Proceedings of the 52nd annual session of the ASHP House of Delegates, June 5 and 7, 2000

Henri R. Manasse, Jr., Secretary

The 52nd annual session of the ASHP House of Delegates was held at the Philadelphia Convention Center, in conjunction with Annual Meeting 2000.

First meeting

The first meeting was convened at 3 p.m., Monday, June 5, by Chair of the House of Delegates Steven L. Sheaffer. Max L. Hunt, Jr., Vice Chair of the Board of Directors, gave the invocation.

Chair Sheaffer introduced the persons seated at the head table: Bruce R. Canaday, Immediate Past President of ASHP and Vice Chair of the House of Delegates; Bruce E. Scott, President of ASHP and Chair of the Board of Directors; Henri R. Manasse, Jr., Executive Vice President of ASHP and Secretary to the House of Delegates; and Joy Myers, Parliamentarian.

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

The roll of official delegates was called. A quorum was present, including 188 voting delegates representing 50 states and the District of Columbia, student delegates, officers and members of the Board of Directors, and past presidents of ASHP. Two Fraternal delegates representing the federal services were also present. Chair Sheaffer pointed out that Fraternal delegates have the privilege of the floor, which includes participating in discussion and debate, introducing amendments and motions, and making Recommendations. . In addition, Chair Sheaffer introduced Larry Ereshefsky, Chair, ASHP Section of Clinical Specialists, and Barbara A. White, Chair, ASHP Section of Home

Care Practitioners. He explained that the section chairs sit in the House as observers and have the privilege of the floor but do not vote.

Chair Sheaffer reminded delegates that the report of the 51st annual session of the ASHP House of Delegates had been published on the ASHP Web site and had been distributed to all delegates. Delegates had been advised earlier to review this report. The proceedings of the 51st House of Delegates session were received without objection.

Board Chair Bruce E. Scott presented the preliminary report on Resolutions.[a] The report, which had been distributed to delegates before the Annual Meeting, consisted of one Resolution from Dennis M. Williams and W.Timothy Giddens, titled "Opposition to the Creation of a 'Pharmacist Assistant' Category of Licensed Pharmacy Personnel."

Chair Sheaffer called on William H. Puckett for the report of the Committee on Nominations.b Nominees were presented as follows:

President-elect

Donald T. Kishi, Pharm.D., FASHP, San Francisco, CA, Clinical Professor of Pharmacy at the University of California at San Francisco School of Pharmacy.

Steven L. Sheaffer, Pharm.D., FASHP, Darby, PA, Director of Pharmacy at Mercy Fitzgerald and Mercy Community Hospitals.

Board of Directors (2001-2004)

Brian L. Erstad, Pharm.D., FASHP, Tucson, AZ, Associate Professor of Pharmacy Practice and Science at the University of Arizona

Douglas R. Lang, St. Louis, MO, Pharmacy Supervisor, BJC Home Care Services

John Manzo, B.S., Pharm.D., FASHP, New York City, NY, Unified Pharmacy Director at Montefiore Medical Center.

Bonnie L. Senst, M.S., Brooklyn Park, MN, Area Vice President, Pharmacy Practice Consulting, McKessonHBOC Med/Management.

Chair, House of Delegates

Roland A. Patry, Dr.P.H., FASHP, Amarillo, TX, Professor of Pharmacy Practice and Associate Dean, Patient Care Services, Texas Tech School of Pharmacy.

Marjorie Shaw Phillips, M.S., FASHP, Augusta, Georgia, Pharmacist, Medical College of Georgia Hospital and Clinics, and Adjunct Clinical Associate Professor, University of Georgia College of Pharmacy

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

Chair of the Board. President Scott referred to his report to the House, which had previously been distributed to delegates, and which included all of the actions taken by the Board since the last House Session. Mr. Scott urged delegates to support proposals that had been brought to the House by the Board, namely, changing the fiscal year of ASHP, governing document amendments relating to voting rights for Fraternal Delegates and the chairs of ASHP's two sections, the ASHP Statement on Reporting Medical Error, and a dues adjustment. (The complete report presented to the House is included in these proceedings.) There was no discussion, and the delegates voted to accept the report of the President and Chair of the Board.

Mr. Scott, on behalf of the Board of Directors, then moved adoption of the proposal regarding Change in ASHP Fiscal Year, which reads as follows:

> To approve a change in the ASHP fiscal year from a calendar year; further,
>
> To amend Article 10.7 of the ASHP Bylaws to state that the fiscal year of

ASHP shall be a 12-month period beginning on June 1 and ending on May 31; further,

To approve that the first cycle of the new ASHP fiscal year consist of a 17-month budget beginning January 1, 2001, and ending on May 31, 2002.

There was no discussion and the proposal was approved.

Mr. Scott, on behalf of the Board of Directors, then moved adoption of the proposal regarding Voting Rights for Fraternal Delegates and Section Chairs, which reads as follows:

To provide voting rights for the Fraternal Delegates and the Chair of the Section of Home Care Practitioners and the Chair of the Section of Clinical Specialists in the ASHP House of Delegates, effective 2001; further,

To amend the ASHP Charter, Article Seventh, Paragraph 2, by adding the language "Fraternal Delegates and the Chair of the Section of Home Care Practitioners and the Chair of the Section of Clinical Specialists" to the classes of voting delegates as shown in Appendix A; further,

To amend and restate the ASHP Bylaws to conform to the amended ASHP Charter, as shown in Appendix A.

