TO: Delegates to the 2014 APhA House of Delegates  
FROM: William Riffee, Speaker of the APhA House of Delegates  
DATE: March 2014  
RE: Delegate Reference Materials and Important Information

Congratulations on your appointment as a Delegate to the 2014 APhA House! I appreciate your willingness to serve the profession and your interest in the policy development process. Within this booklet, you will find schedules, background information, and reports to help you prepare for your important role in the House. Extra copies of this booklet will not be available in Orlando, so please remember to bring this information with you.

Included within your Delegate Reference Materials, you will find:
- 2014 APhA House of Delegates Schedule At A Glance;
- 2013-2014 APhA Policy Committee Report; and
- 2013-2014 APhA New Business Items received.

Policy-Related Webinars Available
Along with Policy Committee Chair Collin Conway, I recently hosted webinars related to the policy topics to be considered by the House. If you were unable to participate in one of these offerings, I encourage you to visit http://www.pharmacist.com/house-of-delegates to view an archived version of the Open Forum on 2014 Proposed Policy Statements. This webinar will give you additional background information on the policy topics, provide the context of the Policy Committee’s discussions, and answer questions raised by your fellow Delegates.

To provide an overview of the New Business Items to be discussed in this year’s House, I will host a New Business Item Webinar from 12:00-1:00pm on March 11, 2014. This webinar will provide an opportunity for you to learn more about the items submitted prior to the Annual Meeting and give you adequate time to prepare for House discussions. To register, please visit the following site: https://www3.gotomeeting.com/register/486231094. If you are unable to participate in the live webinar, the archived version will be available online soon after.

If you are new to the House of Delegates, or if you just want a refresher course on the rules and procedures of the APhA House, I encourage you to view the Delegate Orientation Webinar available online. In addition, if your schedule permits during the Annual Meeting, you will have the opportunity to participate in a live Delegate Orientation session on Friday, March 28, 2014, from 1:00-2:00pm, in Room 308A-B of the Convention Center. See your Schedule At A Glance for further information.
**Delegate Registration**

Onsite Delegate registration for the First Session will be available from 12:00pm-4:00pm on Friday, March 28, 2014, in the Valencia A Foyer. For the Final Session, registration will be available in the same location, from 11:00am-2:00pm on Monday, March 31, 2014. Unless you would like to pick up your Delegate ribbon in advance, there is no need to check-in with the House of Delegates Office or APhA staff prior to these registration times.

To complete registration, Delegates will be required to complete the steps below prior to each House session:

- **Step 1** – Report to the Delegate registration area in the Valencia A Foyer. Please remember to bring this booklet and your name badge with you to registration.
- **Step 2** – Scan your name badge, pick up your Delegate ribbon (if needed), and pick up your electronic voter keypad from APhA staff. Note: you must return the keypad to staff at the conclusion of each House session.

Delegates who have not pre-registered will be required to sign a waiver agreeing to pay a replacement fee if the voter keypad is not returned to APhA staff. Also, Alternate Delegates are not required to register or check-in unless asked to substitute for a Delegate. When registering in place of a Delegate, Alternate Delegates will follow the same check-in procedures as a Delegate.

**House of Delegates Office Hours**

If you have specific questions regarding the policy development process or general House procedures, I encourage you to schedule an appointment to speak with me or the House Parliamentarian during the Annual Meeting. See your Schedule At A Glance for House of Delegates Office Hours, or contact APhA staff at hod@aphanet.org for further information.

**Planning for the 2015 House**

It’s never too early to plan ahead! In early April, APhA will begin the policy development process for 2015. With that in mind, I encourage you to begin thinking about the potential policy topics that should be addressed by the 2015 House of Delegates. Within this booklet, you will find a call for potential policy topics. I encourage you to bring your completed form to Orlando, or visit http://fs3.formsite.com/apha/form220/index.html to submit the form electronically.

On a related note, there are a number of opportunities for you to serve APhA on one of the House of Delegates committees. If you are interested in serving during the 2014-2015 policy development process, I encourage you to complete the committee volunteer interest form at http://fs3.formsite.com/apha/form217/index.html.

Thank you again for your interest in and service to the 2014 House of Delegates! I look forward to seeing you in sunny Orlando! If you have any questions about House activities, please visit http://www.pharmacist.com/house-of-delegates or contact APhA staff at hod@aphanet.org.
## House of Delegates Schedule At A Glance

### FRIDAY, MARCH 28

<table>
<thead>
<tr>
<th>Time</th>
<th>Location</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:00 pm – 4:00 pm</td>
<td>Valencia A Foyer</td>
<td>Delegate Registration</td>
</tr>
<tr>
<td>1:00 pm – 2:00 pm</td>
<td>Room 308A-B</td>
<td>Delegate Orientation</td>
</tr>
<tr>
<td>1:30 pm – 3:00 pm</td>
<td>Room 307B</td>
<td>APhA-APPM Delegate Caucus</td>
</tr>
<tr>
<td>1:30 pm – 3:00 pm</td>
<td>Room 309</td>
<td>APhA-APRS Delegate Caucus</td>
</tr>
<tr>
<td>2:15 pm – 3:15 pm</td>
<td>Valencia A Foyer</td>
<td>Meet the Candidates for the 2014 APhA Elections</td>
</tr>
<tr>
<td>2:00 pm – 2:30 pm</td>
<td>Room 304H</td>
<td>Policy Review Committee Open Hearing</td>
</tr>
<tr>
<td>3:30 pm – 5:30 pm</td>
<td>Valencia A Ballroom</td>
<td>House of Delegates – First Session (Be seated by 3:15pm)</td>
</tr>
</tbody>
</table>

### SATURDAY, MARCH 29

<table>
<thead>
<tr>
<th>Time</th>
<th>Location</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00 pm – 2:30 pm</td>
<td>Room 308A-B</td>
<td>New Business Review Committee Open Hearing</td>
</tr>
</tbody>
</table>

### SUNDAY, MARCH 30

<table>
<thead>
<tr>
<th>Time</th>
<th>Location</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00 pm – 3:00 pm</td>
<td>Room 304F</td>
<td>Policy Committee Open Hearing</td>
</tr>
</tbody>
</table>

### MONDAY, MARCH 31

<table>
<thead>
<tr>
<th>Time</th>
<th>Location</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00 am – 9:30 am</td>
<td>Room 307A</td>
<td>APhA-APPM Delegate Caucus</td>
</tr>
<tr>
<td>9:30 am – 11:00 am</td>
<td>Room 307B</td>
<td>APhA-APRS Delegate Caucus</td>
</tr>
<tr>
<td>11:00 am – 2:00 pm</td>
<td>Valencia A Foyer</td>
<td>Delegate Registration</td>
</tr>
<tr>
<td>1:30 pm – 4:30 pm</td>
<td>Valencia A Ballroom</td>
<td>House of Delegates – Final Session (Be seated by 1:15pm)</td>
</tr>
</tbody>
</table>

### House of Delegates Office Hours - Valencia A Foyer

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thursday, March 27</td>
<td>3:00 pm – 6:00 pm</td>
</tr>
<tr>
<td>Friday, March 28</td>
<td>7:30 am – 3:00 pm</td>
</tr>
<tr>
<td>Saturday, March 29</td>
<td>8:00 am – 3:00 pm</td>
</tr>
<tr>
<td>Sunday, March 30</td>
<td>8:00 am – 3:00 pm</td>
</tr>
<tr>
<td>Monday, March 31</td>
<td>7:30 am – 1:00 pm</td>
</tr>
</tbody>
</table>
FRIDAY, MARCH 28
House of Delegates – First Session

<table>
<thead>
<tr>
<th>Agenda</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Call to Order</td>
</tr>
<tr>
<td>2. Review of Voting Procedures</td>
</tr>
<tr>
<td>3. Credentials Report*</td>
</tr>
<tr>
<td>4. Adoption of Agenda and Rules*</td>
</tr>
<tr>
<td>5. Introduction of Head Table</td>
</tr>
<tr>
<td>6. Report of the Speaker, APhA House of Delegates</td>
</tr>
<tr>
<td>7. APhA House Rules Review Committee Report</td>
</tr>
<tr>
<td>8. New Business Procedure</td>
</tr>
<tr>
<td>9. Report of the Committee on Nominations*</td>
</tr>
<tr>
<td>10. Speaker-elect Candidate Introduction</td>
</tr>
<tr>
<td>11. APhA Policy Review Committee Report – Part 1 (Received)</td>
</tr>
<tr>
<td>12. APhA Policy Committee Report (Received)</td>
</tr>
<tr>
<td>13. Adjourn to a Committee of the Whole for Discussion of the Policy Review Committee and Policy Committee Reports*</td>
</tr>
<tr>
<td>a. APhA Policy Review Committee Report</td>
</tr>
<tr>
<td>b. APhA Policy Committee Report</td>
</tr>
<tr>
<td>14. APhA Policy Review Committee Report Considerations*</td>
</tr>
<tr>
<td>15. APhA Policy Committee Report Considerations*</td>
</tr>
<tr>
<td>17. Meet the Candidates for the 2014 APhA Board of Trustees Election</td>
</tr>
<tr>
<td>18. Housekeeping Announcements</td>
</tr>
<tr>
<td>19. Adjournment of the First House Session</td>
</tr>
</tbody>
</table>

MONDAY, MARCH 31
House of Delegates – Final Session

<table>
<thead>
<tr>
<th>Agenda</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Call to Order</td>
</tr>
<tr>
<td>2. Review of Voting Procedures</td>
</tr>
<tr>
<td>3. Credentials Report*</td>
</tr>
<tr>
<td>4. Adoption of Agenda*</td>
</tr>
<tr>
<td>5. Consideration of Unfinished Business</td>
</tr>
<tr>
<td>a. APhA Policy Committee Report*</td>
</tr>
<tr>
<td>b. APhA Policy Review Committee Report – Part 2*</td>
</tr>
<tr>
<td>6. Speaker-elect Candidate Speeches</td>
</tr>
<tr>
<td>7. Speaker-elect Election</td>
</tr>
<tr>
<td>8. Consideration of New Business*</td>
</tr>
<tr>
<td>9. Announcement of Election Results</td>
</tr>
<tr>
<td>10. Installation of the 2014-2015 Speaker-elect</td>
</tr>
<tr>
<td>11. Installation of the 2014-2015 APhA Board of Trustees</td>
</tr>
<tr>
<td>12. Installation of the 2014-2015 APhA President</td>
</tr>
<tr>
<td>13. Recommendations from APhA Members</td>
</tr>
<tr>
<td>14. Closing Announcements</td>
</tr>
<tr>
<td>15. Adjournment of the 2014 APhA House of Delegates</td>
</tr>
</tbody>
</table>

Please note: (*) asterisk indicates potential opportunities to cast votes.
### Duties of the House of Delegates

The APhA House of Delegates performs a major role in developing policy for the Association. With Delegates representing all segments of the profession, the House serves as a forum for discussion of key issues and articulation of positions reflecting input from a broad cross-section of pharmacy.

The APhA House of Delegates is charged by the APhA Bylaws to serve as a legislative body in the development of Association policy. Policies adopted by the House guide the Association and its Board of Trustees in matters relating to educational, professional, scientific, and public health policy. These policies help to establish the role of the profession and its relationship with other elements of the contemporary health care system and set the objectives and future agenda of APhA in the continuous evolution of health care.

### Composition of the House of Delegates

The approximately 400-member APhA House of Delegates is composed of delegates representing state pharmacy associations, recognized national and federal organizations, APhA’s Academies and Board of Trustees, former APhA Presidents, and former Speakers of the APhA House. Each state-affiliated organization appoints two Delegates, plus one additional Delegate for each 200 APhA Members residing in the state.

Recognized national organizations and recognized Federal organizations appoint two Delegates each. Each of the Association’s three Academies appoints 28 Delegates. Every member of the current APhA Board is a Delegate. Every Delegate must be an APhA member.

### Certification of Delegates

Organizations will be able to certify Alternate Delegates as Delegates upon notification to the Secretary of the APhA House of Delegates as late as 1:00PM on Monday. No Alternate Delegates will be seated after the Final Session of the House commences. The Secretary will announce the number of Delegates in attendance and whether a quorum has been reached based on the electronic system or roll call cards. Delegates who arrive after the quorum announcement should check in with APhA staff at the registration table.

### Officers of the House of Delegates

The APhA Bylaws provide that the officers of the APhA House of Delegates shall be the Speaker, the Speaker-elect, and the Secretary. The Speaker and Speaker-elect are elected by the House. The Bylaws provide that the Executive Vice President of APhA shall serve as Secretary. The position of Speaker spans three years: the first year as Speaker-elect (a non-Trustee position) and the subsequent two years as Speaker and Trustee. Elections for Speaker-elect are held on even-numbered years. The Speaker, Speaker-elect, and the Secretary of the House are members of the APhA House of Delegates and, as such, may claim the floor and are entitled to vote.

### Delegate Orientation

This orientation session is held for those Delegates and Alternate Delegates who are new to the policy process or for those who want a refresher course on the rules and procedures of the APhA House of Delegates.
**APhA HOUSE RULES REVIEW COMMITTEE**

The House Rules Review Committee is charged to review and establish rules and procedures for the conduct of business at each House session.

The Committee meets via conference call at least twice a year:
- Within 30 days after the conclusion of the Final Session of the House, to review and approve language of adopted House policy and to discuss observations of House operations for potential improvement.
- To review and approve the House of Delegates Schedule, make recommendations regarding the proceedings of the House, and to issue a Final Report to the APhA House of Delegates.

The Committee is comprised of 6 APhA members from diverse pharmacy practice backgrounds and is appointed prior to the beginning of the First Session of the House. The Committee’s term concludes prior to the First Session of the House the following year.

**APhA POLICY COMMITTEE**

The Policy Committee is charged with analyzing specific topics assigned by the Board of Trustees and proposing policy on those topics for consideration by the House of Delegates.

- Committee members meet in Washington, DC, to develop policy statements.
- Committee members prepare a report of policy recommendations for presentation to the APhA House of Delegates.
- The Committee is comprised of 7-10 APhA members from diverse pharmacy practice backgrounds.

**APhA POLICY REFERENCE COMMITTEE**

The APhA Policy Reference Committee is charged with providing greater participation in the policy development process and ensuring objective consideration of APhA member comments.

- Committee members listen to Delegate comments during the First Session of the House of Delegates and during the Policy Committee Open Hearing at the APhA Annual Meeting. Following the Open Hearing, Committee members meet in an executive session to review comments and propose modifications to the original Policy Committee report language. The Committee then issues its final report during the Final Session of the House of Delegates.
- The Committee is comprised of the Chair of the Policy Committee, two other members of the Policy Committee, and three or four new members.

**APhA POLICY REVIEW COMMITTEE**

The APhA Policy Review Committee is charged to ensure that adopted policy is relevant and reflects the opinion of the contemporary pharmacy community.

- The Committee meets via conference call to determine whether adopted policy statements should be retained, archived, or rescinded. The Committee can propose New Business Items for those statements needing amendment.
- The Committee’s review is divided into two parts.
  - Part One reviews adopted policy statements according to the schedule outlined in the House of Delegates Rules of Procedure.
  - Part Two reviews adopted policy related to the policy topics assigned to APhA's Policy Committee.
- Committee members participate in the Policy Review Committee Open Hearing at the Annual Meeting. Following the Open Hearing, Committee members meet in an executive session to finalize the report to be considered by the House.
- The Policy Review Committee is comprised of 7-10 APhA members from diverse pharmacy practice backgrounds.

**APhA NEW BUSINESS REVIEW COMMITTEE**

The New Business Review Committee is charged to review proposed policy submitted by Delegates and recommend action on those items.

- Committee members participate in the New Business Review Committee Open Hearing at the Annual Meeting and meet in an executive session to finalize their report to the House.
- The Committee is comprised of 7 APhA members from diverse pharmacy practice backgrounds.
### HOUSE OF DELEGATES COMMITTEE ON NOMINATIONS

The House of Delegates Committee on Nominations is charged to nominate candidates for the office of Speaker-elect of the House of Delegates each even-numbered year.

- The Committee is appointed by the immediate former (non-incumbent) Speaker of the House and is comprised of 5 members.
- The Committee only slates 2 candidates, but additional nominations may be made from the floor of the House. Candidates for Speaker-elect must be current Delegates to the APhA House.
- The Committee presents its report, including the slate of candidates, during the First Session of the House. Each candidate is given 2 minutes to introduce him/herself to the Delegates.
- At the Final Session of the APhA House, each candidate is given 3 minutes to address the APhA House. The election for the office of Speaker-elect is conducted electronically at the Final Session of the APhA House of Delegates.

### COMMITTEE OF CANVASSERS

The Committee of Canvassers is charged to observe the administration of the electronic voting process for the election of Speaker-elect during the Final Session of the APhA House. APhA members are appointed each even-numbered year to perform the responsibilities of this position.

### SUBMISSION OF NEW BUSINESS ITEMS

Items of New Business must be submitted to the Speaker of the House no later than 30 days before the start of the First Session of the House of Delegates. Consideration of urgent items can be done with a suspension of House rules at the House Session where New Business will be acted upon.

### DISTRIBUTION OF MATERIALS IN THE HOUSE OF DELEGATES

Materials may only be distributed in the APhA House of Delegates with the approval of the Secretary of the APhA House of Delegates. Individuals seeking to distribute material in the APhA House must submit a sample to the APhA House of Delegates Office prior to the start of the House Session. Materials to be distributed must relate to subjects and activities that are proposed for House action or information.

### HOUSE OF DELEGATES RULES OF ORDER

The rules contained in *Robert’s Rules of Order Newly Revised* govern the deliberations of the APhA House of Delegates in all cases in which they are applicable and not in conflict with special APhA House Rules or Bylaws. The Speaker of the APhA House appoints a Parliamentarian whose principal duty is to advise the Speaker. It is proper for the Parliamentarian to state his opinion to the APhA House of Delegates only when requested to do so by the Speaker. A parliamentary procedure reference guide is provided with the Delegate materials.

### ACCESS TO THE FLOOR OF THE HOUSE OF DELEGATES

Each Delegate has the right to speak and vote on every issue before the APhA House of Delegates. The Speaker shall announce at the opening session of each House meeting the procedure he/she will follow in recognizing requests from the floor. During the APhA House sessions, the procedure for seeking recognition by the Speaker will be for the Delegate to approach a floor microphone and, when recognized by the Speaker, to state his/her name and delegation affiliation. Only Delegates or individuals recognized by the Speaker shall have access to the microphone.

### AVAILABILITY OF REPORTS

The final report of the APhA Policy Committee will be available to membership by 8:00AM on Monday in the House of Delegates Office. The final report of the APhA New Business Review Committee will be available by 8:00AM on Sunday in the House of Delegates Office.

### VOTING PROCEDURES

Voting will occur via voice vote or by electronic tabulation. For action on Association policy and items of New Business, votes will be cast using voice votes. If the Speaker is unable to determine the outcome of the voice vote, or a Delegate calls for a vote count, the electronic voting system will be used. Voting for the election of Speaker-elect will occur using the electronic voting system.
Rule 1  Delegates and Voting
At the first session of a meeting of the House of Delegates, the Secretary shall report the number of accredited delegates who shall then compose the House of Delegates. Each delegate shall be entitled to one (1) vote. No delegate shall act as proxy of another delegate nor as delegate for more than one (1) association or organization. A member registered as an alternate may, upon proper clearance by the Credentials Committee, be transferred from alternate to delegate at any time during the continuance of business meetings.

Rule 2  Delegate Identification
Each delegate is required to wear a delegate ribbon attached to the convention name badge while seated in a session of the House of Delegates.

Rule 3  Consideration of Committee Reports
The House shall receive and consider the recommendations of each Association Policy Committee on each whole number section of a Policy Committee report during the first session of the APhA House of Delegates at each Association Annual Meeting. The Committee chair will recommend adoption of policy statements and preside over the debate. Action on the report will be governed by Robert's Rules of Order (current edition).

Debate in the first session of the House will be time limited. If the Speaker, the Committee chair or any delegates feel additional debate on the policy statement is warranted, the item may be carried over to an open hearing at which the Policy Reference Committee will preside. The remaining items requiring action will be brought back to the final session of the House of Delegates for action. The Policy Reference Committee may recommend adoption, referral, rejection or amendments to the original Policy Committee report. Action requires a majority vote.

Rule 4  New Business
Items of New Business are due to the Speaker of the House no later than 30 days before the start of the first House of Delegates session. Consideration of urgent items can be done with a suspension of House rules at the House Session where New Business will be acted upon.

Delegates wishing to amend existing APhA policy on topics not covered within the Policy Committee or Policy Review Committee agenda may submit proposed policy statements through the New Business Review Process. Re-statements of existing policy are discouraged.

The New Business Review Committee’s report to the House of Delegates shall include one of the following recommended actions for each New Business Item considered:
(a) Adoption of the New Business Item
(b) Rejection of the New Business Item
(c) Referral of the New Business Item
(d) Adoption of the New Business Item as amended by the committee
(e) No action

If the New Business Review Committee recommends no action on a New Business Item, the Speaker of the House shall place the New Business item before the House of Delegates for consideration and action.
Rule 5 Privilege of the Floor
Only delegates may introduce business on the floor of the House of Delegates. Any individual that is
duly recognized by the Speaker and/or the House may have the privilege of the floor in order to address
the delegates during a session of the House of Delegates. Any individual may present testimony during
an open hearing.

