guidelines and medication use into patient care is a responsibility of all pharmacists and pharmacy departments.

Committee on Nominations

Kelly M. Smith, Chair (Kentucky); Kate Farthing (Oregon); Kimberly A. Galt (Nebraska); Rita K. Jew (California); Michael W. Kelly (Iowa); Alan H. Mutnick (Ohio); Jean M. Scholtz (Pennsylvania)

Educational Steering Committee

Cherry W. Jackson, Chair (Alabama); Michelle D. Wiest, Vice Chair (Ohio); Ericka L. Breden (Virginia); Daniel P. Hays (Arizona); Bob Lobo (Tennessee); Kamakshi V. Rao (North Carolina); Douglas Slain (West Virginia); Susan M. Stein (Oregon); Paul M. Szumita (Massachusetts); Mary Hess, Executive Committee Liaison (Pennsylvania)

Advisory Group on Clinical Leadership

Linda S. Tyler, Chair (Utah); Lori J. Golterman,Vice Chair (Washington, D.C.); Kimberly Binaso-Stwalley (New Jersey); John Clark (Michigan); Susan E. Conway (Oklahoma); Lynn Eschenbacher (North Carolina); Joshua Howell (Texas); Teresa H. Seo (Connecticut); Robert Talbert (Texas); Tate Trujillo (Indiana); Kelly M. Smith, Executive Committee Liaison (Kentucky)

Advisory Group on Emergency Care

Renee M. Petzel, Chair (Illinois); Heather Draper Eppert, Vice Chair (Tennessee); Roshanak Aazami (California); Patrick Bridgeman (New Jersey); Tony Casanova (Washington); Alison Jennett (Massachusetts); Deborah J. Larison (Florida); Melinda J. Ortmann (Maryland); Asad (Sid) Patanwala (Arizona); Joanne Witsil (Illinois); Lea S. Eiland, Executive Committee Liaison (Alabama)

Advisory Group on Gene Therapy

Susan Goodin, Chair (New Jersey); Susan Johnston (Wisconsin); Theresa Mays (Texas); Kim Powell (Texas); James A. Trovato, Executive Committee Liaison (Maryland)

Advisory Group on Preceptor Skills Development

Carol J. Rollins, Chair (Arizona); Allison Jun, Vice Chair (California); George Phillip (Phil) Ayers (Mississippi); Teresa Cavanaugh (Ohio); Dale English (Ohio); Sharon E. Jones (West Virginia); Holly Philips (Colorado); Charlotte A. Ricchetti (Ohio); Samaneh T. Wilkinson (Kansas); Cathy L. Walker (Maryland); Erin Fox, Executive Committee Liaison (Utah)

Network Facilitators

Anticoagulation: Daniel A. Lewis (Kentucky)
Cardiology: Orly Vardeny (Wisconsin)
Critical Care: Steven Pass (Texas)
Drug Information/Pharmacoeconomics: Karen P. Norris (Kansas)
Emergency Medicine: Deborah J. Larison (Florida)
Geriatrics: Rosina M. Stamati (New York)
Hematology/Oncology: Leila R. Mohassel (Virginia)
Immunology/Transplant: Lonnie Smith (Utah)
Infectious Diseases: Andrew DeRyke (Florida)
Nutrition Support: Vivian Zhao, (Georgia)
Pain Management: Mitchell Nazario (Florida)
Pediatrics/Obstetrics–Gynecology/Neonatal: Cathy Y. Poon (Pennsylvania)
Pharmacokinetics: Julie Dumond (North Carolina)
Primary Care/Pharmacotherapy: Beth Bryles Phillips (Georgia)
Psychopharmacy/Neurology: Eric C. Kutscher (South Dakota)

ASHP Section of Home, Ambulatory, and Chronic Care Practitioners

The mission of the ASHP Section of Home, Ambulatory, and Chronic Care Practitioners is to improve patient care and patient health outcomes by advancing and supporting the professional practice of pharmacists who are medication-use specialists, patient care providers, and operational specialists in home, ambulatory, and chronic care settings. The Section dedicates itself to achieving a vision of pharmacy practice in which pharmacists who are medication-use specialists, patient care providers, and operational specialists in home, ambulatory, and chronic care settings will improve patient care and patient health outcomes. To achieve this vision, the Section will provide guidance that improves both the use of medications by patients and the medication-use process in ways that enhance patients' health-related quality of life and patient outcomes.

The Section's goals are to (1) promote the clinical and administrative roles of pharmacists and contribute to the advancement of care across the health care continuum; (2) serve as the voice of and a resource for the Section's practitioners within ASHP, especially in ASHP governance and policy development; (3) engage those who want to improve their professional knowledge and skills with leaders and experts in their practice settings; (4) recruit and cultivate members who are active within the profession, providing a mechanism to develop the future leaders of ASHP; (5) develop a membership that is actively involved in ASHP, that is widely utilized as a resource throughout the profession, and whose contributions are clearly recognized by the Section, ASHP, and other professional organizations; (6) communicate effectively with Section members to ensure that they understand, support, and contribute to the direction and role of the Section in representing their interests; (7) promote collaboration, including networking and services, among the Section's members; (8) create or foster the creation of ASHP products, educational programs, and services that meet the unique needs of the Section's membership, including products, educational programs, and services that utilize advanced technologies for delivery via the Internet or the World-Wide Web; and (9) work with other professional organizations to develop products, educational programs, and services that meet the unique needs of the Section's membership.

2009–2010 Section Highlights. The Section focused in 2009 on reimbursement for cognitive services, growth of ambulatory care services, pain management and palliative care, and development of criteria for postgraduate year two (PGY2) residencies in pain and palliative care. At the end of 2009, the Section had a total primary and secondary membership of 7447.

Dr. Brown served as Chair of the Section. Mr. Klotz served as Chair-elect and will begin his service as Chair beginning in June 2010. Section members also elected Dr. Haines to a two-year term as Director-at-Large. The Committee on Nominations for 2010 will present a slate of candidates for Chair-elect and Director-at-Large-elect.

The Section had a very productive year as it fulfilled members' needs and continued striving to provide leadership and value for its members through its members.

Distinguished Service Award. The Section selected Don Filibeck as the recipient of the 2009 Section of Home, Ambulatory, and Chronic Care Practitioners Distinguished Service Award. Established in 2007, the ASHP Pharmacy Practice Sections Distinguished Service Award recognizes a member from each section whose volunteer activities have supported the section's mission and helped advance the profession. The award was presented at the 2009 Midyear Clinical Meeting (MCM).

Educational Programming. The Section Programming Committee planned 15 hours of educational programming specifically for ambulatory and chronic care practitioners at the 2009 MCM. This programming included a learning community on establishing an ambulatory care practice and a pre-meeting workshop on pain management with comorbid behavioral health conditions. Programming topics included medication adherence, diabetes and the elderly, cardiovascular disease management and quality of life, self-insured clinic business models, and pain management and palliative care. There were also two Section networking sessions at the 2009 MCM, focusing on home care essentials and modern ambulatory care.

Executive Committee

Timothy R. Brown, Chair (Ohio)
Roger S. Klotz, Chair-elect (California)
Marc H. Stranz, Immediate Past Chair (Pennsylvania)
Anna Nowobilski-Vasilios, Director-at-Large (Illinois)
Richard L. Stambaugh, Director-at-Large (Minnesota)
Seena L. Haines, Director-at-Large-elect (Florida)
Gerald E. Meyer, Board Liaison (Pennsylvania)
David F. Chen, Acting Secretary

Advisory Group on Reimbursement for Cognitive Services. The Section Advisory Group on Reimbursement for Cognitive Services organized the Building Ambulatory Services: Best Practices in Design, Reimbursement, and Outcomes Learning Community at the 2009 MCM. The advisory group also produced two webinars on reimbursement for cognitive services and worked on the completion of ASHP's "Reimbursement for Pharmacist's Services in a Hospital-based, Pharmacist-managed Anticoagulation Clinic" document interpreting clinic billing guidance for pharmacists.

Advisory Group on Pain Management and Palliative Care. This advisory group created a 2009 MCM workshop on optimizing the care of patients with comorbid behavioral health conditions and finalized proposed criteria for a PGY2 specialty residency in pain management and palliative care that was approved by the Commission on Credentialing. The group also created a podcast on cardiovascular effects of opioids.

Advisory Group on Home Infusion. This new advisory group is completing an update to the ASHP guidelines for home care pharmacies. The advisory group also sponsored a successful home-infusion-focused track at the 2009 MCM and continued its work on identifying areas of patient transitions of care that ASHP and the Section can provide education and advocacy for on behalf of members.

Advisory Group on Clinical Business Development. The Section established this new advisory group in 2009 to address the growing number of issues challenging pharmacists in their ability to be reimbursed for clinic-based patient-care services. The advisory group is planning a networking session focusing on compliance issues that have to be managed by clinic-based practitioners for the 2010 Summer Meeting. In addition, the advisory group is reviewing the final drafts of a survey tool to begin collecting data on the various business models pharmacists are utilizing to operate clinics and to determine the number of practitioners working and patients cared for in this area of pharmacy practice.