GOVERNING DOCUMENTS OF ASHP
APPENDIX A

EXISTING LANGUAGE	*PROPOSED AMENDING LANGUAGE*
ASHP Charter. **Article Seventh. Number 2.** **2.** ASHP shall have a House of Delegates that shall meet yearly to review, consider, and ultimately approve or disapprove the professional policies recommended to it by its Directors and to review the affairs of ASHP; voting delegates in the House of Delegates shall consist of the following classes: state delegates, who shall be active members and shall be deemed to represent the aliquot portion of the active membership of ASHP, plus student delegates, plus Directors, plus eligible Past Presidents of ASHP.	**ASHP Charter.** **Article Seventh. Number 2.** **2.** ASHP shall have a House of Del review, consider, and ultimately ap policies recommended to it by its D ASHP; voting delegates in the Hou following classes: state delegates, shall be deemed to represent the ali membership of ASHP, plus student eligible Past Presidents of ASHP~~.~~, chair of the Section of Home Care Section of Clinical Specialists.
Bylaws: 7.1 The House of Delegates shall consist of 161 voting state delegates, who shall represent a proportionate number of active members in each state; plus all Directors of ASHP; plus Past Presidents (if active members) after completing the term of office of Immediate Past President; plus two (voting) student delegates; plus (nonvoting) fraternal delegates. Each delegate shall have one vote, and no delegate may have more than one vote by virtue of any dual capacity in the House of Delegates. 7.1.1.5 The United States Army, Navy, Air Force, Public Health Service, and Veterans Administration shall each be entitled to designate one non-voting fraternal delegate.	**Bylaws:** 7.1 The House of Delegates shall c who shall represent a proportionate state; plus all Directors of ASHP; p members) after completing the tern President; plus two (voting) studen fraternal delegates~~.~~, plus the (voting Practitioners and the (voting) chair Specialists. Each delegate shall hav have more than one vote by virtue Delegates. 7.1.1.5 The United States Army Service, and Veterans Administ designate one ~~non-~~voting fratern 7.1.1.6 The chair of the Sectio chair of the Section of Clinical one voting delegate. ~~7.1.1.~~67.1.1.7 Alternates for v ……

Underline = new language
~~Strikethrough~~ = delete

It was moved and seconded to divide the question to consider this action as two policies, one for Fraternal Delegates and one for Section Chairs. Following discussion, the motion to divide was defeated. After further discussion, the proposal as originally presented was approved.

Mr. Scott, on behalf of the Board of Directors, then moved adoption of the "ASHP Statement on Reporting Medical Errors." It was moved and seconded to amend the policy by 1) moving the last paragraph under 'Requirements' beginning with the words "The fundamental purpose…" to the 2nd paragraph under 'Position'; 2) changing the words in the first sentence of that paragraph "medical errors is to learn how to prevent them." to "medication errors is to learn how to improve the medication use process to prevent these errors."; 3) adding a third point in the 2nd paragraph under 'Position' which reads "strengthen efforts to implement process changes that reduce the risk of future errors and improve patient care."; 4) deleting the word 'accountability' in the 1st sentence of the 1st paragraph under 'Requirements' and to replace it with "to foster accountability for health system changes to prevent errors or events"; and 5) to add the words "and the information submitted" following "health care workers" under 'Requirements - Item 2.' This amendment was approved.

It was moved and seconded to amend the paragraph beginning with "The fundamental purpose…" by removing the words "improve the medication use process to" in the first sentence. The amendment was approved. It was then moved and seconded to insert the words "improve the health care delivery process" following the words "The fundamental purpose of reporting systems for medical errors is to learn how to." The amendment was approved. It was then moved and

seconded to delete the words “health system” in the 1st sentence of the 1st paragraph under ‘ Requirements’ and replace it with “health care delivery process.” The amendment was approved.

It was then moved and seconded to amend the 2nd paragraph under “Requirements” by changing it to read “ASHP cannot support a mandatory reporting system unless it has the following characteristics:”. Following discussion and a division of the House, the amendment was defeated.

The policy, as amended, was moved, seconded and adopted (see attachment ???). **Nancy, I’ve attached the statement per Bill’s request.**
(See the report of the second meeting of this session, "Board of Directors duly considered matters," for final action on the above issue.c)

On behalf of the Board of Directors, Mr. Scott then moved adoption of the proposal regarding Proposal to Increase the ASHP Dues Rate which reads as follows:

> To increase the ASHP dues rate for active members from $155 to $195, effective January 1, 2001; further,
>
> To stipulate that this increase will be in lieu of any CPI adjustment in the dues rate for 2001.

There was no discussion and the proposal was adopted.

Treasurer. David A. Zilz presented the report of the Treasurer. There was no discussion, and the delegates voted to accept the Treasurer's report.

Executive Vice President. Henri R. Manasse, Jr., presented the report of the Executive Vice President. He supplemented his report with brief comments on some of its elements. He praised the ASHP staff and Board of Directors for their extraordinary work and he recognized the contributions of retired staff members Dr. Mary Jo Reilly and Mr. David D. Almquist. He commented on the formation of the ASHP Center on Patient Safety; the upgrade of the computer system at ASHP; the addition of the push news service and the upgrading of our membership database. He discussed the advent of 'teleworkers' at ASHP and the integration of new technology to the *AHFS DI* with the introduction of *AHFSfirst*. He concluded by highlighting the need to continue our partnerships with groups interested in providing health-system pharmacists with opportunities to improve their skills and broaden their knowledge base.

With the approval of the House, Chair Sheaffer deferred the presentation of Recommendations until the 2nd meeting of the House on Wednesday.

Council reports. (Note: The policy recommendations within the complete council reports were published in the April 1, 2000, issue of AJHP. The complete reports, including background on the policy recommendations and information on other council activities, were published on the ASHP Web site (ashp.org) and were distributed to delegates.

Chair Sheaffer outlined the process used to generate council reports. He announced that each of the council's recommended policies would be introduced as a block. He further advised the House that any delegate could raise questions and discussion without having to "divide the question," and that

a motion to divide the question would be necessary only when a delegate desires to amend a specific proposal or to take an action on one proposal separate from the rest of the recommendations. Requests to divide the question would be granted unless another delegate objected.