Rule 6 Nomination and Election of Speaker-elect
The House of Delegates Committee on Nominations shall consist of five delegates including the
Chairman, and shall be appointed by the Immediate Past (non-incumbent) Speaker of the House of
Delegates, and that Committee shall meet preceding the first session of the House of Delegates at the
Association Annual Meeting to select candidates for the office of Speaker-elect of the House of
Delegates.

Elections for Speaker-elect will occur every even-numbered year. Only two candidates for the office of
Speaker-elect of the House of Delegates shall be nominated by the Committee on Nominations, and this
report shall be presented at the first session of the House of Delegates. No member of the Committee on
Nominations shall be nominated by that Committee. All candidates examined by the Committee shall be
notified of the results as soon as possible after the nominees have been selected by the Committee on
Nominations.

Nominations may then be made from the floor at the first session of the House of Delegates by any
delegate immediately following the presentation of the Report of the Committee on Nominations.
Candidates nominated from the floor must submit biographical data to the Secretary of the House not less
than 24 hours prior to the start of the final session of the House of Delegates in order to qualify as a
candidate.

All candidates must be an APhA Member as defined in Article III, Section 2, of the APhA Bylaws, and a
seated delegate in the House of Delegates. Candidates will be introduced at the first session of the House
of Delegates and permitted to speak to the House for no more than two (2) minutes. Candidates will then
be permitted to address the House for a maximum of three (3) minutes at the second session prior to
voting on the candidates by the House. Candidates shall be listed in alphabetical order on the ballot
regardless of whether they were slated by the Committee on Nominations or nominated from the floor of
the House. A majority vote of delegates present and voting is required for election. If no majority is
obtained on the first ballot, a second ballot shall be cast for the two candidates who received the largest
vote on the first ballot. If electronic voting mechanisms are available, then the election shall be conducted
utilizing the technology, with the results not publicly displayed.

If a vacancy occurs in the office of Speaker, the vacancy process detailed in Article VI, Section 5, of the
APhA Bylaws shall be followed.

Rule 7 Amendments to Resolutions
All amendments to Policy Committee recommendations or New Business Resolutions shall be submitted
in writing to the Secretary on a form provided to Delegates. There are no “friendly” amendments. The
Speaker will rule any Delegates out of order who express a desire to make a “friendly amendment.”

Rule 8 Amendments to House of Delegates Rules
Every proposed amendment of these rules shall be submitted in writing and will require a two-third vote
for passage. A motion to suspend the rules shall require an affirmative vote of two-thirds of the total
number of delegates present and voting.

Rule 9 Rules of Order
The procedures of the House of Delegates shall be governed by the latest edition of Robert's Rules of
Order provided they are consistent with the APhA Bylaws and the House of Delegates Rules of
Procedure.
**Rule 10 Policy Review Committee**
The House shall receive and consider the recommendations of the House Policy Review Committee to archive existing statements into the historical policy category, to rescind existing policy, or amend existing policy at each Annual Meeting of the Association. A singular motion to archive, rescind, or retain, all such existing policy, with limited debate, shall be in order. Items identified by the Policy Review Committee as needing amendment shall be submitted to the New Business Committee for consideration. Any such existing policy will be subject to review every five years or less. Starting with the 2014-2015 Policy Review Committee, and every 4 years from there (not on an even year when there is a Speaker election), the Policy Review Committee shall review any policy that has not been reviewed or had policies added in the past 4 years.

The Speaker may engage the Policy Review Committee to review contemporary issues, where appropriate.

**Rule 11 Grammar/Punctuation Corrections**
The House shall allow the APhA Speaker and staff to the APhA House make to grammar and punctuation corrections to adopted House policy immediately after the conclusion of the House session. To ensure that these corrections do not inadvertently change the meaning of the adopted policy statement, the current sitting APhA House Rules Review Committee will review and approve the corrected statements.

**Rule 12 Policy Reference Committee**
The House of Delegates Policy Reference Committee shall consist of the chair of the Policy Committee, two members of the Policy Committee, and three or four new members appointed by the Speaker of the House of Delegates. The Policy Reference Committee will hear comments during the First Session of the House of Delegates and the Open Hearing of the Policy Committee at the APhA Annual Meeting and issue the Final Report of the House of Delegates.
<table>
<thead>
<tr>
<th>To Do This:</th>
<th>You Say This:</th>
<th>Must you interrupt speaker?</th>
<th>Must you be seconded?</th>
<th>Debatable?</th>
<th>Amendable?</th>
<th>Vote Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduce business (primary motion)</td>
<td>“I move that…”</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Minority</td>
</tr>
<tr>
<td>Amend a motion</td>
<td>“I move that this motion be amended by…”</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Minority</td>
</tr>
<tr>
<td>End debate</td>
<td>“I move the previous question.”</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Two-thirds</td>
</tr>
<tr>
<td>Request information</td>
<td>“Point of information.”</td>
<td>Yes</td>
<td>No (urgent)</td>
<td>No</td>
<td>No</td>
<td>No vote</td>
</tr>
<tr>
<td>Verify a voice vote</td>
<td>“I call for division of the House.”</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No vote</td>
</tr>
<tr>
<td>Complain about noise, room temperature, smoking</td>
<td>“Question of privilege.”</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Chair decides</td>
</tr>
<tr>
<td>Object to procedure or to a personal affront</td>
<td>“Point of order.”</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Chair decides</td>
</tr>
<tr>
<td>Lay aside an issue temporarily because of emergency</td>
<td>“I move to lay on the table …”</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
</tr>
<tr>
<td>Take up a matter previously tabled</td>
<td>“I move to take from the table…”</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
</tr>
<tr>
<td>Consider something out of scheduled order</td>
<td>“I move to suspend the rules to consider…”</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Two-thirds</td>
</tr>
<tr>
<td>Vote on a ruling by the Chair</td>
<td>“I appeal the decision.”</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Majority</td>
</tr>
<tr>
<td>Postpone consideration of something</td>
<td>“I move we postpone this matter until…”</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
</tr>
<tr>
<td>Reconsider something already disposed of</td>
<td>“I move to reconsider the vote on issue X…”</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Majority</td>
</tr>
<tr>
<td>Have something studied further</td>
<td>“I move to refer this to…”</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
</tr>
</tbody>
</table>
We need your assistance in planning for the 2014-2015 policy development process. Let us know what policy topics should be addressed by the 2015 House of Delegates.

Your recommendation will be considered by the Academies Joint Policy Standing Committee and the Board of Trustees for potential assignment to the 2014-2015 APhA Policy Committee.

Delegate Name and Email: ________________________________

Delegation: ________________________________

Proposed Policy Topic:

1. What problem(s) would this proposed policy topic address?

2. What factors have contributed to the problem(s)?

3. Why is this proposed policy topic necessary for the profession?

4. What specific issues should this proposed policy topic address? What specific areas should the Board of Trustees and Policy Committee consider in crafting language related to this topic?

5. Who are the target audiences for the proposed policy topic? (e.g., the public, pharmacists, other health professionals, regulatory bodies)

6. Other comments.

Please return this form to APhA staff before you leave this House session or provide your recommendations online at: http://fs3.formsite.com/apha/form220/index.html.
American Pharmacists Association

2014 House of Delegates
Report of the House Rules Review Committee

Committee Members

Karen Whalen, Chair
Bethany Boyd
Samy Elsherbini
Susan Holden
Kathy Petsos
Michael Ira Smith

Ex Officio
William Riffee, Speaker of the House
The 2013-2014 APhA House Rules Review Committee (HRRC) consists of the following APhA members and long-time delegates:

Karen Whalen, Chair  
Gainesville, FL

Bethany J. Boyd  
Allen, TX

Samy Elsherbin  
Harrisburg, NC

Susan Holden  
Stoughton, MA

Kathy Petsos  
Cape Canaveral, FL

Michael Ira Smith  
Scottsdale, AZ

Overall Charge and Duties

The House Rules Review Committee is appointed each year at the beginning of the First Session of the APhA House of Delegates to review and establish rules and procedures for the conduct of business at each House session (Adopted 1995). The APhA Speaker may assign year-specific charges to the Committee as warranted.

2013-2014 Specific Charges / Work Plan

This year, the following charges were assigned to the HRRC:

1. Observe the 2013 APhA House of Delegates proceedings, review House-related feedback, and make recommendations for improvement.
2. Review and approve, from a grammatical and copy-editing perspective, adopted policy from the 2013 APhA House of Delegates.
3. Review and approve the 2014 APhA House of Delegates schedule and make recommendations for improvement.

The HRRC met via conference call on April 5, 2013, and January 22, 2014 and made the following recommendations.

1. Observation of the 2013 APhA House of Delegates

Upon completing its review of the proceedings of the 2013 APhA House of Delegates, the Committee took the following action:

By CONSENT, the House Rules Review Committee observed no violations of the House Rules during the proceedings of the 2013 APhA House of Delegates. The Committee observed, reviewed, and discussed challenges and opportunities to maximize the efficiency of House operations. Several clarifications to the APhA House of Delegates Rules were suggested for consideration by delegates (see Sections 3 and 5)
2. Review of Policy Adopted by the 2013 APhA House of Delegates

The HRRC reviewed, from a grammatical and copy-editing perspective, the policy language approved by the 2013 House of Delegates. Upon completing its review, the HRRC took the following action:

By CONSENT, the House Rules Review Committee approved the 2013 Report of the APhA House of Delegates Report as prepared by APhA staff.

3. Recommendations to the APhA House of Delegates

The HRRC reviewed comments received from delegates, members, leaders and staff via surveys, live discussions and other mechanisms, regarding the activities of the House of Delegates.

- Delegate Education
  - The HRRC recommends the continued use of webinars to educate and engage APhA members in the Association’s policy development process. The HRRC recommends additional marketing to members and Delegates regarding upcoming webinars, the scheduling of webinars outside of normal business hours, and the availability of webinars on-demand.
  - The HRRC recommends the inclusion of general parliamentary procedure information in Delegate orientation materials and in related webinars. The HRRC recommends the implementation of Delegate “testing” related to House procedures and Robert’s Rules of Order and proposed that this testing could occur during the routine testing of the electronic keypads.

- Delegate Registration
  - The HRRC recommends the clarification of Delegate registration procedures with respect to the posted “office hours” of the House of Delegates Office.

- Timing of House Sessions
  - The HRRC recommends that APhA evaluate the timing of House sessions to allow for greater participation in continuing education sessions and possibly allow for greater flexibility in making travel arrangements. The HRRC also asks that APhA evaluate the possible awarding of continuing education credit for participation in the House of Delegates.

- Policy Review Committee
  - The HRRC discussed the current charges of the Policy Review Committee and procedures related to the amending of policies and introduction of New Business Items. The HRRC recommends a language revision as shown in Section 5 below.
  - The HRRC evaluated the timing and schedule placement of the Policy Review Committee Part II review and report. The HRRC recommends no procedural change at this time, but encourages the continued monitoring of this process.

- 2013 APhA Bylaws Amendments
  - The HRRC reviewed the bylaws amendments approved during the 2013 APhA Election Cycle and asked that related information be incorporated in the Delegate Reference Materials, Delegate Orientation presentation, and other areas as appropriate.

The HRRC evaluated the 2014 APhA House of Delegates Schedule and other newly revised Delegate materials. Upon completing its review, the HRRC took the following action:

**By CONSENT, the House Rules Review Committee approved the schedule of the 2014 APhA House of Delegates.**


After thorough consideration, and in conjunction with the feedback received from Delegates, members, and staff, the HRRC unanimously recommends the following revisions to the APhA House of Delegates Rules of Procedure. Note: proposed additions are underlined and proposed deletions are struck through.

**Rule 10—Policy Review Committee**

The House shall receive and consider the recommendations of the House Policy Review Committee to archive existing statements into the historical policy category, to rescind existing policy, retain, or amend existing policy at each Annual Meeting of the Association. A singular motion to archive, rescind, or retain, all such existing policy, with limited debate, shall be in order. Items identified by the Policy Review Committee as needing amendment shall be submitted to the New Business Review Committee for consideration, if the amendment changes the original policy intent. Any such existing policy will be subject to review every five years or less. Starting with the 2014-2015 Policy Review Committee, and every 4 years from there (not on an even year when there is a Speaker election), the Policy Review Committee shall review any policy that has not been reviewed or had policies added in the past 4 years.

The Speaker may engage the Policy Review Committee to review contemporary issues, where appropriate.

**By CONSENT, the House Rules Review Committee approves the APhA House of Delegates Rules of Procedure as proposed and recommends these revisions to be effective immediately upon adoption by the House of Delegates.**

The report is presented for approval by the APhA House of Delegates by Karen Whalen, Chair of the House Rules Review Committee.
American Pharmacists Association

2014 House of Delegates
Report of the Policy Review Committee

Part I
Policies last reviewed in 2009

Part II
Policies related to the 2014 policy topics

Committee Members
Ally Dering-Anderson, Chair
Irene Ahlstrom
Dee Ann Dugan
Terry Gubbins
Nicholas Leon
Brenna Neumann
Natalie Nguyen
Kayce Shealy
Allison Strobel

Ex Officio
William Riffee, Speaker of the House

This report is disseminated for consideration by the APhA House of Delegates and does not represent the position of the Association. Only those statements adopted by the House are considered official Association policy.
2013-2014 APhA Policy Review Committee Report

Note: Highlighting indicates a recommendation to archive the policy statement.

PART I

DISASTER PREPAREDNESS

1. The Committee recommends RETAINING the following policy statement as written.

2007 Pharmacy Personnel Immunization Rates
1. APhA supports efforts to increase immunization rates of healthcare professionals, for the purposes of protecting patients, and urges all pharmacy personnel to receive all immunizations recommended by the Centers for Disease Control (CDC) for healthcare workers.
2. APhA encourages employers to provide necessary immunizations to all pharmacy personnel.
3. APhA encourages federal, state, and local public health officials to recognize pharmacists as first responders (like physicians, nurses, police, etc.) and prioritize pharmacists to receive medications and immunizations.

(JAPhA NS45(5):580 September/October 2007) (Reviewed 2009)

2. The Committee recommends RETAINING the following policy statement as written.

APhA supports the continuing efforts of the Joint Commission of Pharmacy Practitioners working group on emergency preparedness and response to network with the Office of Homeland Security and with any other relevant governmental and/or military agency.


DISPENSING AUTHORITY

3. The Committee recommends RETAINING the following policy statement as written.

2003/2000 Emergency Contraception
APhA supports the voluntary involvement of pharmacists, in collaboration with other health care providers, in emergency contraceptive programs that include patient evaluation, patient education, and direct provision of emergency contraceptive medications.


DRUG ABUSE, CONTROL AND EDUCATION

4. The Committee recommends RETAINING the following policy statement as written.

1999 Sale of Sterile Syringes
APhA encourages state legislatures and boards of pharmacy to revise laws and regulations to permit the unrestricted sale or distribution of sterile syringes and needles by or with the knowledge of a pharmacist in an effort to decrease the transmission of blood-borne diseases.

DRUG CLASSIFICATION

5. The Committee recommends ARCHIVING the following policy statement as written.

2005/2001 Non-Prescription Availability of Nonsedating Antihistamines

APhA, as an issue of public safety, encourages manufacturers and the Food and Drug Administration (FDA) to transition nonsedating antihistamines from prescription to nonprescription status.


COMMENTS: Because nonsedating antihistamines are widely available over-the-counter, the Policy Review Committee recommends that this policy should be archived.

DRUG PRODUCT SELECTION

6. The Committee recommends RETAINING the following policy statement as written.

2009 Non-FDA-Approved Drugs and Patient Safety

1. The American Pharmacists Association calls for education and collaboration among health professional organizations, federal agencies, and other stakeholders to ensure that all manufacturer, distributor, and repackager marketed prescription drugs used in patient care have been FDA-approved as safe and effective.
2. APhA supports initiatives aimed at closing regulatory and distribution-system loopholes that facilitate market entry of new prescription drugs products without FDA approval.
3. APhA encourages health professionals to consider FDA approval status of prescription drug products when making decisions about prescribing, dispensing, substitution, purchasing, formulary development, and in the development of pharmacy/medical education programs and drug information compendia.

(JAPhA NS49(4):492 July/August 2009)

7. The Committee recommends RETAINING the following policy statement as written.

2005/1997 Complementary and Alternative Medications

1. APhA supports pharmacists using professional judgment to make informed decisions regarding the appropriateness of use or the sale of complementary and alternative medicines.
2. APhA shall assist pharmacists and student pharmacists in becoming knowledgeable about complementary and alternative medications to facilitate the counseling of patients regarding effectiveness, proper use, indications, safety and possible interactions.


8. The Committee recommends RETAINING the following policy statement as written.

2001 Credentialing and Pharmaceutical Care

1. APhA should continue to assist in the unification of the profession and the development of a national strategy by its continued support of the Council on Credentialing in Pharmacy as the body responsible for the leadership, standards, public information and coordination of the professions voluntary credentialing programs.
2. APhA, in conjunction and cooperation with the Council on Credentialing and other national associations, should provide competence-based material and testing via technology, such as the APhA Web site and state association Web sites, to further the professions self-assessment.
3. APhA, in conjunction and cooperation with the Council on Credentialing and other national associations, should develop the necessary products and programs to educate the public, insurers, and health professionals on credentialing and make them available to state associations at cost.
4. APhA supports the development, on a continuing basis, of programs such as Project ImPACT, which provide the opportunity to promote the profession and its impact on clinical, economic, and humanistic patient outcomes.

9. The Committee recommends RETAINING the following policy statement as written.

2005 Continuing Professional Development
1. APhA supports continuing professional development, a self-directed, individualized, systematic approach to life-long learning, to support pharmacist’s efforts to maintain professional competence in their practice.
2. APhA should work with appropriate organizations to provide self-assessment and plan development tools. APhA shall help identify and facilitate access to quality educational programs.
3. APhA encourages employers to foster and support pharmacist participation in continuing professional development.
4. Continuing professional development is a learning process that requires full participation to achieve desired individual outcomes. To facilitate that participation, each pharmacist controls disclosure of their individual assessments and outcomes.

INTERNET PHARMACY

10. The Committee recommends RETAINING the following policy statement as written.

2005/2004/1999 Telemedicine/Telehealth/Telepharmacy
1. APhA supports the pharmacist as the only appropriate provider of telepharmacy services, a component of telehealth, for which compensation should be provided. Telepharmacy is defined as the provision of pharmaceutical care to patients through the use of telecommunications and information technologies.
2. APhA shall assist pharmacists and student pharmacists in becoming knowledgeable about telepharmacy and telehealth.
3. APhA shall participate in the ongoing development of the telehealth infrastructure, including but not limited to regulations, standards development, security guidelines, information systems, and compensation.
4. APhA acknowledges that state boards of pharmacy are primarily responsible for the regulation of the practice of telepharmacy, encourages appropriate regulatory action that facilitates the practice of telepharmacy and maintains appropriate guidelines to protect the public health and patient confidentiality.

PATIENT/PHARMACIST RELATIONSHIPS

11. The Committee recommends RETAINING the following policy statement as written.

2006 Cultural Health Beliefs and Medication Use
1. APhA supports culturally sensitive outreach efforts to increase mutual understanding of the risks and other issues of using prescription medications without a prescription order or using unapproved products.
2. APhA supports expanding culturally competent health care services in all communities.
12. The Committee recommends **RETAINING** the following policy statement as written.

**2005/2002 Health Literacy**
1. APhA encourages pharmacists and student pharmacists to increase their awareness of health literacy. Health literacy is the degree to which people can obtain, process, and understand basic health information and services they need to make appropriate health decisions.
2. APhA encourages pharmacists and student pharmacists to assess patients’ health literacy and then implement appropriate communications and education.
3. APhA encourages the review of all patient information for health literacy appropriateness.


13. The Committee recommends **RETAINING** the following policy statement as written.

**2001 Administrative Contributions to Medication Errors**
1. APhA encourages implementation of a standard prescription drug card to improve the dispensing process and encourages the use of technology in this implementation.
2. APhA supports the use of technology to facilitate record-keeping of patient prescription information for third-party audit purposes and regulatory compliance.
3. APhA supports education of the public regarding the responsibility to be informed consumers of their pharmacy benefits provided through third-party plans.
4. APhA encourages third-party plans to provide pharmacies all information necessary for benefits administration in a timely organized manner or to provide access to the information through the Internet or similar technologies at no cost to the pharmacy.
5. APhA supports the distinction of plan management messages (e.g., days’ supply limitations or formulary management) from drug utilization review messages (e.g., drug-drug interactions). APhA supports the communication of all plan management options available (e.g., approved formulary alternatives) from the claims processor to the pharmacist.
6. APhA supports the development and use of systems to communicate in-pharmacy drug utilization review messages with on-line claims processing systems to eliminate redundant and/or repetitive messages.
7. APhA encourages the transmission of pre-adjudication drug utilization review messages (i.e., drug utilization review communication between the prescriber and claims processor) to the pharmacist.
8. APhA supports efforts to:
   (a) improve on-line drug utilization review messages by the establishment of evidence-based criteria to prevent drug related conflicts that have the potential for causing serious harm, and
   (b) eliminate drug utilization review messages that have questionable or inconsequential impact on patient outcomes.