Membership and Marketing Committee. The Section established this new 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 started its work with developing the Section's communication plan and evaluating the different mechanisms the Section could use to recruit members.

Ambulatory Care Specialty Credential. ASHP, along with the American College of Clinical Pharmacy and the American Pharmacists Association, continues to support the process for establishing an ambulatory care specialty credential. With the specialty now approved, the Section will seek to support ASHP and its role with

the Board of Pharmaceutical Specialties as they develop the exam, preparatory courses, and promotion of the credential.

Advocacy. Many Section members represent ASHP on various coalitions and committees. These include the Pharmacy Services Technical Advisory Coalition, The Joint Commission Professional and Technical Advisory Committees on ambulatory care and home care, and the National Asthma Education and Prevention Program. These members provide the pharmacist's perspective in discussions that have an impact on patient care nationwide. Section members continue to support ASHP's efforts in advocacy for the expansion and payment of pharmacists and medication management services.

Advisory Group on Cognitive Reimbursement Resources

Seena L. Haines, Chair (Florida); Amy L. Stump, Vice Chair (Wyoming); Becky Armor (Oklahoma); Kristy Butler (Oregon); Kelly T. Epplen (Ohio); Roger S. Klotz (California); Sandra Leal (Arizona); John R. Miller (Ohio); Laura D. Roller (Utah); Laura Traynor (Minnesota); Betsy Bryant-Shilliday (North Carolina); Richard L. Stambaugh, Executive Committee Liaison (Minnesota)

Advisory Group on Pain Management and Palliative Care

Suzanne A. Nesbit, Chair (Maryland); Virginia Ghafoor, Vice Chair (Minnesota); Sondra Adkinson (Florida); David Craig (Florida); Ernest Dole (New Mexico); Victoria Ferraresi (California); Christopher Herndon (Illinois); Lee Kral (Iowa); Mary Lynn McPherson (Maryland); Douglas Nee (California); Lori Reisner (California); Scott Strassels (Texas); Jennifer Strickland (Florida); Richard L. Stambaugh, Executive Committee Liaison (Minnesota)

Advisory Group on Home Infusion

Donald J. Filibeck, Chair (Ohio); Daniel B. Dobson, Vice Chair (Washington); Jeannie Barkett (Oregon); Michael P. Carrol (Vermont); Kim Ehlert (Minnesota); Douglas R. Lang (Missouri); Taeho Oh (Florida); Steven M. Pate (Tennessee); Anthony Sardone (New Jersey); Anna Nowobilski-Vasilios, Executive Committee Liaison (Illinois)

Advisory Group on Clinical Business Development

Mary Ann Kliethermes, Chair (Illinois); Gloria Sachdev, Vice Chair (Indiana); Jeffrey M. Brewer (New York); Dan Buffington (Florida); Sandra Chase (Michigan); Kathy Donley (Ohio); Anna Garrett (North Carolina); John Hutchinson (New Mexico); Santha Masilamani (Texas); Edith Nutescu (Illinois); Gregory Polk (Michigan); Jeffrey Rapp (Illinois); Steven M. Riddle (Washington); Jeffrey Steffey (Michigan); Tim R. Brown, Executive Committee Liaison (Ohio)

Membership and Marketing Committee

Pam Letzkus, Chair (Illinois); Binita Patel (Naik), Vice Chair (Wisconsin); Kevin D. Burns (Minnesota); Jenna Buskohl (Minnesota); John Hutchinson (New Mexico); Anthony Sardone (New Jersey); Ronald Smetana (Ohio); Eureva Walker (Illinois); Anna Nowobilski-Vasilios, Executive Committee Liaison (Illinois)

Educational Steering Committee

Michele L. Matthews, Chair (Massachusetts); Jennifer P. Askew (North Carolina); Michelle Cudnik (Ohio); Michelle A. Fritsch (Maryland); Katie V. Lai (Washington); Jeannie Kim Lee (Arizona); Kimberly Braxton Lloyd (Alabama); Tracy A. Martinez (Michigan); Mary Lynn McPherson (Maryland); Edward P. Sheridan (Indiana); Pamela L. Stamm (Alabama); Marc H. Stranz, Executive Committee Liaison (Pennsylvania)

Committee on Nominations

Marc H. Stranz, Chair (Pennsylvania); Sondra Adkinson (Florida); Caryn M. Bing (Nevada); Sandra Chase (Michigan); Ernest Dole (New Mexico); Mary Ann Kliethermes (Illinois); Steven Riddle (Washington)

ASHP Section of Inpatient Care Practitioners

The Section of Inpatient Care Practitioners was launched in September 2003 to meet the needs of the frontline pharmacist. The Section dedicates itself to achieving a vision of pharmacy practice in which pharmacists practicing in an inpatient setting safely integrate clinical (direct patient care or indirect patient care), distributive, and operational functions and are focused on improving inpatient care. To achieve this vision, the Section will (1) serve as a voice for inpatient care practitioners and members of the Section within ASHP, including ASHP governance and integration of Section policy development within ASHP; (2) facilitate the integration of drug distribution and clinical practice for inpatient care practitioners and members of the Section; (3) assist in a concerted rural health care strategy that will strengthen ASHP's rural health care advocacy efforts, facilitate promotion of ASHP's policies and agenda in rural and frontier America, and elevate ASHP's standing in rural communities; (4) promote the professional development of inpatient care practitioners and members of the Section through education and skills development; (5) increase communication with Section members on key issues for the profession and the Section; (6) encourage, facilitate, and educate on 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.

2009–2010 Section Highlights. Now in its sixth year, the Section has grown to more than 9000 members. Through educational programming, networking, advocacy, and volunteer opportunities, the Section Executive Committee has worked to develop member services that support the needs of the frontline pharmacist. A new Section Advisory Group on Pharmacy Support Services was formed, and two new component groups—Investigational Drug Services and Operating Room (OR)/Anesthesiology—were transitioned from the Section of Clinical Specialists and Scientists to the Section of Inpatient Care Practitioners. 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. For the first time, the Section's Executive Committee hosted a networking session at the 2009 Midyear Clinical Meeting (MCM). Participants at this session discussed the results of the Section's survey on pharmacists' quality of work life. Section members elected Dr. Benson as Chair and Dr. Chapman as Director-at-Large; both will be installed at the June 2010 Summer Meeting. The Committee on Nominations works to aggressively recruit qualified candidates for nomination and develop a slate of candidates that will serve as officers to fulfill Section initiatives. The committee will present a slate of candidates for Chair and Director-at-Large. The Executive Committee selected Dale English as the third winner of the Section's Distinguished Service Award. Dr. English received his award at the Distinguished Service Award Reception at the 2009 MCM.

Educational Programming. The Section conducted 18 hours of successful educational sessions at the 2009 MCM. For the fourth consecutive year, a day of programming for pharmacists working in small and rural hospitals was offered. This programming, coordinated by the Section Advisory Group on Small and Rural Hospitals and entitled "Programming for Small and Rural Hospitals," featured as its opening speaker Beth Landon, President of the National Rural Health Association (NRHA) and Director of Alaska's Area Health Education Center (AHEC). Other rural program topics included "Making the Case for Remote Pharmacist Services in Small or Rural Institutions," "Selecting a Drug Distribution Model for Small and Rural Institutions," and "Residencies in Rural Settings." Organizations represented on the program's speaker panel included the Health Resources and Services Administration (HRSA) Office of Rural Health Policy (ORHP) and Office of Pharmacy Affairs (OPA) as well as the Institute for Safe Medication Practices (ISMP). Additional MCM programming of interest to Section members addressed updates on pediatrics for the non-pediatric specialist, intravenous lines and various medication devices, and optimization of patient comfort with safe and effective sedation practices. The Section's Educational Steering Committee, chaired by Angela Cassano, met at the 2009 MCM to discuss and select topics for Section programming for the 2010 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 topic selection. The new charge for this committee has been expanded to also include providing suggestions for content for Summer Meeting programming, developing creative and innovative webinars, and seeking publication opportunities and channeling articles for publication in the *American Journal of Health-System Pharmacy* (*AJHP*) and the Section's Web pages. Members of this committee have contributed to ASHP's consumer drug information Web site (www.safemedication.com) and successfully had articles published in the Section's *AJHP* column, Frontline Pharmacist.

Executive Committee

Debby Lynn Painter Cowan, Chair (North Carolina)
Brian D. Benson, Chair-elect (Iowa)
Randy L. Kuiper, Immediate Past Chair (Montana)
Noelle R. M. Chapman (Illinois)
Jennifer M. Edwards (Montana)
Richard J. Pacitti (Pennsylvania)
Lisa M. Gersema, Board Liaison (Minnesota)
Anthea V. Francis, Secretary

Resources for Inpatient Care Practitioners. The Section's page on the ASHP Web site features information pertinent to the needs of frontline pharmacists. The information includes recent news, practical tools, webinars, and member spotlights. All Section members receive a monthly Chair's message and electronic NewsLink containing information of interest to staff pharmacists and notifying members of opportunities within the Section and ASHP. The Section electronic discussion group continues to be an effective networking mechanism. Similar discussion groups for small and rural hospitals and investigational drug services continue to be active and serve as a necessary resource for these component groups.