T. Mark Woods, Board Liaison to the Council on Administrative Affairs, presented the council's policy recommendations A through E. Following a request to consider Policy Recommendation B separately, it was moved and seconded to amend the recommendation by adding a 2nd paragraph, which reads: "further, To encourage the appropriate regulatory bodies during times of drug shortages, to discourage the practice of pharmaceutical manufacturers, distributors, and group purchasing organizations taking advantage of the shortage in order to better position alternate brands or alternative drug products." There was no discussion and the amendment was approved. It was then moved and seconded to add a 3rd paragraph which reads "That the FDA must take a more active role in the advanced notification of pharmacists of impending drug shortages to prevent interruption of patient care." There was no discussion and the amendment was approved. Following discussion, the policy as amended was adopted. It reads as follows (words to be added are in italics):

B. *Drug shortages*

To declare that pharmaceutical manufacturers, distributors, group purchasing organizations, and regulatory bodies, when making decisions that may create drug product shortages, should strive to prevent those decisions from compromising the quality and safety of patient care*; further,*

To encourage the appropriate regulatory bodies during times of drug shortages, to discourage the practice of pharmaceutical manufacturers, distributors, and group purchasing organizations taking

advantage of the shortage in order to better position alternate brands or alternative drug products; further,

That the FDA must take a more active role in the advanced notification of pharmacists of impending drug shortages to prevent interruption of patient care.

(See the report of the second meeting of this session, "Board of Directors duly considered matters," for final action on the above issue.c)

Policy Recommendations A, C, D and E were then adopted. They read as follows:

A. *Pharmacy work force*

To encourage pharmacy managers to work in collaboration with physicians, nurses, and health-system administrators to outline key pharmacist services that are essential to patient care and to establish strategies within their practice setting that address pharmacist staffing shortages; further,

To factor into such strategies legal requirements and professional standards of practice.

C. *Financial management skills*

To replace ASHP policy 8301, Financial Management Skills, with the following:

> To foster the systematic and ongoing development of management skills for all health-system pharmacists in the areas of (a) health-system economics, (b) business plan development, (c) financial analysis, (d) pharmacoeconomic analysis, (e) diversified pharmacy services, and (f) compensation for pharmaceutical care; further,
>
> To encourage schools of pharmacy to incorporate these management areas in students' course work and clerkships; further,
>
> To integrate these management areas into the practice management requirements in the ASHP Standard for Residency in Pharmacy Practice (with an Emphasis on Pharmaceutical Care).

D. *Compensation for pharmacists' services*

To replace ASHP policy 9308, Reimbursement Status for Clinical Pharmacy Services, with the following:

> To pursue the development of a standard mechanism for compensation of pharmacists for patient care services by federal and state programs and other third-party payers; further,
>
> To pursue changes in federal, state, and third-party programs to (a) define pharmacists as providers of patient care and (b) issue provider numbers to pharmacists that allow them to bill for patient care services; further,
>
> To assist pharmacists in their efforts to attain provider status and receive compensation for patient care services.

E. *Materials management*

To discontinue ASHP policy 8303, Materials Management, which reads:

> To reiterate the following elements of ASHP's position on the topic of materials management (Board of Directors' minutes, November 15–16, 1979):
>
> To alert hospital pharmacists of current trends in hospital materials management; further,
>
> To advise AHA that a hospital's pharmacy department must be considered part of the institution's clinical services and should not be administered as a function of the materials handling department.
>
> Further, to consider the following in an effort to assist members in quantifying and dealing with this perceived problem:

- Development of a model survey questionnaire on the topic; this questionnaire would be used by ASHP's affiliated state chapters and would be designated to quantify and qualify the nature of this apparent trend.
- Expansion of communication and liaison with such groups as materials management associations and the American College of Hospital Administrators.
- Communication of the nature of this problem to the National Association of Boards of Pharmacy (specifically those instances in which pharmacy control of the drug-use process is seriously impaired).

Sam K. Shimomura, Board Liaison to the Council on Educational Affairs, presented the Council's Policy Recommendations A through D.

Following a request to consider Policy Recommendation C separately, it was moved and seconded to refer the recommendation. Following discussion, the move to refer was defeated. Policy Recommendation C was then adopted. It reads as follows:

C. *Technician certification.*

To support the concept of health systems requiring the pharmacy technicians they employ to be certified by the Pharmacy Technician Certification Board.

Following a request to consider Policy Recommendation B separately. it was moved and seconded to amend the recommendation by deleting the last two paragraphs and moving them to the background. Following discussion, the amendment was approved. There was no discussion and the policy as amended was adopted. It reads as follows (words to be deleted are underscored):

B. *Pharmacist credentialing*

To support the position that credentialing is a voluntary professional activity distinct and separate from the licensing process; further,

To endorse the goals and the standards-based approach to credentialing being pursued by the Council on Credentialing in Pharmacy (CCP); further,

To support the position that all widely accepted postlicensure pharmacy credentialing programs must meet quality standards that are being established by CCP; further,

To encourage expedited action by CCP to develop and disseminate its operating procedures; further,

To encourage CCP to include in its activities all national pharmacy organizations that are involved in practitioner credentialing.

(See the report of the second meeting of this session, "Board of Directors duly considered matters," for final action on the above issue.c)

Policy Recommendations A and D were then adopted. They read as follows:

A. *Residency Training for Pharmacists Who Provide Direct Patient Care*:

To recognize that optimal direct patient care by a pharmacist requires the development of clinical judgment, which can be acquired only through experience and reflection on that experience; further,

To establish as a goal that pharmacists who provide direct patient care should have completed an ASHP-accredited residency or have attained comparable skills through practice experience.

D. *Mediated continuing-education programming*

To discontinue ASHP policy 8207, Mediated Continuing-Education Programming, which reads:

> To develop a pilot educational program for presentation to ASHP members sent through a video satellite network teleconferencing medium; further,
>
> To consider the topic of reimbursement for pharmacy services for the first teleconferencing program; further,
>
> To conduct the first program in 1982, if feasible; further,
>
> To establish, within ASHP's organizational structure, a responsibility center to advise how electronic technologies can be used in continuing education and member communication activities and to recommend a timetable for implementing these applications.

Donald T. Kishi, Board Liaison to the Council on Legal and Public Affairs, presented the Council's Policy Recommendations A through K. Following a request to considering Policy Recommendation C separately, it was moved and seconded to amend the recommendation by changing the first paragraph to read: "To establish a position that pharmacists are responsible for all medication dispensing functions including those performed by non pharmacists and non prescribers." and by changing the word "role" following the words "should preserve the" to "responsibility and accountability." Following discussion, the amendment was defeated. It was then moved and seconded to add "(d) providing education (counseling) regarding use of the medication" at the end of paragraph two. Following discussion, the amendment was defeated. Policy Recommendation C as originally presented was then adopted. It reads as follows:

C. *Dispensing by Nonpharmacists and Nonprescribers*:

To reaffirm the position that all medication dispensing functions must be performed by, or under the supervision of, a pharmacist; further, to reaffirm the position that any relationships that are established between a pharmacist and other individuals in order to carry out the dispensing function should preserve the role of the pharmacist in (a) maintaining appropriate patient protection and safety, (b) complying with regulatory and legal requirements, and (c) providing individualized patient care.

