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

Congratulations on your appointment as a Delegate to the 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 San Diego, so please remember to bring this information with you. If you wish to receive a printed copy of the materials prior to APhA2015, please submit your request here.

Included within your Delegate Reference Materials, you will find:
- APhA House of Delegates Schedule At-A-Glance;
- 2014-2015 APhA Policy Committee Report; and
- 2014-2015 APhA New Business Items received.

Policy-Related Webinars Available
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participate in one of these offerings, I encourage you to visit http://www.pharmacist.com/house-of-delegates/ to view an archived version of the Open Forum on 2015 Proposed Policy Statements.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 two New Business Item Webinar sessions from 12:00-1:30pm on March 4, 2015 and from 7:00-8:30pm on March 11, please try to participate in one of the two webinars. These webinars will provide an opportunity for you to learn more about the items submitted prior to the Annual Meeting and gives you adequate time to prepare for House discussions. You must register to participate in the webinars. If you find that you are unable to participate in one of the live webinars, 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 recording 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 27, 2015, from 1:00-2:00pm, in Room 33A 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 27, 2015, outside of Room 6A of the Convention Center.** The Final Session, registration will be available in the same location, from **11:00am-2:00pm on Monday, March 30, 2015.** 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.

Delegates are required to complete the following steps below prior to each House session:

- **Step 1** – Report to the Delegate registration area outside of Room 6A. 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 2016 House**
It’s never too early to plan ahead! In early April, APhA will begin the policy development process for 2016. With that in mind, I encourage you to begin thinking about the potential policy topics that should be addressed by the House of Delegates. Within this booklet, you will find a call for potential policy topics. I encourage you to bring your completed form to San Diego, or visit [http://fs3.formsite.com/apha/form220/index.html](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 2015-2016 policy development process, I encourage you to complete the committee volunteer interest form at [http://fs3.formsite.com/apha/form217/index.html](http://fs3.formsite.com/apha/form217/index.html).

Thank you again for your interest in and service to the 2015 House of Delegates! I look forward to seeing you in San Diego! If you have any questions about House activities, please visit [http://www.pharmacist.com/house-of-delegates/](http://www.pharmacist.com/house-of-delegates/) or contact APhA staff at hod@aphanet.org.
Delegates Checklist

Prior to the Meeting:

☐ Sign-up for the House sessions you wish to attend here


☐ Join in policy discussions via APhA Engage HOD communities

☐ Review Delegate Materials prior to the HOD meeting

☐ March 4 and March 11 - Attend a New Business Item webinar

☐ Prepare your amendment recommendations prior to House proceedings (Sample Amendment forms online)

While at the Meeting: (Check the Schedule At A Glance for Time/Room Information)

☐ Check-in on Friday, March 27 to receive your Delegate ribbon in Ballroom 6A/B (Must be seated by 3:15pm)

☐ Friday, March 27 - Delegate Orientation

☐ Friday, March 27 - Policy Review Committee Open Hearing

☐ Saturday, March 28 - New Business Review Committee Open Hearing

☐ Sunday, March 29 - Policy Committee Open Hearing

☐ Check-in on Monday, March 30 to receive your Delegate ribbon in Ballroom 6A/B (Must be seated by 1:15pm)

After the Meeting:


☐ Contact your State, Academy or Recognized Organization to make sure you are listed as a delegate for 2016!
# House of Delegates Schedule At A Glance

## FRIDAY, MARCH 27

<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>Room 6A Foyer</td>
<td>Delegate Registration</td>
</tr>
<tr>
<td>1:00 pm – 2:00 pm</td>
<td>Room 33A</td>
<td>Delegate Orientation</td>
</tr>
<tr>
<td>1:30 pm – 3:00 pm</td>
<td>Room 24C</td>
<td>APhA-APPM Delegate Caucus</td>
</tr>
<tr>
<td>1:30 pm – 3:00 pm</td>
<td>Room 24A</td>
<td>APhA-APRS Delegate Caucus</td>
</tr>
<tr>
<td>2:15 pm – 3:15 pm</td>
<td>Room 6A Foyer</td>
<td>Meet the Candidates for the 2015 APhA Elections</td>
</tr>
<tr>
<td>2:00 pm – 2:30 pm</td>
<td>Room 33B</td>
<td>Policy Review Committee Open Hearing</td>
</tr>
<tr>
<td>3:30 pm – 5:30 pm</td>
<td>Room 6A</td>
<td>House of Delegates – First Session (Be seated by 3:15pm)</td>
</tr>
</tbody>
</table>

## SATURDAY, MARCH 28

<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 33A</td>
<td>New Business Review Committee Open Hearing</td>
</tr>
</tbody>
</table>

## SUNDAY, MARCH 29

<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 33A</td>
<td>Policy Committee Open Hearing</td>
</tr>
</tbody>
</table>

## MONDAY, MARCH 30

<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 24C</td>
<td>APhA-APPM Delegate Caucus</td>
</tr>
<tr>
<td>9:30 am – 11:00 am</td>
<td>Room 24A</td>
<td>APhA-APRS Delegate Caucus</td>
</tr>
<tr>
<td>11:00 am – 2:00 pm</td>
<td>Room 6A Foyer</td>
<td>Delegate Registration</td>
</tr>
<tr>
<td>12:15pm – 1:15pm</td>
<td>Room 6A Foyer</td>
<td>Meet the Candidates for the 2015 APhA Elections</td>
</tr>
<tr>
<td>1:30 pm – 4:30 pm</td>
<td>Room 6A</td>
<td>House of Delegates – Final Session (Be seated by 1:15pm)</td>
</tr>
</tbody>
</table>

## House of Delegates Office Hours - Room 6A Foyer

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thursday, March 26</td>
<td>3:00 pm – 6:00 pm</td>
</tr>
<tr>
<td>Friday, March 27</td>
<td>7:30 am – 3:00 pm</td>
</tr>
<tr>
<td>Saturday, March 28</td>
<td>8:00 am – 3:00 pm</td>
</tr>
<tr>
<td>Sunday, March 29</td>
<td>8:00 am – 3:00 pm</td>
</tr>
<tr>
<td>Monday, March 30</td>
<td>7:30 am – 1:00 pm</td>
</tr>
</tbody>
</table>
### FRIDAY, MARCH 27

**House of Delegates – First Session**

**Agenda**

1. Call to Order
2. Review of Voting Procedures
3. Credentials Report*
4. Adoption of Agenda and Rules*
5. Introduction of Head Table
6. Report of the Speaker, APhA House of Delegates
7. APhA House Rules Review Committee Report
8. New Business Procedure
9. APhA Policy Review Committee Report – Part 1 (Received)
10. APhA Policy Committee Report (Received)
11. Adjourn to a Committee of the Whole for Discussion of the Policy Review Committee and Policy Committee Reports*
   a. APhA Policy Review Committee Report
   b. APhA Policy Committee Report
12. APhA Policy Review Committee Report Considerations*
13. APhA Policy Committee Report Considerations*
15. Meet the Candidates for the 2015 APhA Board of Trustees Election
16. Housekeeping Announcements
17. Adjournment of the First House Session

### MONDAY, MARCH 30

**House of Delegates – Final Session**

**Agenda**

1. Call to Order
2. Review of Voting Procedures
3. Credentials Report*
4. Adoption of Agenda*
5. Consideration of Unfinished Business
   a. APhA Policy Committee Report*
   b. APhA Policy Review Committee Report – Part 2*
6. Consideration of New Business*
7. Installation of the 2015-2017 Speaker of the House
8. Installation of the APhA Board of Trustees
9. Installation of the 2015-2016 APhA President
10. Recommendations from APhA Members
11. Closing Announcements
12. Adjournment of the 2015 APhA House of Delegates

*Please note: (*) asterisk indicates potential opportunities to cast votes.*
# General Information for Delegates

<table>
<thead>
<tr>
<th><strong>DUTIES OF THE HOUSE OF DELEGATES</strong></th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COMPOSITION OF THE HOUSE OF DELEGATES</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>CERTIFICATION OF DELEGATES</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>OFFICERS OF THE HOUSE OF DELEGATES</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>DELEGATE ORIENTATION</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
| **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, rescind, 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.

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.
### Parliamentary Procedures At A Glance

<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>Majority</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>Majority</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 2015-16 policy development process. Let us know what policy topics should be addressed by the 2016 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 2015-16 APhA Policy Committee.

Delegate Name: ________________________________________________

Delegation: _____________________________________________

Proposed Policy Topic:

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

2. What factors have contributed to the problems(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 recommendations online at http://fs3.formsite.com/apha/form220/index.html.
2015 House of Delegates
Report of the House Rules Review Committee

Committee Members
Bethany Boyd, Chair
Vibhuti Arya
Katherine Hale
Macary Weck Marciniak
Daniel Zlott

Ex Officio Members
William Riffe, Speaker of the House
Theresa Tolle, Speaker-elect of the House
The 2014-2015 APhA House Rules Review Committee (HRRC) consists of the following APhA members and long-time Delegates:

Bethany Boyd, Chair
Allen, TX

Vibhuti Arya
Brooklyn, NY

Macary Weck Marciniak
Chapel Hill, NC

Katherine Hale
Missoula, MT

Daniel Zlott
Lovettsville, VA

**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.

**2014-2015 Specific Charges / Work Plan**

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

1. Observe the 2014 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 2014 APhA House of Delegates.
3. Review and approve the 2015 APhA House of Delegates schedule and make recommendations for improvement.

The HRRC met via conference call on May 1, 2014, June 19, 2014, and August 15, 2014, and made the following recommendations.

**1. Observation of the 2014 APhA House of Delegates**

Upon completing its review of the proceedings of the 2014 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 2014 APhA House of Delegates. The Committee observed, reviewed, and discussed challenges and opportunities to maximize the efficiency of House operations. One change to the APhA House of Delegates Rules was suggested for consideration by Delegates (see Sections 3 and 5).

The HRRC reviewed, from a grammatical and copy-editing perspective, the policy language approved by the 2014 House of Delegates. Upon completing its review, the HRRC took the following action:

*By CONSENT, the House Rules Review Committee approved the 2014 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 Committee of the Whole and general parliamentary procedure information in Delegate orientation materials and in related webinars. The HRRC recommends the continued use of Delegate “testing” related to House procedures and Robert’s Rules of Order during routine testing of the electronic keypads.

- **New Business Items**
  - The HRRC recommends that Delegates who submit new business items, within the prescribed deadline prior to the APhA Annual Meeting, be strongly encouraged to present the item during the New Business Open Hearing.
  - The HRRC agreed that the new process of submitting items 30 days in advance worked well. House rules may be suspended for the purpose of considering urgent items not submitted 30 days in advance.

- **Consideration of New Business Items**
  - The HRRC recommends that each New Business Item whole-numbered statement be considered and voted on separately, similar to the process used for the consideration of the Report of the APhA Policy Committee. Delegates may move to suspend house rules in order to consider all whole number statements under a policy topic as one vote.

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

- **House of Delegates Materials**
  - The HRRC recommends that all Delegate materials be provided electronically unless otherwise requested by a Delegate. A limited number of Delegate materials will be made available onsite.
Unfilled Delegation Seats
  - The HRRC reviewed and approved the process by which APhA House of Delegates staff will track unfilled seats in accordance with the 2013 APhA Bylaws change. The process is as follows: *APhA Staff will calculate the number of unfilled seats in each delegation for each Session of the House. The number officially recorded will reflect the Session in which a delegation had the lowest number of unfilled seats. For example, a delegation with one unfilled seat during the First Session and two unfilled seats during the Final Session will be recorded as having one unfilled seat for that year’s House of Delegates.*


The HRRC reviewed and evaluated the 2015 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 and Delegate materials for the 2015 APhA House of Delegates.

5. Review of the APhA House of Delegates Rules of Procedure

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.

**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. Each whole-numbered statement within the New Business Item shall be considered separately. Consideration of the New Business Item in its entirety requires suspension of House rules.
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.

This report is presented for approval by the APhA House of Delegates by Bethany Boyd, Chair of the House Rules Review Committee.
Part I
Policies last reviewed in 2010

Part II
Policies related to the 2015 policy topics

Committee Members
Catherine Kuhn, Chair
Jeffrey Bratberg
David Catalano
Michelle Lee Chu
Ann Gorman
Lindsey Hunt
Abby Kahaleh
Matthew Lacroix
Larry Selkow

Ex Officio
William Riffe, Speaker of the House
Theresa Tolle, Speaker-elect 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.

Note: Highlighting indicates a recommendation to archive the policy statement. Underlined sections designate a recommendation to make an amendment that does not change the intent of the policy statement.

PART I

ADVERTISING

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

2010 Transfer Incentives
APhA advocates the elimination of coupons, rebates, discounts, and other incentives provided to patients that promote the transfer of prescriptions between competitors.
(JAPhA NS40(4):471 July/August 2010)

BIOTECHNOLOGY

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

1991 Biotechnology
APhA encourages the development of appropriate educational materials and guidelines to assist pharmacists in addressing the ethical issues associated with the appropriate use of biotechnology-based products.

3. The Committee Recommends AMENDING the following policy statement as written.

2005, 1988 Pharmaceutical Biotechnology/Biosimilar Products
APhA recognizes the urgent need for education and training of pharmacists and student pharmacists relative to the therapeutic and diagnostic use of pharmaceutical biotechnology and biosimilar products. APhA, therefore, supports the continuing development and implementation of such education and training.

[COMMENTS: The Policy Review Committee recommends amending the policy statement to add the term “biosimilar” to reflect contemporary terminology.]

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

2005, 2000 Pharmacogenomics
1. Recognizing the benefits and risks of pharmacogenomics and applications of this technology, APhA supports further research and assessment of the clinical, economic, and humanistic impact of pharmacogenomics on the health care system. This includes collaboration with other health care and consumer organizations for information sharing and development of pharmaceutical care processes involving these therapies. Pharmacogenomics is defined as the application of genomic technology in drug development and therapy.
2. APhA supports ongoing vigilance by all individuals and organizations with access to genetic information to maintain the confidentiality of the information.
3. APhA supports the development of educational materials to train and educate pharmacists, student pharmacists, pharmacy technicians, and consumers regarding pharmacogenomics.

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

2010 Pharmacogenomics/Personalized Medicine
1. APhA supports evidence-based personalized medicine, defined as the use of a person’s clinical, genetic, genomic, and environmental information to select a medication or its dose, to choose a therapy, or to recommend preventive measures, as a means to improve patient safety and optimize health outcomes.
2. APhA promotes pharmacists as health care providers in the collection, use, interpretation, and application of pharmacogenomic data to optimize health outcomes.
3. APhA supports the development and implementation of programs, tools, and clinical guidelines that facilitate the translation and application of pharmacogenomic data into clinical practice.
4. APhA supports the inclusion of pharmacogenomic analysis in the drug development/approval and postmarketing surveillance processes.
(JAPhA NS50(4):471 July/August 2010)

DISASTER PREPAREDNESS

6. 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.

2001 Biological Terrorism, Infectious Diseases, and Pharmacy
APhA supports pharmacist involvement in bioterrorism preparedness planning.

COMMENTS: The Policy Review Committee intends to submit a New Business Item to create a more comprehensive policy which includes emergency preparedness, emerging infectious diseases (i.e. Ebola, Enterovirus D68, SARS, etc.). This policy should also recognize pharmacists’ role beyond planning, to include response, recovery, surveillance, and more. If the New Business Item is adopted, the Committee recommends archiving this policy statement.

DISPENSING CRITERIA

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

APhA supports vigorous enforcement of laws to ensure that all those who sell or dispense prescription and non-prescription drugs comply with legal criteria.
DRUG ABUSE, CONTROL AND EDUCATION

8. The Committee Recommends AMENDING the following policy statement as written.

1986 Use of Performance-enhancing Drugs by Athletes
1. APhA is opposed to the use of performance-enhancing drugs by athletes.
2. APhA supports the development of educational materials on dangers of the use of performance enhancing drugs by athletes should educate the public on the dangers of the use of performance-enhancing drugs by athletes.
3. APhA encourages enforcement of laws related to the use of performance-enhancing drugs by athletes.

COMMENTS: The Policy Review Committee reviewed the policy statement and recommends amending. The Committee felt that the modifications would better align with the Association’s objectives.

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

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)

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

1982 Innovative Approaches to Combating Pharmacy Crime
1. APhA encourages federal government agencies to provide mechanisms for supporting experimental, drug-dependence, treatment programs based on principles of maintenance and/or detoxification.
2. APhA supports the development of a comprehensive educational program on drug use and misuse, starting with children in primary grades (kindergarten-Grade 5).
DRUG PRICING AND DISTRIBUTION

11. The Committee Recommends ARCHIVING the following policy statement as written.

**1989 Patient Education on Medication Storage**
APhA supports the continued development and use of educational resources for patients regarding the proper storage of drug products.

| COMMENTS: The Policy Review Committee recommends archiving this policy because more contemporary and comprehensive policy exists. |

DRUG PRODUCT SELECTION

12. The Committee Recommends RETAINING the following policy statement as written.

**2004, 1970 Licensure/Registration of Drug Manufacturers**
APhA supports the requirements that all drug manufacturers must obtain a federal license or registration, conditioned upon an inspection of the manufacturer’s facilities, before manufacturing is begun.

EDUCATION, CURRICULUM AND COMPETENCE FOR PHARMACISTS

13. 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.

**2010 Introductory Pharmacy Practice Experience**
APhA supports a collaborative effort amongst stakeholders (e.g., professional pharmacy organizations, deans, faculty, preceptors, and student pharmacists) to develop and implement a nationally defined set of competencies to assess the successful completion of introductory pharmacy practice experiences (IPPEs). APhA believes that these competencies should reflect the professional knowledge, attitudes, and skills necessary for entry into advanced pharmacy practice experiences (APPEs).
(JAPhA NS40(4):471 July/August 2010)

| COMMENTS: The Policy Review Committee intends to submit a New Business Item to make the existing policy more comprehensive in regards to experiential education and more inclusive to all stakeholders. If the New Business Item is adopted, the Committee recommends archiving this statement. |
14. The Committee Recommends RETAINING the following policy statement as written.

**2009 Pharmacist’s Role in Patient Safety**

1. It is APhA’s position that patient safety initiatives must include pharmacists in leadership roles.
2. APhA encourages dissemination of best practices derived from nationally aggregated reporting data systems to pharmacists for the purpose of improving the medication use process and making informed decisions that directly impact patient safety and quality.
3. APhA encourages the profession of pharmacy to continually review and evaluate ways to enhance training, curricula, continuing education and accountability of pharmacists to improve patient safety.
4. APhA encourages risk management and post-marketing surveillance programs to be standardized and include infrastructures and compensation necessary to allow pharmacists to support these patient safety programs.
5. APhA supports the creation of voluntary, standardized and interoperable reporting systems for patient safety events to minimize barriers to pharmacist participation and to enable aggregation of data and improve quality of medication use systems. The system should be free, voluntary, non-punitive, easily accessible, and user friendly for all providers within the healthcare system.
6. APhA supports the elimination of hand-written prescriptions or medication orders.

**(JAPhA NS49(4):492 July/August 2009) (Reviewed 2010)**

**EMPLOYER/EMPLOYEE RELATIONS**

15. The Committee Recommends RETAINING the following policy statement as written

**2004, 1994 Sexual Harassment in the Workplace**

1. APhA supports the principle that all work environments and educational settings be free of sexual harassment.
2. APhA recommends all pharmacy practice environments and educational settings have a written policy on sexual harassment prevention and grievance procedures.
3. APhA recommends that every owner/employer in facilities where pharmacists work institute a sexual harassment awareness education and training program for all employees.
4. APhA supports the wide distribution of the model guidelines on “Sexual Harassment Prevention and Grievance Procedures”.


**ENVIRONMENTAL CONCERNS**

16. The Committee Recommends ARCHIVING the following policy statement as written.

**2004, 1977 Fluorinated Hydrocarbons: Utilization in Aerosol Products**

APhA supports legislative or regulatory actions banning the non-essential use of fluorinated hydrocarbons; however, APhA recognizes the essential role played by fluorinated hydrocarbons in some medicinal aerosols and supports the selective exemption of medicinal aerosols.


**COMMENTS:** The Policy Review Committee recommends archiving this policy because fluorinated hydrocarbon products are no longer an issue and have been removed from the market.
ETHICAL ISSUES

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

1989 Ethics and Technology
APhA, in recognition of pharmacists’ professional and ethical responsibility to society, endorses the consideration of ethical principles in the design, conduct, and application of scientific research.