Advisory Group on Small and Rural Hospitals. The Section Advisory Group on Small and Rural Hospitals maintains an active electronic discussion group and planned a successful educational track featuring eight hours of pharmacist continuing education credits. Additionally, the advisory group organized a successful and well-attended networking session for the 2009 MCM. Planning for content for the 2010 MCM Programming for Small and Rural Hospitals is currently under way. This advisory group served as a pilot for ASHP's webinar-on-demand series and developed an informative and timely webinar entitled "Creative Funding Ideas for Clinical Pharmacy Services in Rural Healthcare Institutions." The group updated and maintains the Small and Rural Hospital Web Resource Center. Due to the wide range of issues this advisory group addresses and advocates on behalf of, the considerable contributions the group has made to rural health care practice, and the percentage of ASHP members that practice in rural and frontier America, the Executive Committee has prompted ASHP to enhance its efforts related to rural health care policy, advocacy, education, and training as part of the Society's Leadership Agenda. The Executive Committee will continue to help ASHP recognize the role that small and rural hospitals, critical access hospitals, and other rural health care institutions play in the health care reform debate and the unique needs of these institutions. Furthermore, the Executive Committee will continue to stress the importance of expanding the advisory group's efforts to collaborate and engage with rural health care stakeholders.

Advisory Group on Pharmacy Support Services. This newly formed advisory group held its first conference call in October 2009. The group's focus has been to develop its goals and objectives. Ultimately, the group's efforts will be directed towards assisting and supporting ASHP's Pharmacy Technician Initiative (PTI) and working with ASHP state affiliates to provide quality continuing education for certified pharmacy technicians. The advisory group recognizes the importance of conducting surveys and gap analyses that address the value of pharmacy technicians and identify the practice resources pharmacy support personnel and their supervisors need. The advisory group has a desire to investigate innovative roles for pharmacy support personnel and recommend approaches for incorporation of these roles into the Pharmacy Practice Model Initiative (PPMI).

Advisory Group on Medication Safety. This advisory group, formed in August 2006, is charged with providing tools and resources for medication safety officers or pharmacists who have medication safety responsibility as a component of their positions. The group provided educational content for the 2009 MCM in the form of its third "Safety and Quality Pearls" session. In response to recent punitive actions directed toward pharmacists' dispensing errors, the advisory group sponsored a webinar entitled "Creating an Environment of Safety: Just Culture in the Workplace." This was the second of the advisory group's annual medication safety webinar series. The panel of presenters hailed from ISMP, Outcome Engineering, and Fairview Health Services. The webinar drew more than 200 participants and is posted on the Section's Web page. Additionally, the group continues to conduct successful networking sessions at the Summer Meeting and MCM.

Advisory Group on Pharmacy Practice Experiences. This advisory group was formed to provide tools and resources for frontline pharmacist preceptors and potential preceptors to foster favorable student experiences as students matriculate through their pharmacy rotations. The group updated its *Starting a New Student Rotation* web resource and created the *ASHP Preceptor Tool Kit*; both are available on the Section's Web page. The advisory group hosted a successful networking session and provided a platform presentation at the 2009 MCM. During the networking session, the members of the advisory group surveyed attendees, and the group plans to use results from the survey to inform the development of educational programs and resources. Additionally, the advisory members represented ASHP through poster and platform presentations at NRHA's 2009 Medication Use in Rural America (MURA) conference, of which ASHP was a major sponsor.

Advocacy. Through 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 each of their health care providers, and promote the roles of hospital and health-system pharmacists to the public.

The Section Advisory Group on Medication Safety has been a constant advocate for providing robust and rigorous education and training for medication safety officers. This advisory group will for the first time contribute to the safety and quality programming provided at ASHP meetings by developing a continuing education program for the 2010 Summer Meeting that addresses best practices in medication safety. This group will continue its concerted effort to demonstrate the importance of ASHP assuming a lead role in this endeavor, encourage collaboration with reputable safety organizations and associations to develop relevant and meaningful education and training materials for medication safety officers, and explore the business case for ASHP's Summer Meeting serving as a venue for providing medication safety officers with current information on safe medication policies and practice for this evolving area of health care.

Upon the recommendation of the Section Advisory Group on Small and Rural Hospitals, the Executive Committee has sought ways to expand ASHP's network with rural health care organizations and agencies. Section staff have helped lead efforts to strengthen ASHP's relationship with NRHA, OPA, ORHP, Institute of Healthcare Initiatives (IHI), and ISMP. The Section Advisory Group on Small and Rural Hospitals has used its MCM Sunday Programming for Small and Rural Hospitals and the Section Web page to help communicate efforts of the HRSA/OPA's Patient Safety Pharmacy Collaborative and IHI's 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. ASHP has served as a major sponsor for NRHA's two annual MURA conferences, and the Section is directly involved in the conference planning for the third conference, which will convene June 16–18, 2010, in Kansas City, Missouri. 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 and agenda in rural and frontier America, and elevate ASHP's standing in rural health care centers, organizations, and communities.

Educational Steering Committee

Angela Cassano, Chair (Virginia); Catherine Christen (Michigan); Tammy Cohen (Texas); Julie Golembiewski (Illinois); Matthew Levanda (New Jersey); Darlette Luke (Minnesota); Jacqueline Olin (North Carolina); Lois F. Parker (Massachusetts); Kimberly Pesaturo (Massachusetts); Wes Pitts (Mississippi); Gina Ryan (Georgia); Ronald Seto (Ontario, Canada); Susan Skledar (Pennsylvania); Linda Spooner (Massachusetts); Jason Topolski (New York); Laura Wachter (Maryland); Carol Wesolowski (Maryland); Trish Wegner (Illinois); Richard Pacitti, Executive Committee Liaison (Pennsylvania); Michelle Abalos, ASHP Staff and Educational Services Division Liaison (Maryland)

Advisory Group on Medication Safety

Joanne Kowiatek, Chair (Pennsylvania); May Alomari (Michigan); Jorge Carillo (Texas); Paul F. Davern (Connecticut); Dan Degnan (Indiana); Lynn Eschenbacher (North Carolina); Jody Gembarski (Student Representative, University of Michigan) Nancy Granger (Tennessee); Chris Hartman (Massachusetts); Janice Hoyt (Washington); Nicole L. Mollenkopf (Maryland); Kathryn Montanya (North Carolina); Victoria Tamis (Washington); Linda Tyler (Utah); Allen Vaida, ISMP Liaison (Pennsylvania); Randy Kuiper, Executive Committee Liaison (Montana); Bona Benjamin, ASHP Staff and Pharmacy Practice Development Division Liaison

Advisory Group on Pharmacy Support Services

Trey Wynn, Chair (Texas); Alaric Barber (California); Helen Calmes (Louisiana); Delia Charest (Student Representative, McWhorter School of Pharmacy, Samford University, Alabama); Scott Meyers (Illinois); Terri Mundy (Louisiana); Robert Parsons (Ohio); Winona Thomas (Louisiana); Brian Benson, Executive Committee Liaison (Iowa); Geralyn Trujillo, ASHP Staff and Government Affairs Liaison (Maryland)

Advisory Group on Small and Rural Hospitals

Todd Lemke, Chair (Minnesota); Emily Alexander (Texas); Jessica Bannon (Student Representative, University of Colorado at Denver); Matthew P. Fricker, ISMP Liaison (Pennsylvania); Paul K. Moore, NRHA Liaison (Oklahoma); Ann Marie Prazak (University of Utah Health Clinics); Timothy P. Stratton (Minnesota); Allen J. Vaida, ISMP Liaison (Pennsylvania); Debra L. Cowan, Executive Committee Liaison (North Carolina)

Advisory Group on Pharmacy Practice Experiences

Beth Ferguson, Chair (Minnesota); Lijian Cai (Illinois); Dale E. English II (Ohio); Laura F. Hamilton (Student Representative, McWhorter School of Pharmacy, Samford University, Alabama); T. Kristopher Harrell (Mississippi); Emily Knapp (Student Representative, University of Maryland); Scott D. Geene (Pennsylvania); Debbie Sisson (Minnesota); Rony Zeeny (Byblos, Lebanon); Jennifer Edwards, Executive Committee Liaison (Montana)

Committee on Nominations

Helen Calmes, Chair (Louisiana); Randy Kuiper, Vice Chair (Montana); Dale English, Immediate Past Chair (Ohio); Ronald Barnes (Georgia); Shahira Ghobrial (Maryland); Megan McMurray (Illinois)

2009 MCM SICP Networking Session Facilitators

Peggy Bickham (Illinois); Beth Ferguson (Minnesota); Joanne Kowiatek (Pennsylvania); Bruce Thompson (Minnesota); Ron Seto (Canada); SICP Executive Committee

ASHP Section of Pharmacy Informatics and Technology

The mission of the Section of Pharmacy Informatics and Technology (SOPIT) is to improve health outcomes through the use and integration of data, information, knowledge, technology, and automation in the medication-use process. In that role, the Section continually seeks to define and promote the optimal synergy between technology and the pharmacy professional in an effort to enhance and support practice models that bring the full benefit of the pharmacist's training and experience to the medication-use process. The Section is dedicated to achieving a vision in which members will (1) be enabled by technology to focus on providing optimal pharmaceutical care to each patient; (2) participate in all aspects of medical informatics that support the medication-use process through multidisciplinary collaboration across the entire health care system; (3) collaborate domestically and internationally with other organizations and governmental agencies to promote the use of medical informatics in the provision of quality health care; (4) take a leadership role in medical informatics, at all levels of health care, to ensure that health information technology (IT) supports safe medication use; (5) promote the development of a set of practical medical informatics competencies to manage medication-related data and information challenges across the continuum of care; and (6) stimulate an environment that focuses on setting the agenda for designing and conducting research to expand medical informatics knowledge and its use in supporting patient care. The Section is dedicated to improving health outcomes through the use and integration of data, information, knowledge, technology, and automation in the medication-use process. This Section is excited to carry its mission forward in an area that is quickly changing the face of health care.