Policy Recommendations A, B, D, E, F, G, H, I, J, and K were then adopted.

A. *New and Emerging Pharmacy Systems*:

To support the use of new and emerging medication ordering and distribution systems (e.g., via the World Wide Web) when such systems (a) provide the elements of pharmaceutical care, (b) ensure that patients will not receive improperly labeled and packaged, deteriorated, outdated, counterfeit, or non-FDA-approved drug products, (c) provide appropriate relationships between an authorized prescriber and patient, (d) enhance the continuity of patient care, and (e) support the pharmacist's role as a patient care advocate.

B. *Online Pharmacy and Internet Prescribing*:

To support collaborative efforts of the Food and Drug Administration, the National Association of Boards of Pharmacy, and the Federation of State Medical Boards, as stated in the Principles of Understanding on the Sale of Drugs on the Internet, to regulate prescribing and dispensing of medications via the Internet; further,

To support legislation or regulation that requires pharmacy World Wide Web sites to list the states in which the pharmacy and pharmacists are licensed, and, if prescribing services are offered, requires that the sites (a) ensure that a legitimate patient-prescriber relationship exists (consistent with professional practice standards) and (b) list the states in which the prescribers are licensed; further, to support the concept of voluntary accreditation of pharmacy Web sites and appropriate consumer education about the risks and benefits of using Internet pharmacies; further,

To support the principle that any medication distribution or drug therapy management system must provide timely access to, and interaction with, appropriate professional pharmacist patient care services.

D. *ASHP Statement on Its Economic Status Program*

To discontinue the ASHP Statement on Its Economic Status Program.

E. *Statutory Protection for Medication-Error Reporting*:

To collaborate with other health care providers, professions, and stakeholders to advocate and support federal legislative and regulatory initiatives that provide liability protection for the reporting of actual and potential medication errors by individuals and health care providers; further,

To seek federal liability protection for medication-error reporting that is similar in concept to that which applies to reporting safety incidents and accidents in the aviation industry.

F. *FDA's Public Health Mission*

To replace ASHP policy 9606, FDA Reform, with the following:

To support the Food and Drug Administration's public health mission of ensuring the safety and effectiveness of drugs, biologics, and medical devices through risk assessment, appropriate product approval, labeling approval, manufacturing oversight, and consultation with health professionals, while deferring to state regulation and professional self-regulation on matters related to the use of drugs, biologics, and medical devices; further,

To support the allocation of sufficient federal resources to allow FDA to meet its defined public health mission; further,

To support the appointment of practicing pharmacists to FDA advisory committees as one mechanism of ensuring that decisions made by the agency incorporate the unique knowledge of the profession of pharmacy for the further benefit of the patient; further,

To support an ongoing dialogue between FDA and ASHP for the purpose of exploring ways to advocate the best use of FDA-regulated products by consumers and health care professionals.

G. *Patient's Right to Choose*

To replace ASHP policy 9406, Patient's Right to Choose, with the following:

To support the right of the patient or his or her representative as allowed under state law to develop, implement, and make informed decisions regarding his or her plan of care; further,

To acknowledge that the patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment; further,

To support the right of the patient in accord with state law to (a) formulate advance directives and (b) have health care practitioners who comply with those directives.

H. *Prudent Purchasing of Pharmaceuticals*

To combine ASHP policies 9003 and 9105 in a single policy that reads:

> To support existing laws and legitimate practices that allow organized health care settings to purchase drug products and related supplies at prices that minimize health care costs; further, to support the principle of prudent purchase of pharmaceutical products and related supplies by public and private entities using appropriate professional practices to achieve that end; further,
>
> To encourage government support of existing local professional activities (e.g., drug-use review, formulary systems, pharmacy and therapeutics committees, and patient counseling) already practiced in organized health care settings that are methods of promoting quality and cost-effective pharmaceutical care for patients.

I. . *Vaccine availability*

To discontinue ASHP policy 8707, Vaccine Availability, which reads:

> To support federal efforts intended to ensure the continued availability and affordability of vaccines and other drug products in a manner that maintains their highest possible quality and provides adequate incentives for ongoing research, development, and distribution.

J. Bulk resale of drug products

To discontinue ASHP policy 8520, Bulk Resale of Drug Products, which reads:

> To support legislation that would specifically prohibit bulk resale of drugs by pharmacies except for: (1) sales otherwise permitted by law to affiliated corporations in furtherance of a

planned, integrated approach to delivery of health care within a health care corporate structure, and (2) sales by bona fide group purchasing arrangements to members.

K. *DEA record-keeping requirements*

To discontinue ASHP policy 8312, DEA Record Keeping Requirements, which reads:

> To work in conjunction with the Drug Enforcement Administration to establish regulations that provide alternative methods to the present record keeping requirements for less abused controlled substances.

Daniel M. Ashby, Board Liaison to the Council on Organizational Affairs, presented the Council's report, which did not contain any policy recommendations. There was no discussion and the report was received.

Debra S. Devereaux, Board Liaison to the Council on Professional Affairs, presented the Council's Policy Recommendations A through O. Following a request to consider Policy Recommendation E separately, it was moved and seconded to amend the recommendation by adding the words “and providing” following the word “promoting” in the first paragraph. Following discussion, the amendment was approved. It was then moved and seconded to 1) add the following words as a third paragraph “To advocate the inclusion of the pharmacists’ role in immunization and its application in school of pharmacy curricula.” and 2) change the word “providing” following the word “promoting” in the first sentence to “administering.” It was then moved and seconded to amend the amendment by adding the words “providing and” before the word “administering.” This

was approved. The amendment as amended was approved. Following discussion, the policy as amended was adopted. It reads as follows (words to be added are in *italics)*:

E. *Pharmacists' Role in Immunization*

To replace ASHP policy 9113, Pharmacists' Role in Immunization, with the following:

To affirm that pharmacists have a role in promoting, *providing, and administering* proper immunization to patients and employees in all organized health care settings; further,

To encourage pharmacists to seek opportunities for involvement in disease prevention through community immunization programs; *further,*

To advocate the inclusion of the pharmacist's role in immunization and its application in school of pharmacy curricula.