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

2004, 1998 Pharmacist Conscience Clause
1. APhA recognizes the individual pharmacist’s right to exercise conscientious refusal and supports the establishment of systems to ensure patient’s access to legally prescribed therapy without compromising the pharmacist’s right of conscientious refusal.
2. APhA shall appoint a council on an as needed basis to serve as a resource for the profession in addressing and understanding ethical issues.

19. 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.

2004, 1985 Pharmacist Involvement in Execution by Lethal Injection
1. APhA opposes the use of the term “drug” for chemicals when used in lethal injections.
2. APhA opposes laws and regulations which mandate or prohibit the participation of pharmacists in the process of execution by lethal injection.

COMMENTS: The Policy Review Committee is aware of the possible introduction of a New Business Item and has elected to defer taking action on this policy statement.

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

2004, 1997 Physician Assisted Suicide
1. APhA supports informed decision-making based upon the professional judgment of pharmacists, rather than endorsing a particular moral stance on the issue of physician-assisted suicide.
2. APhA opposes laws and regulations which mandate or prohibit the participation of pharmacists in physician-assisted suicide.

FEDERAL PROGRAMS AND POLICIES

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

2004, 1980 IRS Drug Deduction
APhA supports amendment of the federal and state personal income tax laws to permit all personal expenditures for medicines and drugs to be totally deductible and exempt from any exclusionary limits.
22. The Committee Recommends RETAINING the following policy statement as written.

1985 Reduction of Federal Laws and Regulations (Paperwork Burden)
APhA supports the reduction and simplification of laws, regulations, and record-keeping requirements which affect pharmacy practice and are not beneficial in protecting the public welfare.

23. The Committee Recommends RETAINING the following policy statement as written.

2004, 1994 Small Business Set-Asides
APhA encourages all federal agencies (such as the Office of Personnel Management) to eliminate inconsistencies in federal contracts which in any way affect community pharmacies operating as small businesses.

INTERPROFESSIONAL RELATIONS

24. The Committee Recommends RETAINING the following policy statement as written.

2004, 1990 Freedom to Choose
APhA supports the patient’s freedom to choose a provider of health care services and a provider’s right to be offered participation in governmental or other third-party programs under equal terms and conditions.

APhA opposes government or other third-party programs that impose financial disincentives or penalties that inhibit the patient’s freedom to choose a provider or health care services.

APhA supports that patients who must rely upon governmentally-financed or administered programs are entitled to the same high quality of pharmaceutical services as are provided to the population as a whole.

25. The Committee Recommends RETAINING the following policy statement as written.

2004, 1964 Community Health Councils
APhA encourages pharmacists’ active participation in health care organizations within their communities to assist in the public health efforts of community health and foster better community understanding of the profession of pharmacy.

26. The Committee Recommends RETAINING the following policy statement as written.

2004, 1970 Consumer Organizations
APhA, as well as state and local pharmacy organizations, shall continue to establish liaisons with the growing number of consumer groups, attend their meetings, and seek to be included on their programs.

27. The Committee Recommends RETAINING the following policy statement as written.

2004, 1988 Pharmacists’ Relationship to Veterinarians
APhA encourages pharmacists and student pharmacists to become more knowledgeable about veterinary drugs and their usage.
LABELING

28. The Committee Recommends RETAINING the following policy statement as written.

APhA supports legislation or regulation to require a full disclosure of therapeutically inactive, as well as active ingredients of all drug products.

29. The Committee Recommends RETAINING the following policy statement as written.

2004, 1980 Identification of Prescription Drug Products
APhA supports a federal legislative or regulatory requirement that a name, trademark, number, or code be included on the drug dosage form.

30. The Committee Recommends RETAINING the following policy statement as written.

2004, 1969 Manufacturer’s Name Included on Labels
APhA supports legislation that would require the name of the actual manufacturer of the dosage forms on all drug products.

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

APhA supports modification of the National Drug Code system to provide uniform identification numbers for the same drug entity, dosage form, strength, and quantity in addition to a manufacturer’s identification number.

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

2004, 1968 Standardized Manufacturers’ Control Numbers
APhA encourages manufacturers to adopt a standardized system of control numbers which meets the following guidelines:
1. The number should be legible.
2. The numbers should be placed in a standard position on the label.
3. The date of manufacture should be obvious from the control number.
4. The number should be on both the carton and the original container.

LICENSURE, REGISTRATION, AND REGULATION

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

2008 Boards of Pharmacy: Consumer Representation
APhA encourages state pharmaceutical associations to actively seek appointment of lay representation of the public to their respective boards of pharmacy and other health profession licensing and regulatory agencies.
34. The Committee Recommends RETAINING the following policy statement as written.

**2004, 1977 Licensing Boards: Inspection of Pharmacies**
1. APhA supports that all non-criminal inspections of pharmacies shall be under the direct control of each state board of pharmacy.
2. APhA recommends that state boards of pharmacy require that all pharmacy inspectors be licensed pharmacists who regularly update their knowledge of pharmacy practice.
3. APhA encourages NABP to develop and maintain uniform guidelines and standards for non-criminal inspections of pharmacies.

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

**1980 Reciprocity**
APhA supports systems of reciprocity which recognize a current license issued by any state and eliminate the requirement for pharmacists to maintain active practice licenses in the states of initial licensure.

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

**1985 Regulation of Mobile Facilities**
APhA supports enactment of state and federal laws and regulations which would govern the dispensing and issuing of legend drugs from mobile facilities.

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

**2004, 1996 Technician Licensure and Registration**
APhA recognizes the following definitions with regards to technician licensure and registration:
(a) Licensure: The process by which an agency of government grants permission an individual to engage in a given occupation upon finding that the applicant has attained the minimal degree of competency necessary to ensure that the public health, safety, and welfare will be reasonably well protected. Within pharmacy, a pharmacist is licensed by a State Board of Pharmacy.
(b) Registration: The process of making a list or being enrolled in an existing list.

38. The Committee Recommends ARCHIVING the following policy statement as written.

**1993 Universal Unique Identifier Numbering System**
APhA supports the development and use of a universal unique identifier numbering system that identifies all health care professionals involved with medication use.

**COMMENTS:** The Policy Review Committee felt that this policy statement should be archived because the National Provider Identifier system has been established and is being used by health care professionals.
MISCELLANEOUS POLICIES

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

2004, 1984 Center for Human Organ Acquisition
1. APhA supports activities that would increase voluntary human organ donations.
2. APhA encourages all pharmacists to consider becoming organ donors themselves, and to inform and encourage their patients to participate in organ donor programs.
3. APhA strongly urges all pharmacists, especially those in emergency room and intensive/critical care settings, to sensitize the other health care team members to the basic need for asking if a patient is an organ donor as part of the admission.

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

2004, 1986 Rationing of Expensive Health Care Services
1. APhA supports programs that will actively market the cost-effective benefits of comprehensive pharmacy services to patients and payers.
2. APhA supports the utilization of management tools to assist the pharmacist in maximizing available revenues in an environment of expensive and/or scarce health services and funding.

NEW DRUG APPLICATIONS AND INVESTIGATIONAL NEW DRUGS

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

1981 Investigational New Drug (IND) Studies
APhA encourages investigators and sponsors who are conducting IND studies to utilize the professional services of pharmacists in carrying out such studies.

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

1990 Reimbursement of Pharmacy Services Associated with Drugs Undergoing Assessment
1. APhA recognizes that investigational new drugs (IND) play a significant role in the delivery of innovative drug therapy approaches and as adjunctive aids in various diagnostics testing modalities.
2. APhA supports coverage by government and other third-party payers for pharmacy services associated with the use of drugs undergoing assessment.

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

2004, 1980 Therapeutic Orphans
APhA supports the adoption of policies in the new drug application (NDA) process that, beyond the pre-market, clinical testing, would result in post-marketing, clinical testing of the drug for important new clinical uses or population groups. Post-marketing studies may also be preferable for other indications where circumstances may require a lengthy gathering of data due to limitations in numbers of clinical cases, and for which initial marketing approval for the major indication(s) or population groups should not be delayed.
OFF-LABEL INDICATIONS

44. The Committee Recommends RETAINING the following policy statement as written.

**1994 Off-label Use of FDA-approved Products**
1. APhA advocates the collaboration of pharmacists, other health care professionals, industry, and the FDA in developing procedures to evaluate off-label use of FDA-approved products.
2. APhA encourages industry and government cooperation to streamline approval of beneficial off-label therapeutic or diagnostic use of FDA-approved products.
3. APhA advocates removal of restrictions on reimbursement of pharmaceutical services and FDA-approved products when, in the judgment of the pharmacist, those products are for medically acceptable, off-label uses.


ORPHAN DRUGS

45. The Committee Recommends RETAINING the following policy statement as written.

**2004, 1981 Needed Drugs of Limited Commercial Value (Orphan Drugs)**
1. APhA supports incentives to manufacturers, private foundations, academic and public institutions, and others for the development, manufacture, and distribution of needed drugs (including biological) and drug dosage forms of limited commercial value.
2. APhA supports the federal government bearing the responsibility to make orphan drugs and drug dosage forms available when incentives alone fail to achieve the availability of needed drugs (including biologicals) of limited commercial value.


PATIENT/PHARMACIST RELATIONSHIPS

46. The Committee Recommends RETAINING the following policy statement as written.

1a. Patients have the right to be informed participants in decisions related to their personal health care.
1b. Pharmacists have a professional obligation to contribute to the education of patients to help achieve optimal drug therapy.
1c. Pharmacist should provide drug related information to their patients (or patients’ agent) by face-to-face oral consultation, supplemented by written or printed material, or any other means or combination of means that is best suited to an individual patient’s needs for specific information.
2. APhA acknowledges that the pharmacist is responsible for initiating pharmacist/patient dialogue and assessing the patient’s ability to comprehend and communicate so as to optimize the patient’s understanding of and compliance with drug therapy.
3. APhA encourages the research and development of ancillary communication aids and techniques to maximize patient understanding of medication and its proper use.

PHARMACEUTICAL CARE

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

**2008 Billing and Documentation of Medication Therapy Management (MTM) Services**
1. APhA encourages the development and use of a system for billing of MTM services that:
   a. includes a standardized data set for transmission of billing claims;
   b. utilizes a standardized process that is consistent with claim billing by other healthcare providers;
   c. utilizes a billing platform that is accepted by the Centers for Medicare and Medicaid Services (CMS) and is compliant with the Health Insurance Portability and Accountability Act (HIPAA)
2. APhA supports the pharmacist’s or pharmacy’s choice of a documentation system that allows for transmission of any MTM billing claim and interfaces with the billing platform used by the insurer or payer.
4. APhA supports efforts to further develop CPT codes for billing of pharmacists’ services, through the work of the Pharmacist Services Technical Advisory Coalition (PSTAC).

*(JAPhA NS48(4):471 July/August 2008) (Reviewed 2010)*

PHARMACY PRACTICE

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

**2004, 1980 Development of the Cost Effectiveness of Clinical Pharmacy Services**
APhA encourages development and maintenance of programs, tools, and data useful in assessing the cost effective nature and benefits of patients oriented services within all areas of pharmacy practice.


49. The Committee Recommends **AMENDING** the following policy statement as written.

**2004, 1978 Drug Information**
APhA supports the profession of pharmacy having the primary responsibility to foster the development of an organized system for the accumulation, and dissemination, and organization of drug information and knowledge.


**COMMENTS:** The Policy Review Committee felt that reorganizing the existing policy statement was necessary to clarify the true intent of the statement.

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

**1988 Drug Usage Evaluation (DUE)**
1. APhA supports drug usage evaluation (DUE) as one element of a quality assurance program for medication use.
2. APhA advocates that DUE must address enhancement of the quality of care as well as the control of costs.
3. APhA advocates pharmacists’ participation along with other health care providers and consumers in the development, implementation, and administration of DUE programs.
4. APhA encourages further development of data collection systems to improve the extent and accuracy of DUE programs.
5. APhA maintains that the primary emphasis of DUE intervention should be educational with the goal of positive behavior modification.


51. The Committee Recommends RETAINING the following policy statement as written.

2004, 1989 Drug Use Control by Pharmacists for All Prescription Drugs
1. APhA supports the authority and responsibility of pharmacists in the management and control of all approved and investigational drug products.
2. APhA encourages corporate, government, and health-care organizations to recognize and utilize the unique expertise of the pharmacist in the management and control of all approved and investigational drug products.


52. The Committee Recommends RETAINING the following policy statement as written.

1991 Mission of Pharmacy Practice
APhA affirms that the mission of pharmacy practice is to serve society as the profession responsible for the appropriate use of medications, devices, and medication management services to achieve optimal therapeutic and pharmacoeconomic outcomes.


53. The Committee Recommends AMENDING the following policy statement as written.

1993 Patient Compliance Adherence: Industry Programs
1. APhA supports the development of patient compliance adherence programs that will follow adhere to the principles of pharmaceutical care and are intended to improve the patient’s health.
2. APhA should exert a leadership position in a collaborative effort with industry, the medical profession, and other organizations to develop guidelines for patient compliance adherence programs.
3. APhA opposes patient compliance adherence programs that compromise a pharmacist’s ability to provide pharmaceutical care to a patient.


COMMENTS: The Policy Review Committee reviewed the policy statement and recommended amending the statement to replace “Compliance” with “Adherence” to reflect contemporary terminology.

54. The Committee Recommends AMENDING the following policy statement as written.

1993 Patient Compliance Adherence: Pharmacists’ Responsibilities
1. APhA affirms that pharmacists are responsible for assisting patients to become active, informed, decision makers regarding compliance adherence with their prescribed therapeutic plans.
2. APhA will convey to the public, employee benefit managers, third-party payers, and other health care decision makers, the value and cost-effectiveness of the role of the pharmacist in comprehensive medication-use management.


COMMENTS: The Policy Review Committee reviewed the policy statement and recommended amending the statement to replace “Compliance” with “Adherence” to reflect contemporary terminology.
55. The Committee Recommends RETAINING the following policy statement as written.

1983 Stocking a Complete Inventory of Pharmaceutical Product
APhA supports the rights and responsibilities of individual pharmacists to determine their inventory and dispensing practices based on patient need, practice economics, practice security, and professional judgment.

POISON PREVENTION

56. The Committee Recommends AMENDING the following policy statement as written.

APhA recommends that pharmacists take an active role in poison prevention and establishing poison information, poison treatment, and poison control centers where none exists.

COMMENTS: The Policy Review Committee reviewed the policy statement and recommended removing the word “more.” The committee felt the statement accomplishes its purpose without the additional wording.

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

1. APhA encourages pharmacists to familiarize themselves with the available resources on poisons and toxicology.
2. APhA encourages pharmacists to become familiar with the poison control, information and treatment center in their localities.

POST-MARKETING SURVEILLANCE

58. The Committee Recommends RETAINING the following policy statement as written.

1988 Post-marketing Surveillance
1. APhA supports and encourages the active participation of pharmacists in initiating, organizing, and maintaining post-marketing surveillance programs including, but not limited to, adverse drug reaction reporting and drug product problem reporting for drugs and other health care products.
2. APhA recognizes post-marketing surveillance as a process that systematically and comprehensively monitors the patterns of use and the harmful or beneficial effects (whether expected or unexpected) of prescription and non-prescription drugs and other health care products as they are used in the general population. The ultimate purpose of post-marketing surveillance is to develop and systematically disseminate information that can be used to provide safe and cost-effective drug therapy.
3. APhA supports the development of educational programs to foster the active involvement of pharmacy practitioners and students in post-marketing surveillance programs.
4. APhA encourages public and private collaboration in the funding and development of post-marketing surveillance methodologies and programs.
5. APhA encourages FDA and the pharmaceutical industry to actively involve pharmacists in spontaneous adverse reaction reporting systems and to provide appropriate and timely feedback on collected data.
QUALITY ASSURANCE

59. The Committee Recommends ARCHIVING the following policy statement as written.

2000 Quality Assessment
APhA reaffirms the 2000, 1980 and 1995 policy statements on quality assessment and improvement and supports the expanded implementation of those statements.
(JAPhA NS40(5):Suppl.1:S8 September/October 2000)

COMMENTS: The Policy Review Committee recommends archiving because more contemporary and comprehensive policy exists.

RECORD SYSTEMS

60. The Committee Recommends AMENDING the following policy statement as written.

1994 Confidentiality of Computer-generated Patient Records
APhA, in cooperation with the National Council of Prescription Drug Programs, Inc. (NCPDP) and similar groups, shall encourage the development and implementation of uniform, prescription, computer software standards to prevent unauthorized access to confidential patient records.

COMMENTS: The Policy Review Committee reviewed the existing policy statement and recommends adding “and similar groups” to capture other stakeholders outside of NCPDP.

61. The Committee Recommends ARCHIVING the following policy statement as written.

1996 Confidentiality of Patient Data
APhA supports the establishment of uniform national privacy protection standards for personally identifiable health information. These standards should:
(a) include provisions for patients to access and request modification of their health information, and disclosure of who will have access to the information;
(b) establish broad privacy protections for the individual patient without compromising patient care or creating an excessive administrative burden for health care providers; and
(c) make a distinction between the clinical information required for communication among health care professionals, and the administrative or financial information required by others (e.g., claims processors and payers).

COMMENTS: The Policy Review Committee recommends archiving this policy because it is no longer relevant since HIPAA is fully implemented and the Association has more contemporary and comprehensive policy on confidentiality.
62. The Committee Recommends AMENDING the following policy statement as written.

1993 Patient Information
1. APhA shall facilitate the development, dissemination, and use of an information system that documents the components of comprehensive medication-use-management services.
2. APhA encourages development of quality assurance standards that guarantee the integrity and accuracy of information included in proprietary and non-proprietary information systems.


COMMENTS: The Policy Review Committee recommends removing the word “use” and adding “non-proprietary.” The Committee felt this language broadens the existing policy and expands the scope of information exchanged.

REIMBURSEMENT AND COMPENSATION

63. The Committee Recommends RETAINING the following policy statement as written.

1994 Product and Payment Systems
1. APhA shall work with public and private sectors in developing timely educational processes which assist pharmacists to implement patient care, understand new payment systems, and apply emerging therapeutic advances to achieve desired patient outcomes.
2. APhA supports payment systems that distinguish between compensation for the provision of pharmaceutical care and reimbursement for product distribution.
3. APhA shall participate in the identification, development, and implementation of models for procurement and handling of therapeutic and diagnostic pharmaceutical products and devices which assure the continuous provision of pharmaceutical care by pharmacists.


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

2004 Tablet Splitting
APhA opposes mandatory tablet splitting.

PART II

INTEROPERABILITY OF COMMUNICATIONS AMONG HEALTHCARE PROVIDERS TO IMPROVE QUALITY OF PATIENT CARE

Related APhA Policy

1. 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.

2. 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 on-going 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.

3. 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)
4. 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 pharmacist 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)

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, 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.
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.

(JAPhA NS49(4):492 July/August 2009) (Reviewed 2010) (Reviewed 2013)

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

**2001 Automation and Technical Assistance**

APhA supports the use of automation for prescription preparation and supports technical and personnel assistance for performing administrative duties and facilitating pharmacist’s provision of pharmaceutical care.

7. The Committee recommends **RETAI**ning the following policy statement as written.

**2003 Prior Authorization**

1. APhA opposes prior authorization programs that create barriers to patient care.
2. Patients, prescribers, and pharmacists should have ready access to the coverage conditions for medications or devices requiring prior authorization.
3. Prescription drug benefit plan sponsors and administrators should actively seek and integrate the input of network pharmacists in the design and operation of prior authorization programs.
4. APhA supports prior authorization programs that allow pharmacists to provide the necessary information to determine appropriate patient care.
5. APhA expects prescription drug benefit plan sponsors to compensate pharmacy providers who complete third-party payer authorization procedures. Compensation should be in addition to dispensing fee arrangements.
6. APhA should work with relevant groups to improve prior authorization design and decrease prescription processing inefficiencies.


**INTEGRATED NATIONWIDE PRESCRIPTION DRUG MONITORING PROGRAM**

*Related APhA Policy*

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

**1989 Multiple Copy, Prescription Order Programs**

1. APhA opposes federally mandated, multiple copy, prescription order programs.
2. APhA supports the right of individual states to develop programs to prevent drug abuse and drug diversion.


Comments: The Policy Review Committee recommends archiving because more contemporary and comprehensive policy exists.