14. The Committee recommends **RETAINING** the following policy statement as written.

**2000 Medication Errors**
1. APhA, as the national professional society of pharmacists, will work to ensure that pharmacy is the profession responsible for providing leadership in developing a safe, error-free medication use process.
2. APhA supports continuation and expansion of medication error reporting programs.
3. Medication error reporting programs should be non-punitive in nature and allow appropriate anonymity to facilitate error reporting and development of solutions to eliminate error.
4. APhA supports identifying the system-based causes of errors and building systems to support safe medication practice.

(JAPhA NS(9):40 September/October 2000) (Reviewed 2007) (Reviewed 2009)
15. The Committee recommends RETAINING the following policy statement as written.

2005 Compounding with Multicomponent Vehicles
1. APhA encourages companies that offer multi-component vehicles for compounding to list all ingredients and to restrict claims about the vehicles to the structure and function of the ingredients in those vehicles unless clinical evidence exists to support more specific claims.
2. When claims are made by companies for systemic delivery of active ingredients in multi-component vehicles, APhA encourages pharmacists to secure bioavailability data in support of such claims.

(JAPhA NS45(5):555 September/October 2005)(Reviewed 2009)

16. The Committee recommends RETAINING the following policy statement as written.

2005/2003/1996 Empowerment of Pharmacists as Drug Therapy Managers
1. APhA encourages pharmacists to take an active role in achieving the goals of the Healthy People program regarding immunizations through:
   (a) advocacy,
   (b) contracting with other health care professionals, or
   (c) pharmacists administering vaccines to vulnerable patients.
2. APhA encourages the availability of all vaccines to all pharmacies in order to meet public health needs.
3. APhA supports the compensation of pharmacists for the administration of immunizations and the reimbursement for vaccine distribution.
4. APhA should facilitate the development of programs that educate pharmacists about their role in immunizations in public health.


17. The Committee recommends RETAINING the following policy statement as written.

2001 Medication Error Reporting
1. APhA strongly encourages participation in error reporting at the organizational (pharmacy/institution) level and in other established state and national reporting programs.
2. APhA encourages direct error reporting by the individual(s) involved in the incident to ensure that the most relevant and detailed information is available for evaluation of the incident and for systems improvement.
3. Error reporting programs should regularly analyze and report information about the leading types and causes of errors reported to their system so that practitioners can utilize this information for systems enhancements and quality improvement.
4. APhA encourages state boards of pharmacy and other responsible entities to consider pharmacists participation in reporting of errors as a mitigating factor in determining any legal or disciplinary action related to the incident.


18. The Committee recommends RETAINING the following policy statement as written.

1991 Emerging Technologies
1. APhA supports programs to monitor the development of emerging technologies and their impact on the delivery of pharmaceutical care.
2. APhA supports education of pharmacists regarding emerging technology including their development and impact on the delivery of pharmaceutical care.
3. APhA supports the inclusion of pharmacists in the development and application of the emerging
technologies in the delivery of pharmaceutical care.

PUBLIC HEALTH

19. The Committee recommends RETAINING the following policy statement as written.

2005/1971 Cigarette Sales in Pharmacies
1. APhA recommends that tobacco products not be sold in pharmacies.
2. APhA recommends that state and local pharmacist associations develop similar policy statements
   for their membership and increase their involvement in public educational programs regarding the
   health hazards of smoking.
3. APhA recommends that individual pharmacists give particular attention to educating young people
   on the health hazards of smoking.
4. APhA recommends that APhA-ASP develop projects aimed at educating young people on the
   health hazards of smoking, such as visiting schools and conducting health education programs.

20. The Committee recommends RETAINING the following policy statement as written.

2005/1968 Cigarette Sales in Pharmacies
APhA recommends that pharmacists not allow smoking in their prescription departments.

21. The Committee recommends RETAINING the following policy statement as written.

1996 Exclusion of Alcohol and Tobacco Sales in Pharmacy Practice Settings
APhA opposes the sale of tobacco products and non-medicinal alcoholic beverages in pharmacies.

22. The Committee recommends RETAINING the following policy statement as written unless a
revised statement is adopted as a New Business Item by the House. If a new statement is adopted, the
Committee recommends ARCHIVING this policy statement.

2005/1986 Pharmacists Responsibilities in Community Medication Awareness Programs
1. APhA supports the development of a comprehensive educational program on the proper use of
   prescription and non-prescription medication.
2. Pharmacists should take a major educational responsibility in proactive programs which optimize
   therapeutic outcomes and minimize risks from inappropriate medication use.

COMMENTS: The Policy Review Committee intends to submit a New Business Item which
incorporates information on general educational programs and medication disposal programs. If
the New Business Item is adopted, the Committee recommends archiving this policy statement.
23. The Committee recommends **RETAINING** the following policy statement as written.

**2000 Medication Use in Schools**

APhA recognizes the role of pharmacists in improving the use of medications in schools and supports pharmacist activities to work with teachers, school nurses, parents, school administrators and other personnel to improve medication use in this environment. APhA recommends that pharmacists be involved in the development of guidelines for medication use in schools.


### HIV/AIDS

24. The Committee recommends **RETAINING** the following policy statement as written.

**2005/1993 HIV Testing**

1. APhA opposes mandatory HIV testing of pharmacists, student pharmacists, and pharmacy personnel.
2. APhA supports voluntary and confidential HIV testing of pharmacists, student pharmacists, and pharmacy personnel, to facilitate early detection and disease intervention.
3. APhA supports training designed to foster compliance with infection control procedures outlined in current Centers for Disease Control and Prevention (CDC) guidelines for universal precautions and OSHA standards for blood-borne pathogens.
4. APhA encourages the development of support networks to assist HIV-positive health care professionals and students.


25. The Committee recommends **RETAINING** the following policy statement as written.

**2005/1993 HIV/AIDS Education**

1. APhA encourages pharmacists and student pharmacists to become more knowledgeable about HIV/AIDS.
2. APhA supports the development of cooperative efforts among health care organizations and agencies to facilitate the collection, evaluation, and distribution of information on HIV/AIDS.
3. APhA supports the development of educational programs for pharmacists and student pharmacists that would enable them to assume a service role in the prevention and treatment of HIV/AIDS.


26. The Committee recommends **RETAINING** the following policy statement as written.

**2005/1990 Needle/Syringe Exchange Programs in the Prevention of the Spread of Human Immunodeficiency Virus (HIV) and Other Infections**

1. APhA supports distribution of educational materials on the risks of sharing needles/syringes with respect to the spread of human immunodeficiency virus (HIV) and other blood-borne infectious diseases.
2. APhA supports the objective gathering and analysis of data and information about the effectiveness of pilot needle/syringe exchange programs in preventing the spread of HIV and other blood-borne infectious diseases.
3. APhA supports needle/syringe exchange programs when part of a comprehensive approach in the prevention of the spread of HIV and other blood-borne infections.

27. The Committee recommends **RETIumbing to women, including education about the availability and benefits of HIV testing in pregnancy to decrease the risk of HIV transmission to unborn children, APhA encourages pharmacists to provide education about the availability and benefits of HIV testing in pregnancy.


28. The Committee recommends **RETIumbing to the public educational materials, prophylactic devices, and adequate instructions for use in combating sexually transmitted infections.**


29. The Committee recommends **RETIumbing supports the demonstration of safety and efficacy of homeopathic products from adequate, well-designed scientific studies before pharmacists advocate or sell homeopathic products.**


30. The Committee recommends **RETIumbing the development of practice guidelines to identify, resolve, and prevent dispensing-related problems.**

31. The Committee recommends RETAINING the following policy statement as written.

**2005/1993 Documentation**

1. APhA encourages development of systems that document review of patient therapy, the type and intensity of services provided, and the result or outcome of the services.
2. APhA believes that systems of payment and documentation must be compatible with contemporary computer systems used by providers and payers and should emphasize administrative efficiency.


32. The Committee recommends RETAINING the following policy statement as written.

**1994 Implications of On-line Prospective DUR on the Application of Pharmacists' Scientific and Clinical Judgments**

1. APhA recognizes that effective drug utilization review (prospective, concurrent, retrospective), as a component of pharmaceutical care, depends upon complete and accurate patient information.
2. APhA advocates eliminating the economic and operational obstacles pharmacists encounter when conducting drug utilization review for optimal patient care.
4. APhA encourages the development of a standardized method of electronic transfer of patient medical data between all health professionals involved in the care of a patient.


33. The Committee recommends RETAINING the following policy statement as written.

**1983 Patient Medication Program**

1. APhA shall strongly and actively encourage pharmacists to be available for and provide patient consultation, including written drug information, when requested or professionally appropriate.
2. APhA supports patient information programs that include reference to seeking medication information from pharmacists and does not endorse programs which, by ignoring the professional capabilities of pharmacists, may limit the patient’s ability to receive needed drug information and consultation.


**REIMBURSEMENT AND COMPENSATION**

34. The Committee recommends RETAINING the following policy statement as written.

**2005/1987 Catastrophic Illness: Coverage for Pharmacist Services Included**

1. APhA supports comprehensive, catastrophic illness insurance coverage that recognizes the essential need for pharmaceutical products and pharmacist services in all patient care environments, including the home.
2. APhA encourages inclusion of pharmacist services and the most efficient and readily accessible system of drug delivery in any insurance coverage for catastrophic illness that may be enacted.

35. The Committee recommends RETAINING the following policy statement as written.

**2005/1985 Pharmacists and Home Health Care**  
1. APhA supports establishment of pharmacist consulting services for home care.  
2. Medicaid and other third-party programs should recognize the consulting role of the pharmacist in reducing the misuse of drugs and maximizing their therapeutic effectiveness through fair and equitable reimbursement for consulting functions which is not tied to the provision of medications.  
3. Medicaid and other third-party programs also should reimburse pharmacists for innovative packaging and services that will maximize adherence, increase the opportunity for drug utilization review, and better meet the informational needs of the patient and the care giver.  


36. The Committee recommends RETAINING the following policy statement as written.

**2005/1990 Reimbursement for Unapproved (Off-label) Uses of FDA-Approved Drug Products**  
APhA supports coverage of FDA-approved drugs and pharmacist services connected with the delivery of such drugs by government and other third-party payers when used rationally for indications other than those specified in the product labeling.


37. The Committee recommends RETAINING the following policy statement as written.

**2005/1969 Medicare: Reimbursement Procedures**  
APhA should educate pharmacists on aspects of reimbursement procedures and concepts associated with Medicare.


38. The Committee recommends RETAINING the following policy statement as written.

**1969 Medicare Task Force: Policy Guidelines**  
The following guidelines supplement those adopted by APhA in 1967  
1. Provide for beneficiary contribution toward program financing.  
2. Provide for government reimbursement of claims directly to the pharmacist.  
3. Compensate pharmacists by means of a professional fee commensurate with the level of professional service performed in addition to making reimbursement for the cost of the drugs.  
4. Establish a per-prescription, fixed amount (co-payment) which must be paid by the beneficiary when obtaining drugs.  
5. To assure patients of receiving safe and effective drugs, establish a list of reimbursable amounts for each drug based on a nationally available product of acceptable quality and cost.  
6. Include all drugs having therapeutic use, whether for chronic or acute conditions.  
7. Include all persons eligible for Part B Medicare coverage.


39. The Committee recommends RETAINING the following policy statement as written.

**1967 Drugs Provided Under Social Security Act: Guidelines for Pharmacists’ Services**  
Since it is probable or likely that APhA may have to consider and act upon some proposals in the area of drug costs before the next annual meeting, we recommend that APhA Board of Trustees be guided by whether the proposals:  
1. Permit pharmacists to select and dispense a quality drug product;  
2. Establish some mechanism to assist pharmacists in selecting quality, drug products under the cost and other criteria established;  
3. Permit the use of any available drug product when unique medical circumstances so require;  
4. Establish a reasonable remuneration base for pharmacists rendering services under the program;
5. Guarantee recipients free choice of pharmacy; and
6. Limit the reimbursement for pharmacists’ services to those provided by duly licensed pharmacists.

40. The Committee recommends RETAINING the following policy statement as written.

**2005/1971 National Health Insurance (NHI)**

APhA endorses the concept of national health insurance as one means by which the costs of health care may be controlled and rational order brought to the health care system:
(a) A national health insurance plan must recognize that high quality health care is a right of every citizen regardless of his economic or social status.
(b) A national health insurance plan must, as a point of departure, provide a health care delivery system which will correct the inadequacies in the delivery of health care.
(c) A national health insurance plan must allow for maximum utilization of pharmacists in health care roles.
(d) Group practices established under national health insurance must permit pharmacists participation on an equitable basis and not merely as employees of physician-controlled groups.
(e) A national health insurance plan should, to the extent feasible, utilize existing community pharmacies as health care facilities.

41. The Committee recommends RETAINING the following policy statement as written.

**1977 National Health Insurance: Pharmaceutical Service Benefit**

1. A National Health Insurance pharmaceutical service benefit must include acceptable methods for ensuring equitable reimbursement to pharmacists for products and services which are to be provided under the program.
2. Reimbursement to pharmacists for dispensed medication and devices under a NHI plan should be based on professional fees for professional services, plus reimbursement for the actual cost of any drug product or device provided.
3. A NHI, pharmaceutical service benefit must optimize administrative efficiency and minimize administrative costs.

42. The Committee recommends RETAINING the following policy statement as written.

**1995 Integrated Risk/Capitation Payment Systems**

1. APhA should provide pharmacists with tools to evaluate compensation for their pharmaceutical care services through mechanisms based on concepts other than fee-for-service.
2. APhA must facilitate both economic and clinical research on cost-to-outcomes benefits of pharmaceutical care services under integrated risk/capitated health care systems.
3. APhA affirms the principle that any pharmacist or pharmacy that adheres to a programs quality standards and agrees to accept its compensation plan shall be able to participate in an integrated risk/capitated system or network.

43. The Committee recommends RETAINING the following policy statement as written.

**2005/1975 Periodic Adjustments of Professional Fees in Federal Programs**

It is essential that federal regulations governing pharmacist professional fees in federally-supported, health care programs require review and equitable adjustments on a regularized, periodic basis.
44. The Committee recommends **RETAINING** the following policy statement as written.

**2005/1984 Exemption from the Employee Retirement Income Security Act (ERISA)**

APhA seeks introduction of legislation exempting state, third-party, and prescription program legislation from preemption by ERISA.


45. The Committee recommends **RETAINING** the following policy statement as written.

**2005/1981 Third-party Reimbursement Legislation**

APhA supports enactment of legislation requiring that third-party program reimbursement to pharmacists be at least equal to the pharmacists prevailing charges to the self-paying public for comparable services and products, plus additional documented direct and indirect costs, which are generated by participating in the program.


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**RESEARCH**

46. The Committee recommends **RETAINING** the following policy statement as written.

**2005 Public Access to Clinical Trials Data**

APhA supports access by healthcare professionals and the public to all clinical trial data derived from scientifically valid studies. APhA supports the establishment of a single, independent, publicly accessible clinical trials database that includes but is not limited to the following components:

(a) includes all studies, pre and post drug approval, throughout the research period (whether completed, in-progress or discontinued)
(b) clearly states the size, demographics, limitations and citations, if published, of each study listed
(c) includes an interpretative statement by an independent review body regarding the purpose of the study, methodology and outcomes to assist the public in understanding the posted information in a timely manner
(d) includes warnings to the public regarding inappropriate or incomplete use of the data in making clinical decisions in absence of an interpretive statement
(e) the sponsor and any supporting company, organization, or partnered institution of each clinical trial listed shall be clearly identified. (This includes Clinical Research Organizations, Academic Research Organizations, Site Management Organizations or any other group that is responsible other than the investigator’s research site.)

(JAPhA NS45(5):554-555 September/October 2005) (Reviewed 2009)

47. The Committee recommends **RETAINING** the following policy statement as written.

**2005/1986/1981 Use of Animals in Drug Research**

1. APhA recognizes that animal experiments continue to be an essential, and indeed irreplaceable, component of biomedical research and testing.
2. When animals must be used for biomedical research and testing, APhA strongly supports humane treatment and adequate regulation, controls, and enforcement of appropriate measures relating to animal procurement, transportation, housing, care, and treatment.
3. APhA encourages the further development of methods of biomedical research and testing which do not require the use of animals.
4. APhA opposes legislative provisions that would penalize the properly controlled and conducted use of animals for biomedical research and testing.

48. The Committee recommends **RETAINING** the following policy statement as written.

**2005/1990 Use of Representative Populations in Clinical Studies**

1. APhA supports the use of representative populations in clinical studies, including the use of women, minorities, the elderly, and children when appropriate.
2. APhA encourages the development of research techniques which would identify possible problems not readily detected in adult clinical investigations to aid in the safe and effective evaluation of drugs in children.


49. The Committee recommends **RETAINING** the following policy statement as written.

**1990 Federal Funding to Evaluate the Impact of Health Care Policies**

1. APhA supports the study of economic, scientific, and social issues related to health care, particularly pharmaceutical services.
2. APhA urges the federal government to establish funding mechanisms for objective research to assess the impact of public policy on the health care system, particularly pharmaceutical services.
3. APhA urges that all federally-funded research addressing public policy pertaining to pharmaceutical services incorporate input from organized pharmacy.


50. The Committee recommends **RETAINING** the following policy statement as written.

**1989 Pharmacists as Principal Investigators in Clinical Drug Research**

1. APhA urges the sponsors of drug research to permit pharmacists to serve as principal investigators.
2. APhA encourages state and federal agencies to eliminate regulatory and policy obstacles that prohibit pharmacists from being investigators, including principal investigators, in drug research or sponsors of Investigational New Drug Applications, Investigational Device Evaluations, and Animal Investigational New Drug Applications.


51. The Committee recommends **RETAINING** the following policy statement as written.

**1989 Scientist Manpower**

APhA supports efforts to increase the number of pharmacists pursuing graduate education and research in the pharmaceutical sciences, including, but not limited to
1. Dissemination of information to create awareness about graduate programs and career opportunities.
2. Pursuit of increased government, industry, and foundation funding.
3. Encouragement of innovative recruitment programs and curricula to facilitate career development.


52. The Committee recommends **RETAINING** the following policy statement as written.

**1987 Impact of National Institutes of Health (NIH) Budget on Future Research**

APhA recognizes the fundamental role of biomedical research in the profession of pharmacy and actively supports continued and predictable funding of NIH research.

53. The Committee recommends RETAINING the following policy statement as written.

1986 Positive Controls Versus Placebo Controls in Testing New Drugs
APhA recognizes the importance of and the need for placebo-controlled trials in testing new drugs. In addition, APhA supports the use of alternative study designs (such as positive controls), as well as innovative methodologies where they appear to be appropriate and useful.

54. The Committee recommends RETAINING the following policy statement as written.

1981 Modification of Patent Periods
APhA supports modifications of patent periods for prescription drugs and drug products that would create reasonable incentives for needed research on new drugs and drug products.

55. The Committee recommends RETAINING the following policy statement as written.

1966 APhA Study Proposal
APhA should expand its research programs and plans to help the profession find solutions to its problems, discover new opportunities for service, and improve its present practices.

56. The Committee recommends RETAINING the following policy statement as written unless a revised statement is adopted as a New Business Item by the House. If a new statement is adopted, the Committee recommends ARCHIVING this policy statement.

1984 Freedom of Scientific Information
APhA supports the principle of the free dissemination and exchange of scientific information with only the following exceptions:
(a) prior mutual confidentiality agreement between sponsor and researcher,
(b) material that is essential to national security, and
(c) legitimate trade secrets and/or proprietary information.

COMMENTS: The Policy Review Committee intends to submit a New Business Item related to the exchange of scientific information. If the New Business Item is adopted, the Committee recommends archiving this policy statement.

VACCINES

57. The Committee recommends RETAINING the following policy statement as written.

1997 Standards for Pharmacy-Based Immunization Advocacy
(Note: Guidelines approved by the APhA Board of Trustees in May, 1997; noted in Appendix.)
APhA should adopt and disseminate standards for immunization advocacy and delivery by pharmacists.
58. The Committee recommends **RETAINING** the following policy statement as written.

**1987 Encouraging Availability and Use of Vaccines**

1. APhA encourages the continued availability of vaccines to meet public health needs.
2. APhA supports the development of programs that educate the public about the role of immunizations in public health.
3. APhA supports the reimbursement by public and private third-party payers for immunizations.


59. The Committee recommends **ARCHIVING** the following policy statement as written.

**1981 Vaccine Liability Programs**

APhA supports legislative action to create a joint pharmaceutical industry/government program which would compensate victims and reduce the liability of vaccine manufacturers and health care professionals arising from adverse effects associated with the appropriate administration of properly manufactured vaccines.


COMMENTS: The Policy Review Committee felt that this policy statement is no longer relevant because the National Vaccine Injury Compensation Program was created in 1988.

60. The Committee recommends **RETAINING** the following policy statement as written.

**2002/1986 Quack Therapy**

APhA encourages efforts that would require the listing of all active ingredients of a food promoted as a drug or drug product in written promotional and advertising material.


61. The Committee recommends **RETAINING** the following policy statement as written.

**1988 Vitamins, Minerals, and Other Nutritional Supplement Usage**

1. APhA advocates programs which address the public health implications of the misuse and/or abuse of vitamins, minerals, and other nutritional supplements.
2. APhA encourages pharmacists to provide health education regarding unsubstantiated and/or misleading health claims as they apply to vitamins, minerals, and other nutritional supplements.