(See the report of the second meeting of this session, "Board of Directors duly considered matters," for final actions on the above issue.c)

Following a request to consider Policy Recommendation A separately, it was moved and seconded to amend the recommendation by adding a second paragraph which reads "further; To advocate the inclusion of Internet and telepharmacy issues and applications in schools of pharmacy curricula." The amendment was approved. Policy Recommendation A as amended was then adopted. It reads as follows (words to be added are in *italics*):

A. *Internet and Telepharmacy*:

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

To advocate the inclusion of Internet and telepharmacy issues and applications in school of pharmacy curricula.

(See the report of the second meeting of this session, "Board of Directors duly considered matters," for final actions on the above issue.c)

Policy Recommendations B, C, D, F, G, H, I, J, K, L, M, N, and O were then adopted. They read:

B. *Pharmacogenomics*:

To encourage pharmacists to take a leadership role in the therapeutic applications of pharmacogenomics; further,

To advocate the inclusion of pharmacogenomics and its application to therapeutic decision-making in school of pharmacy curricula.

C. *Biologic Therapies*:

To encourage pharmacists to take a leadership role in their health systems for all aspects of the proper use of biologic therapies, including preparation, storage, control, distribution, administration procedures, safe handling, and therapeutic applications.

D. *Inline Filters*:

To support the principle that pharmacists be involved in the development of policies in their practice settings on the use of inline filtration for intravenous administration of fluids, nutrients, and medications.

F. *Drug Names, Labeling, and Packaging Associated with Medication Errors*

To replace ASHP policy 9007, Drug Names, Labeling, and Packaging, with the following:

To urge drug manufacturers and FDA to involve practicing pharmacists, nurses, and physicians in decisions about drug names, labeling, and packaging to help eliminate (a) look-alike and sound-alike drug names, and (b) labeling and packaging characteristics that contribute to medication errors; further,

To inform pharmacists and others, as appropriate, about specific drug names, labeling, and packaging that have documented association with medication errors.

G. *Medication Errors and Risk Management*

To replace ASHP policy 8614, Medical Errors and Risk Management, with the following:

To urge that pharmacists be included in health care organizations' risk management processes for the purpose of (a) assessing medication-use systems for vulnerabilities to medication errors, (b) implementing medication-error prevention strategies, and (c) reviewing occurrences of medication errors and developing corrective actions.

H. *Investigational Use of Drugs*

To replace ASHP policy 8616, Investigational Use of Drugs, with the following:

To reaffirm that pharmacists should be included in the management of drug products used in the conduct of clinical research; further, to urge pharmacists to develop formal liaison relationships between institutional review boards and pharmacy and therapeutics committees in the management and conduct of clinical drug research studies.

I.. *Single-unit packages*

To discontinue ASHP policy 8516, Single Unit Packages, which reads:

To express concern about the following aspects of single unit packaging: (1) the small size of some single unit packages, which makes their labeling difficult to read; and (2) the variability in size and shape of outer cartons, which complicates inventory management; further,

To notify PMA of these concerns.

J. *Recognition of oncology pharmacy practice as a specialty*

To discontinue ASHP policy 9310, Recognition of Oncology Pharmacy Practice as a Specialty, which reads:

To endorse a petition to the Board of Pharmaceutical Specialties (BPS) requesting recognition of oncology pharmacy practice as a specialty.

K. Recognition of psychopharmacy practice as a specialty

To discontinue ASHP policy 9122, Recognition of Psychopharmacy Practice as a Specialty, which reads:

To endorse a petition to the Board of Pharmaceutical Specialties (BPS) requesting recognition of psychopharmacy practice as a specialty.

L. *Recognition of nutritional support pharmacy practice as a specialty*

To discontinue ASHP policy 8812, Recognition of Nutritional Support Pharmacy Practice as a Specialty, which reads:

To endorse the petition to the Board of Pharmaceutical Specialties (BPS) requesting recognition of nutritional support pharmacy practice as a specialty.

M. *Medication error reporting*

To discontinue ASHP policy 9206, Medication Error Reporting, which reads:

To support the concept of a multidisciplinary reporting system for medication errors that is (a) designed to collect data to identify preventable serious errors and opportunities for drug use improvement and (b) designed to maintain confidentiality; further,

To review and evaluate pilot medication error reporting efforts in order to study their effectiveness and the utility of the data they produce.

N. *The pharmaceutical industry and design of investigational studies in institutions*

To discontinue ASHP policy 8712, The Pharmaceutical Industry and Design of Investigational Studies in Institutions, which reads:

To develop a recommended procedural model for the pharmaceutical industry and other sponsors of clinical studies to use in the promotion, development, and implementation of investigational drug studies in institutions; and to educate the pharmaceutical industry and

other sponsors of clinical studies in the key aspects of pharmacy involvement in investigational drug studies and the importance of adherence to this recommended model.

O. *Nontraditional pharmacy practice settings*

To discontinue ASHP policy 8619, Nontraditional Pharmacy Practice Settings, which reads:

> To give appropriate emphasis to pharmacy practice settings outside the hospital in future revisions of ASHP Statements, Guidelines, and Technical Assistance Bulletins.

Chair Sheaffer reminded delegates of the process for the submission of New Business items. Announcements were then made, and the meeting adjourned at 6:10 p.m.

Second meeting

The second and final meeting of the House of Delegates session convened on Wednesday, June 7, at 2:30 p.m. A quorum was present.

Chair Sheaffer announced the appointment of tellers to canvass the ballots for the election of Chair of the House of Delegates. Those appointed were Mark Isopi (MI), Gwendolyn Gill (WV), and Therese Wavrin (OR).