9. The Committee recommends **RETAI**ning the following policy statement as written.

**2002 National Framework for Practice Regulation**

1. APhA supports state-based systems to regulate pharmacy and pharmacist practice.
2. APhA encourages states to provide pharmacy boards with the following: (a) adequate resources; (b) independent authority, including autonomy from other agencies; and (c) assistance in meeting their mission to protect the public health and safety of consumers.
3. APhA supports efforts of state boards of pharmacy to adopt uniform standards and definitions of pharmacy and pharmacist practice.
4. APhA encourages state boards of pharmacy to recognize and facilitate innovations in pharmacy and pharmacist practice.

ROLE OF THE PHARMACIST IN THE CARE OF PATIENTS USING CANNABIS

Related APhA Policy

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

1980 Medicinal Use of Marijuana

1. APhA supports research by properly qualified investigators operating under the investigational new drug (IND) process to explore fully the potential medicinal uses of marijuana and its constituents or derivatives.
2. APhA opposes state by state, marijuana specific, or other drug specific legislation intended to circumvent the federal laws and regulations pertaining to (a) marketing approval of new drugs based on demonstrated safety and efficacy, or; (b) control restrictions relating to those substances having a recognized hazard of abuse.


Comments: The Policy Review Committee recommends archiving because more contemporary and comprehensive policy exists.

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

2003, 1983 The Use of Controlled Substances in the Treatment of Intractable Pain

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 that 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.


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

2012 Controlled Substances Regulation and Patient Care

1. APhA encourages the Drug Enforcement Administration (DEA) and other regulatory agencies to recognize pharmacists as partners that are committed to ensuring that patients in legitimate need of controlled substances are able to receive the medications.
2. APhA supports efforts to modernize and harmonize state and federal controlled substance laws.
3. APhA urges DEA and other regulatory agencies to balance patient care and regulatory issues when developing, interpreting, and enforcing laws and regulations.
4. APhA encourages DEA and other regulatory agencies to recognize the changes occurring in health care delivery and to establish a transparent and inclusive process for the timely updating of laws and regulations.
5. APhA encourages the U.S. Department of Justice to collaborate with professional organizations to identify and reduce:
   (a) the burdens on health care providers,
   (b) the cost of health care delivery, and
   (c) the barriers to patient care in the establishment and enforcement of controlled substance laws.

(JAPhA NS52(4) 457 July/August 2012)
13. The Committee recommends **RETAINING** the following policy statement as written.

**2014 Controlled Substances and Other Medications with the Potential for Abuse and Use of Opioid Reversal Agents**

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 supports 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 misuse, abuse, and/or diversion.

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

4. APhA supports the development and implementation of state and federal laws and regulations that permit pharmacists to furnish 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 about the proper use of opioid reversal agents to prevent opioid related deaths due to overdose.

*(JAPhA 54(4) July/August 2014)*
American Pharmacists Association

2015 House of Delegates
Report of the Policy Committee

Interoperability of Communications among Health Care Providers to Improve Quality of Patient Care
Integrated Nationwide Prescription Drug Monitoring Program
Role of the Pharmacist in the Care of Patients Using Cannabis

Committee Members
Michael Moné, Chair
Laura Carpenter
Susan Dickey
Betsy Elswick
Terry Gubbins
Kayla Hansen
Brenna Neumann
Eric Roath
Thomas Worrall

Ex Officio
William Riffee, Speaker of the House
Theresa Tolle, Speaker-elect 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 the establishment of secure, portable, and interoperable electronic patient health care records.
   [Refer to Summary of Discussion Item 3.]

2. APhA supports the engagement of pharmacists with other stakeholders in the development and implementation of multidirectional electronic communication systems to improve patient safety, enhance quality care, and facilitate care transitions.
   [Refer to Summary of Discussion Item 4.]

3. APhA advocates for the inclusion of pharmacists in the development and enhancement of electronic health care information technologies and systems that must be interoperable, HIPAA compliant, integrated with claims processing, updated in a timely fashion, and with minimal cost to providers.
   [Refer to Summary of Discussion Item 4, 5, 6.]

4. APhA advocates for pharmacists and other health care providers to have comprehensive read-and-write access to electronic health records. Information shared between providers using a health information exchange should utilize a standardized secure interface based on recognized international health record standards for the transmission of health information.
   [Refer to Summary of Discussion Item 7.]

5. APhA supports the integration of federal, state, and territory health information exchanges into an accessible, standardized, nationwide system.
   [Refer to Summary of Discussion Item 10, 11, 12.]

6. APhA opposes business practices and policies that obstruct the electronic access and exchange of patient health information because these practices compromise patient safety and the provision of optimal patient care.
   [Refer to Summary of Discussion Item 13.]

7. APhA advocates for the development of systems that facilitate and support electronic communication between pharmacists and prescribers concerning patient adherence, medication discontinuation, and other clinical factors that support quality care transitions.
   [Refer to Summary of Discussion Item 14.]

8. APhA supports the development of education and training programs for pharmacists and other health care professionals in the appropriate use of electronic health records to reduce errors and improve the quality and safety of patient care.
   [Refer to Summary of Discussion Item 15.]

9. APhA supports the creation of a voluntary, non-punitive, standardized, interoperable system for reporting errors associated with the use of electronic health care information technologies and systems to enable aggregation of protected data and develop recommendations for improved quality.
   [Refer to Summary of Discussion Item 16.]
Summary of Discussion

1. The Committee reviewed current APhA policy related to electronic health records, electronic prescribing, and health information technology and recognized continuing challenges in these areas.
2. The Committee discussed challenges related to current electronic prescribing systems and recognized that e-prescribing is one piece of a larger interoperability issue.
3. The Committee discussed the need for an overall vision for interoperability and felt that statement 1 accurately reflects that vision.
4. The Committee recognized inconsistencies in the engagement of pharmacists in the development and implementation of electronic communication systems.
5. The Committee agreed that electronic health information must be multi-directional, HIPAA compliant, billing accessible, and timely. The term “timely” refers to the idea that the information being received is current and useable by the practitioner when he or she is working with the patient. The term “billing accessible” refers to the fact that electronic health information should be integrated with claims processing systems.
6. The Committee discussed the costs that could be incurred by pharmacists and other health care providers related to interoperability of systems and agreed that costs to the providers should be minimized to the extent possible.
7. The Committee recognized the importance of pharmacists having access to information that would assist them in making both collaborative and clinical decisions. In addition, pharmacists and other health care team members should have read-and-write access.
8. The Committee discussed the effect of meaningful-use incentive programs on the use of electronic health records and health information exchanges. These payment systems are driving some clinicians to use these systems, but not all members of the health care team have access. The Committee agreed that health care professionals who are not incentivized through meaningful-use programs must still be included in the use of these electronic systems.
9. The Committee considered patients’ access to and control of their own electronic health records. The Committee agreed that HIPAA regulations adequately address this issue because patients may request access to their health information at any time.
10. The Committee discussed current technologies versus new technologies and agreed that some current systems could be enhanced to meet the goal of interoperable systems that improve the quality of patient care.
11. The Committee discussed the need for health information exchanges to move beyond just state- and regional-based exchanges. The Committee considered the difference between a nationwide system and standards that connect state and regional exchanges and agreed that an infrastructure should be created to facilitate the exchange of information among existing systems. The Committee also recognized the need for standardization of a secure interface based on recognized international standards.
12. The Committee recognized that federal entities, such as Veterans Affairs, currently utilize nationwide electronic health records but noted that these systems do not necessarily integrate and exchange information with state and territory exchanges.
13. The Committee discussed business entities that may withhold patient health information for their own financial benefit. These practices and proprietary systems hinder or prevent the sharing of patient health information, negatively affect patient care, and should be avoided.

14. The Committee discussed how systems could facilitate communication between pharmacies and prescribers during care transitions. Communications related to patient adherence and medication discontinuation would be especially helpful to support the quality of patient care and patient safety during care transitions.

15. The Committee agreed that education of all stakeholders is a key aspect of appropriate and effective utilization of health information technology. Effective utilization will support improved quality of patient care and patient safety.

16. The Committee considered how the reporting of issues with electronic prescriptions could be used for quality improvement and research and agreed that continuous quality improvement is key to effective utilization of health information technology. The Committee recognized that no system is currently in place to accomplish this goal.

Attachment
Background Paper prepared for the 2014-15 APhA Policy Committee
INTEROPERABILITY OF COMMUNICATIONS AMONG
HEALTH CARE PROVIDERS
TO IMPROVE QUALITY OF PATIENT CARE

Background Paper Prepared for the 2014−2015 APhA Policy Committee

Brian Wall, PharmD
2014−2015 Executive Resident
American Pharmacists Association Foundation

Issue

The American Pharmacists Association (APhA) Board of Trustees has directed the 2014−2015 Policy Committee to recommend policy to the APhA House of Delegates related to the interoperability of communications among health care providers to improve quality of patient care. The Board’s guidance on this topic included, but was not limited to, real-time pharmacist access to patient information, bidirectional communication protocols that include pharmacists, impact on patient safety through the use of electronic prescribing, and standardized training and qualifications for using electronic prescribing systems.

Summary of Key Concepts

- The lack of real-time pharmacist access to patient information prevents proper, timely, and comprehensive patient care from occurring and creates a gap in communication with the rest of the health care team.
- Improvement in patient safety or health care practices may be found with the usage of bidirectional communication systems between all members of the health care team.
- Correct use of electronic prescribing systems can enhance patient care and streamline communication between the pharmacy and other members of the health care team, particularly prescribers.
- Communication errors through electronic prescribing systems continue to exist without universal standards for training and/or qualifications in place.
- The lack of system interface between various electronic prescribing systems increases the potential for errors and causes the need for extra time to correct the error at the pharmacy level.
- Use of newer technologies, such as web-based systems for patient and healthcare provider access, may improve the quality of patient care and improve transitions of care.
- E-Rx systems must be built with the same standards in mind, and they must be integrated into electronic health records (EHR) systems and state-based databases.
- Pharmacists could play a much more active role in the continuity of care for patients and offer more disease state or medication management services with access to relevant patient health information.

Background

Definition

According to the Healthcare Information Management Systems Society (HIMSS), the definition of “interoperability” is multifaceted. On the highest level, HIMSS describes interoperability as
the ability of different information technology systems and software applications to communicate, exchange data, and use the information that has been exchanged. In the expanded definition, HIMSS cites the American Academy of Family Physicians as stating that data exchange should be shared across clinicians, laboratories, hospitals, pharmacies, and patients regardless of the application or application vendor.² HIMSS also states that three levels of health information technology interoperability exist: foundational, structural, and semantic. Each level has varying functionality; the goal of the semantic level is full information access and interpretation. The three levels of interoperability are defined as follows:

1. **Foundational** interoperability allows data exchange between information technology systems but does not require the receiving information technology system to be able to interpret the data.

2. **Structural** interoperability is an intermediate level that defines the structure or format of data exchange (i.e., the message format standards) where there is uniform movement of health data from one system to another such that the clinical or operational purpose and meaning of the data is preserved and unaltered. Structural interoperability defines the syntax of the data exchange. It ensures that data exchanges between information technology systems can be interpreted at the data field level.

3. **Semantic** interoperability provides interoperability at the highest level, which is the ability of two or more systems or elements to exchange information and to use the information that has been exchanged. Semantic interoperability takes advantage of both the structuring of the data exchange and the codification of the data, including vocabulary, so that the receiving information technology systems can interpret the data. This level of interoperability supports the electronic exchange of health-related financial data, patient-created wellness data, and patient summary information among caregivers and other authorized parties. This level of interoperability is possible via potentially disparate EHR systems, business-related information systems, medical devices, mobile technologies, and other systems to improve wellness, as well as the quality, safety, cost-effectiveness, and access to health care delivery.¹

**Current Health Care Information Technology Landscape**

The current landscape of health care information technology (HIT) is evolving at a rapid pace. The effects are noticeable in every aspect of the health care continuum including pharmacy. Meaningful use standards and the EHR Incentive Program through the Centers for Medicare & Medicaid Services (CMS) are expanding physician practice and hospital usage of electronic patient information. In 2011, 57,000 eligible professionals and more than 800 hospitals successfully attested to Stage 1 meaningful use.³ More than 487,000 eligible professionals, eligible hospitals, and critical access hospitals were actively registered as of July 31, 2014.⁴ An increase of about 430,000 users at the Stage 1 level of meaningful use in just 3 years highlights the increasing utilization of electronic patient records. These incentives unfortunately do not provide direct funding to pharmacists or pharmacies to enhance pharmacy-specific electronic medical record technology.⁵ However, pharmacy schools may receive grants for incorporating electronic personal health technology into clinical education.⁶

A fundamental part of the expansion for meaningful use standards is the national expansion of health information exchanges (HIEs). Through the Office of the National Coordinator for Health Information Technology (ONC), funding was awarded to states, eligible territories, and qualified state-designated entities to construct HIEs under the Cooperative Agreement Program. As of 2011, all 56 entities have received an award to implement their plan.⁷ These HIE networks will serve as access ports for the communication of patient information across the health care system both within and across states. The ONC hopes to create a nationwide interoperable health
The profession of pharmacy has actively positioned itself so that it is included in changes occurring within the HIT landscape. However, despite increased involvement from national pharmacy associations through the Pharmacy Health Information Technology Collaborative (Collaborative), certain challenges remain. One of the most significant challenges to pharmacists’ access to patient information is their lack of designation as providers under CMS.

Access here refers to electronic access through interoperable systems; if pharmacists are not designated as providers, they are not eligible for meaningful use incentives. Currently, only doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatry, doctors of optometry, and chiropractors are eligible for Medicare-based meaningful use incentives. Pharmacists are allowed access to patient information by complying with regulations under the Health Insurance Portability and Accountability Act (HIPAA), but in most cases this request for access occurs via fax or telephone versus an integrated EHR. Pharmacists are commonly excluded from the conversation involving access to patient health information, and the concern is that many HIT systems, on a local and national level, are being created without pharmacist input.

Pharmacists are challenged on a daily basis to verify patient and provider information, medication information, and the validity of a prescription. Usually these questions are resolved by communicating with the physician or a physician office staff member. These multiple areas of inquiry require constant communication interrupting both the physician’s and pharmacist’s practice environments. Unfortunately for pharmacy, these interruptions led the American...
Medical Association (AMA) to pass a policy on inappropriate inquiries. Policy D-35.981, titled “AMA Response to Pharmacy Intrusion into Medical Practice,” states that “Our AMA deems inappropriate inquiries from pharmacies to verify the medical rationale behind prescriptions, diagnoses, and treatment plans to be an interference with the practice of medicine and unwarranted.”14 The policy was created in reference to the verification of legitimate controlled substance prescriptions, but it makes the point that these types of interruptions can detract from overall patient care. This policy and frustration by physicians could have been avoided had there been adequate access to patient information and interoperable communication between physicians and pharmacists.

As mentioned earlier, the Collaborative has been actively involved in promoting pharmacy involvement in the planning of HIT services on the national level. The Collaborative has created multiple work groups to identify key areas within the realm of HIT where pharmacists should be included. These areas are highlighted within a document produced by the Collaborative titled “The Roadmap for Pharmacy Health Information Technology Integration in U.S. Health Care.”15 The Collaborative is currently updating these goals, which coincide with the purpose of this background document. Along with general guiding principles, they serve as the Collaborative’s strategic plan.

Collaborative Goals15

- Ensure HIT supports pharmacists in health care service delivery
- Achieve integration of clinical data with electronic prescribing (e-prescribing) information
- Advocate pharmacist recognition in existing programs and policies
- Ensure HIT infrastructure includes and supports MTM services
- Integrate pharmacist-delivered immunizations into the EHR
- Achieve recognition of pharmacist as meaningful users of EHR quality measures
- Advance system vendor EHR certification
- Promote pharmacist adoption and use of HIT and EHRs
- Achieve integration of pharmacies and pharmacists into health information exchanges
- Establish the value and effective use of HIT solutions by pharmacists

Collaborative Guiding Principles16

- Identify (through the consensus work of expert panelists) the minimum data set and functional EHR requirements for the delivery, documentation, and billing of pharmacist-provided medication management services. Such requirements include access to key medical information, such as laboratory data, and bidirectional communication flow among all practitioners
- Structure and support implementation of a Pharmacy Practitioner HIT roadmap (Roadmap). The Roadmap is a document that directs and establishes benchmarks. These benchmarks will describe the development, implementation, and application of technology in an efficient and effective manner for pharmacists to affect improved medication use
- Build cooperative relationships within pharmacy and among pharmacy and other stakeholders to communicate and advocate for the Pharmacy Practitioner minimum data set and Roadmap leading to a certified EHR as defined in the Federal Register
- Ensure pharmacy representation on key HIT-related committees and workgroups

This Roadmap also discusses the role that pharmacists can play with increased access to patient information. MTM services are performed in almost every pharmacy setting with documentation
Access to and Interpretation of Patient Information

Gaining access to patient information is easier said than done. Gaining access is also merely the first step to proper use of patient information. The interpretation of data to benefit patient outcomes or safety is the next step to full meaningful use. Focusing on access issues reveals not only an initial physical barrier due to a lack of interoperability between technologies, but also a privacy barrier due to a lack of patient permission or the need to comply with statutory requirements. In addition, misinterpretation of privacy laws by those in control of patient information further complicates the access issue.

The lack of interface among different pieces of HIT, along with the inconsistency of HIT use, sums up the need for increased interoperability between all methods of communication involving health care providers. Current overall access to patient medical records is limited, and, as revealed by the ASHP ambulatory care conference pharmacists’ limited access to patient information is a barrier to proper care.

The privacy barriers stem from federal statutes along with individual patient preference and a varying interpretation of HIPAA laws within health care organizations. Data segmentation is quickly becoming more prevalent as more providers gain access to patient information. Specifically, future research should examine the role of genomic data in affecting medication adherence.
therapies. Patients have the ability to restrict access to certain data such as lab results or genomic test results and can also restrict the users who can see that data. Patient engagement will be a key factor to best manage user preference for data sharing between health care providers as data segmentation moves forward. Building a strong relationship between patients, providers, and pharmacists will ensure trust to share data openly. As decisions are made in this area, the importance of educating the patient regarding pharmacist access to health information will increase.

Proper and effective use of patient information is important once access is obtained. A pharmacist has the clinical knowledge to interpret patient information and make clinically based recommendations. These recommendations can be effective only if they are communicated not only to the patient but also to the primary care provider and other health care team members. Bidirectional communication is essential for the proper use of patient data. This communication should take a reasonable amount of time and be unencumbered by complicated systems.

**Electronic Prescribing**

A reduction in medication errors, improved quality of care, and reduced time gap between point of care and point of service were the main drivers to incorporate e-prescribing systems within pharmacies. Legibility of prescription information and problems with physician signatures were issues commonly encountered with hand-written prescriptions. Early e-prescribing systems reduced errors caused by these problems. However, e-prescribing may have created the opportunity for different types of errors.

Standards exist for e-prescribing operations within the realm of electronic communication from system to system. These standards, referred to as the NCPDP SCRIPT Standard, were created and are continually managed by the National Council for Prescription Drug Programs (NCPDP). The SCRIPT Standard includes specifications for pharmacies, prescribers, and other entities (e.g., payers, processors, health plans, intermediaries). NCPDP is constantly working to advance these standards beyond current capabilities to expand opportunities for pharmacy through e-prescribing software.

No universal standards exist related to qualifications of users or training requirements before using e-prescribing software. Multiple e-prescribing systems with varying functionality exist in the marketplace. Two general types of systems are those that are integrated into EHRs and those that are stand-alone. Within these two general types, systems may have medication decision support of varying degrees or be without these support functions.

With several different types of e-prescribing software available in the marketplace, the potential for error is multiplied. Best practices for use of e-prescribing software are contained in a toolkit from the Agency for Healthcare Research and Quality (AHRQ) that is meant to help reduce error potential. The toolkit suggests continual education beyond the initial training session to instill the importance of proper e-prescribing techniques. The extent to which this toolkit is used is unknown, and if users do not stay up to date with their current e-prescribing system, then errors may become more prevalent. AHRQ also identified some articles that set forth best practices for use and implementation, but they were published between 2004 and 2006 and may not be up to date with current e-prescribing capabilities. An article published in 2008 from a chain
pharmacy practice outlines the general recommendations for pharmacy usage; however, this article might also be outdated. Surescripts has published its own version of e-prescribing best practices, but what is needed is one set standard for all e-prescribing companies within the marketplace.