62. The Committee recommends **RETAINING** the following policy statement as written.

**1981 Federal Regulation of Salt in Processed Foods**

APhA encourages manufacturers of processed foods to voluntarily reduce the salt (sodium chloride) added to their products and to use the minimum amount of salt necessary in the manufacturing process.


63. The Committee recommends **RETAINING** the following policy statement as written.

**1980 Food Labeling**

APhA supports requirements for disclosure in the labeling of processed food and the identity and, whenever appropriate, the quantity of ingredients, such as those preservatives, artificial colors and flavors, salts, sugars, and other substances that represent a potential risk to the health or therapy of a portion of the general population.

64. The Committee recommends RETAINING the following policy statement as written.

**1979 Consideration of the Equal Rights Amendment**

APhA supports efforts to assure equal rights of all persons.

(AmPharm NS19(7):60 June 1979) (Reviewed 2009)
PART II

Note: **Highlighting** indicates a recommendation to archive the policy statement.
The following recommendations of the Policy Review Committee will be considered after
the House completes action on the Policy Committee report.

CARE TRANSITIONS

*Related APhA Policy*

1. The Committee recommends **RETAINING** the following policy statement as written.

2010 E-prescribing Standardization

1. APhA supports the standardization of user interfaces to improve quality and reduce errors unique
to e-prescribing.
2. APhA supports reporting mechanisms and research efforts to evaluate the effectiveness, safety, and
quality of e-prescribing systems, computerized prescriber order entry (CPOE) systems, and the e-
prescriptions that they produce, in order to improve health information technology systems and,
ultimately, patient care.
3. APhA supports the development of financial incentives for pharmacists and prescribers to provide
high quality e-prescribing activities.
4. APhA supports the inclusion of pharmacists in quality improvement and meaningful use activities
related to the use of e-prescribing and other health information technology that would positively
impact patient health outcomes.

(JAPhA NS40(4):471 July/August 2010)

2. The Committee recommends **RETAINING** the following policy statement as written.

2010 Personal Health Records

1. APhA supports patient utilization of personal health records, defined as records of health-related
information managed, shared, and controlled by the individual, to facilitate self-management and
communication across the continuum of care.
2. APhA urges both public and private entities to identify and include pharmacists and other
stakeholders in the development of personal health record systems and the adoption of standards,
including but not limited to terminology, security, documentation, and coding of data contained
within personal health records.
3. APhA supports the development, implementation, and maintenance of personal health record
systems that are accessible and searchable by pharmacists and other health care providers,
interoperable and portable across health information systems, customizable to the needs of the patient,
and able to differentiate information provided by a health care provider and the patient.
4. APhA supports pharmacists taking the leadership role in educating the public about the importance
of maintaining current and accurate medication-related information within personal health records.

(JAPhA NS40(4):471 July/August 2010)(Reviewed 2013)

3. The Committee recommends **RETAINING** the following policy statement as written.

2006 Continuity of Care

1. APhA supports the pharmacist as the most appropriate member of the health care team responsible
for reconciling medication use when patients move between practice settings within the continuum of
care.
2. APhA supports the development and use, in practice, of a standardized, portable, accessible,
HIPAA compliant, and secure Electronic Health Record (EHR) to facilitate continuity of care across
all practice settings. The EHR shall include the clinical data elements necessary to support the
performance of medication reconciliation.
3. APhA supports patient access to pharmacists with specialized skills and expertise. The patient’s
pharmacist should make patient referrals where appropriate.

4. The Committee recommends RETAINING the following policy statement as written.

2004 Automation and Technology in Pharmacy Practice
1. APhA supports the use of automation and technology in pharmacy practice, with pharmacists
maintaining oversight of these systems.
2. APhA recommends that pharmacists and other pharmacy personnel implement policies and
procedures addressing the use of technology and automation to ensure safety, accuracy, security, data
integrity, and patient confidentiality.
3. APhA supports initial and ongoing system-specific education and training of all affected personnel
when automation and technology are utilized in the workplace.
4. APhA shall work with all relevant parties to facilitate the appropriate use of automation and
technology in pharmacy practice.

5. The Committee recommends RETAINING the following policy statement as written.

2009 Health Information Technology
1. APhA supports the delivery of informatics education within pharmacy schools and continuing
education programs to improve patient care, understand interoperability among systems, understand
where to find information, increase productivity, and improve the ability to measure and report the
value of pharmacists in the health care system.
2. APhA urges that pharmacists have read/write access to electronic health record data for the
purposes of improving patient care and medication use outcomes.
3. APhA encourages inclusion of pharmacists in the definition, development, and implementation of
health information technologies for the purpose of improving the quality of patient-centric health
care.
4. APhA urges public and private entities to include pharmacist representatives in the creation of
standards, the certification of systems, and the integration of medication use systems with health
information technology.

AUDITS OF HEALTH CARE PRACTICES
Related APhA Policy

6. The Committee recommends RETAINING the following policy statement as written.

2005-1970 Medicare, Medicaid, and Other Third-party Payment Programs
1. APhA advocates a professional fee system of reimbursement in Medicare and Medicaid and other
third-party payment programs which would recognize variations in services provided and costs
incurred by individual pharmacies.
2. APhA supports maintaining close liaison with proponents of national health insurance programs to
ensure that pharmacy will have an opportunity to make its views known in the development of such
proposals.
USE OF SOCIAL MEDIA
Related APhA Policy

7. The Committee recommends ARCHIVING the following policy statement as written.

1977 Employers’ Use of Lie Detection Tests
   1. Polygraph tests should not be used as a means of pre-employment screening in pharmacies.
   2. Polygraph tests should not be used in pharmacies for routine “security” checking of employees.
   3. Polygraph tests should not be used in pharmacies in the course of investigations for cause.

   COMMENTS: Because employers have many options for completing pre-employment screenings, the Policy Review Committee felt that this policy statement was no longer applicable to contemporary pharmacy practice.

8. The Committee recommends RETAINING the following policy statement as written.

1987 Future of Pharmacy
   1. APhA supports programs which plan for the future of pharmacy.
   2. APhA supports programs which encourage innovations in the practice of pharmacy in a changing health care environment.
   3. APhA supports programs which reflect a positive image of pharmacists.

9. The Committee recommends RETAINING the following policy statement as written.

1991 Pharmaceutical Care and the Provision of Cognitive Services with Technologies
   1. APhA supports the utilization of technologies to enhance the pharmacist's ability to provide pharmaceutical care.
   2. APhA believes that the use of technologies should not replace the pharmacist/patient relationship.
   3. APhA emphasizes that maximizing patient benefit from technologies depends on the pharmacist/patient relationship.
   4. APhA affirms that the utilization of technologies by pharmacists shall not compromise the patient's right to confidentiality.

10. The Committee recommends RETAINING the following policy statement as written.

1998 Access and Contribution to Health Records
   1. APhA urges the integration of pharmacy-based patient data into patient health records to facilitate the delivery of integrated care.
   2. APhA recognizes pharmacists’ need for patient health care data and information and supports their access and contribution to patient health records.
   3. APhA supports public policies that protect the patient’s privacy yet preserve access to personal health data for research when the patient has consented to such research or when the patient’s identity is protected.
   4. APhA encourages interdisciplinary discussion regarding accountability and oversight for appropriate use of health information.
American Pharmacists Association

2014 House of Delegates
Report of the Policy Committee

Care Transitions
Audits of Health Care Practices
Use of Social Media

Committee Members
Collin Conway, Chair
Kelli Barnes
Kimberly Croley
Heather Free
Jerame Hill
Joey Mattingly
Ann McManis
Marissa Schlaifer
Norman Tomaka

Ex Officio
William Riffe, Speaker of the House

This report is disseminated for consideration by the APhA House of Delegates, but does not represent the position of the Association. Only those statements adopted by the House are official Association policy.
The Committee recommends that the Association adopt the following statements:

1. APhA supports pharmacists leading medication management activities during care transitions to ensure safe and effective medication use.
   [Refer to Summary of Discussion Item 2.]

2. APhA supports the integral role of pharmacists during care transitions for improving quality of patient-centered care and reducing overall costs to the health care system.
   [Refer to Summary of Discussion Items 2, 3.]

3. APhA strongly encourages collaboration and accountability among patients, family members, caregivers, pharmacists and other health care providers during care transitions.
   [Refer to Summary of Discussion Items 3, 4.]

4. APhA supports the development and utilization of standardized processes that facilitate real-time, bidirectional communication of protected health information during care transitions.
   [Refer to Summary of Discussion Item 7.]

5. APhA supports that documentation of health outcomes is an essential component of any care transition program to demonstrate value and ensure continuous quality improvement.
   [Refer to Summary of Discussion Item 5.]

6. APhA supports payment models that recognize the value of pharmacists’ services, including, but not limited to, services provided during care transitions.
   [Refer to Summary of Discussion Item 8.]

7. APhA strongly urges the development and implementation of multi-disciplinary, interprofessional, and team-based training for health care practitioners and students to improve the quality and consistency of care transition services.
   [Refer to Summary of Discussion Items 9, 11, 12.]

8. APhA urges the collaboration and partnership of community pharmacies with health care systems, institutions, and other entities involved in care transitions.
   [Refer to Summary of Discussion Item 10.]
Summary of Discussion

1. The committee reviewed the 2006 APhA policy on continuity of care and recognized continuing challenges to attaining and implementing the pharmacist’s role in care transitions.

2. The committee recognized pharmacists’ leadership role within the medication use process during care transitions, including, but not limited to medication reconciliation; discharge counseling process; transfer of medication information between health care providers, facilities, and levels of care; transfer of medication information between health plans; and the communication of medication related information to family members, caregivers, and other health care providers. The committee agreed that having pharmacists as leaders of this process will positively impact overall health care costs and quality related to readmissions and medication errors.

3. The committee affirmed the importance of interprofessional, multi-disciplinary collaboration and communication throughout care transitions. Each health care team member has an identified role in the care transition process, and their activities must be coordinated and communicated.

4. The committee recognized the importance of the accountability and involvement of patients, family members, caregivers, and health care providers to the overall success of care transitions.

5. The committee recognized existing barriers and resource requirements to implementing these programs. The committee acknowledged the need for documentation of outcome measures that highlight the value of the pharmacist and quality improvement resulting from care transition programs. In addition, the committee identified a need for resources to help pharmacists educate decision makers regarding the business case for implementing pharmacist-led care transition programs. The committee reviewed and acknowledged the work conducted by APhA and ASHP in assimilating best practices and developing guidance to practitioners.

6. The committee agreed that patient privacy is an important component within care transitions and felt that existing APhA policy regarding this issue adequately addressed concerns.

7. The committee agreed that technologies utilized in the provision of patient care should communicate and be interoperable across care transitions. Critical to achieving maximum benefit is the ability to obtain pertinent and timely patient information. The committee discussed the misinterpretation of HIPAA requirements by some individuals and organizations that prevent pharmacists from having access to patient information. Having timely access to patient information during patient care transitions is critical.

8. The committee supported diverse compensation models (ACO, medical home, bundled payment, etc.) that recognize the value of pharmacists’ services, including, but not limited to services provided during care transitions. As with any health care service, the ability to provide a service in a timely manner is dependent upon having adequate resources.

9. The committee agreed that any processes and procedures related to care transitions should be efficient and allow pharmacists to participate easily.

10. The committee identified that care transitions occur as the patient moves throughout the health care system, including between providers and health plans. In particular, the committee recognized three major transition points being home, hospital and long term care settings. They recognized the value of communications and collaboration on behalf of the patient between practice settings and in particular the need to better integrate community pharmacy within the process. This includes the establishment of bidirectional communication as the patient moves from the community setting to the hospital and vice versa. The committee recognized the important partnership between community practitioners, patients, and other health care providers in the success and efficiency of care transitions.

11. The committee recognized the use of technology and pharmacist extenders (i.e., student pharmacists, pharmacy technicians) in supporting the care transition process and the pharmacist’s role in the process. The committee felt that existing APhA policy regarding technology and pharmacist extenders applied to their role in care transitions, and that their inclusion in the care transitions process was in support of, not replacement of, the pharmacist.
12. The committee recognized that health care providers involved in care transition processes might need additional training and education on practicing as a member of a multi-disciplinary health care team. This training should encompass communication, documentation, and collaboration, leading to improvements in quality of care, health outcomes, and system efficiencies.

Attachment

Background Paper prepared for the 2013-2014 APhA Policy Committee
Issue

The American Pharmacists Association (APhA) Board of Trustees has directed the 2013–2014 Policy Committee to recommend policy to the APhA House of Delegates related to care transitions across the health care spectrum. Specifically, the Board asked the committee to explore concepts including care transition standards, communication between health care providers, medication reconciliation as a component of care transitions, and the role of the pharmacist during these transitions.

Many barriers prevent effective care transitions. Breakdowns in communication between care providers, patients, and those taking care of patients, for example, can result in serious medical errors and a lack of patient/caregiver understanding. At times, patients and caregivers can receive conflicting information regarding self-management, complex medication regimens with no explanation, and unclear follow-up instructions. This lack of effective communication results in patients and caregivers who are often not well prepared for self-care and can cause misuse of medications, decreased adherence, and medication adverse events. Also, ineffective communication and the inadequate hand-off of information between health care providers can result in increased medication errors such as duplication or deletion of intended therapies, inappropriate dosing, and unintentional adverse events secondary to allergic reactions or drug interactions. A lack of consistent medication reconciliation practices and patient or caregiver education greatly affects the possibility of successful care transitions.1-3

At this time, no practice standards have been developed to guide health care providers in the development and execution of care transition programs, although a white paper published by APhA and the American Society of Health-System Pharmacists (ASHP) addresses improvement of these transitions through optimization of medication reconciliation.4 Despite increasing resources, many deficiencies related to the consistency of care transition quality have been identified and remain unresolved. In an effort to provide more detail about successful care transition practices, APhA and ASHP jointly issued a call for best practices in relation to the role of the pharmacist in care transition processes. The purpose of this project was to identify and describe successful care transition models that could be adopted across the broad network of health care practices. A special publication highlighting these best practices was published by the organizations.

Summary of Key Concepts

- Effective care transitions can improve medication use, improve health outcomes, and decrease hospital readmission rates.
- Barriers such as ineffective communication, a lack of detailed patient education, and unclear medication regimen information can prevent the successful transition of patients from one health care setting or provider to another.
- Although medication reconciliation is an expected component of the safe and effective care of patients, no defined system for successfully reconciling medications throughout the care continuum has been identified.
- Medication reconciliation should be performed at every step of the care process, including admission, changes in practitioners or levels of care, discharge, and even post discharge, to ensure all medication discrepancies have been identified.
Medication reconciliation, when performed appropriately, should include the core components of medication therapy management services.

Timely follow-up regarding self-management is essential to ensure patients and caregivers understand the plan of care and can prevent unintended medication errors and adverse drug events.

Pharmacists are considered medication experts and often have access to patients across many steps of the care continuum, making them the ideal practitioners to coordinate care transitions and ensure appropriate knowledge of medications by all involved.

Successful care transition programs include collaboration between all care providers and the patient, integration of the pharmacy team in the care plan, electronic transfer of medical information between providers, and shared partnerships with health care providers in a variety of settings.

Background

What Are Care Transitions?

The term “care transition” refers to a continuous process in which patients move between health care providers and settings as their condition or health care needs change. An example of a care transition would be a patient who is treated by a primary care physician in an ambulatory clinic before being admitted to the hospital for further treatment. This same patient would undergo another care transition upon discharge to either a long-term care facility or home.

Ineffective care transitions can result in decreased health and increased cost to both the patient and the health care institution. Specifically, poorly managed care transitions can lead to an increased number of adverse events and higher hospital readmission rates.

The Joint Commission

The Joint Commission currently has an initiative related to care transitions and recognizes the importance of collaboration among various health care providers to ensure continuity of care for patients as they transfer between settings. The goal of this initiative is to “define methods for achieving improvement in the effectiveness of transitions of patients between health care organizations, which provide for the continuation of safe, quality care for patients in all settings.” Although standards, National Patient Safety Goals (NPSG), and education are aimed at care transitions, all of these elements focus on transitions within singular health care settings and do not address the transition of patients after they leave the hospital or during the crossing of settings.

One Joint Commission initiative that contributes to the formation of successful care transitions is the Targeted Solutions Tool (TST) for Hand-off Communications. This tool is used to evaluate the efficacy of current hand-off practices for personal health information as patients move within the organization or to another health care setting. TST also provides solutions for improvement of these transitions. The Joint Commission provides resources regarding transition programs via the Transitions of Care Portal on its website.

Centers for Medicare & Medicaid Services (CMS)

Currently, one in every five Medicare patients discharged from the hospital is readmitted within 30 days, which adds to the overall increase in health care costs. Through the establishment of the Hospital
Readmissions Reduction Program, CMS will be required to provide decreased reimbursement to hospitals with excessive readmission rates. This decreased reimbursement will be effective for discharges that took place on or after October 1, 2012. By October 2014, hospitals with excessive readmission rates will experience penalties of up to 3% in Medicare payment.

To help reduce readmission rates, the Affordable Care Act has set aside $500 million to aid in the development of improved care transition programs for Medicare patients. The Community-based Care Transitions Program is part of the CMS Partnership for Patients and is directed at improving care transitions. By improving these transitions, the program’s goals include improving the quality of care provided, reducing readmission rates, and providing documentation regarding cost-savings to the Medicare program.

**Identification of Key Players**

Many individuals have been identified as vital to the team-based approach for care transition models. These individuals can be characterized as clinical or nonclinical staff and are associated with a variety of different patient care settings. In general, the team includes patients, family members or caregivers, physicians, pharmacists in the inpatient and outpatient settings, nurses, case managers, and other support personnel. A few key individuals have been identified as having integral roles on the care transition team. These key players include the case manager, who is responsible for discharge planning; the transition coach, who prepares patients for each transition and provides tools for self-management; and the hospitalist, who spends a great deal of time with patients while they are in the hospital. The pharmacist can also play an important role in all care transition activities, particularly during discharge when medication reconciliation and counseling are key components of proper medication use. As more care transition programs are developed, a more defined list of key players must be identified. In addition, the health care professional overseeing the transition process must be identified.

In settings such as provision of care through an accountable care organization (ACO) in which groups of physicians, hospitals, and other health care providers work collaboratively to provide high-quality care, the use of effective care transitions can be enhanced. The goal of ACOs is to provide coordinated care while avoiding unnecessary duplication of services as well as errors including medication-related errors. This goal aligns well with some of the goals of care transition programs. Other settings in which care transitions may work well are team-based care models, which use a collaborative approach, and medical home models, which emphasize continuity of care.

**Discussion**

**Role of the Pharmacist in Medication Reconciliation**

An integral part of care transitions is medication reconciliation. In 2007, APhA and ASHP convened an expert panel to create a definition of this process. The expert panel developed a white paper that described medication reconciliation as a process involving detailed evaluation of a patient’s medication regimen any time a change occurs in therapy or the patient’s care transitions from one provider or setting to another. This process can also include a change in the level of care within the same setting, such as changing units in the hospital. The medication regimen should be evaluated for errors such as duplications in therapy, missing medications, errors in dosing, drug interactions, adverse drug reactions, and decreased adherence.

The main goal of medication reconciliation is to identify and reconcile medication discrepancies in order to improve “patient well-being through education, empowerment, and active involvement in the accurate transfer of medication information throughout transitions along the health care continuum.” Through
effective medication reconciliation, improvements can be made to patient safety and clinical outcomes. As a result of successful medication interventions, hospital readmission rates can be decreased by as much as 30%.11

Also demonstrating the importance of this process is the development of the NPSG, which describes the requirements for medication reconciliation. The Joint Commission describes the process of medication reconciliation using five elements of performance. The five steps include:

- Development of a current medication list
- Development of a list of medications to be prescribed by the health care provider
- Comparison of the two lists to identify similarities and differences
- Development of a clinical plan based on the comparison
- Communication of the new medication list to the patient and all caregivers9

Although the current NPSG is shorter than the originally intended medication reconciliation goal, which had 17 elements, implementation of a successful medication reconciliation program is a complex process.

**Potential Approach to Medication Reconciliation**

As detailed in the APhA-ASHP white paper, the implementation of medication reconciliation involves a team-based approach and often includes collaboration between pharmacists, physicians, nurses, administrators, patients, caregivers, and other health care providers.9 As medication experts, pharmacists are the ideal team members to take the leadership role in medication reconciliation and should also promote collaboration between other members of the health care team. In addition, pharmacists should take an active role in the development and implementation of the patient-centered medication reconciliation program; provide education to health care professionals, patients, and caregivers regarding the benefits and possible limitations associated with medication reconciliation; and “serve as patient advocates throughout care transitions.”4

A proposed, standardized approach to medication reconciliation outlines the specific tasks a pharmacist can perform to provide medication therapy management (MTM). The proposed MTM service approach involves the pharmacist first performing a comprehensive medication review for the patient, including a review of home prescriptions, over-the-counter medications and herbal supplements, inpatient prescriptions, and those medications intended for treatment by the health care team. After reviewing all of these medications, the pharmacist should create a personal medication record and a medication-related action plan for each patient. These tools can then be used to collaborate with other health care providers for evaluation of the medication regimens and resolution of any medication-related issues. Also, the use of health information technology (HIT), such as electronic medical records and electronic communication, can aid the health care team in successful transition of the patient. Through proper documentation and communication with providers across the spectrum, the pharmacist can greatly improve the care transition process.4

Another important aspect during care transitions is appropriate and thorough patient education and training. Many medication-related issues, such as treatment failures, adverse effects, and adherence problems, are the result of inadequate patient education, lack of timely patient follow-up, and a lapse in the continuity of care.12 Detailed patient education regarding medications and self-management provided before and after discharge has been shown to prevent or ameliorate a significant number of medication-related adverse events.
Because pharmacists have the medication expertise necessary to identify medication-related issues at various stages of the care continuum, they are the ideal health care professionals to provide patient education about medications as well as post-discharge follow-up. Pharmacists also possess clinical patient education and motivational interviewing skills and training, which allow for effective patient communication regarding appropriate medication use and the importance of adhering to medication regimens.