Resolutions

President Scott presented the report on Resolutions. He presented the Resolution from Dennis M. Williams and W. Timothy Giddens on "Opposition to the Creation of a 'Pharmacist Assistant' Category of Licensed Pharmacy Personnel." Following discussion, the Resolution was adopted. It reads as follows:

Opposition to the Creation of a 'Pharmacist Assistant' Category of Licensed Pharmacy Personnel

Motion:

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

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

Further, to note that some interest groups in pharmacy have advocated for the creation of a new category of licensed personnel called "Pharmacist Assistant" that would have (a) less education and training than pharmacists and (b) independent legal authority to perform many of the functions that are currently restricted to licensed pharmacists; further,

To support the optimal use of well-trained, certified pharmacy technicians under the supervision of licensed pharmacists; further,

To oppose the creation of a category of licensed personnel in pharmacy such as “Pharmacist Assistant” that would have legal authority to perform independently those professional pharmacy functions that are currently restricted to licensed pharmacists

Background

The role of the pharmacist in drug use control is well documented. Pharmacists are most qualified to ensure public safety related to the use of medications.

ASHP has a longstanding position supporting the important role of pharmacy technicians. ASHP recognizes that the successful implementation of pharmaceutical care practices requires, in part, the presence of well-trained and competent pharmacy technicians in the workforce. Pharmacists should be accountable for the work of pharmacy technicians and foster innovation in the use of technicians under the supervision of pharmacists.

An NABP Task Force has recommended recently recognition for three levels of pharmacy support personnel: Pharmacist Assistant, Certified Pharmacy Technician and Pharmacy Technician. The task force also offered suggestions about education, training and scope of practice for each level.

This strategy designed, in part, to address professional manpower issues has significant problems. It would create a new class of supportive personnel, or ‘paraprofessionals’. It undermines the goal of ASHP to promote the optimal use of certified pharmacy technicians.

Related Policies:

9912: To support the concept of uniform standards and training of all pharmacy technicians; further, to take a leadership role in advocating the development and adoption of uniform standards for the education and training of all pharmacy technicians.

9704: (paraphrased) "To support registration and voluntary certification for technical personnel…and to oppose state licensure…."

8610: To work toward removal of legislative and regulatory barriers preventing pharmacists from delegating certain technical activities to other trained personnel.

White Paper on Pharmacy Technicians: Endorsed by BOD in March 1996

Suggested Outcome: An official position from the ASHP House of Delegates to be used at the state and federal level when this issue is considered.

Recommendations. Chair Sheaffer called on members of the House of Delegates for Recommendations. (The name and state of the delegate who introduced the item and the subject of the item precede each Recommendation.)

Jean Carter and Randy Kuiper (MT): Medication error reduction recognition program

Recommendation: ASHP implement an annual competition for organizations who have reduced medication errors through new programs. Award-winning programs will be presented at the annual meeting. (ASHP may specify types of med errors to be considered based on existing data.)

Background: This approach will accomplish several things:

1. It will use data already collected by ISMP and others.
2. It will promote reduction of errors, not just error data collection.

3. It will produce information about methods for reducing errors that may be adapted in other organizations.
4. It will promote a change in the "culture" of med error reporting and reduction.
5. It is a pro-active approach.
6. ISMP has already implemented a similar program (CHEERS) and could provide ideas for such a program in ASHP.

Michael D. Katz (AZ): Commitment of residency candidates to the match

Recommendation: ASHP strengthen the language regarding residency applicants' commitment to the match in the Residency Match materials. ASHP should also consider sanctions against residency applicants who do not follow through after the match.

Background: There appears to be an increasing number of residency applicants who are not maintaining their commitment to their matched residency. Virtually every residency program in the State of Arizona had at least one matched candidate "bail out" of their commitment. Such situations place a great burden on the residency program to fill unexpectedly open positions. While there may be a variety of reasons for this apparent increase, the current job market may be a significant consideration. Residency applicants must better understand the nature of their commitment to the match process and to the residency to which they match. Such lack of commitment for reasons other than unexpected emergencies, is unprofessional. Strengthening the language in the Residency Match materials could better alert the residency applicant to the serious nature of their commitment Institution of some type of sanction, such as publishing names in AJHP of those who do not meet their commitment, also may allow such candidates to reconsider the implications of their decision.

Johnny Goad (NM) (endorsed by NM, TX, NY, NJ, DE and LA): Pharmacy Technicians

Recommendation: That ASHP, in conjunction with the ASHP Organizational Task Force, consider the establishment of a pharmacy technician component group, e.g., the Pharmacy Technician Forum, consistent with the provisions of Article 6 of the ASHP Bylaws.

Background: Health-system pharmacists have long recognized the importance of highly qualified, well-trained pharmacy technicians to health-system pharmacy practice. Through its actions and policies, ASHP has demonstrated a leadership role in the development of the pharmacy technician as a well-defined occupational entity within health-system pharmacy practice.

In accordance with Article 3 of the ASHP Bylaws, associate membership is afforded pharmacy technicians who pay established dues and wish to further the purposes of ASHP. Those purposes, as delineated in the Third Article of the ASHP Charter, include "fostering an adequate supply of well-trained, competent pharmacists and associated personnel" and "developing and conducting programs for maintaining and improving the competence of pharmacists and associated personnel".

ASHP has devoted substantial resources to pharmacy technicians and the issues surrounding the use of technicians in health-system pharmacy practice. The ASHP "White Paper on Pharmacy Technicians" was published in AJHP in 1996. The Society established the Pharmacy Technician Advisory Group as an ASHP component and maintains an active role with the Pharmacy Technician Certification Board. Additional technician member support services and initiatives were outlined in the 2000 Annual Report of the ASHP Executive Vice President.

ASHP has gained valuable and relevant experience in the development, administration, and operation of component groups, with establishment of the Section of Clinical Specialists, the Section of Home Care Practitioners, and the Pharmacy Student Forum.

Suggested Outcomes: Establishment of a pharmacy technician component group would serve to:

1. provide a common home for pharmacy technician members within ASHP.
2. strengthen lines of communication between ASHP and pharmacy technicians.
3. assist ASHP in meeting the educational needs of this unique member category.
4. facilitate development of ASHP products and services intended to enhance the contributions of pharmacy technicians to health system pharmacy practice.
5. further the established purposes of ASHP.