2009–2010 Section Highlights. During 2009, the Section added more than 3900 members. About 16% of the Section's members have selected this group as their primary membership group. Total Section membership has increased by 26.2% from the previous year. Nearly one quarter of the Section membership is student members. In the 2009 elections, the Section's membership elected Mr. Christopher Urbanski as Chair-elect. Ms. Mackowiak was elected as a Director-at-Large; both will be installed at the June 2010 ASHP Summer Meeting. The Section also selected Denny C. Briley as the winner of the Section of Pharmacy Informatics and Technology Distinguished Service Award. Established in 2007, the ASHP Pharmacy Practice Sections Distinguished Service Award recognizes a member of the Section whose volunteer activities have supported the mission of their Section and helped advance the profession. The award was presented at the 2009 Midyear Clinical Meeting (MCM).

"Technology-enabled practice: A vision statement by the ASHP Section of Pharmacy Informatics and Technology" was published in *The American Journal of Health-System Pharmacy* (*AJHP*) in September 2009. The vision statement describes the current state of medication ordering and dispensing. The vision statement describes increased opportunities for pharmacist-provided patient care. The proposed technology-enabled practice model creates information requirements that permit the migration of pharmacists away from the current emphasis on medication product distribution and near-universal medication order review toward the management of the pharmaceutical care of patients. The vision statement describes the minimal automated infrastructure and several barriers that will need to be overcome to enact a new technology-enabled practice model. The Executive Committee has been active in providing feedback to ASHP on the upcoming Pharmacy Practice Model Initiative.

The Section, working with ASHP Government Affairs Division and ASHP Practice Development Division, has been successful placing members on work groups and expert panels of key health information technology (HIT) groups, such as National Association of Boards of Pharmacy (NABP) Task Force on Electronic Prescribing, Certification Commission for Health Information Technology (CCHIT), and the National Quality Forum (NQF). The Section has assisted ASHP in developing comments to governmental agencies related to HIT matters, including Drug Enforcement Agency (DEA), Centers for Medicare & Medicaid Services (CMS), Office of the National Coordinator for HIT (ONC), and the Food and Drug Administration (FDA).

Executive Committee

J. Chad Hardy, Chair (Texas)
Christopher J. Urbanski, Chair-elect (Indiana)
Dennis A. Tribble, Immediate Past Chair (Florida)
Anne M. Bobb (Illinois)
Brent I. Fox (Alabama)
Leslie R. Mackowiak (Tennessee)
Janet A. Silvester, Board Liaison (Virginia)
Karl F. Gumpper, Secretary

Educational Programming. The Section's programming for the 2009 MCM consisted of over 15 hours of continuing education. Topics that were presented included bar-code medication administration (BCMA), selecting IV robotics, implementing technology, positive identification, technology and the technician role, and the Web's influence on pharmacy practice. Maritza Lew of the Section's Educational Steering Committee coordinated the Informatics Bytes: Pearls Session. Michael McGregory was the Chair of the Section's 2009–2010 Educational Steering Committee.

Planning for the 2010 MCM is currently in progress. The Educational Steering Committee is developing programming on the following topics: "meaningful use" of electronic health records, advanced clinical decision support, technology-supported National Patient Safety Goals, electronic pedigree, computerized provider order entry (CPOE), and BCMA. Lynn Sanders of the Section's Educational Steering Committee will coordinate the Informatics Bytes: Pearls Session.

Drs. Fox and Fortier worked with ASHP Educational Services Division to plan an informatics series at the 2009 Summer Meeting. An informatics session was scheduled during all six of the meeting's educational opportunities. Topics that were presented included quality improvement through CPOE, implementation of new technology, telepharmacy, medication reconciliation and electronic prescribing, closed-loop medication management systems, and clinical surveillance systems.

Drs. Fox and Fortier planned an Informatics Series for the 2010 Summer Meeting, whose topics include American Reinvestment and Recovery Act (ARRA), "meaningful use" of electronic health records, project management of technologies, applying technology to facilitate error reporting, maximizing operational efficiencies, and oncology informatics applications.

The Section also planned and implemented four networking sessions at the 2009 MCM. Each of the Section's advisory groups planned a thematic program related to their primary charge. A networking session is planned for the 2010 Summer Meeting to be facilitated by the Executive Committee.

Electronic Networking Opportunities. The Section's electronic NewsLink is distributed monthly to more than 3000 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's electronic discussion group, which includes 2800 participants, provides a forum for Section members to exchange information and ideas on a wide variety of topics related to pharmacy informatics and technology. The most-visited Web sites 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 Web site and promote its available resources to members. 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.

Revised Charges for Section Advisory Groups. During the Section's Executive Committee June 2009 meeting, the Executive Committee formalized and standardized the charge of each of the four advisory groups. Each advisory group will share seven common charges: (1) contribute to the "Informatics Interchange" column in the *AJHP*, (2) coordinate a webinar for the Section membership on a related topic area, (3) review the relevant content area on the Section's Web site on an annual basis, (4) develop programming for the MCM, (5) appoint a working group to manage the frequent call for comments for various government and regulatory groups, (6) encourage members to contribute and post to the Section's listserver and ASHP Connect, and (7) coordinate a networking session at the MCM on a topic relevant to the advisory group's purview. Each section advisory group and committee will further have projects and deliverables focused on the group's scope and content knowledge.

Advisory Group on Clinical Information Systems. Activities of the Section Advisory Group on Clinical Information Systems included the development of CPOE guidelines and clinical decision support systems (CDSS). Draft guidelines on planning for and implementing CPOE are being developed by the advisory group and are in the final stage of editing. The advisory group deferred work on a pharmacist allergy processing resource document that was started by the previous advisory group. The advisory group has started work on an adverse drug event surveillance database that would encourage members to share CDSS rules. These rules would be based on previous trigger work that has been published and incorporate other innovative rules that members would be willing to share. There is a Web template that the advisory group is utilizing. The advisory group is determining the correct fields and structure of the database. The advisory group may require further resources to complete this project, but they are still within the test and development stage.

Advisory Group on Pharmacy Operations Automation. Activities of the Section Advisory Group on Pharmacy Operations Automation include electronic/automated management of the medication supply chain process, preparation of medications and dispensing of medications with robotics, medication administration with bar-code medication technologies and smart pumps, formulary management with multiple applications within multiple hospital settings, and clinical documentation. The advisory group completed the revisions on the automated dispensing cabinet guidelines this past year. With the help of the Executive Committee, the advisory group is completing its work on a statement addressing bar-code dispensing and preparation of medications. The advisory group has developed four work groups to address electronic formulary management, robotics, smart pumps, and repackaging/relabeling of medications. These work groups will be utilizing multiple tactics to communicate their work to Section members.

Advisory Group on Ambulatory Care Informatics. The Section Advisory Group on Ambulatory Care Informatics has started projects on electronic prescribing, documentation of medication therapy management, and radio frequency identification integration/electronic pedigree compliance. The advisory group launched a survey on drug-drug interactions (DDI) to direct the advisory group's efforts in developing recommendations concerning DDIs in pharmacy and integrated electronic systems. This project was based on a recommendation from the Council on Therapeutics on establishing a multidisciplinary group or meeting that includes representatives of professional associations, drug information publishers, and software companies to develop consistent standards for the development and inclusion of drug interaction information in CDSS. The Council recommended developing guidelines on best practices for the assessment and management of potential drug interactions identified by CDS software and other drug information sources. Two members of the Council are participating on this work group. Summary recommendations of the group should be available for the Executive Committee to review in the spring of 2010. Other projects that this advisory group has been assigned are electronic prescribing, electronic medication reconciliation, and Risk Evaluation and Mitigation Strategies (REMS) programs. The advisory group is investigating further guidance documents and a possible webinar to the members for the spring of 2010.