A study by Schnipper and colleagues showed a significantly lower rate of preventable adverse medication events identified at 30 days after hospital discharge when pharmacists were involved in the care transition from hospital to home. In the study, the pharmacist conducted thorough medication reviews throughout the hospital stay and at discharge, provided patient/caregiver education before discharge, and conducted a telephone follow-up once the patient was home for a few days.12 Hospital readmission rates and the number of emergency department visits were reduced because of pharmacist intervention.12

**Benefits of Care Transition Programs**

Decreasing health care costs in the United States is one of the aims of health care reform and other initiatives.5 Currently, a hospital readmission can cost an average of $7,200, and about 76% of these instances are considered preventable. Care transition programs enable hospitals to reduce readmissions and associated costs by improving the transfer of patients and information between practitioners and settings. These programs can be generally inexpensive to develop and implement, and the potential cost savings to the institution greatly outweighs the start-up and maintenance costs. A Colorado-based hospital system implemented the Care Transitions Intervention Model and was able to reduce hospital readmissions by 35% to 50% using a system that costs a total of $74,310 annually while saving the health care system a projected $289,594.13

In previous policy, APhA has shown support for continuity of care across the health care continuum. APhA also recognizes that the formation of more structured transition programs has the ability to improve readmission rates, reduce medication errors, and optimize medication therapy throughout different health care settings. These improvements in the medication use process would result in improved health outcomes for patients.

In addition, the Association recognizes the need for teamwork and collaboration during these care transitions. The key to successful collaboration is clear and frequent communication between all members of the health care team, including clinical team members such as pharmacists, physicians, and nurses as well as care coordinators, discharge planners, caregivers, and the patient. Effective communication across the continuum of care will result in better self-management by patients once they return home following a hospital stay or doctor’s visit, improved understanding of the health care plan by all members of the team, and decreased adverse events and cost to the health care system.

To aid in this communication, APhA supports the use of technology and the electronic health record to facilitate continuity of care across a variety of practice settings. The Association also supports the use of personal health records that can be accessed by pharmacists and other health care providers for the purpose of care transitions. These records are completed by the patient or caregiver and include information related to health issues, visits to any health care providers, reasons for treatment, medications prescribed, etc. However, it should be noted that, although these records can provide some information during care transitions, they rely solely on the accuracy and perspective of the patient or caregiver and can sometimes lack important medical information.
Strategies for Improving Care Transitions

The Medication Management in Care Transitions (MMCT) project, created in collaboration by APhA and ASHP, was developed to identify best practice models for care transitions, evaluate and share the benefits and barriers seen in these programs, and offer examples of how pharmacists can be utilized in these models.\textsuperscript{14}

Expert panels composed of pharmacists with experience working in MMCT programs were convened to review submitted programs and identify best practices. The panels also identified a series of key successful elements identified across many of the best practice models. These elements include multidisciplinary collaboration and support, which was found in all successful models. During this collaboration, a pharmacist often served as a leader in the care transition program, which helped illustrate the benefit of having a medication expert take an active role in this process.

Patient Education

Another important element identified in many successful care transition programs is the integration of the pharmacy team. Successful MMCT models often integrate not only pharmacists but also student pharmacists, pharmacy residents, pharmacy technicians, and even non-pharmacy staff referred to as “pharmacy extenders.” Education and training were provided to the entire team regarding medication management during care transitions, including medication reconciliation, documentation of activities, communication with other health care providers regarding medication-related issues, prior authorization practices, and data management.\textsuperscript{14}

The ability to collect data and justify resources is another important strategy that can be used to improve care transition programs. Many successful programs collect data related to readmissions, length of stay, emergency department visits, medication-related problems identified via medication reconciliation, disease-specific metrics, and patient satisfaction. By providing results with regard to these aspects of patient care, programs can better evaluate and improve their care transition practices.

Other aspects of successful programs include the transfer of patient information via electronic means. HIT improved communication efficiencies and the development of strong partnerships between hospital pharmacy departments, community pharmacies, pharmacy chains, ambulatory clinics, home infusion pharmacies, and health clinic pharmacies. Outside organizations such as behavioral health support and patient outreach organizations were also among the partnerships in successful care transition programs. By aligning many resources, more unified patient care was possible.

Barriers to Implementation of Care Transition Models

Expert panels also evaluated programs for common barriers encountered during the development and implementation of successful care transition initiatives. Barriers to successful implementation include issues in financial compensation and staffing resources as well as lack of connectivity between providers throughout the health care continuum.

Compensation for Interventions

Although payment for physician services during care transitions has been considered, the ability to bill for care transition services is not currently a common reality for pharmacists, although billing codes do exist that allow pharmacists to bill for follow-up phone calls and visits within predetermined time frames.\textsuperscript{15} At this time, many of the interventions made during care transition programs, such as medication reconciliation and patient counseling, require the expertise of the pharmacist for implementation. Many
pharmacists perform some of these duties as part of their daily responsibilities, but the attention needed to develop, implement, and maintain a successful care transition program would require more time and resources than many pharmacists and pharmacy departments currently possess. To develop successful programs, pharmacists will need to be recognized for these interventions and receive compensation to allow for more focus on safe and effective care transitions.

**Electronic Transfer of Patient Information**

The lack of connectivity between providers throughout the health care continuum is a barrier that can significantly affect care transitions. Although technology is used in the health care setting, it is not properly utilized as a technique to improve the quality of care provided between different providers and across various settings. Specific barriers with regard to technology include the amount of time spent during documentation of care as well as the inability of some medical records to be viewed on both an inpatient and outpatient level. Because many computer systems used in health care settings do not communicate well with each other, health care providers may spend more time re-creating the same documentation in each specific system. Also, when the electronic health record for a patient is not easily transferable between the inpatient and outpatient settings, the potential breakdown in communication can delay effective care. Many providers are moving in the direction of improving HIT, but the adoption rate of these practices remains relatively low.

**The Care Transitions Intervention**

This intervention was conducted in Colorado and encouraged patients and caregivers to take a more active approach to health care and care transitions. Four pillars were considered to be the essential components of the program:

- Medication self-management assistance provided by the care intervention team
- A patient-centered medical record owned and maintained by the patient and used for facilitation of health-related information transfers between settings and providers
- Prompt follow-up with a primary care physician or specialist when needed
- A list of indications and conditions that indicate a worsening in health status and how to respond to these issues

In addition to a personal health record, the intervention included a series of telephone calls and visits with a transition coach who provided encouragement to the patient and caregiver. In this intervention, the transition coaches were advanced nurse practitioners who served as facilitators of the patient and caregiver roles in self-care.

This intervention led to improved knowledge with regard to self-management and skills for many patients and caregivers. Improvements were seen specifically in the management of medications, management of the disease state, and patient confidence with regard to self-management during and after the transition period.

**Patient Perspectives of Care Transitions**

Although care transition interventions have proven valuable in the health care setting, the patient perspective of these interventions is lacking in the literature. A study by Cawthon and colleagues aimed to identify the patient-perceived importance of these interventions. During this study, pharmacists provided medication reconciliation and education, tools to assist with medication management, and post-discharge telephone follow-up. Following the intervention, patients were asked to complete a brief survey to assess
the utility of the different components. The most helpful components identified by the patients included speaking directly to the pharmacist, which was rated as very helpful; receiving an illustrated medication management tool such as a schedule; and receiving the follow-up phone call. Specific counseling points identified as most helpful by the patients included specific directions regarding medication administration as well as counseling regarding prevention and management of medication-related adverse events.17

This study demonstrates that patients value pharmacist-led interventions. Patients who participated in the intervention felt like they understood their medication regimens better and felt better equipped to take their medications as their physicians had intended. Overall, patients felt more comfortable discussing their medication regimens with providers after participating in the intervention.

Conclusion

Because understanding the role of medication management in care transitions is vital to the success of such programs, it is important for members of the health care team, including the pharmacist, to work in collaboration with one another to provide quality care for patients. Also, during the development of these methods, it is important for members of the health care team to define specifically what needs to be done to perform successful care transitions, the best approach for ensuring this success, and the types of contributions each team member can make.

Pharmacists are well prepared to serve in leadership roles in the development and implementation of care transition programs. As medication experts, pharmacists can perform important medication management services throughout the care continuum, such as assessment and reconciliation of drug therapies at each transition, provision of education to patients and caregivers to improve self-management, and communication with various health care providers. As more standardized methods are introduced for care transition initiatives, it is important for pharmacists to continue to have an active role in ensuring the safe and effective use of medications in all settings. Providers should receive compensation for care transition activities that support the need for additional resources.

References


Relevant APhA Policies

**E-prescribing Standardization (2010)**

1. APhA supports the standardization of user interfaces to improve quality and reduce errors unique to e-prescribing.

2. APhA supports reporting mechanisms and research efforts to evaluate the effectiveness, safety, and quality of e-prescribing systems, computerized prescriber order entry (CPOE) systems, and the e-prescriptions that they produce, in order to improve health information technology systems and, ultimately, patient care.

3. APhA supports the development of financial incentives for pharmacists and prescribers to provide high quality e-prescribing activities.

4. APhA supports the inclusion of pharmacists in quality improvement and meaningful use activities related to the use of e-prescribing and other health information technology that would positively impact patient health outcomes.

*(JAPhA NS40(4):471 July/August 2010)*
**Personal Health Records (2010)**

1. APhA supports patient utilization of personal health records, defined as records of health-related information managed, shared, and controlled by the individual, to facilitate self-management and communication across the continuum of care.

2. APhA urges both public and private entities to identify and include pharmacists and other stakeholders in the development of personal health record systems and the adoption of standards, including but not limited to terminology, security, documentation, and coding of data contained within personal health records.

3. APhA supports the development, implementation, and maintenance of personal health record systems that are accessible and searchable by pharmacists and other health care providers, interoperable and portable across health information systems, customizable to the needs of the patient, and able to differentiate information provided by a health care provider and the patient.

4. APhA supports pharmacists taking the leadership role in educating the public about the importance of maintaining current and accurate medication-related information within personal health records.

*(JAPhA NS40(4):471 July/August 2010)*

**Continuity of Care (2006)**

1. APhA supports the pharmacist as the most appropriate member of the health care team responsible for reconciling medication use when patients move between practice settings within the continuum of care.

2. APhA supports the development and use, in practice, of a standardized, portable, accessible, HIPAA compliant, and secure Electronic Health Record (EHR) to facilitate continuity of care across all practice settings. The EHR shall include the clinical data elements necessary to support the performance of medication reconciliation.

3. APhA supports patient access to pharmacists with specialized skills and expertise. The patient’s pharmacist should make patient referrals where appropriate.


**Automation and Technology in Pharmacy Practice (2004)**

1. APhA supports the use of automation and technology in pharmacy practice, with pharmacists maintaining oversight of these systems.

2. APhA recommends that pharmacists and other pharmacy personnel implement policies and procedures addressing the use of technology and automation to ensure safety, accuracy, security, data integrity and patient confidentiality.

3. APhA supports initial and on-going system-specific education and training of all affected personnel when automation and technology are utilized in the workplace.


**Health Information Technology (2009)**

1. APhA supports the delivery of informatics education within pharmacy schools and continuing education programs to improve patient care, to understand interoperability among systems, to understand where to find information, to increase productivity, and to improve the ability to measure and report the value of pharmacists in the health care system.

2. APhA urges that pharmacists have read/write access to electronic health record data for the purposes of improving patient care and medication use outcomes.
3. APhA encourages inclusion of pharmacists in the defining, development and implementation of health information technologies for the purpose of improving the quality of patient-centric health care.

(JAPhA NS49(4):492 July/August 2009) (Reviewed 2010)
The Committee recommends that the Association adopt the following statements:

1. APhA recognizes that audits of health care practices, when used appropriately, improve patient care and deter fraud, waste and abuse.
   [Refer to Summary of Discussion Item 1, 11.]

2. APhA advocates for the use of standardized and efficient audit procedures with transparent criteria clearly communicated by the payor and readily accessible to providers in advance.
   [Refer to Summary of Discussion Items 2, 4.]

3. APhA advocates that audit processes should have minimal disruption to practice work flow, minimal financial burden, and not impact patient care.
   [Refer to Summary of Discussion Item 5.]

4. APhA urges timely notification and scheduling of audits to minimize disruption of patient care delivery.
   [Refer to Summary of Discussion Item 6.]

5. APhA supports the inclusion of provider education as a component of the audit process to improve documentation of services, meet payor requirements, and enhance the quality of care delivery.
   [Refer to Summary of Discussion Items 3, 7.]

6. APhA opposes incentive-based auditor compensation and the use of statistical methodologies such as sample extrapolation for determination of recoupment of funds from health care providers or health care organizations.
   [Refer to Summary of Discussion Items 9, 10.]

7. APhA advocates that audit reports include complete information listing audit discrepancies and appropriate guidelines for documenting and appealing these findings.
   [Refer to Summary of Discussion Item 8.]

8. APhA advocates that pharmacy audits be performed in a professional manner by a certified pharmacy technician or pharmacist.
   [Refer to Summary of Discussion Item 7.]
Summary of Discussion

1. The committee recognized the rationale and need for the auditing of health care practices to improve quality and to deter fraud, waste, and abuse. The committee recognized that use of audits is increasing and the role of the government funded health care will impact this activity. However, the committee expressed concern over the lack of transparency of audits of health care practices, variability in the conducting of audits, and the use of extrapolation to determine the recoupment of funds. Feedback received during webinars and other comments from pharmacists reiterated these concerns.

2. The committee acknowledged the need to address audit practices and procedures of non-dispensing activities of pharmacists as these services continue to evolve.

3. The committee agreed that audits of health care practices should serve as a quality improvement measure rather than a strictly punitive process designed for payers to recoup money. Audit activities could help practitioners identify medication use issues by patients utilizing multiple providers. The committee discussed opportunities for health care professionals to be educated through the audit process and for best practices to be developed.

4. The committee recognized that there is no clear, consistent, standardized guidance throughout the auditing of health care practices. The committee encouraged APhA to work with legislative and regulatory bodies, standard-setting organizations, such as the National Council for Prescription Drug Programs (NCPDP), and other stakeholders to explore methods of standardizing audit processes.

5. The committee acknowledged feedback received during webinars and from members related to auditing processes and the potential disruption of patient care.

6. The committee discussed the staff time and resources required by a practice undergoing an audit and identified that there are certain times where an audit would have less of an impact on the delivery of patient care. Having prior notice and the opportunity to identify better times to have auditors in the practice would be beneficial and allow the practitioner to work with the auditor.

7. The committee agreed that the individual conducting the desk or onsite audit should have pharmacy practice experience, including experience as a pharmacist or pharmacy technician certified through a nationally recognized certification body. The committee also discussed the need for auditors to be respectful of the patient care process and to make an effort to avoid interfering in the health care practice’s workflow during an audit. This includes, but is not limited to, advanced and timely notification of the audit.

8. The committee agreed that there was a need for transparency of the audit process and that practitioners should receive complete information and reasoning behind audit findings and how to appeal the findings if necessary.

9. The committee discussed the use of statistical methodology, such as extrapolation, to determine recoupment of funds from health care providers. The committee opposed the use of this method and instead believes recoupment of fund requests should be based on actual claim / document observations. During this discussion, the committee utilized the following definition of extrapolation:

   Extrapolation occurs when the auditor uses a sample of prescription drug benefit claims submitted by a pharmacy to estimate audit results for a larger batch or group of claims not reviewed by the auditor. For further explanation, extrapolation occurs when a sampling of prescriptions (or procedures) uncovers an error in a prescription for X drug (or X procedure). The auditor then applies that error occurrence to all prescriptions for X drug (or X procedure performed) for plan participants during the audit time period.

   See the following resources for further information:

10. The committee identified concerns with the use of incentive-based compensation where the auditor’s compensation is based on a percentage of recoupment. For example, the auditor or audit company
receives X% of all dollars recouped as a result of their audits. This may lead to unfair auditing practices and potential conflicts of interest.

11. The committee acknowledged there are several different types of audits and not all audits are claims-based. For instance, a quality-based audit might consider the use of evidence-based practice guidelines and may improve patient care (e.g., a diabetic patient receiving appropriate treatment according to evidence-based guidelines).

Attachment

Background Paper developed for the 2013-2014 APhA Policy Committee
AUDITS OF HEALTH CARE PRACTICES

Background Paper for the 2013–2014 APhA Policy Committee

Issue

The American Pharmacists Association (APhA) Board of Trustees has directed the 2013–2014 Policy Committee to recommend policy to the APhA House of Delegates related to audits of health care practices. The Board’s guidance on the scope for the topic review included, but was not limited to, the increase in audit rates by state Medicaid programs, variance among auditing programs, and differences in audit practices between state and federal governments, corporations, and specific auditors. This paper is intended to provide background information on audit practices within the health care system.

Summary of Key Concepts

- Audits of health care practices are increasingly common as managed care organizations (MCOs) work to identify fraud, waste, and abuse within the health care system in addition to improving the quality of patient care.
- Pharmacy providers are burdened by the lack of consistency of auditing procedures among different MCOs. This lack of consistency translates into significant time commitments and affects pharmacists’ ability to provide patient care.
- Non-pharmacy health care professionals are experiencing similar increases in audits by insurance plans and other organizations as a result of perceived increases in fraudulent activities in the health care industry and cost-containment pressures.
- The Academy of Managed Care Pharmacy (AMCP) published best practice guidelines in 2012 to aid both MCOs and pharmacy providers in developing standard procedures when conducting audits.
- Twenty-five states have passed legislation related to standard auditing procedures for MCOs and pharmacy providers. However, clear federal regulations are lacking in regard to auditing practices in pharmacy and health care generally.

Introduction

Fraud and abuse have been traditionally defined by Medicare as “the misconduct in the delivery and financing of health care.” More recently, this definition has been expanded and now includes inadequate and low-quality care provided by health care professionals. Medicaid regulations define fraud and abuse separately. Fraud, as defined by Medicaid, is “an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person.” Abuse is defined as “provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care.” Federal Medicaid regulations do not formally define waste; however, the National Association for Medicaid
Directors states that waste is the “over-utilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act.”

Fraud, waste, and abuse are a growing concern within the U.S. health care system. In 2011, more than four billion health insurance claims were processed and the total health expenditure in the United States was $2.27 trillion. Published in *Health Affairs*, the estimated health expenditure for prescription drugs in the United States during 2010 was $259.1 billion. The National Health Care Anti-Fraud Association estimates that between 3% and 10% of all annual health care expenditures are a direct result of fraud in the U.S. health system. This fraud contributes significantly to the rising costs of health care and can be dangerous to patients if services provided are not medically necessary or avoided completely.

A 2012 Department of Health and Human Services (HHS) report estimated that $19.2 billion of the annual federal Medicaid share of health care expenditures was a result of improper payments. Medicaid Integrity Contractors (MICs) were hired at a total annual cost of $42 million in 2010. Three different types of contractors were hired: review MICs, audit MICs, and education MICs. Review MICs are responsible for designing and utilizing algorithms that analyze Medicaid claims data in hopes of identifying unusual claims and areas of vulnerability regarding claims. Review MICs provide audit MICs with leads to potential providers who should be audited. Audit MICs perform audits of the providers identified and are responsible for informing states regarding overpayments. Finally, education MICs are responsible for providing training materials and other tools to Medicaid providers to ensure program integrity and improve upon quality-of-care issues.

The Division of Medicaid Integrity Contracting (DMIC) oversees MICs and is responsible for ensuring the performance of companies and providing them with direction. DMIC ensures that MICs are complying with the terms of their contract and performs annual performance assessments. The payment model for MICs is unclear in the Deficit Reduction Act.

To combat the rate of improper payments, the Department of Justice (DOJ) and HHS focused efforts to recover $4.2 billion in taxpayer dollars for fiscal year (FY) 2012 as a result of fraud, waste, and abuse within Medicare and Medicaid. This amount is the highest recovered since the creation of antifraud programs established by the federal government through the Centers for Medicare & Medicaid Services (CMS).

CMS established Medicare Program Integrity and the Medicaid Integrity Program (MIP) in 1996 and 2006, respectively. Together with other organizations, the Health Care Prevention and Enforcement Action Team (HEAT) and the Health Care Fraud and Abuse Control (HCFAC) program were created to detect fraud, waste, and abuse by health care providers. Their objectives are to decrease the number of payment errors and develop activities that prevent, detect, investigate, and ultimately prosecute health care fraud. CMS contracts with private companies to perform auditing of network providers, review medical need for specific claims, and conduct investigations of providers. These contractors then refer cases to HHS and DOJ in the event that fraud is suspected.