Tom Woller, Pam Ploetz, Lynnae Mahaney (WI): CPI Methodology used to determine annual dues increase

Recommendation: That ASHP explore more appropriate alternatives to the current CPI methodology to adjust dues on an annual basis.

Background: The current methodology does not appear to accurately reflect inflation for a business like ASHP. This results in a need to make periodic adjustments to the dues to keep up with expenses.

Suggested outcome: A more realistic price index for a business like ASHP is in place.

Bonnie Pitt (MD): Suggested additions to the Treasurer's Report

Recommendation: In light of ASHP's changing fiscal year, the Maryland delegation suggests expanding the Treasurer's Report to include:

- Detailed financial performance for the prior fiscal year;
- Financial performance, fiscal year-to-date;
- The forecasted budget for the next fiscal year.

Background: With the change in fiscal year the Delegates will not have the final figures for the financial performance of the current fiscal year. The Regional Delegates Conferences will occur prior to close of the fiscal year. The delegates would appreciate additional detail in the Treasurer's Report, so they can understand the full impact of the changes and ASHP's financial position.

Mitch Wood, Martha Cato (GA): Medicare J-codes: Awareness/accuracy issues; need for ASHP involvement

Recommendation:

That

a) ASHP provide educational programming in various formats on J-code assignment and APC billing processes;

b) The Board or assigned Council review current J-code development and assignment, and make a recommendation for improving the accuracy and decreasing the complexity of this process; and
c) The Board and/or ASHP staff become actively involved with the AMA to gain a means for pharmacist involvement to assist in improving the system.

Background: Accurate medication coding for reimbursement is a major fraud and abuse issue in healthcare systems. Pharmacy billing systems often utilize several thousand charge codes, requiring assignment of accurate J-codes for Medicare billing purposes.

With increasing volumes of patient activity shifting to outpatient settings, accuracy in these assignments is increasingly important in assuring regulatory compliance.

Fundamental problems in managing J-code assignments include:

- Lack of awareness of this issue in health system pharmacy departments;
- Lack of internal communication within health systems, resulting in erroneous J-code assignments by financial departments with no involvement from the pharmacy department;
- J-codes produced and distributed at the Federal level may themselves be inaccurate, having erroneous 'per mg' or 'per ml' classifications, or may simply have no relationship with the size and strength of the medication available for distribution.

Pharmacists need a better understanding of these coding systems, implications for fraud and abuse, as well as an opportunity to assist in improving them.

Carey C. Cotterell (CA): Technician certification

Recommendation: That approved Policy Recommendation "C" from the Council on Educational Affairs' report, entitled "Technician Certification" and ASHP Policy 9704, entitled "Pharmacy Technicians" be referred back to an appropriate body for consolidation into a single, updated, consistent policy statement.

Background: The House approved Recommendation "C" from COEA at its first meeting on Monday. This new policy may conflict with existing Policy 9704, and no revision to 9704 was offered. These policies should be evaluated by an appropriate body within ASHP to consolidate into a single policy. Consideration should also be given as to ASHP's policy position on:

1. voluntary vs. mandatory certification, and
2. applicability to all practice settings and employers, not just "health-systems" (see the last sentence in the first paragraph under "Background" for this policy recommendation in the Council's report).

Suggested outcome: To create a single policy statement updating ASHP's position on technician certification across all practice settings.

Carey C. Cotterell (CA): ASHP Statement on Reporting Medical Errors

Recommendation: That approved ASHP Statement on Reporting Medical Errors be carefully evaluated for possible editorial revisions which would clarify the intent of the amended document.

Background: At its first meeting on Monday, the House approved the subject Statement after substantial and significant amending language was incorporated. It is important that this Statement clearly and unambiguously represents ASHP's position on the issues discussed. Because the printed Statement will be used by many people with many diverse audiences, it is imperative that the message be clear and the language unambiguous. Given the problems potentially introduced by extensive on-the-fly amendments in the House, some minor editorial changes may be in order to achieve the objectives previously stated.

Suggested outcome: To assure that the ASHP Statement on Reporting Medical Errors is consistent in format with other ASHP Statements, and that the position of ASHP on the issues discussed be clear and unambiguous to multiple audiences.

Therese M. Wavrin (OR): Prescriber computerized order systems

Recommendation: That ASHP work with companies that are developing prescriber computerized order systems so that these systems include clinical factors such as the indication for use of medications, the expected patient outcome and length of time to achieve that expected outcome.

Background: In light of the goal to decrease medication errors, prescriber computerized order entry is one of the components of the seamless medication use process. Pharmacists are in a unique

position to provide the needed input for development of systems that will provide for a better understanding and monitoring of the use of medications.

Suggested outcome: That these presciber computerized order systems enhance the pharmacists ability to make clinical decisions and improve patient outcomes, in addition to decreasing medication related errors.

R. Paul Baumgartner (PA): Pharmacist responsibility

Recommendation: I recommend that ASHP advance a basic professional standard that establishes the responsibility of pharmacists with respect to issues such as supervision of supportive personnel, dispensing functions, drug distribution systems, etc. Contemporary legal and regulatory language utilizes terms such as "direct supervision", "may supervise not more than three (3) technicians", "must personally review and affix the label" which has the effect of establishing pharmacy **process** rather than patient **outcome**.

Process does not necessarily establish professional accountability in case of error or patient injury or death unless it can be established that **process standards** were not followed. Further, law and regulation that define these standards either must be continually updated or become a barrier to new technology.

Through utilization of language such as "the pharmacist is responsible for" supportive personnel or the accuracy of dispensed medications, we establish the concept of professional responsibility for

patient **outcomes**. Establishment of responsibility for **outcomes** will advance the pharmacist's professional status and better establishes the professional authority of employee pharmacists practicing in large organizations. Adopting the concept of pharmacist responsibility will markedly reduce the complexity of legal and regulatory definitions and will better establish accountability for safe medication use.

R. Paul Baumgartner (PA): Membership

Recommendation: I strongly recommend that ASHP initiate a Toll Free Telephone and Fax access as a means to improve membership recruitment, enhance communication, and strengthen member services.