As previously mentioned, e-prescribing systems solved some issues but then opened the door to new problems. With inadequate or improper training, users may enter incorrect information into the wrong field or add conflicting instructions in the Additional Comments section. One study found an error rate of 1 in 10 prescriptions, which matched the previously found error rate for handwritten prescriptions. Errors in the selection of pull-down menu items have also been an area of concern. In addition, there is limited access to error reporting systems related to e-prescribing. The PEER Portal was created to collect data related to errors found specifically in a pharmacy setting. This web-based platform showed that the majority of errors were related to SIG/directions (25%) and quantity selection (18%), followed by electronic prescriptions containing conflicting information (11%) and dose selection (10%). The median time spent resolving errors was 10 minutes, which was found to cost about $9 per corrected e-prescription error. To resolve technology errors, system vendors must be aware of what is not working. If technology vendors do not make system modifications voluntarily, standards must be revised and enforced to mandate the problem resolution.

New Technologies
At present, an almost unlimited amount of information can be accessed by the swipe of a fingertip. Health care data is no different, and new technologies should always be considered to positively affect patient care. Many web-based health information platforms are in operation today. Some hospitals allow patients to view lab results, schedule appointments, and even send inquiries to their providers. The Health and Human Services Blue Button Initiative gives patients secure access to personal health records. Access to this data can also be provided to various designated recipients. Data can be accessed online or through a phone or tablet-based application. The use of new technology enabling patients to become more involved in their personal health care must be considered by all health professionals.

The importance of health and pharmacy informatics will continue to grow as new technologies are created and require detailed knowledge for proper integration. Integrated systems will need to merge different types of data formats, which highlights another barrier. A recent collaboration between Walgreens and Greenway Health overcame this barrier by allowing such access, which resulted in the largest centralized pharmacy cloud-based EHR system in existence today. Future integration between EHRs, e-prescribing, prescription drug monitoring programs, immunization registries, and others will be essential to enhancing patient care among all health professionals. Much of the needed data exchange can occur seamlessly without additional effort from health providers. Meaningfully and appropriately utilizing the information will be the challenge for providers.
Conclusion

The world of HIT is evolving rapidly and will continue to do so into the future. The profession of pharmacy must play an active role in obtaining equal and effective access to patient information through the work of the Pharmacy HIT Collaborative. Access to relevant patient data in an EHR should be straightforward and allow for timely exchange of information between the pharmacist and physician. The pharmacist’s ability to provide advanced patient care services and enhance patient safety will be expanded through adequate access to patient information. Use of e-prescribing and EHR systems should require enhanced training or qualifications to prevent the occurrence of medication errors. Standardization of interface abilities and ease of use between e-prescribing and EHR systems should be considered as more and more health professionals gain access to these capabilities. Through these various actions, the profession of pharmacy will have a better chance to break out of silos and expand the impact to patients provided through pharmacist patient care services.

References

2. American Academy of Family Physicians (AAFP), Center for Health IT, 2013


29. The Alliance for Patient Medication Safety (APMS) and The National Alliance of State Pharmacy Associations (NASPA). E-Prescribing/Patient Safety Analysis utilizing the Pharmacy...

Relevant APhA Policies

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.

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

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

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

2009 Health Information Technology
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) (Reviewed 2013)

2001 Automation and Technical Assistance
APhA supports the use of automation for prescription preparation and supports technical and personnel assistance for performing administrative duties and facilitating pharmacist’s provision of pharmaceutical care.


2003 Prior Authorization
1. APhA opposes prior authorization programs that create barriers to patient care.
2. Patients, prescribers, and pharmacists should have ready access to the coverage conditions for medications or devices requiring prior authorization.
3. Prescription drug benefit plan sponsors and administrators should actively seek and integrate the input of network pharmacists in the design and operation of prior authorization programs.
4. APhA supports prior authorization programs that allow pharmacists to provide the necessary information to determine appropriate patient care.
5. APhA expects prescription drug benefit plan sponsors to compensate pharmacy providers who complete third-party payer authorization procedures. Compensation should be in addition to dispensing fee arrangements.
6. APhA should work with relevant groups to improve prior authorization design and decrease prescription processing inefficiencies.

Integrated Nationwide Prescription Drug Monitoring Program

The Committee recommends that the Association adopt the following statements:

1. APhA supports the establishment of a standardized and integrated nationwide prescription drug monitoring program (PDMP) that includes all federal, state, and territory databases for the purpose of providing health care professionals with accurate and real-time information to assist in clinical decision making when prescribing and dispensing controlled substances.
   [Refer to Summary of Discussion Item 2, 3, 4, 5.]

2. APhA supports pharmacist involvement in the development of uniform standards for an integrated nationwide prescription drug monitoring program (PDMP) that includes the definition of authorized registered users, documentation, reporting requirements, system response time, security of information, minimum reporting data sets, and standard transaction format.
   [Refer to Summary of Discussion Item 5, 6, 7.]

3. APhA supports mandatory prescription drug monitoring program (PDMP) enrollment by all health care providers who prescribe or dispense controlled substances, system query before prescribing controlled substances, and reporting by all those who dispense controlled substances.
   [Refer to Summary of Discussion Item 9.]

4. APhA advocates for the development of seamless workflow integration systems that would enable consistent use of a nationwide prescription drug monitoring program (PDMP) by prescribers and pharmacists to facilitate prospective drug review as a standard of practice before the prescribing and dispensing of controlled substances.
   [Refer to Summary of Discussion Item 10, 11.]

5. APhA advocates for continuous, sustainable federal funding sources for practitioners and system operators to utilize and maintain a standardized integrated and real-time nationwide prescription drug monitoring program (PDMP).
   [Refer to Summary of Discussion Item 12.]

6. APhA supports the use of interprofessional advisory boards to coordinate collaborative efforts for (1) compiling, analyzing, and using prescription drug monitoring program (PDMP) data trends related to controlled substance misuse, abuse, and/or fraud; (2) providing focused provider education and patient referral to treatment programs; and (3) supporting research activities on the impact of PDMP programs.
   [Refer to Summary of Discussion Item 13.]

7. APhA supports education and training for authorized users about a nationwide prescription drug monitoring program (PDMP) to ensure proper data integrity, use, and confidentiality.
   [Refer to Summary of Discussion Item 14.]
Summary of Discussion

1. The Committee reviewed the 1989 APhA policy related to multiple-copy prescription order programs and agreed on a need to revisit APhA’s position on this issue.

2. The Committee recognized the current lack of nationwide connectivity among state-based PDMPs. The term “nationwide” was used intentionally to describe a system that connects data rather than one system at the national level.

3. The Committee agreed that these systems should be used for clinical decision making and that part of the clinical decision-making process includes the consideration of misuse, abuse, diversion, and fraud regarding controlled substances.

4. The Committee discussed platforms, such as NABP PMP InterConnect, that connect state-based information but noted that the lack of nationwide connectivity interferes with prescribers’ and pharmacists’ ability to make sound clinical judgments related to the prescribing and dispensing of controlled substances.

5. The Committee agreed on the need to support a system that allows for interconnectivity of the data currently being collected in each state.

6. The Committee discussed the need to have uniform standards for integrated nationwide prescription drug monitoring and agreed that pharmacists must be involved in the development of such standards. Recognizing that each state currently has its own requirements related to these programs, the development of standards will be key to successful implementation of a nationwide program. The Committee agreed that funding will be a key driver in the development of nationwide standards.

7. The Committee discussed the issue of access to the information housed in PDMPs. The definition of an authorized registered user and the level of user access may vary among states and should be addressed in the creation of nationwide standards. The Committee also agreed that pharmacists’ ability to delegate access should be addressed in nationwide standards.

8. The Committee discussed the need for pharmacists to document when they refuse to fill a prescription and return it to the patient based on information found in the PDMP. Lack of documentation may pose a risk to the pharmacist if he or she is unable to explain why the database was accessed for a particular patient. The Committee felt that this concept is addressed by “documentation” in statement 2.

9. The Committee agreed that enrollment in a PDMP must be mandatory to ensure that both prescribers and pharmacists participate in the program. Optional enrollment could result in a lack of participation. Discussion centered on the need to develop systems that enable the programs to be used consistently and within the standard of practice.

10. The Committee agreed that the use of these systems should not interfere with the delivery of legitimate patient care. The seamless integration of these systems into both prescriber and pharmacist workflow is essential for the successful implementation of an integrated nationwide program.

11. The Committee discussed the fact that pharmacists have a duty to protect the public and using PDMPs in the course of patient care assists pharmacists in performing this duty.

12. The Committee recognized the costs associated with the creation and implementation of any nationwide system and agreed that sustainable funding is necessary to facilitate the
development of such a program. The Committee believes that federal funding drives implementation of nationwide standards.

13. The Committee agreed on the need to have an interprofessional advisory board to guide collaborative efforts related to PDMPs. Compiling, analyzing, and using program data will assist in providing focused provider education. In addition, analyzing data trends may help providers identify and refer patients who need addiction treatment.

14. The Committee recognized the need for ongoing education and training related to the use of a nationwide PDMP to ensure that users of the system understand how data should be maintained and utilized to ensure patient confidentiality.

Attachment

Background Paper prepared for the 2014-15 APhA Policy Committee
Issue

The American Pharmacists Association (APhA) Board of Trustees has directed the 2014–2015 Policy Committee to recommend policy to the APhA House of Delegates concerning a National Prescription Drug Monitoring Program (NPDMP). Topics to be explored, per the direction of the APhA Board of Trustees, include components and standardization of an NPDMP, variability among controlled substance regulations between states, incorporation of drug monitoring programs into the pharmacist’s patient care process, data reporting, and financial feasibility of an NPDMP.

The abuse, misuse, and diversion of controlled medications is a nationwide problem. Between 1999 and 2010, prescription opioid sales quadrupled. The rise in opioid prescriptions was mirrored by an increase in opioid-related deaths, resulting in a mortality rate four times higher in 2008 than in 1999. In addition to a rise in opioid-related deaths, a rise in emergency department visits for opioid-related medical problems doubled between 2004 and 2007. Likewise, admissions to abuse treatment centers rose, with prescription opioids being the second leading cause of admissions. In response to the rise in opioid prescription abuse, misuse, and diversion, prescription monitoring programs were developed, first in California using resources available such as carbon copies, U.S. mail, and triplicate forms. In 2011, through national funding and the increased focus on prescription monitoring by the White House Office of National Drug Control Policy, states received additional support to create prescription drug monitoring programs (PDMPs). By 2013, 49 states passed laws enabling the creation of these programs.¹

Currently, participating states oversee their own drug monitoring programs. Despite the growth and implementation of PDMPs in each state, their inability to facilitate interstate communication limits pharmacists’ and physicians’ ability to utilize these tools to their fullest potential. The National Institutes of Health published a manuscript addressing the concerns associated with PDMPs’ inability to allow interstate communication and barriers associated with varying PDMPs.¹ Other authors attempt to study the impact that state PDMPs have on treatment referral, medication abuse, misuse, and diversion, as well as the impact on patient care, but the researchers find generalizing the data or combining PDMP data difficult due to the variations in state PDMPs.²⁻³ It seems that a national prescription drug monitoring program may be beneficial, but no organizations or groups have published reports outlining standards or recommendations for an NPDMP.
Summary of Concepts

- Medication abuse, misuse, and diversion is a national problem affecting all states.
- The use of a national prescription drug monitoring program would assist with PDMP data sharing and interstate connectivity.
- Barriers such as ineffective communication, inconsistency between state monitoring programs, insufficient funding, and lack of incorporation into the patient care process prevent efficient and optimal use of PDMPs.
- Although use of PDMPs in most states is expected, no defined regulations have been created to ensure the appropriate, consistent, efficient, and optimal use and access of PDMP data. Pharmacists, as medication experts and dispensers, have an opportunity to play a significant role in helping to curtail medication abuse, misuse, and diversion.
- PDMPs should be incorporated into health care professionals’ workflow through the study of current pilot programs and the use of health information technology (IT) to provide access to the data for all health care providers.
- A number of key aspects have been identified that allow for a successful PDMP.
- DMPs should continue to be studied to ensure their quality, efficacy, and efficiency for health care providers and patients.

Background

Definitions
For the purposes of this discussion paper, the following definitions will be used:

**Prescription Drug Monitoring Program (PDMP)**
According to the National Alliance for Model State Drug Laws (NAMSDL), a PDMP is a *statewide* electronic database that collects designated data on substances dispensed in the state. The PDMP is housed by a specified statewide regulatory, administrative, or law enforcement agency. The housing agency distributes data from the database to individuals who are authorized under state law to receive the information for purposes of their profession.4

**Controlled Substances**
A controlled substance is a drug or chemical whose manufacture, possession, or use is regulated by a government and whose general availability is restricted. Controlled substances are subject to government control. They may include prescription medications and drugs or other substances that are strictly regulated or outlawed because of their potential for abuse or addiction.4

**White House Office of National Drug Control Policy (ONDCP)**
ONDCP was created by the Anti-Drug Abuse Act of 1988. ONDCP advises the President on drug-control issues, coordinates drug-control activities and related funding across the federal government, and produces the annual National Drug Control Strategy, which outlines administration efforts to reduce illicit drug use, manufacturing and trafficking, drug-related crime and violence, and drug-related health consequences.5
**National Drug Control Strategy**

The ONDCP’s National Drug Control Strategy outlines innovative policies and programs and recognizes that substance use is not only a criminal justice issue but also a major public health concern.6

**2014 Reform Drug Policy**

This policy focuses on prevention, expansion, reform, and support. Prevention strategies will use education to prevent drug use before it begins. Expansion will increase patient access to treatment centers. Reform will change the legal system to break the cycle of drug use, crime, and incarceration while maintaining the safety of the public. Support will focus on working to eliminate or reduce the stigma associated with substance abuse or disorders to provide greater support for Americans struggling with substance abuse.7

**Benefits of PDMPs**

The overview provided by NAMSDL clearly identifies the benefits of a PDMP as a tool used by states to address prescription drug abuse, addiction, and diversion. It may serve several purposes:

1. Support access to legitimate medical use of controlled substances
2. Either prevent or identify and deter drug abuse and diversion
3. Facilitate and encourage the identification of persons potentially involved in medication abuse, misuse, or diversion
4. Inform public health initiatives through outlining medication use and abuse trends
5. Educate individuals about PDMPs and the use, abuse, diversion of, and addiction to prescription drugs4

**PDMP facts**

As of June 2014, 49 states and the District of Columbia (DC) have enacted PDMP legislation, and 48 of the 49 states currently have operational PDMP programs; only DC and New Hampshire do not have operational programs. The majority of the states’ programs require submission of prescription data within 1 week of collection, with a few processing the information within 1 to 3 days. Oklahoma is the only state that processes the information in real time. The majority of states’ PDMP information is housed in health departments, single state authorities, or the board of pharmacy, but the PDMPs of five states are regulated by law enforcement agencies. For example, Georgia’s PDMP is regulated by the Narcotic and Drug Agency under the direction and oversight of the Board of Pharmacy. Although each state’s program regulations vary concerning who can access the PDMP information, the majority allow access by the following entities: licensing and regulatory boards; practitioners; authorized agents; law enforcement officials (pursuant to an active investigation); judicial and prosecutorial officials; Medicare, Medicaid, and State Health Insurance Programs; patients; parents (either with or without a consent form); prescribers; and dispensers. In addition, approximately 50% of the states provide immunity to prescribers and dispensers, meaning the data collected through PDMPs cannot be used to accuse prescribers or dispensers of illegal or unethical activity.
Finally, the majority of states have some regulation in place to deter users of PDMP services from disclosing or obtaining information unethically.4

Components of a Strong Prescription Drug Monitoring Program as identified by the National Alliance for Modern State Drug Laws4

1. **Drugs Monitored:** The medications monitored should be those having high abuse potential, including controlled substances, but also medications that have a history of abuse but are not classified as a C-II through C-V medication.

2. **Disclosure:** PDMPs should proactively provide information to prescribers, dispensers, law enforcement, and occupational licensing individuals.

3. **De-identified Information:** De-identified information should be allowed for release to individuals, groups, or organizations using the information for any of the following purposes: statistical analysis, public research, public policy, or educational purposes. Information that should be removed must include anything that could identify or reasonably identify the patient, prescriber, dispenser, or other person who is the subject of the information.

4. **Authorized Users:** Authorized persons include dispensers, prescribers, law enforcement officials (pursuant to an active investigation), prosecutorial officials, health licensing agencies, boards for prescribers or dispensers, and patients. In addition, other authorized users who may be considered are those who will use this information to enhance patient care or patient safety, for example, medical examiners, coroners, and representatives of drug and alcohol abuse treatment centers.

5. **Authorized Users Training and Education:** All authorized users who may access the information should prove they have the education and training to use the PDMP data appropriately.

6. **Standards of Procedure for Access and Use of PDMP Data:** Providing standards of use should stand to decrease abuse and misuse of the system. In addition, standards of procedure will allow the PDMP to be utilized to its full capacity to improve patient care and safety.

7. **Linkage to Addiction Treatment Professionals:** Allowing linkage to addiction treatment professionals may enhance the PDMP’s ability to identify patients who qualify for addiction treatment centers.

8. **Interstate Sharing of PDMP Data:** Recipients of PDMP data from other states may include prescribers, dispensers, law enforcement representatives, PDMP officials, or other specified authorities.

9. **Confidentiality Protections:** The confidentiality protections should not only outline regulations but also provide information concerning penalties for nonessential disclosure of the confidential information. To prevent improper disclosure, the PDMP managing body should maintain procedures to protect the privacy and confidentiality of patients and to ensure that data collected, recorded, transmitted, and maintained pursuant to the PDMP law are not disclosed or used except as authorized by the law.

10. **Evaluation Component:** The evaluation component of the PDMP is necessary to determine the cost benefit of the program and identify the impacts of the use of PDMP data on authorized users’ practices. It will also provide a means to identify potential operational improvements. It is suggested that the evaluation component consist of an advisory committee.
Discussion

Due to the rise in prescription drug abuse, misuse, and diversion in the United States, the government provided national funding through the White House ONDCP to support the development of prescription monitoring programs for each state. By condensing prescription dispensing information into one database, PDMPs provide health care providers with the opportunity to review a patient’s medication history and assist them with decisions concerning their medication regimen. For example, PDMPs allow physicians to identify patients who may benefit from substance abuse counseling, prevent prescribing that may result in overdose, help coordinate patient care, and perhaps identify patients and practitioners who abuse or divert prescription drugs. It is for these reasons that the Centers for Disease Control and Prevention (CDC) as well as the President support the use of PDMPs.²

Despite national support of the development of state-based drug monitoring programs, the creation of these programs has been controversial. Prescription monitoring programs were originally designed to assist with law enforcement and decrease opioid abuse and diversion; however, they have secondarily facilitated addressing public health concerns by allowing monitoring of physician prescribing and identifying opportunities for addiction services. This secondary role has left some physicians feeling scrutinized, which may affect their opioid prescribing. This situation in turn may lead to over- or under-prescribing of opioids resulting in inappropriate or inadequate pain management. In addition, concerns are raised about privacy and the inadvertent release of private information. In conjunction with privacy concerns are concerns about who should have access to data collected by drug monitoring programs and how often. Finally, the impact of prescription monitoring programs on patient care is also under question. It is yet to be determined whether PDMPs improve or worsen patient care. No evidence exists to support the notion that PDMPs have significantly assisted with situations mentioned above or helped regulatory agencies identify illegal activities. Lack of significant data could be due to an inconsistency among different state programs, including variations and frequent changes in PDMP laws.