Advisory Group on Pharmacy Informatics Education. Activities of the Section Advisory Group on Pharmacy Informatics Education include updating and maintaining the Section's Web pages and resource centers; supporting the development of informatics residency programs and other educational opportunities for pharmacists, students, technicians, and vendors; and facilitating a column in *AJHP*. The "Informatics Interchange" column has been successful in obtaining manuscripts to support a monthly publication, and there are scheduled submissions for the next six months. The advisory group will investigate the need for further training of pharmacists in informatics and evaluate certification possibilities for pharmacy informatics practitioners. Evaluation of the Board of Pharmaceutical Specialties or the Health Information Management and Systems Society's Certified Professional in Healthcare Information and Management Systems (CPHIMS) will be considered. The advisory group is conducting a survey to postgraduate year-one (PGY1) residency program directors to determine the incorporation of the medication safety and informatics standards into their residency programs. This survey will provide valuable information on residency training on medication safety and informatics, and the information will be shared with the Section and the Commission on Credentialing. The advisory group is developing strategies to engage practitioners in informatics to support the clinical role of the pharmacist and assessing the educational needs of students, residents, practitioners, and pharmacy technicians.

Advisory Group on Ambulatory Care Informatics

Marc Young, Chair (Texas); James Russell, Vice Chair (Wisconsin); Jennifer Boehne (Massachusetts); Janet Crawford (Missouri); Sharon L. Ellison (North Carolina); Helen L. Figge (New York); Abraham Gilbert, Technician Member (Georgia); John R. Horn (Washington); Anne Johnston (Florida); Co Lai, (Georgia); Kevin C. Marvin (Vermont); Paul G. Miller, Jr. (Michigan); Teresa (Teri) Ann Miller (California); Sandra Mitchell (Maryland); George A. Robinson (Indiana); Mark H. Siska (Minnesota); Douglas R. Smith (Texas); Robert L. Stein (California); Ron Schneider (District of Columbia); Sylvia Thomley (Wisconsin); Ed Chin, Student Member (Ohio); Roger S. Klotz, Section of Home, Ambulatory, and Chronic Care Practitioners Liaison (California); Ronald J. Campbell, Jr., Council on Therapeutics Liaison (Pennsylvania); Patrick J. McDonnell, Council on Therapeutics Liaison (Pennsylvania); J. Chad Hardy, Executive Committee Liaison (Texas)

Advisory Group on Clinical Information Systems

John C. Poikonen, Chair (Massachusetts); Allen Flynn, Vice Chair (Michigan); May Alomari (Michigan); Lynn Boecler (Illinois); Denny C. Briley (Kansas); James Carpenter (Oregon); Bruce Chaffee (Michigan); Franklin P. Crownover (Massachusetts); Charles R. Downs (Maryland); W. Lynn Ethridge (South Carolina); Randy Herring (Georgia); Richard S. Jacobs (Washington); Tara K. Jellison (Indiana); Michael A. Jones (Colorado); Joan E. Kapusnik-Uner (California); Joseph Lassiter (Oregon); Te Jung Lin (Texas); Adam Lisi (New Jersey); Timothy W. Lynch (Washington); Tommy Mannino (Louisiana); Gregory Matsuura (Washington); Brendan Reichert (Maryland); Andrew C. Seger (Massachusetts); Robert Silverman (Illinois); Nancy R. Smestad (North Dakota); Kirby Stiening (Virginia); David L. Troiano (Texas); J. Scott Turner (Alabama); Laura L. Tyndall (Pennsylvania); Lori Wright (Tennessee); Karen Umali, New Practitioner Member (California); Jason Kinyon, Student Member (Maryland); Anne M. Bobb, Executive Committee Liaison (Illinois)

Advisory Group on Pharmacy Automation Operations

Ron Burnette, Chair (Florida); Gwen Volpe, Vice Chair (Illinois); Dawn M. Biller (Indiana); Leslie Brookins (Missouri); Richard Capps III (South Carolina); Kavish J. Choudhary (Utah); Seth Aaron Cohen (Maryland); Thomas W. Cooley (Massachusetts); Arash T.

Dabestani (California); Charles De la Torre (Florida); Doina Dumitru (Texas); Christopher Fortier (South Carolina); Barbara Lane Giacomelli (New Jersey); Staci Hermann (Kansas); Gary L. Johnson, Jr. (Virginia); Seth A. Kuiper (Ohio); Denise Mckenzie, Technician Member (Missouri); Rhonda B. McManus (California); Beth Prier (Ohio); Brad Rognrud (Minnesota); Kevin A. Scheckelhoff (Ohio); Paul M. Seelinger (California); Suzanne B. Shea (Texas); David A. Tjhio (Illinois); Christopher J. Urbanski (Indiana); Rayburn Brian Vrabel (California); Robynn P. Wolfschlag (Colorado); Eric C. Nemec II, New Practitioner Member (Connecticut); Marvin H. Choi, Student Member (Maryland); Dennis A. Tribble, Executive Committee Liaison (Florida)

Advisory Group on Pharmacy Informatics Education

Kevin Clauson, Chair (Florida); Lou Barone, Vice Chair (Ohio); Jerry Fahrni (California); Elizabeth Fields (Tennessee); Carol Hope (Utah); Patrice S. Johnson (District of Columbia); Douglas B. Kent (Pennsylvania); John Paul Marcus (Illinois); Terry Seaton (Missouri); Judith Silman-Greenspan (Minnesota); Pamela Schindler (Alabama); Kathleen Vieson (Florida); Stephanie M. Ferrell, New Practitioner Member (California); Beju Shah, Student Member (South Carolina); Brent Fox, Executive Committee Liaison (Alabama)

Committee on Nominations

Dennis A. Tribble, Chair (Florida); Denny C. Briley (Illinois); Kevin C. Marvin (Vermont); Scott R. McCreadie (Michigan); Kevin A. Scheckelhoff (Ohio)

Educational Steering Committee

Michael McGregory, Chair (Indiana); Maritza Lew, Vice Chair (California); Robert Christiansen (Pennsylvania); Alan Chung (District of Columbia); John Manzo (New York); Dallas Moore (Utah); Lynn C. Sanders (District of Columbia); Michael D. Schlesselman (Connecticut); Armen Simonian (California); Lolita White (Maryland); Christopher J. Urbanski, Executive Committee Liaison (Indiana)

ASHP Section of Pharmacy Practice Managers

The mission of the Section of Pharmacy Practice Managers is to help members manage pharmacy resources, maximize the safety of medication-use systems, develop future leaders, and promote the pharmacist's role in patient care. The Section Executive Committee has developed a strategic plan linked to the mission and goals of the Section. These goals are (1) maximizing communications and interactions with and among Section members; (2) fostering education, training, and development opportunities for managers and leaders; (3) recommending professional policy and advocacy on issues of importance to Section members; (4) supporting members in developing and managing staff and in the advancement of pharmacy practice; and (5) helping members improve adherence to ASHP practice standards and other best practices. The Section 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.

2009–2010 Section Highlights. The Section has 8016 members, with approximately 42% of the Section's members having selected the Section as their primary membership group. Section members elected Dr. Knoer as Chair and Dr. Karpinski as a Director-at-Large; both will be installed at the 2010 Summer Meeting. The Section recognized Christene Jolowski 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 2009 Midyear Clinical Meeting (MCM).

Educational and Networking Opportunities. Under the leadership of Rafael Saenz, the 2008–2009 Educational Steering Committee designed educational sessions for pharmacy managers and directors that were presented at the 2009 MCM. The topics included human resource management, mentoring new practitioners, hazardous waste management, inpatient and outpatient prospective payment system rules and regulations, and management pearls. All of these sessions were recorded and synchronized with the presentation slides so that they can be made available to members. The Section also planned and implemented networking sessions at the 2009 MCM on leadership in a tough economy, administrative residencies, maintaining quality with shrinking resources, and safe handling of contrast media. For the 2010 MCM, the committee is planning sessions on succession planning, inpatient and outpatient prospective payment system rules and regulations, managing practice model change, working with consultants, effective models for introductory and advanced pharmacy practice experiences programs, and leading collaborative resolution to patient safety initiatives.

The Section continues to distribute a monthly electronic NewsLink that serves over 8000 ASHP members. The NewsLink provides management paradigms, business information, relevant research, legislative updates, regulatory alerts, and health policy/health care news. The Section also continues to facilitate an electronic discussion group with approximately 1900 participants. The electronic discussion group provides a forum for Section members to exchange information and ideas on a wide variety of topics related to pharmacy management and leadership.

Advisory Group on Leadership Development. This advisory group coordinated the Student Leadership Development (SLD) Workshop, which is a significant accomplishment of the Section. The workshop is a three-hour program to introduce students to leadership opportunities and network with other students interested in leadership. The program has been implemented at 12 ASHP state affiliates and at one college of pharmacy, was integrated into the 2009 Summer Meeting student education track, and will be repeated at the 2010 Summer Meeting. The advisory group has organized networking sessions to promote administrative residencies and the benefits of residency training at the 2008 and 2009 MCMs. The group has also been engaged with the ASHP Foundation and its efforts on identifying opportunities for new practitioner and student leadership development. In addition, the advisory group led the planning of an education session at the 2009 MCM on mentoring the next generation of pharmacy leaders. In spring 2010 the advisory group will conduct a webinar networking session on strategies for succession planning.