MIP was established as part of the Deficit Reduction Act of 2005. This program was set up to develop a national strategy that would effectively combat fraud, waste, and abuse among Medicaid providers. In FY
2011, 70 million low-income children and adults were covered under Medicaid.6 This number is expected
to increase when additional coverage requirements roll out under the Affordable Care Act in 2014. As a
result of the size, nature, and complexity of Medicaid, the Government Accountability Office (GAO)
labels the program “high risk” for fraud, waste, and abuse.8

Recovery Audit Contractors (RACs) are additional third-party organizations hired by CMS to identify
inappropriate billing of patient care services in hospitals and outpatient physician offices. In FY 2010,
RACs identified just $75.4 million in overpayments billed to Medicare.9 In FY 2012, more than $2,291.3
million was recovered in overpayments.9 This difference can be attributed to CMS’s increased investment
in audits performed by RACs. The amount of money recovered in overpayments is expected to continue
to grow as the scope of audits is expanded to include Current Procedural Terminology (CPT) billing
codes used by physician offices. This expanded scope was recommended by the HHS Office of the
Inspector General. During the audit process, if RACs identify underpayment of a service, then the
appropriate monetary value is returned to the billing organization.10

Pharmacy Benefit Managers (PBMs) are companies responsible for providing prescription drug benefits
to covered members of health plans and, as a result, identify and conduct audits of pharmacy practices.
The purchasers of these services include insurance companies, self-insured employers, and health
maintenance organizations (HMOs). As a whole, these organizations are referred to as managed care
organizations (MCOs).

PBMs promote that they operate by providing their contracted plan sponsors with the highest quality in
prescription drug care for members at the lowest possible cost.11-13 Expansion of services provided by
PBMs has occurred over the past several decades and now includes pharmacy claims processing, mail-
order pharmacy services, rebate negotiations with drug manufacturers, and pharmacy network
development. Additional services include formulary management, drug utilization reviews, generic
substitution, medication therapy management (MTM), and disease management programs.12,13

As the number of audits increases and the federal government articulates the utilization of fraud and abuse
prevention as a cost-savings measure, pharmacy providers perceive that MCOs use the audit process as a
way to recoup money for legitimate prescriptions through a lack of documentation by pharmacies. These
documentation requirements can be in excess of both state and federal regulations and might be difficult
for pharmacy providers to comply with. Furthermore, pharmacy providers report that the time they spend
working with auditors is significant and can negatively affect the time required to provide patient care.14,15

Audits of the Pharmacy Dispensing Process

To date, the majority of pharmacy audits by MCOs focus on the dispensing of prescription drugs. Only
one audit was conducted to evaluate the appropriateness of claims billed for MTM services. This topic
will be covered in a later section. Auditing practices are poorly regulated and not standardized on a
national level.

The State of Vermont published a report of prescription drug audits in 2006. The report included the
results of a third-party company hired to investigate and analyze the state’s Medicaid pharmacy claims.
The company used data mining algorithms to process six million Vermont Medicaid claims paid during FY 2004 and identified up to $2.2 million in possible incorrect payments to pharmacies. This investigation included audits of 220 in-state and out-of-state pharmacies. It was expected that approximately $1.2 million would be recovered in total. The auditing agency stated that it performed the audit under the standards set forth in the Generally Accepted Government Auditing Standards published by the Comptroller General of the United States.16

The Alabama Medicaid Program provides insight into an example of the most common reasons for a pharmacy audit discrepancy.17 These discrepancies result in recoupment of payment experienced by many plans. The following situations account for approximately 95% of all discrepancies found by the Alabama Medicaid Program:

- Dispense as written (DAW) audits—pharmacy use of DAW codes to ensure that the correct product was billed
- Usual and customary (U&C) pricing—comparisons between prescription charges submitted to insurance plans and the general public
- Inaccurate national drug code (NDC) billing—NDC of drug product dispensed should match the NDC of drug product billed to insurance
- Inaccurate days’ supply billing—based on prescription instructions, days’ supply should be appropriate and clinically accurate
- Multiple dispensing fees—documentation of call-in and hardcopy prescriptions must be included to dispense the same product and strength to the same patient within a 30-day window
- Drug name, form, strength, and quantity differ from prescription—documentation of any changes approved by physicians must be included on CII prescriptions
- Requirements for signatures and prescriptions—CII prescriptions must have the original prescription and signature
- Tamper-resistant prescriptions—written prescriptions for Medicaid patients must be on tamper-resistant prescription pads
- Changing claim information to force payment—software recognizes and denies exact duplicate claims; Alteration of prescription information to force payment is illegal
- Timely prescription reversal—prescription must be credited to Medicaid if not picked up within 60 days
- Total parenteral nutrition (TPN)—certification statement of medical need must be found with all physician orders or prescriptions for TPN

There is currently a lack of federal regulation regarding what components of the prescription process can be audited. Each MCO defines specific components required for an audit and may have variance in prescription elements evaluated by an auditor. These components can also differ based on the state in which an audit is performed. As a result, pharmacy providers are often confused or frustrated by the different procedures.

The National Community Pharmacists Association (NCPA) recently published the results of a 2012 survey sent to more than 350 pharmacies in the United States.14 The objective of the study was to determine the impact that auditing practices have had on providing patient care for Medicare Part D
PBMs. The study found that 77% of respondents reported a lack of consistency in auditing requirements among Part D PBMs. Of those same respondents, only 1% felt the auditing requirements were very consistent, and 22% felt they were moderately consistent. This survey also asked pharmacists about record-keeping requirements in PBM contracts. Of the 350 pharmacies surveyed, 31% felt that the pharmacy was always required to maintain record-keeping in excess of state and federal laws in order to fulfill Part D PBM contracts. In addition, 51% stated that the record-keeping requirements were regularly in excess of state and federal requirements. Only 1% responded that Part D PBM audits never required record-keeping in excess of state and federal law. These results could be perceived by pharmacy providers as an opportunity for PBMs to recoup money for even minor noncompliance. When asked about the impact of PBM audit practices on patient care, 59% and 28% of respondents reported a very significant or significant impact on patient care, respectively.14

Survey participants made the following comments in response to this statement: “Please provide examples of contentious Medicare Part D auditing practices that are affecting your ability to provide patient care and remain in business.” 14

- Auditing records from 5 or 6 years ago prior to us having electronic records. It is very hard to find paper copies from that long ago.
- One audit required invoices be pulled on hundreds of products to prove we had bought them. It took my main tech at least 12 hours over several days to pull and copy all the paperwork.
- Audits take 4 to 5 hours of my professional time in addition to 4 to 5 hours to pull Rx hardcopies to prepare for the audit. Then I spend my 16 to 24 hours of staff time rebutting the audits, and prescriber time, for what are mostly clerical errors.

These statements were transcribed verbatim. This study does not provide additional details on its methodology and was not subject to the peer review process. NCPA also does not specify what type of pharmacies were surveyed (i.e., chain, independent, grocery store), making it difficult to generalize from the results of the study. However, the survey results do provide some insight from the pharmacy providers’ standpoint on auditing practices of Medicare Part D PBMs.

**Audits of Patient Care Services**

In 2011, the Minnesota Department of Human Services (DHS) audited providers of MTM.18 These claims were processed between 2008 and 2010. Minnesota DHS provided each pharmacy with a specific list of claims that needed documentation to be submitted for review. The requirements for documentation were provided to each pharmacy and could be found in the Minnesota Health Care Programs provider manual. Pharmacies were given 30 days to submit all of the required documentation to the auditor. These MTM claims were evaluated based on CPT codes. The auditor ensured the accuracy of coding based on the number of prescriptions, medical conditions, and medication-related problems identified. If documentation of the MTM service did not match the CPT code billed, then the pharmacy was notified and payment recouped.

A total of 57 pharmacies were asked to provide documentation. The auditor reviewed 190 claims, which were 4.5% of all claims submitted to Minnesota DHS during that time period. A total of 18 claims were
incorrectly coded at higher CPT levels; however, only 10 claims met the criteria for recoupment based on a preset minimum $50 threshold. Concerns expressed by the auditor regarding the MTM audit included length of visit, actual complexity of a patient’s medical history, adequate documentation of services provided, cost as a medication-related problem, and correct use of CPT codes.¹⁸

This was the first and only audit to look at MTM programs provided by pharmacists. Historically, audits have focused on prescription drug dispensing due to high volumes in drug spending compared with pharmacist-provided MTM. It can be expected that as the number of MTM claims increase on a national level, these types of audits will increase.

Pharmacy providers are not the only health care professionals seeing an increase in audits to combat fraud, waste, and abuse. In April 2013, the New York State Comptroller released a statement that linked a group of six dentists to $2.3 million in Medicaid fraud.¹⁹ Homeless and indigent patients were recruited off the streets and provided transportation to/from an office to undergo treatments. The statement notes that these patients were paid $25 to $30 for their time. Other examples of fraud included billing for 119 procedures on one day in 2010, which would have taken more than 38 hours to perform correctly. Fillings were placed in teeth that patients had already lost. The owner of the dental office faces 1 to 3 years in sentencing and $700,000 in restitution for the fraudulent activities.¹⁹

Medicare and Medicaid auditing practices used with dentists and physicians are similar to those used with pharmacy providers. They may be conducted as desktop audits in which paperwork is mailed or faxed directly to the auditor for review. In-person audits are also common. Stuart Oberman, a lawyer with expertise in health care audits, states that an opening interview is often conducted that outlines the audit process, which might take several weeks to complete. The final results of the audit can take a matter of months to be mailed to the office. As with pharmacy, dental practices are able to appeal claims identified for lack of documentation for services provided. Medicare or Medicaid can also suspend payments to the office or revoke the dental practices contract.²⁰

The American Hospital Association (AHA) tracks the number of RAC audits for more than 2,425 hospitals across the United States.²¹ Each quarter, AHA summarizes data on RAC activity. In the second quarter of 2013, the hospitals reported a 47% increase in requests for medical records by RACs since the fourth quarter of 2012. According to the report, 60% of the medical records did not contain an overpayment, and the most costly denials related to issues of medical necessity. Hospitals filed an appeal on 40% of claims denied by a RAC, which resulted in a 70% success rate. These audits are often costly to hospitals. AHA reports that 63% of hospitals stated the cost to manage RACs was in excess of $10,000 for the first quarter of 2013, and 45% spent more than $25,000 during that same period.²¹

Claims submitted by physicians generally must include the following documentation to be considered sufficient to bill for provided services:²²

- Services charged are in compliance with the physician’s plan of treatment.
- The health record of the patient contains all appropriate documentation of the services provided by the physician or staff. Additional documentation sources may be needed to prove a patient actually received a particular service.
• Claims submitted on the bill are accurate.

Similar to pharmacy audits, physician offices and hospitals are able to dispute the findings of an audit and submit additional documentation to prevent payment from being recouped.

The large dollar amounts retrieved by RACs and other auditors can partly be explained by the use of extrapolation. Extrapolation is a statistical method used to calculate the amount of money to be recouped for payment. Using this method, the auditor takes the results of an audit of a sample of records from the hospital, physician, or pharmacy and determines how many times improper payment has been made based on the sample. This technique has been used for several decades and continues to cause confusion and resentment among providers. Auditors claim that extrapolation is necessary because of the large number of claims processed each year, but several states have successfully passed legislation to prevent the use of extrapolation as a technique to recoup payment from providers.

**Recommendations for the Audit Process**

The Academy of Managed Care Pharmacy (AMCP) published *Model Audit Guidelines for Pharmacy Claims* in 2012. This document was developed by representatives from MCOs, pharmacy providers, and third-party organizations. The goal was to create guidelines for MCOs developing a pharmacy claims audit program as well as to improve the understanding of and requirements for the pharmacy auditing process for pharmacy providers. Audits are the primary means for MCOs to determine the absence of fraud, waste, and abuse. They also serve to ensure that all documentation related to regulatory and contractual requirements is satisfied. MCOs perform three different types of audits: concurrent daily review audits, desktop audits, and in-pharmacy audits.

Concurrent daily review audits are prospective audits used by MCOs to identify unusual quantities, dosages, or incorrect submission of prescription drugs before a claim has been paid. This type of audit includes an immediate telephone call, e-mail, or claim rejection by the MCO to alert the provider to the discrepancy. This notification allows the provider to reverse and rebill a claim without the need for an MCO to recoup payment at a later date. The AMCP guidelines recommend that the final results of the audit be received within 24 hours of providing supporting documentation for a claim.

Desktop audits are a type of retrospective audit. A desktop audit may be preferred by a pharmacy because it causes less disruption in the daily workflow compared with in-pharmacy audits. An MCO should provide the pharmacy with a standardized process in which to submit copies of prescriptions, including other necessary documentation that will satisfy the requirements of an audit. Most commonly these documents are faxed to the MCO for review. The number of prescription claims for this type of audit is typically between 1 and 50, and the claims are usually between 1 and 12 months old. The AMCP guidelines recommend that the final results of the audit be received within 30 to 45 days of the original audit.

In-pharmacy audits are used by MCOs to provide the most comprehensive picture of a pharmacy practice. In this type of audit, a representative of the MCO travels to the pharmacy location. In-pharmacy audits can be very disruptive to the daily workflow of a pharmacy; therefore, the pharmacy should be notified.
well in advance of the in-pharmacy audit. AMCP guidelines recommend that an additional pharmacy staff member be present to assist the auditor; however, this assignment of staff may not always be practical. Additional pharmacy staff may decrease the amount of health information exposure and ensure all documentation is found as efficiently as possible. When 25 to 125 prescription claims must be reviewed, an MCO may choose this type of audit. These claims are generally 1 to 12 months old. AMCP notes that Medicare Part D audits can be well outside this time period. AMCP guidelines recommend that final results of the audit be received within 30 to 45 days of the original audit.

The AMCP guidelines highlight additional considerations to improve the audit process for all parties involved and recommend that MCOs and pharmacy providers use them to improve positive audit performance outcomes:

- Bilateral understanding and adherence to contract obligations
- Transparency of audit guidelines, dispensing requirements, and process
- Avoidance of risk- or incentive-based auditing
- State dispensing regulations and published MCO claim submission requirements must work in concert
- Prescription order documentation
- Electronic documentation and records
- All participants subject to an audit must be informed and professional.

Each type of audit may be appealed by the pharmacy provider once the final audit results have been received. The AMCP guidelines recommend that the pharmacy’s supporting material be received within 30 calendar days, as typically is required in the contract with an MCO. The AMCP guidelines also provide additional guidance on the appeal process. MCOs should accept reasonable documentation from prescribers or patients regarding the legitimacy of dispensing a prescription product. An outline for acceptable documentation requirements should be documented in the contract between the pharmacy and MCO. The pharmacy should send all appeal documents via secure mail service.

A total of 25 states have passed legislation that provides standards for auditing practices of pharmacies by MCOs. In June 2013, Texas became the latest state to pass such legislation. Major regulations from this legislation include the following:

- Performing an on-site audit requires that an MCO give a pharmacist or pharmacy 14 days written notice before the scheduled audit is to occur
- A maximum of two on-site audits can occur annually
- In the event an MCO suspects fraud or misrepresentation of claims, an MCO may audit the pharmacy without any notice
- Contracts between a pharmacy provider and MCO must state detailed audit procedures
- Extrapolation may not be used in on-site or desktop audits
- Dispensing fees may not be revoked except when a prescription was not dispensed or was dispensed in error or without authorization from a physician
- An auditor may not be compensated directly or indirectly based on a percentage of the findings from an audit
An MCO must provide the pharmacy provider with the results of the audit within 60 days, and the pharmacy may submit an appeal within 30 days of receiving the results.

Note: Additional information on states that have passed legislation related to audits and the practice of PBMs can be found in an NCPA document summarizing the laws for each state.25

The American Medical Association (AMA) has worked with CMS to improve the auditing process by Medicare and Medicaid RACs. Some of these improvements include:26

● Limits to the number of medical record requests
● Audit timeframe requirements
● Predefined auditable issues

In 2012, AMA requested that CMS review the Medicare and Medicaid program integrity audits and determine their impact on providers across all health care disciplines. CMS stated that it had completed a review in the beginning of 2012 and was working to develop recommendations for improving the audit process. A white paper, which was published by AMA regarding Medicare and Medicaid program integrity audits, provides insight into AMA’s efforts to streamline the auditing process, improve its accuracy, and decrease the burden placed on physician offices and hospitals.27

Conclusion

Health care providers in the United States are being audited to reduce fraud, waste, and abuse, and in some cases as a cost-savings effort. Of particular concern is the use of sampling and extrapolation to determine the amount of recoupment by an audit organization. The audit process itself is poorly defined and has minimal regulatory oversight, which allows MCOs and other contracted auditing companies to develop individual and varied standards of auditing practices. The result is frustration on the part of health care providers, including pharmacy providers. Providers often feel they are being taken advantage of and are forced to spend numerous hours preparing for and dealing with audits and to appeal claims when adequate care was provided. This time commitment can prevent pharmacists and other health care professionals from providing patient care services. The need to reduce the burden of audits on health care providers is apparent, and improvements to the auditing process are necessary.

References


**Related APhA Policy**

**Medicare, Medicaid, and Other Third-party Payment Programs (2005-1970)**

1. APhA advocates a professional fee system of reimbursement in Medicare and Medicaid and other third-party payment programs which would recognize variations in services provided and costs incurred by individual pharmacies.

2. APhA supports maintaining close liaison with proponents of national health insurance programs to ensure that pharmacy will have an opportunity to make its views known in the development of such proposals.


**Pharmacists and Home Health Care (2005-1985)**

1. APhA supports establishment of pharmacist consulting services for home care.

2. Medicaid and other third-party programs should recognize the consulting role of the pharmacist in reducing the misuse of drugs and maximizing their therapeutic effectiveness through fair and equitable reimbursement for consulting functions which is not tied to the provision of medications.

3. Medicaid and other third-party programs also should reimburse pharmacists for innovative packaging and services that will maximize adherence, increase the opportunity for drug utilization review, and better meet the informational needs of the patient and the care giver.

Use of Social Media

The Committee recommends that the Association adopt the following statements:

1. APhA encourages the use of social media in ways that advance patient care and uphold pharmacists as trusted and accessible health care providers.
   [Refer to Summary of Discussion Items 2, 3.]

2. APhA supports the use of social media as a mechanism for the delivery of patient specific care in a platform that allows for appropriate patient and provider protections, and access to necessary health care information.
   [Refer to Summary of Discussion Items 2, 3, 6, 7, 8.]

3. APhA supports the inclusion of social media education, including but not limited to, appropriate use and professionalism as a component of pharmacy education and continuing professional development.
   [Refer to Summary of Discussion Items 4, 8.]

4. APhA affirms that the patient’s right to privacy and confidentiality shall not be compromised through the use of social media by pharmacists and pharmacies.
   [Refer to Summary of Discussion Items 7.]

5. APhA encourages pharmacists and student pharmacists to monitor their social media presence for professionalism and to strive for posted clinical information to be accurate and appropriate.
   [Refer to Summary of Discussion Items 4, 5, 8, 9, 10.]

6. APhA encourages continued development and utilization of social media by pharmacists and other health care professionals during public health emergencies.
   [Refer to Summary of Discussion Items 11.]
Summary of Discussion

1. The committee recognized that social media encompasses a number of areas, including but not limited to: social networks, discussion boards, and blogs. The committee also recognized that some communication technologies could be considered social media, but not exclusively. In particular, in its truest form, texting and email are not considered social media. However, there are some types of email systems that are integrating more social formats. The definition of social media continues to evolve. For the purposes of this policy discussion, the committee utilized the following definition of social media and considered e-mail and texting to be similar to telephonic communication (and therefore outside of the scope of this policy discussion).

- Social media is "a group of Internet-based applications that build on the ideological and technological foundations of Web 2.0, and that allow the creation and exchange of user-generated content." “User-generated” is the key phrase in that social networking is defined by the community it generates. Social media is fundamentally collaborative, opening communication between participants through mechanisms and platforms that change continuously. (Kaplan, A. M., & Haenlein, M. (2010). Users of the world, unite! The challenges and opportunities of Social Media. Business Horizons, 53(1), 59–68.)

- Social media is the collective of online communications channels dedicated to community-based input, interaction, content-sharing and collaboration. Websites and applications dedicated to forums, microblogging, social networking, social bookmarking, social curation, and wikis are among the different types of social media. Social media is generally considered to be a connective technology that assists communications and information sharing through a mediated public setting. The availability of this technology results in the voluntary sharing of massive amounts of personal information with the online public. (Cain J, Scott DR, Smith K. Use of social media by residency program directors for resident selection. Am J Health Syst Pharm. 2010;67(19):1635-9).


2. The committee recognized that by current definitions, social media is generally editable, interactive, and fluid in nature and focuses on connecting people. Besides potential widespread availability and access in most areas, social media offers pharmacist users an enriched technological system with “viral” capabilities, allowing the rapid spread of information from user to user.

3. The committee recognized that policy statements related to the use of social media are intended to provide guidance on the use of such technologies, not discourage non-utilizers of social media.