In addition to being unable to identify whether PDMPs affect patient care and the control of illegal and unethical activities, PDMPs are also limited by their individual state-to-state use. Because each state has its own program with different regulations and collection guidelines, the information is not readily shared across state lines, making the monitoring of individuals who have moved or travel frequently difficult. With the increase in travel across state lines and the inability to study the impact of PDMPs and their cost benefit, it has been suggested that the creation of a National Prescription Drug Monitoring Program (NPDMP) may be beneficial.⁷ An NPDMP would provide a means to use data from different states when a person travels or moves. However, the NPDMP opportunity does not come without barriers. To create, establish, and execute an NPDMP, legislative action, including funding, will need to commence; then standards and regulations must be created by the appropriate federal agency.
Potential Approach to a National Prescription Drug Monitoring Program

A National Prescription Drug Monitoring Program concept has been mentioned and supported by some health care providers, the Bureau of Justice Assistance, and the National Institutes of Health as a means to enhance the fight against prescription drug abuse, misuse, and diversion; identify patients for abuse treatment programs; provide a database for states not currently using a PDMP; and provide uniform expectations for prescribers, dispensers, and consumers.\textsuperscript{1,8} However, the federal government and CDC do not support a National Prescription Drug Monitoring Program. This lack of support may be due to a lack of awareness of the deficiencies in having individual PDMPs operated in each state. These deficiencies include the inability to adequately study the effects a PDMP has on patient care and safety, the difficulty involved in interstate communication, and a low level of understanding of the issues associated with the lack of standardization or consistency among state PDMPs. The lack of standardization prevents the linkage of state programs. Therefore, the Council of State Governments, Congressman Hal Rogers of Kentucky, and the National Association of Boards of Pharmacy have discussed interoperability standards to facilitate interstate communication.\textsuperscript{1} In addition, standardization would prevent the abuse of some controlled substances from going unidentified. For instance, a patient’s abuse or misuse may continue unidentified due to substitution with a medication that is not on the PDMPs list of medications required to be monitored.

Recommendations include both standardizing the medications to be monitored, and standardizing the way in which access is granted. Web-based PDMPs seem to provide the most benefit, by allowing immediate access to data versus waiting on information via fax, telephone, or mail. Another recommendation is to standardize the length of time prescribers and pharmacists are given to report information to the database. Because daily or real-time reporting may be burdensome and monthly reporting may be suboptimal, it may be most appropriate for pharmacies to report information to the PDMP every week. Determining a standard reporting time would need to be agreed upon nationally and would most likely require further evaluation. Finally, all states should be required to ensure the accuracy of data, determine the impact of the program, and evaluate responses to program changes through an evaluation process.

A key consideration in the discussion of a drug monitoring program is the type of program to be implemented. Studies have shown that proactive programs with periodic unsolicited audits perform better than those that do not require these audits.\textsuperscript{1,9} Standard reviews would provide more data and information pertaining to drug abuse and misuse such as geographical areas of high incidences, patients filling prescriptions from five or more prescribers within a 6-month period, patients who submit prescriptions in an overlapping period, and identification of at-risk co-prescriptions.

Implementing education and training requirements to ensure program awareness as well as an understanding of the protocols and procedures regulating the program may be necessary. One barrier to using the NPDMP may be an inability to incorporate it into clinical workflow. To make the data provided by the NPDMP more accessible, an increase in authorized users of the PDMP may be necessary. Allowing for better incorporation of PDMP data into workflow is supported by the Substance Abuse and Mental Health Services Administration, which
recommends allowing physicians to access the information via medical records and allowing unsolicited alerts inside the medical record to highlight potential abuse or misuse situations.9

Currently, states’ PDMPs are funded individually by general state revenues, licensing board fees, state controlled substance registration fees, health insurers’ fees, and state and federal grants, but a national PDMP would require more extensive funding and might result in better consistency and efficiencies among states. The annual cost of a state PDMP is $125,000 to $1 million.10 A potential revenue source would be the National All Schedules Prescription Electronic Reporting program, which would require Congress to restore funding for the program. It may also be beneficial to consider funding from pharmaceutical companies that have a significant stake in appropriate use of controlled substances. Selling points for industry buy-in are that the NPDP may reduce prescription drug abuse and overuse and thereby decrease the likelihood of more restrictive regulations on controlled substances. In addition, complications from abuse, misuse, and overdose place a high cost burden on pharmaceutical companies, and the successful implementation of a national PDMP could potentially alleviate some of this strain.1

The Bureau of Justice Assistance (BJA) is also focused on improving interoperability and has made this initiative a priority. The BJA has facilitated the creation of a national Prescription Drug Monitoring Information Exchange (PMIX) architecture. PMIX enables nationwide information sharing while allowing states to maintain their current technology. PMIX does not require adoption of a particular system. The primary concern, or barrier, for a national program involves standards, but PMIX standards are free, open, and community-based. Users of PMIX are allowed access to the nationally built standards at no cost. By keeping the standards open and free, PMIX preserves states’ choices to build, buy, or reuse software according to a commonly understood and accepted framework that will facilitate PDMP system interoperability. The second barrier for a national PDMP is common formatting of shared data. PMIX addresses this issue by using the National Information Exchange Model (NIEM). NIEM establishes common data vocabulary and format for interstate information sharing, thereby allowing states to continue managing their information as they currently do, while enabling them to share information across state boundaries. PMIX protects personally identifiable information and protected health information by requiring end-to-end data security and encryption of data. This form of protection ensures that information reaches its intended destination. The security technology used allows incorporation into numerous types of systems, including non-PDMPs and other systems that are consistent with Health Insurance Portability and Accountability Act standards.11

**NABP PMP InterConnect® Platform**

In addition to the approaches described above, the National Association of Boards of Pharmacy launched InterConnect® in July 2011, a platform that facilitates the transfer of PDMP data across state lines to authorized users. It allows participating state PDMPs across the United States to be linked, providing a more effective means of combating drug diversion and drug abuse nationwide. Information about this program is provided as a supplement to this background paper (Appendix A).
Role of Pharmacists in the National Prescription Drug Monitoring Program

Pharmacists using prescription monitoring programs can assist in detecting and then intervening to decrease the abuse, misuse, and diversion of controlled substances state- and nationwide. They can also help determine whether patients are being inadequately controlled for pain. Through identification of patients with inadequate or inappropriate pain control, they can refer the patient to an appropriate resource such as a pain management physician or abuse treatment center. However, pharmacists are limited in their ability to assist with drug diversion without systems that communicate effectively. Development of a user-friendly database providing the means for interstate communication would greatly increase pharmacists’ ability to assist in this situation. Such a database would apportion the responsibility of managing and addressing drug diversion, enable pharmacists to assist prescribers with medication-related decisions, and help them avoid facilitating diversion. Because prescription abuse continues to be a national concern for health care providers, creation of an NPDMP would allow for better transparency of patient history and better patient care assessments by the pharmacist concerning the dispensing and use of controlled substances.

Benefits of a National Prescription Drug Monitoring Program

Creation of a National Prescription Drug Monitoring Program would require states to agree on national standards to regulate their PDMPs to decrease abuse, misuse, and diversion of controlled substances. The use of a national PDMP may be sensible because the problem of abuse, misuse, and diversion exists nationwide; therefore, it should be monitored and regulated with a nationwide program. For patients who do not remain in one state and travel or move from state to state, a national program would allow for continued observation and maintenance of prescription use data. A national program may be created by unification of the current state-regulated PDMPs and therefore decrease the cost burden associated with building a NPDMP. Moreover, a national drug monitoring program could extend beyond communication of information about controlled substances and commonly abused medications; it could also communicate information concerning drug shortages and drug importation. In addition, creation of a national drug monitoring program would increase pharmacists’ ability to assist with pain management, drug diversion, abuse, and misuse and thereby increase their role and involvement in the health care system. Finally, a national program with scheduled reviews could highlight patients who are “doctor shopping,” prescribers who are unethically or illegally prescribing medications, and/or pharmacists who are unethically or illegally dispensing medications.

Barriers to Implementation of a National Prescription Drug Monitoring Program

Funding

Although the government has funded some of the state-level prescription monitoring programs and the BJA has supported the creation of the PMIX, there is currently no identified funding for a national prescription drug monitoring program. While states have the opportunity to take advantage of federal grants, these opportunities are limited. Private, nonfederal grants, such as those from the National Association of State Controlled Substances Authorities, a nonprofit educational program, provide smaller amounts of funding for educating stakeholders, but these
funds would not be sufficient for a national program. The majority of states fund their PDMPs through revenue funds, using state taxes, sales taxes, income taxes, and property taxes. While taxes would be an option for funding a national program, doing so might not receive positive feedback and approval from the public. Other revenue sources for PDMPs include licensing boards, controlled substances registration fees, and other local fees, which would not be appropriate for funding a national prescription drug monitoring program. Due to current state-to-state techniques and strategies for funding PDMPs, finding a financially feasible funding source for a NPDMP may prove difficult. To develop a successful NPDMP, national funding must be identified to ensure an effective and beneficial national program.

**Incorporation into the patient care process**

For an NPDMP to be financially beneficial, all states’ health care practitioners must take advantage of the program and use it to its fullest potential. Currently, however, studies have shown that only five states require prescribers to access PDMPs and those requirements apply only to a specific set of physicians in limited situations. With a national PDMP, access to PDMPs by health care professionals must be mandated and incorporated into the patient care process in a seamless manner. Based on white papers published by the Department of Health and Human Services Office of the National Coordinator for Health Information Technology (ONC), successful incorporation of the PDMP system into physician workflow changes prescribing habits. The Indiana Direct Messaging white paper reports that sending unsolicited secure electronic messages improves prescriber awareness. These messages provide alerts to physicians on a weekly basis identifying persons of interest (POIs) based on a defined “at-risk” threshold. Other projects have incorporated PDMPs into e-prescribing to improve usability and access and have provided direct links inside electronic health records (EHRs) to connect physicians to PDMPs. Projects that combine incorporation into EHRs and identifying POIs increase physicians’ access to and use of PDMPs. However, the use of PDMPs must be incorporated into both physician and pharmacy workflow. A white paper by the ONC identified the possibility of using health IT to implement the current process for identifying patient insurance eligibility to access patients’ prescription use information. This step would eliminate pharmacists’ need to access the information manually and would result in a substantial increase in access to PDMP data.

In addition to the incorporation of patient information into the PDMP, pharmacists are concerned about their ability to manage the information obtained from the system when encountering a potential abuser and protecting their and their staff’s safety. In August 2014, the Joint Commission of Pharmacy Practitioners (JCPP) adopted a statement and principles on pharmacists’ role in addressing prescription medication misuse and abuse. Included within this document were the following points of discussion:

- **Prescription Drug Monitoring Programs**: Prescription drug monitoring programs are useful clinical tools to identify, prevent, and manage prescription medication abuse and misuse. JCPP supports pharmacist access to and use of prescription monitoring programs and dispensing systems that provide timely, bi-directional, and seamless data collection tools to help identify potential abuse and misuse of prescription medications and support access to current relevant
medical information that will allow pharmacists to make appropriate decisions regarding medication therapy.

- **Patient referral mechanisms:** Recognizing that alcohol, chemical, and substance abuse is a disease, health care professionals and law enforcement agencies should have referral and treatment resources available to recommend to patients, family members, and caregivers, and individuals identified with a problem should be encouraged to seek treatment.

- **Need for provider protection:** Systems should be in place to allow providers to anonymously report (1) practitioners who may be abusing prescribing authority and (2) patients who are abusing or misusing prescription medications. Employers and public safety officials must respond to pharmacist and other health care professional calls for assistance, personal security, and legal protections to ensure professional and physical safety related to the reporting and management of situations in which abuse and misuse of prescription pain medications is suspected.

- **Education of providers:** Health care professionals and students who will ultimately prescribe and/or dispense prescription medications with the potential for abuse should have access to continuing education programs and institutes that address the various aspects of addiction, substance abuse, treatment, and recovery, including discussion of prevention, appropriate and safe use, proper storage and proper disposal of medications, patient education, and other related topics.

- **Cost of abuse-prevention systems:** To ensure the sustainability of prescription medication abuse and misuse monitoring and reporting systems, adequate financial and human resources must be available to providers and government agencies.

**Conclusion**

Because prescription abuse, misuse, and diversion is a nationwide issue, it is vital that states work together to share PDMP data and provide a national solution to prescription abuse issues. During the development of solutions to PDMP data access and information exchange, it is important to define standards for monitored drugs, identify persons who will have access, determine funding options, and make other determinations to ensure that a national prescription drug monitoring program meets the needs of all states and is successful in deterring abuse and identifying persons who can benefit from abuse treatment centers.

Pharmacists are well-positioned to provide valuable information for PDMPs and also to identify and recommend patients to abuse treatment centers. As medication experts and dispensers of prescription medications, pharmacists can provide counseling and support to assist with drug abuse and misuse awareness. As standardized methods for incorporating prescription monitoring data become available, it is important for pharmacists to continue to play an active role in prescription use monitoring. Providers should be supplied with proper education on the way in which to incorporate PDMPs into the workflow process, and they should be given additional resources to support their use of the PDMP data.
References


Related APhA Policies

1989 Multiple Copy, Prescription Order Programs
   1. APhA opposes federally mandated, multiple copy, prescription order programs.
   2. APhA supports the right of individual states to develop programs to prevent drug abuse and drug diversion.

2002 National Framework for Practice Regulation
   1. APhA supports state-based systems to regulate pharmacy and pharmacist practice.
   2. APhA encourages states to provide pharmacy boards with the following: (a) adequate resources; (b) independent authority, including autonomy from other agencies; and (c) assistance in meeting their mission to protect the public health and safety of consumers.
   3. APhA supports efforts of state boards of pharmacy to adopt uniform standards and definitions of pharmacy and pharmacist practice.
   4. APhA encourages state boards of pharmacy to recognize and facilitate innovations in pharmacy and pharmacist practice.
NABP PMP InterConnect

Developed by the National Association of Boards of Pharmacy® (NABP®), the NABP PMP InterConnect® was created by the Association to protect public health. Founded in 1904, NABP is the impartial non-profit organization that supports the state boards of pharmacy in protecting public health. NABP aims to ensure the public’s health and safety through its many programs, which range from pharmacist competency assessment programs to pharmacist license transfer to accreditation programs for Internet pharmacies and wholesale distributors. For more details on NABP and how it assists the state boards of pharmacy through its programs, please see page 6.

Overview of the NABP PMP InterConnect

Background on NABP Involvement

Recognizing NABP’s background in assisting boards of pharmacy and other regulators in protecting the public health, NABP was approached by several prescription monitoring program (PMP) administrators in the fall of 2010 about building a low cost, easy to implement, and highly enhanced solution for interstate data sharing that could be implemented in under a year.

NABP PMP InterConnect Design and Intent

At its core, the NABP InterConnect was designed to facilitate interoperability and interstate data sharing between PMPs.

Under the direction of a group of nationally representative PMP administrators, development of the NABP InterConnect began in January 2011. The administrators made several specific requests of the NABP InterConnect design and function:

- Utilize the messaging specification that was an outgrowth of the Bureau of Justice Assistance (BJA) efforts with Prescription Monitoring Information Exchange (PMIX), which would allow for seamless communication of program information between PMP programs.
- Encrypt the requests and responses from PMP to PMP using highly secure, widely deployed encryption technologies, ensuring no Protected Health Information or Personally Identifiable Information is exposed to any entity other than the disclosing and requesting PMPs.
- The NABP InterConnect should be:
  - Built using open standards
  - Cost effective
  - Easy to implement
  - Low maintenance
- The NABP InterConnect should include a rules engine that would allow PMPs to maintain complete control and autonomy over PMP data exchanges with other states participating in NABP InterConnect.

This group of PMP administrators also asked for a simplified process of participating in the InterConnect without having to draft and sign complex memorandums of understanding (MOUs) with every other participating state to ensure that each state’s access rules would be respected and enforced. Through the MOU, each state agrees to participate in the program and investigate reports of unauthorized disclosures of any information obtained by one of its users from another state, and NABP takes on the responsibility for ensuring that the state’s access rules are enforced via the rules engine. This rules engine, coupled with the single MOU, provides a highly effective and efficient pathway for interstate data sharing.

The NABP InterConnect, which launched for nationwide use on July 27, 2011, has effectively met and in many cases exceeded each of the criteria and expectations set by the PMP administrators.
Governance of NABP PMP InterConnect

The NABP InterConnect is governed by a Steering Committee, comprised exclusively of representatives of the PMPs that are participating in the system. The Steering Committee serves as the governing and advisory body as it relates to the administration and function of the NABP InterConnect. No outside organization, public or private, has a vote about, influence over, or the ability to direct the administration and function of the NABP InterConnect. Outside parties and subject matter experts may, however, be asked to provide information for the Steering Committee’s consideration from time to time.

Steering Committee Structure/Function

Currently, there are 26 members on the Steering Committee: Arizona, Arkansas, Colorado, Connecticut, Delaware, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Nevada, New Jersey, New Mexico, North Dakota, Ohio, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, and Wisconsin. Additional members will join as they agree to participate and execute the MOU with NABP.

At the Steering Committee meeting held on August 30-31, 2011, the Steering Committee unanimously adopted “Operating Principals” that will govern the activities and interactions of the committee.

Within those operating principals, the committee dictated the following:

- There shall be a chairperson of the committee, to be appointed annually by the NABP president.
- Voting (active) members of the committee shall be composed of those states that have executed an MOU with NABP for participation in NABP InterConnect.
- The committee, through the chairperson, may invite other states to participate in the Steering Committee as guests. The committee, through the chairperson, may invite other guests to participate, attend, or observe the Steering Committee meetings. Such individuals may include the technology solution provider for NABP InterConnect; NABP software vendors; relevant federal or state agencies or national associations dedicated to patient safety, safe drug use, and deterring diversion of controlled substances; or any other person as determined by the discretion of the chairperson.
- The chairperson will appoint a dispute resolution committee to mediate any disputes between states participating in the NABP PMP InterConnect. The dispute resolution committee shall be composed of three members from states not involved in the dispute, and the committee will be representative of the different types of agencies, eg, law enforcement, health agency, or board of pharmacy, where possible.
- All formal recommendations of the Steering Committee that comprise a significant policy or technical change to the NABP InterConnect, or would otherwise have a fiscal impact on NABP must be ratified by the NABP Executive Committee.

This arrangement is consistent with how all NABP committees and task forces are managed and administered. Further, the NABP executive director/secretary and Executive Committee are responsible for ensuring that all actions of such committees are congruent with the NABP Constitution and Bylaws of NABP, are consistent with the actions of other committees, adhere to state and federal laws and regulations applicable to not-for-profit associations, and adhere to the principals set forth by NABP regarding advancing public health initiatives.

The steering Committee shall meet, either in person, or via teleconference, at least once annually, and additionally at the discretion of the chairperson, or as requested by a simple majority of the members of the Steering Committee.

Adoption of NABP PMP InterConnect

As of February 2014, 26 states have executed an MOU with NABP to participate in the NABP InterConnect: Arizona, Arkansas, Colorado, Connecticut, Delaware, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, New Jersey, New Mexico, Nevada, North Dakota, Ohio, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, and Wisconsin.
The following PMPs intend to sign on to use NABP InterConnect and have MOUs under review: Montana, North Carolina, Rhode Island, and Wyoming. It is anticipated that approximately 30 states will be sharing data or in an MOU to share data using NABP InterConnect in 2014.