Executive Committee

Kathleen S. Pawlicki, Chair (Michigan)
Scott J. Knoer Chair-elect (Minnesota)
James R. Rinehart, Immediate Past Chair (Nebraska)
Paul J. Mosko (Ohio)
Todd A. Karpinski (Wisconsin)
Patricia Killingsworth (Idaho)
Kathryn R. Schultz, Board Liaison (Minnesota)
David F. Chen, Secretary

Advisory Group on Manager Development. The advisory group focused on tools and education to support health-system pharmacy manager development. A key activity was the creation of the Managers Continuous Professional Development Resource Center, which is a curriculum utilizing key management and leadership textbooks that are organized around 11 domains of manager competencies. The advisory group members were also active in organizing the state-affiliate-based SLD workshops. The Group organized a successful 2009 MCM networking session dealing with managing health-system pharmacies in tough economic times.

Advisory Group on Communications and Publications. This advisory group has worked steadily to improve communication of the Section's activities and to complete publications focused on the needs of pharmacy practice managers. Members of this advisory group have facilitated submissions for the Management Consultation column in the *American Journal of Health-System Pharmacy* (*AJHP*). The advisory group has completed five member spotlights for the Section Web page in an effort to recognize Section members that have been active in achieving Section goals. The Group organized a successful 2009 MCM networking session dealing with recent contrast media safe handling guidelines.

Advisory Group on Quality and Compliance. This advisory group completed a number of goals to support members in dealing with the increasing pressure and complexity of quality and compliance issues impacting pharmacy managers. The advisory group organized a networking session on "no-pay" conditions at the 2009 Summer Meeting, an educational session at the 2009 MCM on reimbursement compliance and the new Inpatient and Outpatient Prospective Payment Systems (IPPS and OPPS) rules, and a networking webinar on reimbursement compliance in February 2010. The Group has also created 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.

Advisory Group on Pharmacy Business Development. This advisory group is in its first year after the reorganization of the Section's advisory groups and is the product of merging the past financial management and workload and productivity advisory groups. During the tough impact of the 2009 economy on hospitals and health systems, this advisory group took the lead in conducting a survey of ASHP members. The results of the survey were published on the ASHP Web site and used to create a special day-long networking session at the 2009 Summer Meeting. This past year the advisory group, working with members from the past merged advisory groups, completed and published a workload and

productivity white paper in *AJHP*. The group is currently working on a financial management self-assessment tool and building a collection of return-on-investment models for various pharmacy services that members can utilize.

Conference for Leaders in Health-System Pharmacy. The Section, in collaboration with ASHP Advantage, planned and implemented another successful leadership conference. This event, which attracted approximately 350 participants, included key programs in areas such as increasing the leadership impact of pharmacists, protecting and strengthening core pharmacy services, establishing return on investment for clinical services, and utilizing technology to communicate and connect with peers effectively. In addition, a pre-conference Managers' Boot Camp was conducted for its second year as a freestanding workshop focusing on leadership, executing change, creating a value proposition, and managing financial drivers. As part of the conference proceedings the John W. Webb Lecture Award was presented to William Churchill.

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 Leadership Development

Cyndy Clegg, Chair (Washington); Edward Nold, Vice Chair (Florida); Tad Gomez (Georgia); Philip W. Brummond (Michigan); Richard Burnett (Texas); Jennifer Cimoch (California); Edward Eiland (Alabama); Heath R. Jennings (Illinois); Justin Konkol (Oregon); Richard Montgomery (Florida); David Moore (Florida); Joe Vargas (Illinois); Samaneh T. Wilkinson (Kansas); Jerome Wohleb (Utah); David Wolfrath (Wisconsin); Karol Wollenburg (New York); James R. Rinehart, Executive Committee Liaison (Nebraska)

Advisory Group on Manager Development

Jennifer Tryon, Chair (Oregon); Jennifer Austin, Vice Chair (Florida); John E. Clark, Immediate Past Chair (Florida); Burnis D. Breland (Georgia); Robin J. Ensom (Vancouver, BC); Robert P. Granko (North Carolina); Niesha Griffith (Ohio); Amanda Hafford (Ohio); Lindsey R. Kelley (Pennsylvania); Ronda K. Lehman (Ohio); Garret Newkirk (Wisconsin); Michael C. Nnadi (North Carolina); Adam Dean Orsborn (North Carolina); Ross Thompson (Massachusetts); John Worden (Kansas); Philip Trapskin (Wisconsin); Patricia Killingsworth, Executive Committee Liaison (Colorado)

Advisory Group on Quality and Compliance

Greg Polk, Chair (Michigan); James M. Hoffman, Vice Chair (Tennessee); Christene Jolowsky, Immediate Past Chair (Minnesota); Janinah Barreto-Hernandez (Ohio); Carol Birk (Indiana); Jennifer Burgess (North Carolina); Brian M. Cotter (Maryland); Christian Aaron Hartman (Massachusetts); Margaret A. Huwer (Ohio); Jenny Jastrzembski (Tennessee); Bonnie E. Kirschenbaum (Colorado); Joel Melroy (South Carolina); Yen Nguyen (Minnesota); Stephen R. Novak (North Carolina); Jennifer Reddan (Wisconsin); Kate Schaafsma (Illinois); Mark Thomas (Texas); Teri Wooton (North Carolina); Paul J. Mosko, Executive Committee Liaison (Ohio)

Advisory Group on Communications and Publications

John S. Clark, Chair (Michigan); Audrey Nakamura, Vice Chair (California); Michael D. Sanborn, Immediate Past Chair (Texas); Dominick Caselnova, III (Montana); Steven H. Dzierba (Texas); Rabiah Dys (Massachusetts); Matthew Eberts (Pennsylvania); Erin C. Hendrick (Colorado); Trinh Le (Washington, DC); Michael McGregory (Indiana); James E. Smeeding (Texas); Mark Sullivan (Tennessee); Sylvia M. Thomley (Wisconsin); Michael Todaro (Mississippi); Scott Knoer, Executive Committee Liaison (Minnesota)

Advisory Group on Pharmacy Business Management

Dave A. Ehlert, Chair (Minnesota); Laura Mark, Vice Chair (Pennsylvania); Heather Kokko, Immediate Past Chair (South Carolina); Ernest R. Anderson (Massachusetts); Adam Nicholas Bauman (Florida); Howard S. Glazier (California); Russell K. Hulse (Utah); Karl H. Kappeler (Ohio); Paul Krogh (Minnesota); Shane Madsen (Minnesota); Michael R. McDaniel (Alabama); Fred J. Pane (North Carolina); Rafael Saenz (Pennsylvania); Armando R. Soto (Florida); Chad Stashek (Massachusetts); Jack Temple (Wisconsin); Kathleen S. Pawlicki, Executive Committee Liaison (Michigan)

Educational Steering Committee

John Pastor, Chair (Minnesota); Ryan Forrey, Vice Chair (Ohio); Rafael Saenz, Immediate Past Chair (Pennsylvania); Allan C. Anderson (Tennessee); Doina Dumitru (Texas); Staci Hermann (Kansas); Thomas E. Kirschling (Pennsylvania); James T. Lund (Wisconsin); Stephanie C. Peshek (Florida); Todd Karpinski, Executive Committee Liaison (Wisconsin)

Committee on Nominations

James R. Rinehart, Chair (Nebraska); Steve Rough (Wisconsin); Andrew L. Wilson (Washington, D.C.); David A. Kvancz (Ohio); Scott Mark (Pennsylvania)

ASHP New Practitioners Forum

The New Practitioners Forum is led by a five-member Executive Committee appointed each year by the ASHP President-elect and approved by the Board of Directors. The Executive Committee is responsible for advising the Board and ASHP staff on the overall direction of the Forum, including member services, programs, and resources. The Executive Committee Chair participates in ASHP's strategic planning process and serves as a voting new practitioner member in the ASHP House of Delegates. Each Executive Committee member serves as a liaison to one of the Forum's six advisory groups.

The Executive Committee established five strategic goals to direct the Forum's operations: (1) serve the unique and evolving educational and informational needs of new practitioner members, (2) cultivate professionalism in new practitioners, (3) foster leadership skills in members of the New Practitioners Forum, (4) promote membership and active involvement in the ASHP New Practitioners Forum, and (5) cultivate awareness and engagement of new practitioners in practice advancement initiatives and advocacy.

2009–2010 Forum Highlights. Landmark achievements consistent with these goals in 2009–2010 included (1) relocating the successful *Great eXpectations* conference for new practitioners to the Midyear Clinical Meeting (MCM) and unveiling a new, multifaceted *Great eXpectations eXperience* program that will allow new practitioners to experience the uniqueness of *Great X* in a live format, virtually, and via video year around and on demand; (2) awarding the third New Practitioners Forum Distinguished Service award; (3) providing a series of webinars addressing new practitioners' unique career development needs; (4) utilizing multiple components of ASHP Connect to communicate with our new practitioner members; and (5) enhancing the New Practitioners Forum Web page with member-generated content and more automation that allows members to communicate with ASHP quickly and efficiently. These activities demonstrate the commitment of ASHP and the Forum to meeting the unique needs of over 4000 new practitioner members. The continual creation and provision of career development tools, leadership opportunities, practice resources and 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 Jennifer Askew 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 2009 MCM.