4. The committee recognized that members of the profession should have a general knowledge about the professional implications of using social media, including a need for self-regulation or self-auditing of social media practices. The committee stressed the importance of individuals taking responsibility for monitoring their presence within social media. Digital footprints / tattoos maintain an individual’s long-term social media history (whether good and bad), therefore heightening the importance for appropriate behavior and interaction in the use of social media.

5. The committee reviewed policies and guidance developed by other health professional organizations and determined that APhA’s policy should focus on the professional aspect of pharmacists’ utilization of this technology. However, as professionals, it is difficult to remain separate from personal interactions and portrayals while utilizing social media. Therefore, the committee deferred to codes of professionalism and the individual’s societal obligations and expectations to guide personal behavior.

6. The committee recognized the current state of social media technology and the potential value to practitioners and patients as the technology evolves. Social media has a role, when used appropriately, in population based communication (e.g., encouraging individuals to get a flu shot) and
patient care interactions. The committee recognized the value of social media applications in general outreach and education to patients. As with any form of patient communication, the committee affirmed the absolute necessity to protect patient confidentiality and privacy in all areas of social media.

7. The committee discussed the delivery of direct and personalized patient care and concerns with privacy, confidentiality and maintaining the integrity of patient interactions in current and future social media environments. The committee recognized existing or developing technology that would be appropriate platforms for the delivery of patient care. The committee recommended that health care providers utilizing this technology confirm the existence of appropriate patient and provider protections and ensure that they have access to necessary health care information supporting the delivery of patient care.

8. The committee discussed the delivery of direct and personalized patient care and concerns with privacy, confidentiality and maintaining the integrity of patient interactions in current and future social media environments. The committee recognized existing or developing technology that would be appropriate platforms for the delivery of patient care. The committee recommended that health care providers utilizing this technology confirm the existence of appropriate patient and provider protections and ensure that they have access to necessary health care information supporting the delivery of patient care.

9. The committee did not feel policy requiring pharmacists to police others was appropriate at this time, but that individuals taking responsibility for their own presence on social media would positively impact the greater community.

10. The committee recognized the potential liability related to items posted by pharmacists and other health care professionals on social media and felt that the expectations of social media use are similar to those of other means of communication.

11. The committee affirmed the importance and value of social media technologies in terms of emergency preparedness and in times of crisis. They discussed examples of emergency situations where social media was the only means of communication between health care professionals, patients, and public safety workers.

12. The committee discussed the accessibility of social media applications within the work place and determined no policy statement was necessary. The committee felt that access to social media within the workplace was an employer-employee decision, similar to cell phone usage, but encourage practices to explore the integration of social media as technology and information security improve.

13. The committee discussed the use of social media applications in employment-related areas, including hiring decisions and disciplinary actions and determined that no specific policy statement was necessary. The committee determined that promoting professionalism and continuous professional development addressed the issue.

Attachment

Background Paper prepared for the 2013-2014 APhA Policy Committee
USE OF SOCIAL MEDIA

Background Paper Prepared for the 2013–2014 APhA Policy Committee

Issue

The American Pharmacists Association (APhA) Board of Trustees has directed the 2013–2014 Policy Committee to recommend policy to the APhA House of Delegates related to pharmacists’ use of social media. Social media present both opportunities and risks to the pharmacy profession. It is the intent of this background paper to explore the ways in which pharmacists can use social media in a positive way to remain the most accessible and highly respected health care professionals by providing accurate, up-to-date information to patients and colleagues. In addition, risks associated with social media use will be reviewed, including the potential for inappropriate use to affect employment or residency opportunities and professional collaborations. This paper will also address patient privacy concerns.

Summary of Key Concepts

- The emergence of social media makes possible a method of communicating directly with patients and other health care providers.
- Social media present both an opportunity and a risk in the provision of patient care.
- A number of health care organizations have recently adopted social media–related policies, and it is important for the profession to explore new opportunities and stay current with emerging technologies.
- As highly trained health care professionals, pharmacists should share accurate and useful information that will benefit their patients and social media audience.
- Student pharmacists should be mindful of how social media can affect future residency and employment opportunities and relationships with patients and colleagues.

Definition of Social Media

The definition of social media continues to evolve, but a social medium is generally considered to be a connective technology that assists communications and information-sharing through a mediated public setting. The availability of this technology results in the voluntary sharing of massive amounts of personal information with the online public. Merriam-Webster defines social media as “forms of electronic communication (as Web sites for social networking and micro-blogging) through which users create online communities to share information, ideas, personal messages, and other content (as videos).”

Background

Privacy concerns related to the use of emerging technologies are not necessarily a new issue. Articles dating back to 1876 address the medical community’s concern with patient privacy as it related to the use of the telephone. The use of social media in the United States and around the world continues to rise, which gives pharmacists an opportunity to remain the most accessible health care professionals. Research shows that two of three Internet users have a social media account and 32% of social media users are aged 65 or older. With 140 million Twitter users and 175 million Facebook users, social media undoubtedly present an effective platform for reaching a large number of individuals in just a few simple steps. As trusted health care professionals, pharmacists must ensure they provide accurate, up-to-date information
to patients and colleagues via social media. The many benefits of social media do not come without risks, and pharmacists should be aware of how posts will be received and interpreted by readers.

It has become commonplace for individuals to use social media in both their personal and professional lives, which raises the issue of whether separation of personal and professional accounts is necessary. In addition, pharmacists and student pharmacists should be mindful of how social media might affect future employment opportunities, including postgraduate residencies and fellowships. Social media make it possible to stay in touch with family, friends, and classmates, but they should be used in a manner that upholds the level of professionalism set forth by the Oath of a Pharmacist.

Opportunities for Pharmacists in Social Media

As the most accessible health care providers, pharmacists must incorporate modern technology into their practices to engage their patients and colleagues. With millions of users on Facebook and Twitter, pharmacists have an opportunity to connect with their patients and to provide accurate, up-to-date information. The ways in which pharmacists can use social media will vary depending on practice setting. For example, pharmacists who practice in a community or ambulatory care setting can use social media to provide health tips or medication-related information to their patients. Similarly, pharmacists who practice in an acute care or institutional setting can use social media to provide up-to-date clinical information to their colleagues.

Connecting with the public

Pharmacists may consider using social media to address public health issues. For example, a beneficial use of social media might include promoting immunizations during flu season or educating the public on the dangers of prescription drug abuse and misuse. In addition, pharmacists can raise awareness of their role in public health and patient care. Social media can also be useful in emergency-preparedness efforts when traditional methods of communication are unavailable.5

Connecting with patients

Pharmacists can use social media to empower patients to better manage their own health. In addition to posting health tips and medication advice, pharmacists can answer questions that patients submit anonymously. Overall, social media provide an opportunity for pharmacists to connect with patients in a unique way that takes advantage of emerging technologies. Use of these technologies also provides the pharmacy profession an opportunity to help patients understand how pharmacists are an essential component of the patient care process.

Connecting with the health care team

As the medication experts on the health care team, pharmacists can provide the latest clinical information to their colleagues via social media. Pharmacists should consider providing guideline updates, clinical trial information, and other information that will help their colleagues provide better patient care. Keeping in mind that colleagues may use this information to guide patient care decisions, pharmacists must take care to provide accurate information and cite references whenever possible.

Three Approaches to a Social Media Online Presence6

A pharmacist or student pharmacist can take three approaches in creating and maintaining an online social media presence:
1. Maintain profiles as strictly personal and restrict access to close friends and family (no professional online presence)
2. Create a completely professional profile, with content limited to work-related business (no personal online presence)
3. Adopt a hybrid model by creating both a personal profile and a professional profile and maintaining the content separately, or by creating one profile that contains a blend of both personal and professional details

Social media sites differ in their types and levels of security settings. The capabilities of the three most commonly used sites are discussed here.

Facebook (Facebook, Inc., Menlo Park, CA)

Facebook allows users to “friend” anyone, which requires the approval of the individual receiving the request. Users can upload pictures and videos, post frequent updates, and share their education and work history. All of the posted information is displayed on the user’s timeline, which highlights all past and current Facebook activity. Although an individual’s timeline content is generally under the control of the user, friends may post photos, videos, links, or text on the user’s page. In addition, users can “tag” other users in posts, photos, or videos, and those items will be displayed on the timelines of all tagged users. With appropriate privacy settings, users can limit the types of tagged posts that will appear on their own timeline. They cannot, however, control whether posts in which they are tagged appear on the timelines of other users.

Facebook has several levels of privacy settings, including the ability to restrict each post to predefined groups, with options including Public, Friends, Only Me, and customized settings. Each section of a user’s timeline can be customized with one of these privacy settings. A user may change the settings in a way that requires him or her to review each tagged post before it becomes visible on the timeline.

Twitter (Twitter, Inc., San Francisco, CA)

Twitter allows users to “Tweet” (i.e., post) thoughts, comments, questions, and photos in 140-character messages. Users may “follow” other users, which can include family, friends, celebrities, and businesses. Users can mention other users by using “@” or can categorize a Tweet using a hash tag (#). Location may also be added to the tweet. In addition, users can send each other private messages.

Twitter user profiles generally contain less information than Facebook user profiles. With the exception of the user’s Twitter account name, all other information is optional. Optional information includes name, location, website URL, and a brief biography or quote.

Twitter privacy settings are much less customizable than Facebook privacy settings. Users can protect their Tweets by allowing only their followers to view them. Users also have the ability to require prospective followers to send a request to the user, and the user can approve or deny the request. It is important to note that public Tweets (those not protected by Twitter privacy settings) can be searched through Twitter and search engines such as Google.

LinkedIn (LinkedIn Corporation, Mountain View, CA)

LinkedIn is a valuable networking site for professionals, including recruiters and prospective employees. Users have the option to create different types of accounts including Basic, Business, Business Plus, and Executive. The basic option is free of charge, whereas the other three options require a monthly or annual
fee. The paid accounts offer users access to advanced features including online introductions to
companies, a higher number of viewable profiles in search results, and the ability to contact anyone
directly using LinkedIn e-mail with a guaranteed response. Users can create a professional profile and
upload a curriculum vitae or résumé for others to view. In addition, a profile can contain work-related
experience, skills and expertise, education, personal recommendations from other LinkedIn users,
personal information, and applications. The purpose of LinkedIn is to help recruiters find employment
candidates and to help employees market themselves to the greater professional community.

Users have the ability to customize their profile visibility through privacy settings. Options include My
Connections, My Network, and Everyone. The user can customize what other users see when they view
his or her profile. In addition, users can create both a profile and a public profile. The public profile is
visible to anyone, regardless of whether the viewer is known or unknown to the profile owner. Public
profiles can be found with search engines such as Google, Yahoo!, and Bing.

**Recommendations for Use of Social Media Sites**

Pharmacy professionals should consider four important concepts when using social media sites:

1. **Public domain**
   a. Pharmacists and student pharmacists who choose to create personal pages should
      consider adopting privacy settings that mitigate the potential for the page to be found
      through a search engine.
   b. A professional profile should be set up to allow the user to opt out of disclosing
      identifiable personal data and the capture of such information by third-party databases.
   c. A professional profile should de-identify the profile holder from his or her personal life.

2. **Private domain**
   a. Users should adopt privacy settings that allow them to control who is and is not a contact
      so that they can post private knowledge or content.
   b. A personal profile with private knowledge should include only close friends or family.
   c. A professional profile should allow access to all professional contacts, including
      colleagues, supervisors, and professors.
   d. If a colleague is also a close friend, the user must make an individualized decision.

3. **Screening**
   a. Users should maintain constant control over the content of their personal profile pages,
      including photos, political and religious beliefs, and relationship status. In general,
      strictly professional profiles should not include personal beliefs or relationship status.
   b. Whereas personal profiles may contain photos of family vacations or time spent with
      family and friends, professional pages should include only photos that are professional in
      nature.

4. **Image**
   a. Users should consider how they want other people to view them.
   b. Personal conversations with family or friends should generally not be visible on
      professional pages.
   c. Professional pages should focus on career advancement or patient engagement. Status
      updates should positively reflect on the user’s job and profession.
Other Types of Electronic Media

In addition to social media sites, other forms of electronic media, such as e-mail and text messaging, can present opportunities and risks to pharmacy professionals. Although these methods of communication are generally more private, users must still realize that this information is stored virtually and may therefore be accessible to others.

Effect of Social Media Use on Employment Opportunities

Social media use is gaining attention in the workplace, in academia, and in professional occupations such as pharmacy and medicine. Almost half of all employers have reported using social networking sites to research job candidates. A study conducted in 2009 assessed pharmacy residency program directors’ attitudes and opinions regarding the concept of e-professionalism and examined the use of social media in residency recruitment and selection. The results of the study showed that, in general, residency program directors had strong feelings toward accountability, with 90% responding either “strongly agree” or “agree” that residency candidates should be accountable for unprofessional behavior discovered through social media. In addition, 89% responded “strongly agree” or “agree” that information voluntarily published online was “fair game” for judgments on character, attitudes, and professionalism.

Patient Privacy

Regardless of the electronic medium used, pharmacists and student pharmacists must be extremely mindful of patient privacy as it relates to their employer’s privacy policy and the Health Insurance Portability and Accountability Act (HIPAA). Little specific guidance exists on the use of social media as they relates to HIPAA. However, anything that might be considered a violation of such policies should be avoided, and one must be aware of the consequences of such violations. It is important to keep in mind that posting information about a patient encounter without patient identifiers might still be considered a violation of patient privacy. In general, if there is uncertainty regarding the potential of a social media post to violate a patient’s privacy, it is in the practitioner’s best interest to avoid the post altogether.

Current Policies of Other Health Care Associations

A number of professional health care associations have recently adopted policy or issued guidance regarding the use of social media.

In 2012, the American Society of Health-System Pharmacists (ASHP) released the following position statement:

_The American Society of Health-System Pharmacists (ASHP) encourages pharmacy professionals working in hospitals and health systems who use social media to do so in a professional, responsible, and respectful manner. Such use may complement and enhance their relationships with patients, caregivers, and other members of the health care team, and the public. To achieve that goal, pharmacy professionals should_

- thoroughly consider the purposes and potential outcomes of participation in social media and develop the strategies and skills required to effectively utilize social media to meet their goals, and
- exercise professional judgment and adhere to professional standards, and legal requirements in both private and public social media communications, especially legal and ethical obligations to protect privacy of personal health information._


The American Medical Association (AMA) adopted the following policy regarding the use of social media:

The Internet has created the ability for medical students and physicians to communicate and share information quickly and to reach millions of people easily. Participating in social networking and other similar Internet opportunities can support physicians’ personal expression, enable individual physicians to have a professional presence online, foster collegiality and camaraderie within the profession, provide opportunity to widely disseminate public health messages and other health communication. Social networks, blogs, and other forms of communication online also create new challenges to the patient-physician relationship. Physicians should weigh a number of considerations when maintaining a presence online:

a) Physicians should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must refrain from posting identifiable patient information online.

b) When using the Internet for social networking, physicians should use privacy settings to safeguard personal information and content to the extent possible, but should realize that privacy settings are not absolute and that once on the Internet, content is likely there permanently. Thus, physicians should routinely monitor their own Internet presence to ensure that the personal and professional information on their own sites and, to the extent possible, content posted about them by others, is accurate and appropriate.

c) If they interact with patients on the Internet, physicians must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethical guidelines just as they would in any other context.

d) To maintain appropriate professional boundaries physicians should consider separating personal and professional content online.

e) When physicians see content posted by colleagues that appears unprofessional they have a responsibility to bring that content to the attention of the individual, so that he or she can remove it and/or take other appropriate actions. If the behavior significantly violates professional norms and the individual does not take appropriate action to resolve the situation, the physician should report the matter to appropriate authorities.

f) Physicians must recognize that actions online and content posted may negatively affect their reputations among patients and colleagues, may have consequences for their medical careers (particularly for physicians-in-training and medical students), and can undermine public trust in the medical profession. (I, II, IV) Issued June 2011 based on the report "Professionalism in the Use of Social Media," adopted November 2010.12

The National Council of State Boards of Nursing released a white paper on this topic and provided the following guidelines:

- First and foremost, nurses must recognize that they have an ethical and legal obligation to maintain patient privacy and confidentiality at all times.

- Nurses are strictly prohibited from transmitting by way of any electronic media any patient-related image. In addition, nurses are restricted from transmitting any information that may be reasonably anticipated to violate patient rights to confidentiality or privacy, or otherwise degrade or embarrass the patient.
• Do not share, post or otherwise disseminate any information, including images, about a patient or information gained in the nurse-patient relationship with anyone unless there is a patient care related need to disclose the information or other legal obligation to do so.

• Do not identify patients by name or post or publish information that may lead to the identification of a patient. Limiting access to posting through privacy settings is not sufficient to ensure privacy.

• Do not refer to patients in a disparaging manner, even if the patient is not identified.

• Do not take photos or videos of patients on personal devices, including cell phones. Follow employer policies for taking photographs or video of patients for treatment or other legitimate purposes using employer-provided devices.

• Maintain professional boundaries in the use of electronic media. Like in-person relationships, the nurse has the obligation to establish, communicate and enforce professional boundaries with patients in the online environment. Use caution when having social contact with patients or former patients. Online contact with patients or former patients blurs the distinction between a professional and personal relationship. The fact that a patient may initiate contact with the nurse does not permit the nurse to engage in a personal relationship with the patient.

• Consult employer policies or an appropriate leader within the organization for guidance regarding work related postings.

• Promptly report any identified breach of confidentiality or privacy.

• Be aware of and comply with employer policies regarding use of employer-owned computers, cameras and other electronic devices and use of personal devices in the workplace.

• Do not make disparaging remarks about employers or co-workers. Do not make threatening, harassing, profane, obscene, sexually explicit, racially derogatory, homophobic or other offensive comments.

• Do not post content or otherwise speak on behalf of the employer unless authorized to do so and follow all applicable policies of the employer.\textsuperscript{13}

Conclusion

Pharmacists and student pharmacists can use emerging social media technology to engage patients, caregivers, and colleagues. The ability to provide health information in nearly real-time is an opportunity for pharmacy professionals, but it does not come without risks. Professional judgment and appropriate patient privacy considerations must be exercised when utilizing social media. The decision to separate personal and professional pages should be made on an individual basis, and who is allowed to access such pages must be carefully considered.

References


Relevant APhA Policy

**Employers’ Use of Lie Detection Tests (1977)**
1. Polygraph tests should not be used as a means of pre-employment screening in pharmacies.
2. Polygraph tests should not be used in pharmacies for routine “security” checking of employees.
3. Polygraph tests should not be used in pharmacies in the course of investigations for cause. (JAPhA NS17:450 July 1977) (Reviewed 2004) (Reviewed 2007)

**Future of Pharmacy (1987)**
1. APhA supports programs which plan for the future of pharmacy.
2. APhA supports programs which encourage innovations in the practice of pharmacy in a changing health care environment.

**Emerging Technologies (1991)**
1. APhA supports programs to monitor the development of emerging technologies and their impact on the delivery of pharmaceutical care.
2. APhA supports education of pharmacists regarding emerging technology including their development and impact on the delivery of pharmaceutical care.
APhA 2014 House of Delegates

New Business Review Committee

Brent Reed, Chair

Benjamin Andrick

C. Joseph Carr

Adriane N. Irwin

James Kirby

John Pieper

Carol Reagan

May J. Woo
NEW BUSINESS  
(To be submitted and introduced by Delegates only)

Introduced by: Natalie Nguyen, PharmD Candidate, on behalf of the 2014 APhA House of Delegates Policy Review Committee

January 26, 2014  2014 Policy Review Committee  
(Date)  (Organization)

Subject: Pharmacists’ Responsibilities in Community Medication Awareness Programs

Motion: We, the members of the Policy Review Committee, urge the 2014 House of Delegates to amend the following policy statement:

2005/1986 Pharmacists’ Responsibilities in Community Medication Awareness Programs

1. APhA supports the development of a comprehensive educational program on the proper use of prescription and non-prescription medication.
2. Pharmacists should take a major educational responsibility in proactive programs which optimize therapeutic outcomes and minimize risks from inappropriate medication use.

Current APhA policy with the proposed amendment shown:

2005/1986 Pharmacists’ Responsibilities in Community Medication Awareness Programs

1. APhA supports the development of a comprehensive educational program on the proper use and safe disposal of prescription and non-prescription medication.
2. Pharmacists should take a major educational responsibility in proactive programs which optimize therapeutic outcomes and minimize risks from inappropriate medication use.

Background: 
During its review of previously adopted policy, the Policy Review Committee discussed the relevance of and need for incorporating disposal information within a comprehensive educational program on the proper use of medications. APhA does have separate current policy supporting the implementation of educational programs related to the use of medications and policy related to the safe disposal of medications. However, because these topics go hand-in-hand with the development of a comprehensive educational program regarding medication use and overall medication safety, the Committee recommends adding “and safe disposal” to whole statement 1 as shown underlined above.

To be completed by the Office of the Secretary of the House of Delegates

Item Number: 1  
Date received: 01-26-14  
Time received: 9:53pm
Current APhA Policy & Bylaws:

2013 Medication Take-Back/Disposal Programs

1. APhA encourages pharmacist involvement in the planning and coordination of medication take-back programs for the purpose of disposal.
2. APhA supports increasing public awareness regarding medication take-back programs for the purpose of disposal.
3. APhA urges public and private stakeholders, including local, state, and federal agencies, to coordinate and create uniform, standardized regulations, including issues related to liability and sustainable funding sources, for the proper and safe disposal of unused medications.
4. APhA recommends ongoing medication take-back and disposal programs.