<table>
<thead>
<tr>
<th>NABP PMP InterConnect Development and Implementation Time Line</th>
</tr>
</thead>
</table>
| **January 2011**  
NABP and Appriss, Inc, begin development of NABP InterConnect after consulting with PMP administrators who helped set the business requirements and functional specification for the NABP InterConnect. |
| **March 2011**  
NABP holds an initial Steering Committee meeting of PMP administrators that also included outside participants, such as the BJA, Drug Enforcement Administration, the Alliance of States with Prescription Monitoring Programs, the IJIS Institute, and members of industry. |
| **May 2011**  
Development of NABP InterConnect is completed and NABP begins to work with state PMP software vendors to develop the appropriate interface for NABP InterConnect. |
| **July 2011**  
NABP InterConnect launches for nationwide use. |
| **August 2011**  
- Users of Indiana’s INSPECT program and the Ohio Automated Rx Reporting System (OARRS) program perform the first successful state-to-state data exchange in a live environment.  
- Ohio authorizes statewide access for prescriber and pharmacist users of the OARRS program for Indiana data using NABP InterConnect.  
- NABP, Appriss, and representatives from the Mississippi and Ohio PMPs participate in PMIX architecture meetings sponsored by the Alliance of States with Prescription Monitoring Programs. The purpose of the meeting was to develop a PMIX architecture that would provide a framework for sharing data between multiple interstate sharing “hubs.”  
- Virginia PMP goes live.  
- Steering Committee meeting held to:  
  - Finalize governance structure;  
  - Discuss bringing additional PMPs on board in 2011;  
  - Solicit guidance and feedback about administrative matters;  
  - Approve certain functionality enhancements recommended for NABP InterConnect; and  
  - Strategize about ways to make PMP program information more useful in medical decision-making involving medication therapy.  
- The BJA clarifies guidance allowing use of Harold Rogers PDMP grant funds by InterConnect participants. NABP commits to use of PMIX architecture. On an ongoing basis, NABP continues discussions with BJA and the Office of National Drug Control Policy. |
| **January 2012**  
PMPs in Connecticut and Michigan go live. |
| **March 2012**  
- PMPs in North Dakota and South Carolina go live.  
- Steering Committee convenes to discuss, among other items:  
  - Development of a system for pharmacy PMP data submission;  
  - PMP software search methodologies;  
  - NARXCHECK application;  
  - PMIX Architecture; and  
  - Enhancing Access to PDMPs project and the related pilots. |
| **September 2012**  
- New Mexico PMP goes live.  
- Steering Committee convenes to discuss and make recommendations related to the operation of the NABP InterConnect, including dispute resolution procedures, entry and exit requirements for participation, data security, recommendations for best practices for state PMPs to facilitate interstate sharing, and other policy matters identified. |
| **February 2013**  
Kentucky PMP goes live. |
| **March 2013**  
PMPs in Illinois, Louisiana, and South Dakota go live. |
| **April 2013**  
Steering Committee convenes via conference call to discuss current status and direction of integration projects. The Committee unanimously agrees that there is to be no secondary use (such as collecting, copying, or selling) of PMP data by any party. |
| **May 2013**  
Colorado PMP goes live. |
| **August 2013**  
Tennessee goes live. |
| **October 2013**  
Delaware, Mississippi, and Wisconsin go live. |
| **November 2013**  
Arkansas and Minnesota go live. |
| **February 2014**  
Nevada goes live. |
| **March 2014**  
Idaho and West Virginia go live. |
| **May 2014**  
New Jersey goes live. |
| **June 2014**  
Utah goes live. |
Cost/Funding

Funding for Implementation and Participation

NABP is paying for all costs associated with the development and implementation of the NABP InterConnect, as well as five years of annual participation fees for each participating PMP using, exclusively, its own revenues derived from program resources described previously in this document and its reserves. NABP has the financial resources to make this commitment without the need to use any outside funding sources.

NABP received an unrestricted educational grant from Purdue Pharma L.P. in the amount of one million dollars. Although not restricted by Purdue in any way, the NABP Foundation® has determined that this grant will not be used for any costs associated with the development, implementation, or ongoing operational costs of the NABP InterConnect. This grant will be administered through the NABP Foundation which is a separate non-profit organization. Funds held by the NABP Foundation are used for special educational or public safety projects that are separate from and outside NABP’s core programs and activities. Additionally, no grantor has any access to, influence, decision-making authority, or consideration relative to the NABP InterConnect and its administration and functions. As described above, the governance and administrative guidance for the NABP InterConnect is in the hands of the Steering Committee.

The NABP Foundation is making the Purdue unrestricted grant funds available to any state that needs and requests financial assistance to modify its PMP software to participate in the NABP InterConnect. Again, no NABP Foundation or other grant funds are being used directly for the NABP PMP InterConnect. To this end, as of July 2013, the NABP Foundation has paid out $461,660 to state PMPs or their software vendors for purposes of connecting individual states via the NABP InterConnect.

---

NABP PMP InterConnect

Purdue Pharma L.P. Grant Disbursements as of November 2013

The NABP Foundation is making the Purdue unrestricted grant funds available to any state that needs and requests financial assistance to modify its PMP software to participate in the NABP InterConnect.

<table>
<thead>
<tr>
<th>Date</th>
<th>Vendor</th>
<th>State PMP</th>
<th>Grant Disbursements</th>
<th>Applied To</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/13/2011</td>
<td>Health Information Design, Inc</td>
<td>South Carolina PMP</td>
<td>$40,035</td>
<td>Interface Development</td>
</tr>
<tr>
<td>7/1/2011</td>
<td>Mahantech Corp</td>
<td>West Virginia PMP</td>
<td>$43,200</td>
<td>Interface Development</td>
</tr>
<tr>
<td>8/10/2011</td>
<td>Health Information Design, Inc</td>
<td>North Dakota PMP</td>
<td>$40,035</td>
<td>Interface Development</td>
</tr>
<tr>
<td>8/29/2011</td>
<td>Health Information Design, Inc</td>
<td>Kansas PMP</td>
<td>$40,035</td>
<td>Interface Development</td>
</tr>
<tr>
<td>8/29/2011</td>
<td>Health Information Design, Inc</td>
<td>Arizona PMP</td>
<td>$40,035</td>
<td>Interface Development</td>
</tr>
<tr>
<td>12/21/2011</td>
<td>Mahantech Corp</td>
<td>West Virginia PMP</td>
<td>$4,000</td>
<td>Interface Development</td>
</tr>
<tr>
<td>8/30/2012</td>
<td>Health Information Design, Inc</td>
<td>North Dakota PMP</td>
<td>$18,750</td>
<td>Support &amp; Maintenance</td>
</tr>
<tr>
<td>8/30/2012</td>
<td>Health Information Design, Inc</td>
<td>South Carolina PMP</td>
<td>$17,500</td>
<td>Support &amp; Maintenance</td>
</tr>
<tr>
<td>8/30/2012</td>
<td>Health Information Design, Inc</td>
<td>Kansas PMP</td>
<td>$30,000</td>
<td>Support &amp; Maintenance</td>
</tr>
<tr>
<td>8/30/2012</td>
<td>Health Information Design, Inc</td>
<td>Arizona PMP</td>
<td>$30,000</td>
<td>Support &amp; Maintenance</td>
</tr>
<tr>
<td>11/1/2012</td>
<td>Optimum Technology</td>
<td>New Mexico PMP</td>
<td>$48,000</td>
<td>Interface Development</td>
</tr>
<tr>
<td>11/20/2012</td>
<td>Health Information Design, Inc</td>
<td>Louisiana PMP</td>
<td>$40,035</td>
<td>Interface Development</td>
</tr>
<tr>
<td>2/12/2013</td>
<td>Health Information Design, Inc</td>
<td>South Dakota PMP</td>
<td>$30,000</td>
<td>Support &amp; Maintenance</td>
</tr>
<tr>
<td>2/12/2013</td>
<td>Health Information Design, Inc</td>
<td>South Dakota PMP</td>
<td>$40,035</td>
<td>Interface Development</td>
</tr>
<tr>
<td>9/6/2013</td>
<td>Health Information Design, Inc</td>
<td>South Carolina PMP</td>
<td>$11,250</td>
<td>Support &amp; Maintenance</td>
</tr>
<tr>
<td>9/6/2013</td>
<td>Health Information Design, Inc</td>
<td>Louisiana PMP</td>
<td>$11,250</td>
<td>Support &amp; Maintenance</td>
</tr>
<tr>
<td>11/7/2013</td>
<td>Health Information Design, Inc</td>
<td>Delaware PMP</td>
<td>$40,035</td>
<td>Interface Development</td>
</tr>
<tr>
<td>11/7/2013</td>
<td>Health Information Design, Inc</td>
<td>Delaware PMP</td>
<td>$30,000</td>
<td>Support &amp; Maintenance</td>
</tr>
</tbody>
</table>

Total Grant Disbursements: $554,195
Funding for Enhancements
NABP is currently exploring several different types of pilots and expanded offerings for PMPs that would serve as significant enhancements to the NABP InterConnect and would benefit each participating PMP. Several participating PMPs have already engaged with health information exchanges, major chain pharmacies, and pharmacy software systems that are interested in leveraging the “network” that will be created with NABP InterConnect. Similarly, NABP is finalizing the establishment of a PMP Clearinghouse that would serve as a single point of submission for entities that have to report to multiple PMPs.

As the Clearinghouse and other pilots evolve towards operational systems, NABP plans to reinvest any net revenues from the systems back into the PMPs for future enhancements and functionality.

Beyond the NABP PMP InterConnect
As advised by the Steering Committee at its August 30, 2011 meeting, NABP continues to explore uses of NABP InterConnect, beyond interstate data sharing. Specifically, NABP has established or explored the establishment of the following:

• PMP Clearinghouse for data submission;
• Integration of PMP data into Health Systems Pharmacy Software systems and Emergency Room Software systems in order to integrate queries of the PMP programs into the normal workflow and enhance patient care; and
• To ensure greater continuity of patient care, NABP has also worked with state-level stakeholders and health professionals to explore integration of all prescription data into PMP, thus giving health professionals a much clearer and greater picture of the patient’s drug therapy.

Background on NABP
Organization/Mission
Founded in 1904, the National Association of Boards of Pharmacy is the impartial professional organization that supports the state boards of pharmacy in protecting public health. NABP aims to ensure the public’s health and safety through its pharmacist license transfer and pharmacist competency assessment programs, as well as through its Verified Internet Pharmacy Practice Sites® (VIPPS®), Vet-VIPPS®, Verified-Accredited Wholesale Distributors® (VAWD®), and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) accreditation programs. NABP’s member boards of pharmacy are grouped into eight districts that include all 50 United States, the District of Columbia, Guam, Puerto Rico, the Virgin Islands, Australia, eight Canadian provinces, and New Zealand. The Association is governed by its Executive Committee, whose officers and members are elected during the Association’s Annual Meeting.

NABP is a 501(c)(3) charitable and educational organization that has over 100 years of experience in providing regulatory support and assistance to its member boards, Food and Drug Administration, the Department of Justice, and other state and federal regulatory and patient safety agencies and organizations, all in the interest of protecting the public’s health, safety, and welfare.

The NABP Foundation is a separate 501(c)(3) charitable organization founded to educate the public about important health issues related to the practice of pharmacy and use of prescription medications. Its most important programs include the State Newsletter Program, the AWARxE® Consumer Protection Program, as well as the NABPLAW® Online service, providing quick and targeted access to pharmacy laws in all 50 states, plus DC, Guam, Puerto Rico, and the US Virgin Islands. In addition, the NABP Foundation provides development assistance to NABP for new programs.

How the Organization Supports Itself
NABP offers a wide array of products and services that our member boards of pharmacy utilize as they work to protect the public health through the regulation of the practice of pharmacy and the prescription drug supply chain.

Competency Assessment Programs
NABP’s primary source of revenue comes from its competency assessment programs, such as the North American Pharmacist Licensure Examination® (NAPLEX®), the Multistate Pharmacy Jurisprudence Examination® (MPJE®), the Foreign Pharmacy Graduate Equivalency Examination® (FPGE®), and the Pharmacy Curriculum Outcomes Assessment® (PCOA®). Such competency
assessment programs comprised 49% of 2012 gross revenue. Fees for the assessments offered by NABP are paid by the candidates for licensure and certification and not the states.

**Accreditation Programs**
NABP’s accreditation programs include the DMEPOS accreditation program, (for which NABP is a Centers for Medicare and Medicaid Services-deemed accreditation entity), the VAWD program, the VIPPS program, and the Vet-VIPPS program. NABP’s accreditation programs comprised 28% of 2012 gross revenue. Fees for accreditation are borne by the pharmacies and wholesale distributors and not the states.

**License Transfer**
NABP also facilitates a license transfer program to assist its member states in processing pharmacist licensure transfer requests from state to state. This program accounted for 10% of 2012 gross revenue. In addition, more recently NABP began facilitating license transfer process for pharmacies through the Verified Pharmacy Program™ (VPP™), an inspection service and information sharing network for the state boards of pharmacy.

As noted above, the fees associated with these programs are paid by applicants for licensure and registration and are part of state licensing requirements. State boards of pharmacy are responsible for a member fee of $250 per year, which has remained unchanged since 1985.

The long-term stability of these various programs, coupled with careful financial planning, has contributed to NABP’s financial strength. NABP can continue implementing new initiatives, such as the NABP PMP InterConnect, that will fulfill its mission of assisting its member boards and other regulators in protecting the public health.
The Committee recommends that the Association adopt the following statements:

1. APhA advocates for resolution of the federal and state conflicts surrounding the legal status of cannabis and its various components.
   [Refer to Summary of Discussion Item 4.]

2. APhA supports the establishment of a USP monograph for the standardization of cannabis and its various components.
   [Refer to Summary of Discussion Item 5.]

3. APhA supports regulatory changes to facilitate clinical research related to the clinical efficacy and safety associated with the use of cannabis and its various components.
   [Refer to Summary of Discussion Item 6.]

4. APhA encourages health care provider education related to the clinical efficacy, safety, and management of patients using cannabis and its various components.
   [Refer to Summary of Discussion Item 7.]

5. APhA advocates that the pharmacist collect and document information in the pharmacy patient profile about patient use of cannabis and its various components and provide appropriate patient counseling.
   [Refer to Summary of Discussion Item 8.]

6. APhA supports pharmacist participation in furnishing cannabis and its various components when scientific data support the legitimate medical use of the products and delivery mechanisms and federal, state, or territory laws or regulations permit pharmacists to furnish them.
   [Refer to Summary of Discussion Item 9.]

7. APhA opposes the furnishing of cannabis and its various components for medical purposes unless performed by licensed health care professionals whose scope of practice includes the dispensing of prescription medications and who comply with state and federal regulations.
   [Refer to Summary of Discussion Item 9.]

8. APhA supports the clinical judgment of pharmacists to decide whether to furnish cannabis and its various components for medical use where allowed by law.
   [Refer to Summary of Discussion Item 10.]

9. APhA opposes pharmacist involvement in furnishing cannabis and its various components for recreational use.
   [Refer to Summary of Discussion Item 9.]
Summary of Discussion

1. The Committee reviewed 1980 APhA policy related to the medicinal use of marijuana and agreed that further policy in this area is warranted.
2. The Committee reviewed the use of the term “cannabis” versus “marijuana” and chose “cannabis” because it comprehensively covers the various forms of the plant. The Merriam-Webster dictionary defines cannabis as any of the preparations (e.g., marijuana or hashish) or chemicals (e.g., THC) that are derived from the hemp and are psychoactive.
3. The Committee reviewed the terms “dispense,” “distribute,” and “furnish” related to pharmacies’ handling of cannabis products. The Committee chose to use the term “furnish” as it appears in prior APhA policies.
4. The Committee discussed how the current conflict between state and federal laws puts pharmacists and pharmacies at risk for potential litigation related to pharmacist licensure and pharmacy DEA licensure.
5. The Committee discussed the issues related to quality and purity of the product. In doing so, it identified the USP as a reliable entity for the creation of a cannabis drug monograph. It also identified FDA as a source of proper medical indication and usage.
6. The Committee reviewed policies passed by the American Medical Association related to the rescheduling of cannabis for the purposes of research.
7. The Committee agreed that education is key to pharmacists’ ability to appropriately counsel patients regardless of whether the product is being used for medical or recreational use.
8. The Committee discussed the need for pharmacists to include cannabis within their patient medication records to assess for clinical interactions. Screening for cannabis is only in terms of questioning the patient, and pharmacists should not be required to actually obtain test results for the presence of illicit substances. This practice would be similar to the way in which health care professionals currently assess patient use of tobacco, alcohol, and other substances. Patient/pharmacist confidentiality will be maintained.
9. The Committee agreed that pharmacists should have a role in furnishing cannabis only which it has an approved medical use defined by FDA and has been rescheduled outside of a schedule 1 substance by DEA.
10. The Committee discussed the use of pharmacist conscience clause information related to cannabis and the issue of pharmacists being held liable in the furnishing of cannabis products. Pharmacists should be able to use their own independent professional judgment concerning whether to dispense cannabis in a pharmacy. The Committee felt that the conscience clause adequately covers this issue, and it chose to use the term “clinical judgment” rather than “professional judgment.”

Attachment

Background Paper prepared for the 2014-15 APhA Policy Committee
ROLE OF THE PHARMACIST IN THE CARE OF PATIENTS USING CANNABIS

Background Paper Prepared for the 2014–2015 APhA Policy Committee

Sean T. Lasota, PharmD
Assistant Professor
University of Saint Joseph School of Pharmacy

Issue

The American Pharmacists Association (APhA) Board of Trustees has directed the 2014–2015 Policy Committee to recommend policy to the APhA House of Delegates related to the sale of cannabis in pharmacies. Specifically, the Board asked the committee to comment on the increasing availability of inhaled cannabis for both medical and recreational use and the pharmacist’s role in the care of patients who use inhaled cannabis.

Currently, more than 23 states and Washington, DC, have laws and regulations regarding the use of medical marijuana. Two of those states, Colorado and Washington, have written legislation to legalize the recreational use of medical marijuana. Although various states have allowed the use of inhaled cannabis for medical purposes, federal statutes still classify inhaled cannabis as a Schedule I substance. The Controlled Substances Act was signed into law in 1970 by President Richard Nixon, and the legislation defined different classes based on physical dependence, abuse potential, and appropriate medical use. Schedule I substances are defined as substances that have a high potential for abuse, no current medical use in the United States, and a lack of accepted safety when used under medical supervision. According to federal statute, inhaled cannabis shall not be used for medical reasons in the United States, despite changes in state laws. In terms of compliance with both state and federal statutes, pharmacists must comply with the law that is most stringent, in this case recognizing inhaled cannabis as a Schedule I substance. Violation of federal statutes can result in fines, imprisonment, and/or the revocation of the pharmacy’s Drug Enforcement Agency (DEA) registration, preventing the dispensing of controlled substances.

Despite not being able to legally dispense or stock inhaled cannabis according to federal law, clinical issues have been raised by pharmacists in managing patients who use inhaled cannabis. The concerns that have been raised include the use of inhaled cannabis in disease states in which efficacy and safety have not been evaluated, restrictions on patients who are able to access inhaled cannabis, and the effect of inhaled cannabis on patient decision-making skills as well as their medication regimen. With few credible large-scale trials on inhaled cannabis, coupled with the potential legal ramifications on pharmacist involvement with a patient’s inhaled cannabis regimen and lack of guidance by the Food and Drug Administration (FDA), pharmacists are hesitant to jeopardize their careers by dispensing inhaled cannabis, and they are concerned about their inability to make clinically sound decisions to assess its appropriateness in therapy. Current APhA policy (adopted in 1980 and last reviewed in 2011) on medical marijuana supports research on its use but not the circumvention of federal law involving marijuana.
Summary of Key Concepts

- There is very limited peer-reviewed, published literature on the therapeutic use of inhaled cannabis, but the research that does exist supports its efficacy. However, a litany of identified potential adverse effects from the use of inhaled cannabis raises issues of safety for the patient.
- Currently, more than 20 states have legalized medical marijuana use, with two of them legalizing marijuana for recreational use as well. At this time, federal law still states that marijuana is a Schedule I drug, without a purpose for medical use.
- Distribution and regulation remain a concern for pharmacists; if they were to dispense inhaled cannabis, they would want to ensure that they have a product with consistent quality and purity falling under the same regulations as other FDA-approved medications.
- Safety concerns for pharmacists and other personnel working in pharmacies stocking inhaled cannabis involve being at risk for burglaries and robberies and diversion by pharmacy staff.
- Currently, Connecticut is the only state in which a pharmacist dispenses inhaled cannabis for medical use. Connecticut could be viewed as a model for other states in evaluating the role of pharmacists in dispensing inhaled cannabis for medical purposes. Other states, like Minnesota, are considering legislation that gives pharmacists a consultative role within the manufacturing and dispensing process.

Background

What is inhaled cannabis and why is it a concern for pharmacists?

Inhaled cannabis, also known as “smoked marijuana,” has been in existence since the third century A.D. It was first utilized for medical purposes in the mid-nineteenth century by Dr. O’Shaugnessy, who used cannabis for a wide array of medical conditions. The major psychoactive component of *cannabis sativa* was identified as ∆^9^-tetrahydrocannabinol (THC). THC has been shown to increase pulse rate, decrease blood pressure, cause muscle weakening, increase appetite, cause euphoria, and decrease memory recollection, among other symptoms. Research showed that the body has two different types of cannabinoid receptors, both of which are from the G-protein-coupled receptor family. The brain has a high concentration of CB1 receptors, which have a GABAergic effect on the body. Likewise, cannabis has a dopaminergic effect on the body via stimulation of the nucleus accumbens. The CB2 receptor is found in the periphery of the body, most notably in the spleen, macrophages, kidneys, lungs, and other internal organs. The CB1 receptor has been shown to increase appetite, provide analgesia, impair cognition, and relax muscles, whereas the CB2 receptors are immunosuppressive and decrease inflammation. In terms of how cannabis affects the human body for medical purposes, studies have shown cannabis to have a significant antiemetic effect. Other medical uses include stimulating appetite and treating associated protein wasting of patients with advanced human immunodeficiency virus (HIV), as well as providing a potent analgesic compared with codeine.