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. This year, the Executive Committee re-engineered the structure of the groups by appointing a returning advisory group member to the chair position and executive committee members to liaison roles in each advisory group.

Communications and Technology Advisory Group. This advisory group is charged with enhancing the Forum's image and outreach using various electronic communication tools. Priorities this year included researching various components of social media and recommending how the Forum should use each of these outlets, developing a survey and making subsequent recommendations on how to improve the usability of the ASHP Connect Discussion Board, and providing recommendations on improving the ASHP Mentor Exchange.

Executive Committee

Michael A. DeCoske, Chair (North Carolina)
Lindsay A. Garris, Vice Chair (District of Columbia)
John B. Hertig (Ohio)
Monica Nayar (Massachusetts)
Majid R. Tanas (Oregon)
James G. Stevenson, Board Liaison (Michigan)
Jill L. Haug, Secretary

Leadership and Career Development Advisory Group. This advisory group is charged with advancing strategic goals 2 and 3. Priorities this year included developing a leadership journal club package that can be used by members to initiate this activity at their residency or practice sites, developing a webinar on advanced practice management degrees and the existing opportunities available, and highlighting new practitioners involved in innovative clinical practices.

Membership and Outreach Advisory Group. This advisory group is charged with advancing strategic goal 4. Priorities this year included discussing the role social media has in communicating with both members and potential members; developing strategies to increase the utilization of the ASHP Connect Discussion Board, recognizing that this type of engagement can increase membership satisfaction; creating a presentation to be utilized by the ASHP Pharmacy Student Forum that highlights the benefits of transitioning to the New Practitioners Forum after graduation; and discussing the role the Forum should have in encouraging new practitioner involvement with state affiliates.

Professional Practice Advisory Group. This advisory group is charged with advancing strategic goal 1, specific to professional practice issues. Priorities this year included developing a resource that outlines the new functionality and provides guidance in navigating the new PubMed, developing a resource that highlights key professional transitions made during the new practitioner years, collaborating with the Science and Research Advisory Group on an article outlining the steps to getting published, and developing a resource that provides guidance on establishing a new clinical service.

Public Affairs and Advocacy Advisory Group. This advisory group is charged with advancing strategic goal 5. Priorities this year included providing education for new practitioners on how to get involved with advocacy activities at the state and national levels, collaborating with the ASHP Government Affairs Division to encourage new practitioner involvement with ASHP-PAC activities, exploring the role a new practitioner can have with student societies to influence student involvement with advocacy and legislative activites, and utilizing the ASHP Connect Discussion Board to engage new practitioners in timely, active discussion on health care policy issues.

Science and Research Advisory Group. This advisory group is charged with advancing goal 1, specific to science and research issues. Priorities this year included developing education for new practitioners on adaptive clinical trials, creating a statistics resource that is a useful and practical guide to assist in dissecting studies, and collaborating with the Professional Practice Advisory Group on an article outlining the steps to getting published.

Meetings and Programming. Previously existing as a stand-alone conference for new practitioners, *Great eXpectations* was moved to the MCM 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. During the upcoming year, the successful *Great eXpectations* program will be expanded to the *Great eXpectations eXperience* and will provide a broader audience of new practitioners the opportunity to experience *Great X's* unique education and networking in person, virtually, and via video.

The 2009 MCM 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* 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 members of the Forum's Executive Committee or advisory groups. Executive Committee members also represented the Forum in the ASHP Experience Membership booth.

The Forum added several webinars to its online library this year, including: "Keys to Unlocking the Past, Present and Future of Health-System Pharmacy," "Curriculum Vitae Development and Interviewing Tips for the New Practitioner," and "Defenders of Our Future: Political Advocacy for New Practitioners." The Forum recognizes that practitioners early in their careers cannot always attend national meetings, and these webinar programs provide new practitioner members the opportunity to take advantage of ASHP programs from a distance.

Communications. The Forum discontinued its listserver in August and primarily relies on the ASHP Connect Discussion Board for new practitioner members to communicate on practice and career development issues. This technology allows members the ability to self-select discussion areas of interest. The Forum created the following seven discussion areas: Postgraduate Year One (PGY1), Postgraduate Year Two (PGY2), Fellows and Other Post-Graduates, Science and Research, Professional Practice, Career Development, and Open Discussion. ASHP Connect provides members the convenience of only participating in discussions of interest and has reduced the volume of e-mails members receive from ASHP.

All Forum members receive the ASHP New Practitioners Forum NewsLink twice 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; identify new practitioners to highlight on the Web page; feature messages from the Forum Executive Committee; and highlight resident tips.

The Forum has its own area on the ASHP Web site where new practitioners can find information pertinent to their needs, such as updates on Forum activities, career development resources, leadership opportunities, and a personal message from the Forum Executive Committee. Efforts have focused on making the site a clearinghouse for career development, clinical, precepting, and administrative and management resources to meet new practitioners' varying informational needs. This section of the Web site also highlights each member of the Executive Committee and allows Forum members to communicate directly with these leaders.

The Forum has been actively involved with the various components of ASHP Connect and continues to explore the best ways to utilize social media as a way to communicate with current and potential members.

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 levels. Forum leaders also represented the Forum at each of the seven 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 second 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. The involvement opportunities vary and include speaking opportunities, webinar coordination, leadership roles, educational program coordination or other opportunities such as reviewing or writing. Through this endeavor, the Forum identified 114 new practitioners and contacted them with a personalized message encouraging them to consider greater involvement in these activities at the recommendation of their peers.

Section Collaboration. Forum members share common professional and career development needs, but their varied practice needs are addressed through involvement in the ASHP pharmacy practice sections. Many new practitioners hold positions on section committees and advisory groups.

Mentor Exchange. This program provides the opportunity for new practitioners to seek guidance and professional development advice from more experienced practitioners. Use of this members-only benefit from ASHP continues to grow, with several hundred mentors and mentees participating.

Membership Video. The Forum developed and continues to distribute a membership video, *Get Connected!*, that demonstrates the numerous ways one can get involved with ASHP, depending on one's interests. The video is available on the Forum's Web page and YouTube, is shown at numerous events, and is distributed through multiple channels throughout the year.

ASHP Resident Visit Program. For many years ASHP has invited residents in accredited programs to visit ASHP headquarters. These all-day visits give residents an inside glimpse of ASHP operations and an opportunity to learn about the many ways to get involved in ASHP and the resources available to them as new practitioner members. Two visits were held this year, with more than 80 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.

Resident Tips. The New Practitioners Forum launched its Resident Tips program earlier this year. This Web-based resource highlights advice from members to residents, focusing on tips to help residents get the most out of their residency experience. New tips are posted every two weeks and disseminated via the New Practitioners Forum NewsLink.

ASHP's Next Top New Practitioner Interviewer Competition. The New Practitioners Forum launched a competition earlier this year to identify a new practitioner interviewer for the daily ASHP E-News Video Update at the 2009 MCM. The winner, Lindsey Elmore, was selected by judges from a number of video interview submissions. The competition allowed new practitioners the opportunity to gain greater visibility and recognition in the ASHP member community, meet with key thought leaders, and further develop personal communication skills.

Communications and Technology Advisory Group

Jeffrey Little, Chair (Pennsylvania); Lindsay Garris, Executive Committee Liaison (District of Columbia); Ali McBride (Florida); Kayla Hatt (Ohio); Jack Iskander (Texas); Joshua Howell (Texas); Lisa Starost (Indiana); Megan Fitzgerald (Indiana); Molly Billstein (Connecticut); Ted Sindlinger (Pennsylvania); Susie Jiing (Washington); T. Michael Farley (Kentucky)

Leadership and Career Development Advisory Group

Justin Konkol, Chair (Oregon); Monica Nayar, Executive Committee Liaison (Massachusetts); Christopher Murray (North Carolina); Stephen Davis (Pennsylvania); James Mason (Pennsylvania); David Jarnot (Ohio); Katherine Swenson-Palmer (Oregon); Laura Butkievich (Missouri); Patrick Martin (Wisconsin); Pamela Murphy (Iowa); Eric Wombwell (Missouri); Yaman Kaakeh (Indiana)

Membership and Outreach Advisory Group

Benjamin Anderson, Chair (Minnesota); Michael DeCoske, Executive Committee Liaison (North Carolina); Andrew Laegeler (Texas); Ashley Mains (Missouri); Danielle Lykins (Ohio); Julie Leal (South Carolina); Elizabeth Hageman (New York); Erica Tenholder (Connecticut); Kunal Patel (Texas); Leslie Hamilton (Alabama); Jessica Mercer (South Carolina); William Gersch (Colorado)

Professional Practice Advisory Group

Joseph LaRochelle, Chair (Louisiana); Majid Tanas, Executive Committee Liaison (Oregon); Allison King (Missouri); Amanda Castle (Indiana); Jessica Helmer-Brady (Louisiana); Janene Marshall (Illinois); Jessie Lish (District of Columbia); Donna Mogck (Pennsylvania); Meredith Mulvanity (Pennsylvania); Neha Patel (Illinois); Phillip Owen (Georgia); Ola Oyetayo (Texas)

Public Affairs and Advocacy Advisory Group

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ASHP 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 made up of five student members of the ASHP Pharmacy Student Forum Executive Committee who were appointed by the ASHP President in 2009. Each Executive Committee member serves as the chair of one of the five Forum advisory groups: Membership, Meetings and Programming, Student Society and Leadership Development, Policy and Legislative Affairs, and Communications. The Executive Committee 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.