(JPhA 53(4): 365 July/August 2013)

1990 Proper Handling & Disposal of Hazardous Pharmaceuticals & Associated Supplies & Materials

1. APhA supports the proper handling and disposal of hazardous, pharmaceutical products and associated supplies and materials by health professionals and by patients to whom such products, supplies, and materials are provided.
2. APhA supports involvement with representatives from other health professional organizations, industry, and government to develop recommendations for the proper handling and disposal of hazardous pharmaceuticals and associated supplies and materials.
3. APhA supports the development of educational programs for health professionals and patients on the proper handling and disposal of hazardous pharmaceuticals and associated supplies and materials.


New Business Items are due to the Speaker of the House by February 26, 2014 (30 days prior to the start of the first House session). Consideration of urgent items can be presented with a suspension of the House Rules at the session where New Business will be acted upon. Please submit New Business Items to the Speaker of the House via email at hod@aphanet.org, via mail at 2215 Constitution Avenue, NW, Washington DC 20037, or via fax at 202-429-6300.
NEW BUSINESS
(To be submitted and introduced by Delegates only)

Introduced by: Jeffrey N. Baldwin, APhA-APPM Pain, Palliative Care and Addiction Special Interest Group (SIG) Coordinator, and Jeffrey Bratberg, submitting on behalf of APhA-APPM

(Name)

[submission date] APhA Academy of Pharmacy Practice & Management (APhA-APPM)
(Date) (Organization)

Subject: Controlled Substances and Other Medications with the Potential for Abuse and Use of Opioid Reversal Agents

Motion:

1. APhA supports education for pharmacists and student pharmacists to address issues of pain management, palliative care, the appropriate use of opioid reversal agents in overdose and of drug diversion and substance–related and addictive disorders.

2. APhA support recognition of pharmacists as the health care providers who must exercise professional judgment in the assessment of a patient’s conditions to fulfill corresponding responsibility for the use of controlled substances and other medications with the potential for abuse or diversion.

3. APhA supports pharmacists’ access to and use of prescription monitoring programs to identify and prevent drug misuse, abuse or diversion.

4. APhA supports the development and implementation of state and federal laws and regulations that permit pharmacists to initiate therapy of patient-administered opioid reversal agents to prevent opioid related deaths due to overdose.

5. APhA supports the pharmacist's role in selecting appropriate therapy, dosing, initiating and providing education to patients about the proper use of patient-administered opioid reversal agents to prevent opioid related deaths due to overdose.
**Background:**

Addiction and pain management are major challenges to society and the profession. Attempts to divert controlled substances and subvert their control systems cause significant problems in many areas of pharmacy practice. This is confounded by inadequate education at the college level and in continuing pharmacy education (CPE) for practitioners about addiction and pain management. Due to complex issues around the abuse of pain medications, some pharmacists refuse to provide pain medications (“we don’t carry that”) when it is legitimately indicated yet, in other cases, some pharmacists put themselves and the public in jeopardy by filling questionable prescriptions to get the patient out of the pharmacy, fearing confrontation or even being physically harmed. While many colleges have expanded their efforts to educate in these areas, there remains a significant knowledge gap in many graduates. In 2008, 36,450 drug overdose deaths were reported—40% caused by prescription opioid analgesics, more than heroin and cocaine combined. Since 2009, more people have died each year from drug overdoses and other effects than from motor vehicle crashes. Prescription monitoring programs, if implemented correctly and consistently used, should significantly reduce the burden that “doctor shoppers” and others seeking to obtain prescription drugs with a high potential for abuse and misuse for purposes other than legitimate therapy cause in practice and in society. These policies represent appropriate professional responses to the pervasive and increasingly harmful impact of addicting medications.

An innovative approach to preventing drug overdose deaths is increasing “take-home” naloxone availability in the community. Naloxone hydrochloride, an opioid antagonist, is the treatment of choice to reverse the potentially fatal respiratory depression caused by opioids. Naloxone can be administered by intramuscular injection or intranasal spray. “Take-home” naloxone is provided to persons at risk of opioid overdose, their families and friends, and service providers such as police and staff of systems such as ambulances, drop in centers, and homeless shelters. People receiving naloxone are trained about how to administer it, calling 9-1-1, risk factors for opioid overdose, and caring for someone experiencing an opioid overdose, including rescue breathing. The goal of increasing “take-home” naloxone in the community is to allow the bystanders to administer the potentially lifesaving drug as early as possible to reduce the risk of death and neurologic damage caused by hypoxia.

From 1996–2010, community overdose prevention programs reported training and providing naloxone to 53,032 persons, resulting in 10,171 drug overdose reversals using naloxone. Distributing naloxone to heroin users for lay overdose reversal is cost-effective. Communities that received overdose education and naloxone reported significantly fewer deaths than communities that did not receive the overdose training and naloxone\(^1\).

Because pharmacists are one of the most-accessible health professionals and they dispense prescription opioid medications, they can play a critical role in increasing community availability of naloxone as a response to the national epidemic of opioid overdose deaths. Increasing the availability and use of take-home naloxone in the community is one element of multiple interventions to reduce opioid overdose deaths. The other interventions include: promoting safer storage and disposal of opioid medications, health professional education on safer prescribing and dispensing, prescription monitoring programs, public education campaigns about opioid overdose, and other initiatives to discourage medication abuse and misuse.

Note to the Policy Review Committee: If the above proposed policy statements are adopted, we recommend that Items 3, 4, and 5 of the 2003 The Use of Controlled Substances in the Treatment of Intractable Pain, 1983, policy be replaced with the first two statements of our recommendations above (statement 1 above replaces 3 and 5 of the 2003 policy and statement 2 replaces the 2003 statement 4). We recommend no modifications to the remaining policies listed below.

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Submitted on behalf of the APhA-Academy of Pharmacy Practice and Management. The Academy would like to thank the members of the APhA-APPM policy committee and leadership for its work on this NBI: Michael Hogue (Chair); Nicki Hilliard; Andrew Bzowyckyj; Charlie Broussard; Jeff Baldwin; Jenny Arnold; Jeff Bratberg; Amber Briggs; Amy Kennedy; Charles Thomas; Daniel Zlott.

Current APhA Policy & Bylaws:

2003 The Use of Controlled Substances in the Treatment of Intractable Pain 1983
1. APhA supports the continued classification of heroin as a Schedule I controlled substance.
2. APhA supports research by qualified investigators under the Investigational New Drug (IND) process to explore the potential medicinal uses of Schedule I controlled substances and their analogues.
3. APhA supports comprehensive education to maximize the proper use of approved analgesic drugs for treating patients with chronic pain.
4. APhA recognizes pharmacists receiving controlled substance prescription orders used for analgesia have a responsibility to ensure that the medication has been prescribed for a legitimate medical use and that patients achieve the intended therapeutic outcomes.
5. APhA advocates that pharmacists play an important role on the patient care team providing pain control and management.
(Reviewed 2006)(Reviewed 2011)

2006 Conversion of Nonprescription Products into Drugs of Abuse
1. APhA supports legislative, regulatory, and private sector efforts that include input from pharmacists to balance the need for patient/consumer access to medications for legitimate medical purposes with the need to prevent diversion and abuse.
2. APhA supports consumer sales limits of nonprescription drug products that may be illegally converted into drugs for illicit use.
3. APhA encourages education of all personnel involved in the distribution chain of nonprescription products concerning the potential for certain products to be illegally converted into drugs for illicit use.
4. APhA supports public and private initiatives that result in increased funding to address the escalating needs for drug abuse treatment and prevention.
(JAPhA N46(5):561 September/October 2006)(Reviewed 2011)

2005 Efforts to Limit Methamphetamine Access
1. APhA supports legislation that balances the need for patient/consumer access to medications for legitimate medical purposes with the need to prevent diversion and abuse.
2. APhA supports stringent enforcement of criminal laws against individuals who engage in the illegal trafficking of methamphetamine and methamphetamine precursors.
3. APhA supports retail sales limits of non-prescription products that contain methamphetamine precursors to prevent diversion.
4. APhA supports education of employees involved in the distribution chain of methamphetamine precursors about diversion, methamphetamine abuse and prevention of abuse.
5. APhA supports patient/consumer education of consequences of methamphetamine abuse.

1997 Collaborative Practice Agreements
1. APhA supports the establishment of collaborative practice agreements between pharmacists and other health care professionals designed to optimize patient care outcomes.
2. APhA shall promote the establishment and dissemination of guidelines and information to pharmacists and other health care professionals to facilitate the development of collaborative practice agreement.
1999 Sale of Sterile Syringes
APhA encourages state legislatures and boards of pharmacy to revise laws and regulations to permit the unrestricted sale or distribution of sterile syringes and needles by or with the knowledge of a pharmacist in an effort to decrease the transmission of blood-borne diseases.

2001 Syringe Disposal
APhA supports collaboration with other interested health care organizations, public and environmental health groups, waste management groups, syringe manufacturers, health insurers, and patient advocacy groups to develop and promote safer systems and procedures for the disposal of used needles and syringes by patients outside of health care facilities.

2001 Pharmacist Counseling on Administration Devices
APhA encourages patient and caregiver education by a pharmacist on the appropriate use of drug administration devices.

2003/1987 Drug Abuse Education
APhA supports comprehensive drug abuse prevention programs consisting of education and rehabilitation.

2005 Patient Safety
1. Patient safety is influenced by patients, caregivers, health care providers, and health care systems. APhA recognizes that improving patient safety requires a comprehensive, continuous, and collaborative approach to health care.
2. APhA should promote public and provider awareness of and encourage participation in patient safety initiatives.
3. APhA supports research on a more effective, proactive, and integrated health care system focused on improving patient safety. APhA encourages implementation of appropriate recommendations from that research.

2005 The Role of Pharmacists in Public Health Awareness
1. APhA recognizes the unique role and accessibility of pharmacist in public health.
2. APhA encourages pharmacists to provide services, education, and information on public health issues.
3. APhA encourages the development of public health programs for use by pharmacists and student pharmacists.
4. APhA should provide necessary information and materials for student pharmacists and pharmacists to carry out their role in disseminating public health information.
5. APhA encourages organization to include pharmacists and student pharmacists in the development of public health programs.

2009 Medication Disposal
1. APhA encourages appropriate public and private partnerships to accept responsibility for the costs of implementing safe medication disposal programs for consumers. Further, APhA urges DEA to permit the safe disposal of controlled substances by consumers.
2. APhA encourages provision of patient appropriate quantities of medication supplies to minimize unused medications and unnecessary medication disposal.

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NEW BUSINESS

Introduced by: Ally Dering-Anderson, on behalf of 2014 APhA House of Delegates Policy Review Committee

17 February 2014  2014 Policy Review Committee
(Date)                     (Organization)

Subject:  The Use and Sale of Electronic Cigarettes (e-Cigarettes)

Motion: We, the members of the Policy Review Committee, urge the 2014 House of Delegates to adopt the following 4 policy statements:

1. APhA opposes the sale of e-Cigarettes and other vaporized nicotine products in pharmacies until such time that scientific data support the health and environmental safety of these products.

2. APhA opposes the use of e-Cigarettes and other vaporized nicotine products in any health care facility, including pharmacies, until such time that scientific data support the health and environmental safety of these products.

3. APhA urges pharmacists to become more knowledgeable about e-Cigarettes and other vaporized nicotine products.

4. APhA urges the FDA to require the full disclosure of all ingredients in e-Cigarettes and other vaporized nicotine products in both the pre-use and vapor states.

Background:
The Policy Review Committee reviewed existing policy on cigarette / tobacco sales and cigarette / tobacco use in pharmacies. The committee identified a lack of policy on new nicotine delivery technology, such as e-Cigarettes and other vaporized nicotine products. The committee is charged with reviewing existing APhA policy and making recommendations to keep these policies contemporary. The committee determined that the safety in the use of these products is yet to be determined and felt that current APhA policy should include these products; discouraging their use, just as we discourage the use of cigarettes and other tobacco products. Therefore, the committee is introducing this new business item to broaden the scope of existing policy to include these new products.
Current APhA Policy:
2005/1971 Cigarette Sales in Pharmacies
1. APhA recommends that tobacco products not be sold in pharmacies.
2. APhA recommends that state and local pharmacist associations develop similar policy statements for their membership and increase their involvement in public educational programs regarding the health hazards of smoking.
3. APhA recommends that individual pharmacists give particular attention to educating young people on the health hazards of smoking.
4. APhA recommends that APhA-ASP develop projects aimed at educating young people on the health hazards of smoking, such as visiting schools and conducting health education programs.

2005/1968 Cigarette Sales in Pharmacies
APhA recommends that pharmacists not allow smoking in their prescription departments.

1996 Exclusion of Alcohol and Tobacco Sales in Pharmacy Practice Settings
APhA opposes the sale of tobacco products and non-medicinal alcoholic beverages in pharmacies.

2010 Discontinuation of the Sale of Tobacco Products in Pharmacies and Facilities that Include Pharmacies
1. APhA urges pharmacies and facilities that include pharmacies to discontinue the sale of tobacco products.
2. APhA urges the federal government and state governments to limit participation in government-funded prescription programs to pharmacies that do not sell tobacco products.
3. APhA urges state boards of pharmacy to discontinue issuing and renewing licenses to pharmacies that sell tobacco products and to pharmacies that are in facilities that sell tobacco products.
4. APhA urges colleges of pharmacy to only use pharmacies that do not sell tobacco products as experience sites for their students.
5. APhA urges the Accreditation Council for Pharmacy Education (ACPE) to adopt the position that college-administered pharmacy experience programs should only use pharmacies that do not sell tobacco products.
6. APhA urges pharmacists and student pharmacists who are seeking employment opportunities to first consider positions in pharmacies that do not sell tobacco products.
(JAPhA NS40(4):471 July/August 2010)

Other Supporting Information:
- City Council votes to regulate e-cigarette sales in L.A.  http://fw.to/Ct8UOnN
- Randomized Clinical Trial published online in The Lancet  (September 2013) http://download.thelancet.com/pdfs/journals/lancet/PII%0140673613618425.pdf?id=baabQKEKvl_nghCPA8jsu
NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: _____Gary C. Yee & C. Edwin Webb________

(Names)

2/24/14 American College of Clinical Pharmacy
(Date) (Organization)

Subject: Professional use of the terms “specialty” and “specialist”

Motion: (1) The American Pharmacists Association supports the use of the terms “specialty” and “specialist” only in those circumstances that are fully consistent with the definition of those terms as found in the Council on Credentialing in Pharmacy resource paper entitled “Scope of Contemporary Pharmacy Practice: Roles, Responsibilities, and Functions of Pharmacists and Pharmacy Technicians (2009, et.seq.).” Further,

(2) The American Pharmacists Association recommends that all pharmacy organizations, educational institutions, publications and others that represent, serve, or communicate about the profession confine their use of the terms:

“specialty” – to those areas of pharmacy practice in which the specialty being described has been formally recognized through a publicly conducted role delineation and specialty recognition process by an organization that is itself recognized by the American
National Standards Institute (ANSI), the National Commission for Certifying Agencies (NCCA) or other nationally recognized body; and

“specialist” – to a pharmacist who has been certified in a recognized specialty by the Board of Pharmacy Specialties (BPS) or other pharmacy certification organization that conducts its certification programs using processes that meet standards of ASNI, NCCA or other nationally recognized body. Further,

(3) The American Pharmacists Association discourages the use of either of these terms when applied descriptively in relation to any particular drug product, a therapeutic drug class, the cost or pricing structure of a medication or category of medications, or any process of distribution and/or management that the medication’s manufacturer chooses or may be required by regulatory authority to utilize.

Background:

The use of the term “specialty” within segments of the pharmacy profession has inappropriately evolved from defining a level of knowledge, training and certification necessary to care for patients needing complex and often specialized pharmacotherapy needs, to being commonly associated with expensive, limited distribution medications. The leadership role of APhA in the establishment and success of the Board of Pharmacy Specialties (BPS) has been instrumental in addressing both the public’s and profession’s need for standards that relate to specialties and specialists in pharmacy practice. The misapplication of this terminology by segments of the pharmacy business community in what is increasingly referred to as “specialty pharmacy” is both problematic and confusing.

Initially developed to address important policy issues related to the treatment of very rare conditions, the concept of “specialty drugs” and their management and distribution focused on orphan or ultra-orphan drug products that sometimes require unique or challenging drug delivery methods. However, the term “specialty pharmacy” is
increasingly used in describing a much wider range of products with certain business characteristics that include high acquisition cost and/or manufacturer-required or directed management processes. Increasingly this approach is being employed regardless of method of administration of the product to the patient or the rarity of the disorder. For example, hepatitis C virus and HIV infections, cancer, and autoimmune diseases are not “orphan” or “ultra-orphan” conditions.

While such patients often require care by a highly specialized team of healthcare professionals, the nature of such specialization should not be related to the product or its distribution. To the extent that specialization of care is required, it should be provided in the context of the clinical knowledge and skills that exist within currently recognized and emerging specialties both within the pharmacy profession and the other professions that commonly comprise the patient care team.

In summary, the misapplication of the terms “specialty” and “specialist” to define or describe a business and/or product sector within pharmacy, rather than the care and expertise of a highly trained, board-certified pharmacist member of the patient’s health care team, creates confusion both within pharmacy and the health care system and should be discouraged.

**Current APhA Policy & Bylaws:**

**2012, 1989 Recognition of Pharmacy Practice Specialties**

1. APhA endorses the Board of Pharmacy Specialties’ process for recognizing specialties and certifying pharmacists in pharmacy practice specialties.
2. APhA believes that because of the existence of the Board of Pharmacy Specialties’ process, separate governmental recognition of pharmacy specialties and pharmacists in pharmacy practice specialties is not necessary.

NEW BUSINESS
(To be submitted and introduced by Delegates only)

 Introduced by: Nicholas Leon, on behalf of the 2014 APhA House of Delegates Policy Review Committee

2/26/14 2014 Policy Review Committee
(Date) (Organization)

Subject: Freedom of Scientific Information

Motion: We, the members of the Policy Review Committee, urge the 2014 House of Delegates to amend the following policy statement:

1984 Freedom of Scientific Information
APhA supports the principle of the free dissemination and exchange of scientific information with only the following exceptions:
(a) prior mutual confidentiality agreement between sponsor and researcher,
(b) material that is essential to national security, and
(c) legitimate trade secrets and/or proprietary information.

The proposed new business item from the Policy Review Committee would amend the existing policy to strike (a) prior mutual confidentiality agreement between sponsor and researcher from the policy. Since this changes the intent of existing policy, and in accordance with House rules, the Policy Review Committee is submitting its recommendation to amend existing policy as a new business item. Note: if this new business item is not passed, the Committee recommends retaining the existing policy statement as active policy.

Current APhA policy with the proposed amendment shown:

1984 Freedom of Scientific Information
APhA supports the principle of the free dissemination and exchange of scientific information with only the following exceptions:
(a) prior mutual confidentiality agreement between sponsor and researcher,
(b) material that is essential to national security, and
(c) legitimate trade secrets and/or proprietary information.
**Background:**

Publication bias is a large problem that adversely affects patient care as even the most well-read clinician (and patient) can fall victim to not knowing what they don’t know. Exacerbating the problem of publication bias is the prevalence of “missing data” which occurs when data gathered from research that has been conducted is not available for public dissemination. The presence of confidentiality agreements, often buried within contracts signed between study sponsor and researcher (or institution) provides a mechanism that strips the ability of the academic researcher (or institution) to publish results which are not flattering to a study sponsor. Often times, a researcher (or academic institution) has no other recourse but to agree to these terms a priori because attempting to negotiate this clause out of a contract may place the entire project at risk of not moving forward, or, since there is often competition for research dollars, the funding will be given to another institution willing to enter into the agreement. This places the submission of research generated data, which could be submitted to a journal for dissemination to healthcare professionals and the public, at the whim of a study sponsor.

Lastly, there is an ethical component that is often overlooked with this issue – much of the data that is generated, but not disseminated, is done so with the help of human subjects. While this mechanism for withholding data may be buried in the fine print of paperwork signed by human patient subjects, it is likely not emphasized during conversations pertaining to informed consent.

There have been publications attempting to help quantify this subject, but finding good data defining this issue (confidentiality agreements holding back data dissemination) is difficult since the very nature of the confidentiality agreement leads to these matter staying concealed. Clinical trial registries, while a relatively new and positive development, are not really set up to police this issue. Many medical journals have issued public statements expressing their willingness and have policies committed to publishing “negative trials” – but if there is nothing to submit due to a confidentiality agreement being enacted, then these well intentioned efforts well have less of an impact.

**Current APhA Policy:**

**1984 Freedom of Scientific Information**

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NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: __________________________________________________________

(Name)

(Date)                                   (Organization)

Subject:

Motion:

Background:

Current APhA Policy & Bylaws:

New Business Items are due to the Speaker of the House by **February 26, 2014** (30 days prior to the start of the first House session). Consideration of urgent items can be presented with a suspension of the House Rules at the session where New Business will be acted upon. Please submit New Business Items to the Speaker of the House via email at hod@aphanet.org, via mail at 2215 Constitution Avenue, NW, Washington DC 20037, or via fax at 202-429-6300.