Smoking cannabis has been shown to provide a rapid and efficient delivery of THC to the brain and can be detected in the plasma immediately. Peak plasma concentrations can be seen within 10 minutes and then decrease to 20% within 30 minutes of the peak. In comparison, the oral synthetic THC (dronabinol, Marinol®) and THC analogs (nabilone, Cesamet®) have a different
pharmacologic profile because absorption of THC from the gut is slower and exhibits a delayed peak plasma concentration compared with the inhaled formulation. The oral formulation has a bioavailability of 5% to 20% of the dose compared with the inhaled formulation. In short, inhaled cannabis has a better pharmacologic profile and its “rapid on-set and predictable decay means that self-titration of dosing is attainable.”

What is the efficacy of inhaled cannabis in primary literature? The safety profile?

A number of small-scale studies have been conducted to show the efficacy of inhaled cannabis for the treatment of various medical conditions. In a study conducted by Ware et al., inhaled cannabis was shown to improve neuropathic pain (p = 0.023) and provide a better quality sleep (p < 0.05). In a study conducted by Wilsey et al., inhaled cannabis decreased neuropathic pain and allowed for a greater perceived degree of relief (p < 0.05). Other studies assessing the efficacy of inhaled cannabis include the following: fibromyalgia (improvement in pain and stiffness [p < 0.001], enhancement of relaxation and increased somnolence [p < 0.05] and feeling of well-being [p < 0.001]), posttraumatic or postsurgical neuropathic pain (p = 0.023 for pain intensity being lowered), and neuropathic pain associated with HIV (p < 0.016). A decrease in nausea and increase in appetite were also reported in various studies in cancer patients. While it is noted that most studies of this nature use the oral formulation, the pharmacokinetics of cannabis once again show that inhaled cannabis has a more predictable and therapeutic peak plasma concentration compared with the oral formulation.

In contrast with the medical benefits of inhaled cannabis, research has revealed a litany of adverse effects with its use. In a meta-analysis conducted by Crane et al., a list of acute adverse effects was noted with cannabis use in clinical trials. The adverse effects include decreased episodic memory; decreased attention, concentration, and working memory; decreased decision-making capabilities; increased risk-taking; decreased inhibitory control; and decreased psychomotor control. Long-term effects were also seen in the previously listed domains in chronic users of cannabis. Similarly, Pavisian et al. showed the adverse effect of cannabis on cognition in patients with multiple sclerosis. The performance of the cannabis group fell below that of the non-cannabis group on the Paced Auditory Serial Addition Test tasks (p < 0.02) and the 10/36 Spatial Recall Test (p < 0.03). The cannabis users also had more diffuse cerebral activation compared with nonusers in the domain of working memory.

The legality of inhaled cannabis in the United States

Currently, the Controlled Substances Act lists marijuana as a Schedule I substance. This statute states that marijuana has no medical use and is deemed illegal. Contrary to federal legislation, 23 states and the District of Columbia have allowed the use of medical marijuana. Two of those states, Colorado and Washington, allow the recreational use of marijuana. Conflicting federal and state law creates a scenario in which pharmacists can be acting lawfully under state law while simultaneously being at risk of federal prosecution. For this reason, pharmacists have been reluctant to be involved with medical marijuana; federal prosecution could result in severe consequences such as fines and imprisonment. Another concern is that the pharmacy could lose its DEA registration, leading to the inability to dispense controlled substances. Table 1 shows a list of the states that permit the use of medical marijuana and whether the user has to use a
compassion center (defined as a place allowed to dispense marijuana), has the ability to home cultivate, or must use a pharmacy. A list of medically approved uses for marijuana can be found in each state’s statutes and regulations.

Table 1: States With Approved Use of Medical Marijuana

<table>
<thead>
<tr>
<th>States</th>
<th>How to Obtain Medical Marijuana</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>Individual caregiver* or home cultivation</td>
</tr>
<tr>
<td>Arizona</td>
<td>Individual caregiver, compassion center, or home cultivation</td>
</tr>
<tr>
<td>California</td>
<td>Individual caregiver or compassion center</td>
</tr>
<tr>
<td>Colorado</td>
<td>Individual caregiver or dispensary</td>
</tr>
<tr>
<td>Connecticut</td>
<td>Individual caregiver or dispensary. Once regulations are in place, the only area to obtain medical marijuana will be a pharmacy run by a pharmacist.</td>
</tr>
<tr>
<td>Delaware</td>
<td>Individual caregiver or compassion center</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>Individual caregiver or dispensary</td>
</tr>
<tr>
<td>Hawaii</td>
<td>Individual caregiver</td>
</tr>
<tr>
<td>Maine</td>
<td>Individual caregiver or compassion center</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Compassion center</td>
</tr>
<tr>
<td>Michigan</td>
<td>Individual caregiver or home cultivation</td>
</tr>
<tr>
<td>Montana</td>
<td>Individual caregiver or home cultivation</td>
</tr>
<tr>
<td>Nevada</td>
<td>Individual caregiver or home cultivation</td>
</tr>
<tr>
<td>New Jersey</td>
<td>Compassion center</td>
</tr>
<tr>
<td>New Mexico</td>
<td>Individual caregiver or home cultivation</td>
</tr>
<tr>
<td>Oregon</td>
<td>Individual caregiver or home cultivation</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>Individual caregiver, compassion center, or home cultivation</td>
</tr>
<tr>
<td>Vermont</td>
<td>Individual caregiver, compassion center, or home cultivation</td>
</tr>
<tr>
<td>Washington</td>
<td>Individual caregiver, compassion center, or home cultivation</td>
</tr>
</tbody>
</table>

*The definition of “individual caregiver” varies by state.

As noted in Table 1, Connecticut is the only state with direct pharmacist involvement. Although the process is still being formulated, the Connecticut Department of Consumer Protection has issued six dispensary licenses for pharmacists. Before being dispensed, the marijuana must be deemed “pharmaceutical grade” by a state-appointed laboratory. The pharmacist will then hold a consultation session with the patient about the use of marijuana and its effects. Because Connecticut is the only state to utilize a pharmacist in the continuum of care for patients using inhaled medical cannabis, it may be used as a model if marijuana becomes rescheduled by the federal government. How an assessment of a patient’s use of cannabis will be incorporated and documented within the pharmacist’s patient care process is still to be determined.

It is important to note that in 2009, U.S. Attorney General Eric Holder stated that it was not a priority for him to prosecute people who used marijuana for medical purposes, but people using it illicitly would be prosecuted. In 2011, a petition was raised to the DEA to reschedule marijuana, but it was denied with the statement that marijuana still has no scientific or medical evidence for its use. In June 2014, FDA announced that it intends to conduct an 8-factor test to
determine whether cannabis should be rescheduled. On July 28, 2014, a bill, HR 5226, was introduced by co-sponsors Scott Perry (R-PA), Paul Broun (R-GA), Steve Cohen (D-TN), and Dana Rohrabacher (R-CA) to amend the definition of marijuana and to exclude medical marijuana from controlled substance lists.19

Because of increased reports of employment termination and arrests when traveling into states that have not legalized the use of marijuana, patient awareness of marijuana screening and zero-tolerance policy must be addressed.

The Role of the Pharmacist in the Use of Inhaled Cannabis for Medical Purposes

As with any substance used for medical purposes, pharmacists are expected to assess patients’ medication and health status and counsel them on the medical use and adverse effects associated with the use of inhaled cannabis. This expectation will grow if pharmacists are involved in the dispensing of inhaled cannabis, akin to the model currently being utilized in Connecticut. During counseling, pharmacists may discuss the effects of inhaled cannabis on cognition; the risks associated with inhaled carcinogens, which may lead to certain types of cancers; respiratory ailments such as chronic obstructive pulmonary disease; and risks to the reproductive system, such as impaired sperm production, disruption of ovulatory cycle, and decreased birth weight.20 Other adverse effects include psychological dysfunction and cardiac effects (palpitations, syncope, hypotension, stroke, paroxysmal atrial fibrillation). Likewise, the pharmacist must assess drug-drug interactions with other medications such as opioids, barbiturates, central nervous system depressants, protease inhibitors, selective serotonin reuptake inhibitors, sildenafil, theophylline, tricyclic antidepressants, anticholinergics, alpha-agonists, naltrexone, disulfiram, lithium, neuroleptic antipsychotics, and anesthetic agents.21

Pharmacist Concerns Regarding Dispensing Marijuana in a Pharmacy

Pharmacists raised various concerns in a focus group when questioned about dispensing marijuana in a pharmacy. The biggest concern was the potential for federal prosecution of pharmacists for dispensing marijuana. Another concern was how the pharmacy staff would treat marijuana once it reached the pharmacy. The pharmacists feared diversion within the pharmacy by technicians, pharmacists, and other staff. The personal safety of pharmacists and technicians was also a concern. If marijuana were to be stored in a pharmacy, the risk of burglary could potentially increase. In terms of patient safety, pharmacists did not feel confident about counseling patients and dispensing marijuana to them. With the increase in fake prescriptions, pharmacists worry about procedures involving the receipt of valid prescriptions. Another issue concerning the pharmaceutical distribution of inhaled cannabis is the purity of the marijuana dispensed as well as how the product would be distributed to the pharmacy. Finally, some pharmacists expressed concern with a pharmacy selling medical marijuana along with tobacco and cigarettes. Some pharmacists feel that the potential revenue stream associated with dispensing medical marijuana could be similar to the way in which cigarettes are sold—in contradiction to the purpose of a pharmacy as a health care facility.
Unanswered Questions

One area that has not been addressed but is certainly in the forefront of the discussion is the ability to bill for inhaled cannabis. At present, these products are purchased with cash because of current interpretations of the statutes and financial transaction regulations; these sales are illegal drug sales per federal law. In addition, the cost of purchasing these products is increasing with market demand and a desire to obtain state tax revenue. At some point in time, with these products classified for medical use, the public will request coverage by health care benefit programs. If inhaled cannabis is transitioned from Schedule I to another schedule, will health care benefit programs in the public and private sector cover a non-FDA approved medication? Thus far, no health plan has stated that it would be willing to cover medical marijuana as a potential therapy. Another question involves who qualifies for medical marijuana. Each state has its own individual criterion by which patients are determined to be eligible for medical marijuana therapy. One would think that if federally approved, legislation would include criteria for patient eligibility for prescribed medical marijuana. Another question for further evaluation involves the safety profile of marijuana compared with other currently available therapies. Although the data point to the therapeutic effectiveness of inhaled cannabis, the research presents many safety concerns. It is also important to note that a study published in the *Journal of the American Medical Association* concluded that “States with medical cannabis laws had a 24.8% lower mean annual opioid overdose mortality rate compared with states without medical cannabis laws.” Another final question involves the way in which the media will portray the use of medical marijuana. The media may sensationalize its use and thereby cause an increase in public demand.

Conclusion

Inhaled cannabis for medical purposes has been a hot topic in the medical community over the past decade. Although the federal statute still lists marijuana as a Schedule I substance, state governments have allowed for its use medically and, in some cases, decriminalized marijuana entirely. Connecticut is the first state to utilize the pharmacist as the person dispensing medical marijuana, which raises some concerns regarding the role of the pharmacist related to access to and use of medical marijuana. Pharmacists have expressed their concerns about punitive retaliation for breaking federal law and about marijuana’s safety profile; however, pharmacists could play a unique role in fostering the safe and effective use of medical marijuana. Pharmacists should become educated on the therapeutic use of inhaled cannabis as well as the safety issues that arise with chronic inhaled cannabis use. Since the American Pharmacists Association is one of the major leaders in the pharmacy and medical community, it is important to reevaluate APhA’s policy on medical marijuana.
References


Related APhA Policy

1980 Medicinal Use of Marijuana
1. APhA supports research by properly qualified investigators operating under the investigational new drug (IND) process to explore fully the potential medicinal uses of marijuana and its constituents or derivatives.
2. APhA opposes state by state, marijuana specific, or other drug specific legislation intended to circumvent the federal laws and regulations pertaining to (a) marketing approval of new drugs based on demonstrated safety and efficacy, or; (b) control restrictions relating to those substances having a recognized hazard of abuse.


2003, 1983 The Use of Controlled Substances in the Treatment of Intractable Pain
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 that 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.


2012 Controlled Substances Regulation and Patient Care
1. APhA encourages the Drug Enforcement Administration (DEA) and other regulatory agencies to recognize pharmacists as partners that are committed to ensuring that patients in legitimate need of controlled substances are able to receive the medications.
2. APhA supports efforts to modernize and harmonize state and federal controlled substance laws.
3. APhA urges DEA and other regulatory agencies to balance patient care and regulatory issues when developing, interpreting, and enforcing laws and regulations.
4. APhA encourages DEA and other regulatory agencies to recognize the changes occurring in health care delivery and to establish a transparent and inclusive process for the timely updating of laws and regulations.
5. APhA encourages the U.S. Department of Justice to collaborate with professional organizations to identify and reduce:
   a. the burdens on health care providers,
   b. the cost of health care delivery, and
   c. the barriers to patient care in the establishment and enforcement of controlled substance laws.

(JAPhA NS52(4) 457 July/August 2012)

2014 Controlled Substances and Other Medications with the Potential for Abuse and Use of Opioid Reversal Agents

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 supports 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 misuse, abuse, and/or diversion.

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

4. APhA supports the development and implementation of state and federal laws and regulations that permit pharmacists to furnish 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 about the proper use of opioid reversal agents to prevent opioid related.

(JAPhA 54(4) July/August 2014)
2015 House of Delegates
New Business Review Committee

Committee Members
Susan Vos, Chair
Sarah Barden
Robin Cooke
Heather Free
James Kirby
Marc Rizzo
Pamela Piotrowski

Ex Officio Members
William Riffie, Speaker of the House
Theresa Tolle, Speaker-elect of the House
NEW BUSINESS
(To be submitted and introduced by Delegates only)

Introduced by: Abby A. Kahaleh, BSPharm, MS, PhD, MPH, on behalf of the 2015 APhA House of Delegates Policy Review Committee

12-03-14 APhA Policy Review Committee
(Date) (Organization)

Subject: Introductory Pharmacy Practice Experience

Motion: We, the members of the Policy Review Committee, urge the 2015 House of Delegates to amend the following policy statement:

2010 Introductory Pharmacy Practice Experience

APhA supports a collaborative effort amongst stakeholders (e.g., professional pharmacy organizations, deans, faculty, preceptors, and student pharmacists) to develop and implement a nationally defined set of competencies to assess the successful completion of introductory pharmacy practice experiences (IPPEs). APhA believes that these competencies should reflect the professional knowledge, attitudes, and skills necessary for entry into advanced pharmacy practice experiences (APPEs).

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

Current APhA policy with the proposed amendment shown:

2010 Introductory Pharmacy Practice Experience

APhA supports a collaborative effort amongst experiential education stakeholders (e.g., professional pharmacy organizations, deans, faculty, colleges/schools of pharmacy, preceptors, and student pharmacists) to develop and implement a nationally defined set of core competencies to better assess the successful completion of introductory pharmacy practice experiences (IPPEs, IPEs, APPEs). APhA believes that these national standards competencies should reflect the professional knowledge, skills, attitudes, and skills and behaviors necessary for entry into advanced pharmacy practice experiences (APPEs) competent student pharmacists.

(JAPhA NS40(4):471 July/August 2010)
Background: During its review of previously adopted policy, the Policy Review Committee discussed the relevance of and need for making the current policy more comprehensive by including all stakeholders. In addition, the committee discussed the need for broadening the scope of this policy beyond Introductory Pharmacy Practice Experiences.

Current APhA Policy & Bylaws:

2008 Experiential Education

1. APhA urges state boards of pharmacy, the Accreditation Council for Pharmacy Education (ACPE), the American Association of Colleges of Pharmacy (AACP), and other professional associations; employers; and other stakeholders to collaborate in the development of a blueprint that evaluates, streamlines, and consolidates all student pharmacists' experiential education requirements.

2. APhA encourages the American Association of Colleges of Pharmacy (AACP), in collaboration with state boards of pharmacy, practitioner organizations, and other stakeholders, to develop national standardization among schools and colleges of pharmacy to improve the quality of student pharmacists' experiential education. This standardization should be adopted by all schools and colleges of pharmacy and should include the following: (a) a preceptor training program; (b) a model instrument for preceptors to evaluate student pharmacist performance in required pharmacy practice experiences; (c) a set of quality indicators for each required pharmacy practice experience; and (d) a report of quality indicator outcomes made available to all schools and colleges of pharmacy, faculty, and current and prospective students.

3. APhA urges schools and colleges of pharmacy to dedicate adequate and equitable financial and human resources to experiential education.

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: William Fassett

(Name)

2/11/2015 Individual Delegate for APhA-APRS

(Date) (Organization)

Prepared in cooperation with: Robert Day, Leonard Edloe, and Philip Hansten

Subject: Pharmacist Participation in Executions

Motion: The American Pharmacists Association opposes pharmacist participation in executions, either directly or indirectly, on the basis that such activities are fundamentally contrary to the role of pharmacists as providers of health care.

Background:

1. Although APhA has previously adopted policies that deal with lethal injections, it has adopted an essentially neutral position on pharmacist participation in executions. Recent events in Ohio, Oklahoma and Arizona have raised public awareness of the actual or alleged involvement of pharmacists in executions, and make this issue timely for consideration by the 2015 House of Delegates.

2. Pharmacy is a healing profession, dedicated to the relief of disease or suffering. Participation in executions, either directly or indirectly, is fundamentally contrary to the goals of the pharmacy profession. The “Oath of a Pharmacist” adopted by the by both the American Pharmacists Association and the American Association of Colleges of Pharmacy—and taken annually by most, if not all student pharmacists or new graduates of pharmacy schools, as well as at the House of Delegates and many state association meetings—stresses “service to others,” “relief of suffering” and “optimal outcomes” in our patients, all of which are antithetical to participation in executions.
3. The principal mode of involvement by pharmacists is the compounding and/or provision of unapproved lethal chemical formulations for use in execution protocols. Following the enactment of the Drug Quality and Security Act of 2013, such compounding is contrary to federal and virtually all state laws which require pharmacies to compound unapproved drug products only in response to a prescription for an individual patient issued by an authorized prescriber.

4. Four of the nation’s major health care associations, including the American Medical Association, the American Board of Anesthesiology, the American Nurses Association and the National Association of Emergency Medical Technicians have taken positions opposing member participation in executions. (See Appendix I: Positions of Other Health Care Associations) With the exception of Dentistry, Pharmacy is the only major profession of health care providers in the US that has not adopted a policy position against practitioners participating in executions. This is particularly untenable at a time when pharmacists are seeking full recognition of their status as health care providers.

5. Although they have not taken a formal position, the following associations have expressed the view that participation in executions is unethical, including the American Psychiatric Association, World Medical Association, International Council of Nurses, American Public Health Association, and the National Commission on Correctional Health Care.

6. Pharmaceutical companies in Europe, Asia, and the US have refused to provide drugs to be used in executions. (There is a movement among architects to add to their code of ethics wording that would prohibit members from designing execution chambers.)

Current APhA Policy & Bylaws:

2004, 1985

1. APhA opposes the use of the term "drug" for chemicals when used in lethal injections.

2. APhA opposes laws and regulations which mandate or prohibit the participation of pharmacists in the process of execution by lethal injection.


Code of Ethics for Pharmacists

PREAMBLE
Pharmacists are health professionals who assist individuals in making the best use of medications. This Code, prepared and supported by pharmacists, is intended to state publicly the principles that form the fundamental basis of the roles and responsibilities of pharmacists. These principles, based on moral obligations and virtues, are established to guide pharmacists in relationships with patients, health professionals, and society.

I. A pharmacist respects the covenantal relationship between the patient and pharmacist.

Considering the patient-pharmacist relationship as a covenant means that a pharmacist has moral obligations in response to the gift of trust received from society. In return for this gift, a pharmacist promises to help individuals achieve optimum benefit from their medications, to be committed to their welfare, and to maintain their trust.

II. A pharmacist promotes the good of every patient in a caring, compassionate, and confidential manner.

A pharmacist places concern for the well-being of the patient at the center of professional practice. In doing so, a pharmacist considers needs stated by the patient as well as those defined by health science. A pharmacist is dedicated to protecting the dignity of the patient. With a caring attitude and a compassionate spirit, a pharmacist focuses on serving the patient in a private and confidential manner.