The 2009–2010 Executive Committee established a strategic plan with four core goals to direct Forum operations: (1) establish ASHP as the key resource to provide professional and leadership development for students at all levels of pharmacy education who are considering a future in health-system pharmacy; (2) facilitate the collaboration between colleges, state affiliates, and ASHP to achieve the Pharmacy Student Forum vision for the future; (3) inspire and empower pharmacy students to become agents of change for the profession on campus, within health-systems, and in their communities; and(4) cultivate a community of actively engaged and involved students who value and maintain life-long ASHP membership.

2009–2010 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 10,000 and includes students from schools of pharmacy across the nation. The consistent growth trend in the Forum is attributed to the growing number and expansion of pharmacy programs, the structure and strength of the ASHP-SSHP Recognition Program, and 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 a successful grassroots letter-writing campaign, increased presence on several social and professional networking sites, and new student leadership programming at the Summer Meeting.

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 2009–2010 academic year, 50 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 Midyear Clinical Meeting (MCM) in December.

Executive Committee

Dan J. Crona, Chair (Colorado)
Amy F. Baker, Vice Chair (New Mexico)
Emily C. Dotter (Maryland)
Rachel B. Kruer (Kentucky)
Melissa A. Ortega (Florida)
John A. Armitstead, Board Liaison (Kentucky)
Marni D. Lun, Secretary

Communications Advisory Group. The advisory group made significant progress test-piloting and assisting in the launch and expansion of several new communication and networking tools, from the ASHP Blog and Twitter, to members-only resources such as the Discussion Board and MentorExchange. They also served in an advisory capacity to ASHP regarding the digital publishing needs of today's pharmacy student.

Meetings and Programming Advisory Group. The advisory group evaluated and made recommendations to ensure that ASHP offers the highest-quality and most-relevant programming for students at the MCM and Summer Meeting. To help students navigate the wealth of options at the meetings, they created a "Student Guidebook" containing all the essential information for students to maximize their meeting experience. In addition, this group implemented a webinar series to supplement the educational programming offered at the national meetings.

Membership Advisory Group. The advisory group evaluated and provided guidance to improve student membership recruitment materials from ASHP. To assist with recruitment efforts on the campus level, this group designed a guide to help streamline the group membership application process and delivered custom slide presentations for use by the SSHP leaders. They worked to revamp ASHP's Web-based career information tools and resources available for student members to provide insight regarding opportunities in hospitals and health systems.

Policy and Legislative Affairs Advisory Group. The advisory group made significant strides to engage student members in ASHP policy and advocacy efforts. The group organized a highly successful student letter-writing campaign in support of restoration of funding for residency programs that generated over 800 unique contacts with state legislators. They also worked to further develop the student programming at the ASHP Summer Meeting, including a policy primer and student caucus. They are currently working on the creation of a toolkit designed to increase student participation in grassroots advocacy.

Student Society and Leadership Development Advisory Group. The advisory group launched a new resource page for SSHPs on the ASHP Web site. The new site offers valuable information, including tools to launch a new student society or improve the programming for current SSHPs, as well as an online student calendar of events. In addition, the group planned and implemented SSHP Leadership Workshop at the MCM and Summer Meeting and conducted a leadership journal club utilizing the ASHP Connect Discussion Board.

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. Student societies nationwide have the opportunity to earn this official annual recognition from ASHP based on programming and activities completed each year. Criteria for recognition encourage SSHP activities that promote membership in local, state, and national health-system organizations; stimulate interest in health-system pharmacy careers; and encourage career development and professionalism among students aspiring to careers in health-system

pharmacy. In 2009, 73 SSHPs met the criteria for recognition and received benefits, including a complimentary student registration to the MCM, awards for incoming and outgoing officers, and a certificate of recognition.

Outreach, Connection, and Engagement. The 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, which include 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 Web site, the twice-monthly NewsLink E-mail 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 MentorExchange, Discussion Board, Facebook Fan Page, LinkedIn, Twitter, YouTube, and more.

Meetings and Programming. ASHP offers programming designed specifically for student members at both the MCM and Summer Meeting. The 44th annual ASHP MCM in Las Vegas, Nevada attracted more than 4600 pharmacy students. This meeting offered a wealth of options for students, including the Residency Showcase, Personnel Placement Service, research posters, student reception, and a special lounge for first-time attendees. 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 Student Society Showcase, where a record number of schools from across the nation participated and put the spotlight on the excellent work of the SSHPs.

The inaugural year of the Pharmacy Student Leadership Development Program at the 2009 Summer Meeting was a success, attracting emerging pharmacy leaders from schools nationwide. The program consisted of educational programming covering topics such as the ASHP policy process and leadership development. A three-hour workshop coordinated by the Section of Pharmacy Practice Managers served as the centerpiece for the weekend activities. Students were encouraged to get involved in ASHP policy by attending key House of Delegates events and letting their voices be heard at the Student Caucus.

Clinical Skills Competition. The 14th Annual ASHP Clinical Skills Competition, supported by the ASHP Research and Education Foundation, was held at the 2009 ASHP MCM. Teams from 102 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 Tamara Spraker and Sijy Mathew of the University of Texas at Austin.

ASHP Student Leadership Award Program. The ASHP Student Leadership Award program prominently recognizes and celebrates the contributions of students who represent the very best attributes and accomplishments of ASHP student members. The highly competitive program consists of 12 annual awards to four student members in each professional year of pharmacy school, beginning with the second professional year. Award recipients receive a plaque, an ASHP drug information reference library, and a cash award provided by the ASHP Research and Education Foundation and funded through the Walter Jones Memorial Student Financial Aid Fund. The objective of the program is to encourage personal and professional development through a formal program providing well-deserved recognition to student leader role models who have demonstrated an interest in health-system practice and displayed exemplary student involvement in professional organizations. The 2008–2009 ASHP Student Leadership Award recipients were as follows:

Class of 2009: Jennifer Chan, University of Illinois; Edward Doyle, University of Rhode Island; Justin Quintal, University of the Pacific; Lindsay Varga, Temple University.

Class of 2010: Rachel Brewer, University of Cincinnati; Joshua Elder, University of Kentucky; Paulin Heng, University of Southern California; Julie Lauffenburger, University of Pittsburgh.

Class of 2011: Sara Jordan, The Ohio State University; Lauren Riley, Mercer University; Brandon Shank, University of the Sciences in Philadelphia; Xu Ling Yang, University of the Sciences in Philadelphia.

Experiential Education Program. ASHP offers an elective rotation in national association management. The purpose of the experiential education program is to provide students with an understanding of the importance of pharmacy associations to the profession and the value of participation in local, state, and national pharmacy organizations. The rotation 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 2009–2010 academic year, ASHP hosted:

- Beju Shah, South Carolina College of Pharmacy
- Delia Charest, Samford University
- Christina Martin, University of Pittsburgh
- Minh James Pham, Mercer University
- Brittany Warrick, University of Kentucky
- Megan Hinkley, University of Michigan
- Ed Chin, Ohio Northern University
- Amanda Kelly, Palm Beach Atlantic University
- Andria Budwine, University of Mississippi

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 2009, grants were awarded to the following pharmacy programs:

- University of Findlay School of Pharmacy and the Ohio Society of Health-System Pharmacists (OSHP)
- East Tennessee State University Bill Gatton College of Pharmacy and the Tennessee Society of Health-System Pharmacists (TSHP)
- University of Michigan and the Michigan Society of Health-System Pharmacists (MSHP)
- Harding University College of Pharmacy and the Arkansas Association of Health-System Pharmacists (AAHP)
- St. John Fisher College and the New York State Council of Health-System Pharmacists (NYSCHP)
- Northeastern Ohio Universities College of Medicine and Pharmacy and the Ohio Society of Health-System Pharmacists (OSHP)
- Texas A&M Health Science Center and the Texas Society of Health-System Pharmacists (TSHP)
- University of the Incarnate Word and the Texas Society of Health-System Pharmacists (TSHP)
- South Carolina College of Pharmacy and the South Carolina Society of Health-System Pharmacists (SCSHP)

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 2009 recipient was Joshua T. Swan from the University of Mississippi

School of Pharmacy as the leading author of an unpublished paper titled "Systematic Review and Meta-Analysis of Immunosuppressant Therapy Clinical Trials in Membranous Lupus Nephritis."

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Student Society and Leadership Development Advisory Group

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