III. A pharmacist respects the autonomy and dignity of each patient.

A pharmacist promotes the right of self-determination and recognizes individual self-worth by encouraging patients to participate in decisions about their health. A pharmacist communicates with patients in terms that are understandable. In all cases, a pharmacist respects personal and cultural differences among patients.
IV. A pharmacist acts with honesty and integrity in professional relationships.
A pharmacist has a duty to tell the truth and to act with conviction of conscience. A pharmacist avoids discriminatory practices, behavior or work conditions that impair professional judgment, and actions that compromise dedication to the best interests of patients.

V. A pharmacist maintains professional competence.
A pharmacist has a duty to maintain knowledge and abilities as new medications, devices, and technologies become available and as health information advances.

VI. A pharmacist respects the values and abilities of colleagues and other health professionals.
When appropriate, a pharmacist asks for the consultation of colleagues or other health professionals or refers the patient. A pharmacist acknowledges that colleagues and other health professionals may differ in the beliefs and values they apply to the care of the patient.

VII. A pharmacist serves individual, community, and societal needs.
The primary obligation of a pharmacist is to individual patients. However, the obligations of a pharmacist may at times extend beyond the individual to the community and society. In these situations, the pharmacist recognizes the responsibilities that accompany these obligations and acts accordingly.

VIII. A pharmacist seeks justice in the distribution of health resources.
When health resources are allocated, a pharmacist is fair and equitable, balancing the needs of patients and society.

Oath of a Pharmacist
The revised Oath was adopted by the AACP House of Delegates in July 2007 and has been approved by the American Pharmacists Association. AACP member institutions should plan to use the revised Oath of a Pharmacist during the 2008-09 academic year and with spring 2009 graduates.

"I promise to devote myself to a lifetime of service to others through the profession of pharmacy. In fulfilling this vow:

- I will consider the welfare of humanity and relief of suffering my primary concerns.
- I will apply my knowledge, experience, and skills to the best of my ability to assure optimal outcomes for my patients.
- I will respect and protect all personal and health information entrusted to me.
- I will accept the lifelong obligation to improve my professional knowledge and competence.
- I will hold myself and my colleagues to the highest principles of our profession’s moral, ethical and legal conduct.
- I will embrace and advocate changes that improve patient care.
- I will utilize my knowledge, skills, experiences, and values to prepare the next generation of pharmacists.

I take these vows voluntarily with the full realization of the responsibility with which I am entrusted by the public."

Appendix: Positions of Other Health Care Associations:
American Medical Association: AMA Council on Ethical and Judicial Affairs Opinion 2.06 states, in part: “An individual’s opinion on capital punishment is the personal moral decision of the individual. A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution. Physician participation in execution is defined generally as actions which would fall into one or more of the following categories: (1) an action which would directly cause the death of the condemned; (2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; (3) an action which could automatically cause an execution to be carried out on a condemned prisoner.
“Physician participation in an execution includes, but is not limited to, the following actions: prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure; monitoring vital signs on site or remotely (including monitoring electrocardiograms); attending or observing an execution as a physician; and rendering of technical advice regarding execution. In the case where the method of execution is lethal injection, the following actions by the physician would also constitute physician participation in execution: selecting injection sites; starting intravenous lines as a port for a lethal injection device; prescribing, preparing, administering, or supervising injection drugs or their doses or types; inspecting, testing, or maintaining lethal injection devices; and consulting with or supervising lethal injection personnel.”

**American Board of Anesthesiology:** Among the healing professions, perhaps the strongest position is that of ABA, which states that participation by their diplomats (certified practitioners) in lethal injection may result in revocation of board certification.

**American Nurses Association:** The ANA Code of Ethics states that the ANA “is strongly opposed to nurse participation in capital punishment. Participation in executions, either directly or indirectly, is viewed as contrary to the fundamental goals and ethical traditions of the nursing profession.”

**National Association of Emergency Medical Technicians:** NAEMT “is strongly opposed to participation in capital punishment by an EMT, paramedic or other emergency medical professional. Participation in executions is viewed as contrary to the fundamental goals and ethical obligations of emergency medical services.”

---

New Business Items are due to the Speaker of the House by **February 25, 2015** (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.
NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Jeffrey Bratberg, PharmD, BCPS, submitting on behalf of the APhA Policy Review Committee and Brett Feret, PharmD

(Name)

2/25/2015 APhA Policy Review Committee and University of Rhode Island College of Pharmacy

(Date) (Organization)

Subject: Disaster Preparedness

Motion: Amend the 2001 statement as follows:

APhA supports pharmacist involvement in bioterrorism and emerging infectious diseases surveillance, mitigation, preparedness, planning, response, and recovery.

Background:

Although bioterrorism remains a constant threat, emerging infectious diseases like Ebola Virus Disease and Middle Eastern Respiratory Syndrome (MERS), and re-emerging diseases like measles dominate the current national and international consciousness, just as anthrax and pandemic H1N1 influenza did just a few years ago. In fact, bioterrorism is a subset of the larger and more inclusive category of “emerging infectious diseases.” Public health responses by pharmacists to emerging infectious diseases are part of all-hazard emergency preparedness and response.

A 2014 report from the Trust For America’s Health on outbreak response shows some progress toward emerging infectious diseases outbreak response, but also reveals deficiencies amenable to solutions provided by pharmacists at each step of the all-hazard response continuum of surveillance, mitigation, preparedness, planning, response, and recovery.

Worry and fear of contagion drive patients to seek answers from their most trusted and most accessible health professionals, pharmacists. Approximately 93% of American’s live within 5 miles of a pharmacy, and 275 million patients visit pharmacies every week. Pharmacists, as highly trained public health providers, perform
triage functions by educating patients to either manage common infectious disease symptoms with over the counter medicines or refer patients with more serious symptoms to medical providers. Importantly, patients at risk of emerging infections, or worse, who have been unintentionally exposed to bioterrorism agents, will go to pharmacies for advice and treatment of symptoms common to both serious emerging infections and common diseases, such as cough, diarrhea, fever, etc. By the time public health officials confirm one case of Ebola or measles, it’s possible that several contagious, symptomatic contacts sought treatment from a pharmacist at their community pharmacy. Pharmacists regularly participate in infectious diseases surveillance of common infections, and are a natural piece of the surveillance system of emerging and bioterrorism-related diseases.

Emerging infectious disease mitigation includes efforts to diminish the effects of or even prevent these outbreaks. All-hazards mitigation is performed most efficiently and administratively at the local level. Community pharmacists and pharmacy staff members are ideally located and possess the skills to educate the public about the risks for these infections to their patients and how to minimize their exposure and consequences from potential threats in their area.

As part of an all-hazards emergency preparedness planning process, pharmacists from every segment of the profession partner with local, state, and federal emergency and public health preparedness officials to assess emerging and bioterrorism hazards and provide clinical and logistical input to insure efficient responses. Pharmacists participate in preparedness exercises in their communities, work settings, and various emergency response teams, to rigorous test and improve response plans.

Pharmacists lead in several roles during emerging infectious disease responses, and have been particularly helpful in the design and operation of community immunization clinics and mass antibiotic distribution centers. Logistically, pharmacists assisting with the complexities of ordering, storing, and supplying thousands of vaccines and supplies (needles, syringes) to mass vaccination clinics and/or medications for treatment and prophylaxis of bioterrorism or other infections. Operationally, pharmacists also perform their usual medication distributive role by preparing, checking, and properly dispensing vaccines or prophylactic medications, as well as enhancing other personnel by administering vaccines. A pharmacist in a vaccine administration role doubles as a clinic monitor, able to immediately respond to adverse effects, be available as a vaccine information specialist, and/or quickly supply the clinic with more vaccine and vaccine supplies. Overall, pharmacists play a vital role in deploying countermeasures (treatment, mass antibiotic distribution, and/or mass immunization) in emerging infectious diseases responses.

As outbreak countermeasures are deployed and the threat of further infections abates, the community and its citizens enter the recovery phase of response. Pharmacists play an essential role to not only return the community back to normal, with normal staffing and workload, but also to maintain the community resilience and increased awareness of emerging infectious diseases.
Current APhA Policy & Bylaws:

Biological Terrorism, Infectious Diseases, and Pharmacy (2001)

APhA supports pharmacist involvement in bioterrorism preparedness planning.


Role of the Pharmacist in National Defense (re-affirmed 2011, initiated 1963)

APhA endorses the position that the pharmacist, as a member of the health care team, has the ethical responsibility to assume a role in disaster preparedness and emergency care operations. These responsibilities include

1. Pharmacists, by their education and training as medication experts, should be involved intimately in all elements of the procurement, storage, handling, compounding, and dispensing of drugs and supplies in planning for as well as during any national emergency.
2. Pharmacists, by their education in anatomy, physiology, and pharmacology, are readily adaptable to assist in the emergency medical treatment of patients and for training the public in medical self-help.
3. Pharmacists, by their constant contact with the members of the health team, as well as a significant portion of their communities, provide the potential for coordinating preparedness measures, and establishing meaningful standby emergency operational plans.

In view of these responsibilities, it shall be the further policy of APhA

1. To cooperate with all responsible agencies and departments of the federal government.
2. To provide leadership and guidance for the profession of pharmacy by properly assuming its role with other health profession organizations at the national level (including American Medical Association, American Hospital Association, American Dental Association, American Nurses Association, and American Veterinary Medical Association).
3. To assist and cooperate with all national specialty pharmaceutical organizations to provide assistance and coordination in civil defense matters relevant to their area of concern.
4. To encourage and assist the state and local pharmacy associations in their efforts to cooperate with the state and local governments as well as the state and local health profession organizations in order that the pharmacist may assume his proper place in civil defense operations.
5. To provide leadership and guidance so that individual pharmacists can contribute their services to civil defense and disaster planning, training, and operations in a manner consistent with his position as a member of the health team.


New Business Items are due to the Speaker of the House by **February 25, 2015** (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.
NEW BUSINESS
(To be submitted and introduced by Delegates only)

Introduced by:

LCDR James Dvorsky (USPHS)
(Name)

25 Feb 2015
(Date)

Federal Pharmacists
(Organization)

Subject: Pharmacists Role in Promoting Medication Adherence

Motion:

1. APhA recognizes that pharmacists are integral to promoting and improving patient adherence to medications.

2. APhA advocates for pharmacists taking leadership roles in working with administrators, health care professionals, payers, patients and other stakeholders to design processes and systems that promote interoperability and care coordination across settings to improve medication adherence.

3. APhA advocates for the profession of pharmacy to continually review, evaluate, and disseminate evidence-based methods to improve medication adherence.

4. APhA advocates for raising national awareness about the issue of medication adherence.

5. APhA advocates for initiatives promoting medication adherence to include strategies that educate and engage patients in their treatment.
Background:

“Drugs don’t work in the patients who don’t take them” (C. Everett Koop 13th U.S. Surgeon General)

Medications are a cornerstone in managing chronic disease. With nearly half of American adults living with chronic disease, prescription drugs are an integral part of disease management in America. More than 48% of Americans use one or more prescription drugs and 11% use 5 or more.1 Unfortunately, non-adherence remains a critical problem that is reducing the effectiveness for the drugs that are taken. Studies show that 20% to 50% of patients are not adherent to long-term therapy for chronic illness- and this non-adherence comes at a cost.2,3 Each year, optimal medication use for hypertension alone would save 89,000 premature deaths from cardiovascular disease, as well as 278,000 hospitalizations for stroke and 142,000 hospitalizations for heart attacks each year.4 Improved adherence to diabetes medications could avert an estimated 699,000 emergency room visits and 341,000 hospitalizations annually.5

As a complex problem that has always been central to the effective use of medications, it is time to bring medication adherence into the national spotlight. The US has been working to reform its health care system with the triple aim of improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care. Medication, as a pillar of chronic disease treatment and management, is essential for reaching the triple aim by improving the patient experience through improved quality of care and effectiveness of care, improving the health of populations by managing chronic disease and preventing the progression of disease, and reducing the cost of care by preventing the most acute (and expensive) exacerbations of disease.

In the decades since C, Everett Koop articulated the issue, research around improving medication adherence has continued to expand and improve. We have finally reached a point where we have the evidence and interventions to bring medication adherence to the appropriate medications into the national spotlight to make a change.

Pharmacists play a central role ensuring the effective use of prescription drugs...the right drug, at the right dose, at the right time. Pharmacists are at the front line of patient care and it is often the direct interventions of pharmacists, such as medication therapy management and clinical pharmacy services, which directly impact medication adherence and medication safety. As medication adherence continues to come into the national spotlight as an important public health issue, pharmacists should take the opportunity to chart the path forward.

5 Jha AK, Aubert RE, Yao J, Teagarden JR, Epstein RS. Greater Adherence To Diabetes Drugs Is Linked To Less Hospital Use And Could Save Nearly $5 Billion Annually. Health Affairs. 2012;31:1836-1846.
Current APhA Policy & Bylaws:

1993 Patient Compliance: Pharmacists’ Responsibilities
1. APhA affirms that pharmacists are responsible for assisting patients to become active, informed, decision makers regarding compliance with their prescribed therapeutic plans.
2. APhA will convey to the public, employee benefit managers, third-party payers, and other health care decision makers, the value and cost-effectiveness of the role of the pharmacist in comprehensive medication-use management.

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by:  

CDR Heather Hellwig (NAVY)  

(Name)

5 Feb 2015  

(Date)

Federal Pharmacy  

(Organization)

Subject:  

Prenatal Care and Maternal Health

Motion:

1. APhA supports adequate and comprehensive prenatal care for overall maternal and newborn health and wellness.

2. APhA supports pharmacists in providing a continuum of care throughout pregnancy to manage chronic conditions, treat acute illnesses, advise on physical and mental wellbeing, and provide nutritional counseling and supplementation to reduce the risk of birth defects and complications.

3. APhA supports pharmacists providing education to women of childbearing age on the risks and benefits of pharmaceutical interventions during pregnancy.

4. APhA supports pharmacists educating women of childbearing age on the detrimental effects of smoking and substance abuse on fetal development.

5. APhA supports pharmacist’s patient care services for women, including education about the availability of HIV and STD testing and treatment in pregnancy to reduce the risk of HIV disease transmission to unborn children.
Background:

One of the most important markers of the health status in a country is the measure of infant mortality and the United States (US) is falling short. While the infant mortality rate has leveled since 2000, the most recent data from 2005 indicate that the US was ranked 30th in infant mortality rates. This ranks behind nations such as Singapore, Israel, Hungary, Cuba, and the Czech Republic. A main contributing factor to this high mortality rate is the fact that the US also has a high pre-term birth rate as compared to other countries. For instance, if the US had a birth term distribution comparable to Sweden, close to 8,000 infant deaths would be avoided.\(^1\) Pre-term birth, defined as birth before 37 weeks, cuts critical developmental time short for the infant and can have long-term detrimental effects on the child’s brain, lungs, liver, and other organ systems.

More recent data indicate that 35% of all infant deaths in 2010 were pre-term related and accounted for more deaths than any other cause. Moreover, even infants surviving pre-term birth have a much higher risk of lifelong severe disabilities including breathing problems, cerebral palsy, vision abnormalities, and hearing loss. This affects 1 in 9 infants, or 450,000 babies a year, and cannot be ignored. It is of the highest importance to ensure that mothers are well informed and cared for with respect to preconception care, prenatal care, and general maternal health.\(^2\)

This should be a prominent concern for mothers and health-care professionals alike. In the 2011, National Prevention Strategy, the Surgeon General recognized that one of the priorities for improving the health of the nation was a focus on reproductive and sexual health. Planning and having a healthy pregnancy is vital to the health of women, infants, and families.\(^3\) Much of the focus in the past has been on sexually transmitted diseases including HIV and teen pregnancy; however, there are other important components to prenatal care.

Often women are scared or financially unable to see their doctor if they are pregnant, plan to become pregnant, or suspect pregnancy. As a result, do not receive valuable care and counseling essential to their baby’s future health. This is a care gap that pharmacists can fill. Pharmacists are among the most trusted and accessible health professionals in the community and can actively play a role in improving maternal and child health. For example, in a recent gender specific survey\(^4\), 49% of women (1,000 women aged 6-74) did not intend to get a flu vaccination. Although the women were not identified as being pregnant, this is a simple pharmacist-provided intervention that could prevent future complications for a mother or her baby. According to the national vital statistics system, in 2007, only 70% of American women received adequate prenatal care through their pregnancies. Babies whose mothers received prenatal care are three times less likely to be born at low birth weight, and five times less likely to die, than those whose mothers did not receive prenatal care.\(^5\) This is a critical opportunity for pharmacists to become involved and improve our nation's health care on an even larger scale.

Pharmacists are adequately equipped with the knowledge and resources to educate and counsel women on lifestyle and pharmacotherapeutic modifications they can make to optimize maternal and child health. The following list includes initiatives that pharmacists are already involved with, but during pregnancy are of even greater importance:

\(^1\) [http://www.cdc.gov/nchs/data/databriefs/db23.htm](http://www.cdc.gov/nchs/data/databriefs/db23.htm)
\(^2\) [http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/PretermBirth.htm](http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/PretermBirth.htm)
• Smoking Cessation
• Alcohol and Substance Abuse Treatment
• Managing Chronic Conditions
• Providing Immunizations
• Managing Active Infections
• Encouraging a healthy lifestyle including exercise and diet
• Controlling mental and emotional health
• Providing early prenatal supplementation

The policy from 1996, which was reviewed in 2014 is accurate and relevant with respect to HIV in pregnant women, but should be elaborated on. The focus in the past has been STDs, but there are many other manageable areas where pharmacists can provide meaningful clinical interventions to ensure the healthiest pregnancies and newborns. It is recommend to revise the 1996 policy to a much broader statement regarding pharmacists’ role in providing healthcare services to women who pregnant or considering pregnancy, and further elaborate on specific items of importance in sub-points.

Current APhA Policy & Bylaws: (search terms: pregnancy, women, maternal, sexual, infant)


APhA encourages pharmacists to provide pharmaceutical care 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.


Public Health – 1972, 2005 – Prevention and Control of Sexual Transmitted Infections

1. APhA calls upon all producers of prophylactic devices to include in or on their packaging adequate instructions for use so as to better ensure the effectiveness of the devices in the prevention of sexually transmitted infections.
2. APhA urges pharmacists to make more readily available to the public educational materials, prophylactic devices, and adequate instructions for use in combating sexually transmitted infections.


New Business Items are due to the Speaker of the House by February 25, 2015 (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.
NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Virginia Torrise (VA)
(Name)

25 Feb 2015
(Date) Federal Pharmacists
(Organization)

Subject: Antibiotic Stewardship

Motion:

1. APhA recognizes that pharmacists are uniquely positioned to drive the advancement of issues related to antimicrobial stewardship among patients, prescribers, and health systems leadership.

2. APhA encourages the profession of pharmacy to take a proactive role in promoting awareness of antimicrobial stewardship issues on a national level.

3. APhA supports pharmacists working in collaboration with physician colleagues, to lead the development and implementation of antimicrobial stewardship programs and initiatives.

4. APhA supports pharmacists advising prescribers and patients regarding the risks of antibiotic overuse and increasing microbial resistance.

5. APhA supports pharmacists providing education to patients regarding appropriate antibiotic use.
**Background:**

The discovery of antibiotics in the 20th century revolutionized the world of medicine. Antibiotics are often used in the treatment of infectious diseases. The effectiveness of antibiotics and easy access has led to overuse. This overuse of antibiotics, led to antibiotic current and emerging resistance.

Antibiotic resistance is a serious threat to public health. The Centers for Disease Control and Prevention (CDC) estimates that annually at least two million illnesses and 23,000 deaths are caused by antibiotic-resistant bacteria in the United States alone. Controlling antibiotic resistance will require a coordinated and sustained approach by all healthcare partners. The issue of antibiotic resistance can be controlled by support and implementation of robust antimicrobial stewardship programs.

Antibiotic stewardship programs can improve patient outcomes, save lives, and decrease the emergence of resistant bacteria. This in turn can reserve current and future antibiotics for use in later generations. The pharmacist’s drug expertise and leadership make them an integral part of the antibiotic stewardship team. Pharmacist can promote the optimal use of antibiotics by educating and influencing government, academia, industry, patients, prescribers, healthcare partners, and the public.

Controlling antibiotic resistance will require the cooperation of government, academia, industry, healthcare providers, and the general public. Pharmacists are positioned in all these areas and can have a significant impact on antibiotic stewardship.

http://www.cdc.gov/getsmart/healthcare/
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 25, 2015** (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.