There are many practicing pharmacists that are not ASHP members. Improving access for these individuals to information about ASHP will result in many new members. Properly structured, responses to non-member inquiries will be the basis for a member solicitation database, not only for ASHP but for our Affiliated State Chapters as well.

Enhanced communication and input from existing members has been a matter of concern for some time. Establishment of toll free telephone and Fax access will result in a significant and highly visible new service for **existing** members and will **demonstrate ASHP** commitment to strengthen membership services. It will also offer ASHP improved opportunity to market the excellent publications and other services available.

Mark Isopi, Kathy Pawlicki, Mary Burkhardt (MI) (endorsed by WI & IN) : Pharmacist licensure

Recommendation: To encourage ASHP to promote the standardization of a national licensure (rather than state licensure) for pharmacists in the United States.

Background: National licensure would standardize the assessment of competency for all newly licensed pharmacists in the United States. The nation technician certification process has already proven the value of this approach. Additionally, with our transit society, frequent relocation of pharmacists is common.

Suggested outcome: Suggest that ASHP initiate discussions with NABP and other interested organizations regarding national licensure.

Jerry Siegel (OH)

Recommendation: The Ohio delegation recommends that ASHP, as a part of its ongoing initiatives to educate health-system administrators on the value that pharmacists can bring to their organizations, devote resources to a marketing campaign targeting CEO'S, COO'S, CFO's and vice presidents of health-system organization through advertising in trade journals such as Modern Healthcare.

Background: Our constituents in Ohio report spending a great deal of time meeting with administrative officers, educating them as to what health-system pharmacists do and how valuable

they can be to the organization. Further, they have observed advertising in administrative publications that effectively highlights the benefits of certain professions, such as full-page advertisements in business trade journals focusing on what professionals like certified public accountants can do for an organization. The advertisements are sponsored by professional societies, such as the American Institute of Certified Public Accountants.

While ASHP's recent awareness efforts targeting administrative decision-makers are appropriate and beneficial, a well-placed advertising effort is a logical next step to provide health-system pharmacy with a strong presence, reaching the people that have the power to make the financial and staffing decisions in the organization.

Tracey Mosby, Don Johnson (AR): ASHP Push News service

Recommendation: Consider including information on new products in the pipeline as a regular part of the ASHP's Push News service.

Background: This news service is a great membership benefit and would be very useful for planning.

Suggested outcome: Allow better forecasting and planning.

Steve Spravzoff, Tom Batik, John Glover, Michael Katz (AZ): ASHP support for residency programs in small health care settings

Recommendation: ASHP should foster the creation and support of residency programs focused on health care in small settings.

Background: ASHP has created templates for residency programs focused on health care in established health care environments. ASHP's objective is to expand the number of residency opportunities available. ASHP considers the opportunity for residency training an important part of the educational process for entry-level practitioners. This focus does not take into consideration the increased need for pharmacy practitioners and residents in smaller practice settings. Furthermore, there are limited incentives to attract practitioners to the small or rural health environment. The support and creation of residency programs in smaller settings would advance opportunities for the provision of pharmaceutical care in under-served areas.

Renee Marino, Gerald Meyer (PA): Medication error prevention

Recommendation: That the ASHP Board of Directors expeditiously pursue the drafting of a White Paper on Medication Error Prevention.

Background: The ASHP Statement on Reporting Medical Errors affirms that "the incidence of . . .mistakes and accidents in health care is unacceptable."

The ASHP Charter identifies that the ASHP exists (in part): "To advance public health by promoting . . . pharmaceutical services aimed at drug-use control and rational drug therapy." "To

foster rational drug use in society such as through advocating appropriate public policies toward that end."

In his report to the House of Delegates, President Scott stated: "Medication errors are a complex and troublesome national health care problem. As health-system pharmacists, it is our responsibility to ensure safety by setting the quality standard for ... medication-use systems and processes..."

In his report to the House of Delegates, Dr. Manasse reminded us that "we must ... create (e) a fail-safe medication use system without further delay."

The ASHP has numerous guidelines, practice standards, position statements and papers that deal with various aspects of medication error prevention. However, to our knowledge, there is no one document that states the problems, identifies the causes and discusses the components of a high-quality, fail-safe medication-use system.

Pharmacists must assume a major portion of the ownership and responsibility for defining, promoting and implementing medication error prevention strategies. As the major professional organization representing health-system pharmacists, the ASHP should have available a single document on medication error prevention that can be utilized by all its members and staff. Such a document will further the ASHP and its members as the experts in medication error prevention strategies.

Kathy Pawlicki, Mark Isopi (MI): Physician Order Entry Systems

Recommendation: Develop an ASHP policy statement describing the minimum requirements for any Physician Order Entry System, including the pharmacist's role in the development and maintenance of these systems.

Background: Due to the IOM report and technological advances, physician order entry (POE) systems are currently being developed and Health System Pharmacists should play a vital role in placement and use of these systems. It is critical that these systems are put in place with pharmacist involvement. POE software vendors have already begun introducing electronic systems which bypass the pharmacist's involvement in the medication process.

Suggested outcome: Development of an ASHP policy statement and/or guidelines.

William Puckett (TX): Dates of the ASHP Midyear Clinical Meeting

Recommendation: ASHP should once again analyze the possibility and feasibility of moving the dates of the Midyear Clinical Meeting to November, or January, to avoid the holiday season, student exams, and family vacations which occur during its current dates in early December.

Background: Attendance at the ASHP Midyear Clinical Meeting has become a very necessary and important event for many pharmacists, technicians, and students, as evidenced by its continued growth. Yet, it continues to be scheduled during dates that many feel are very inconvenient for the above reasons. The meeting is large enough now, and certainly has the stature and drawing power,

to command preferential rates for facilities during other weeks, particularly in November and January.

Suggested outcome: Report back to House as to results of the analysis and decisions reached.

Barbara Poe (OK): Health Insurance Portability and Accountability Act (HIPAA)

Recommendation: That ASHP provide education (meeting program, web site, etc.) on HIPAA to the membership in a timely fashion.

Background: This legislation is purported to be the most sweeping legislation for health care since Medicare was signed into law.

Suggested outcome: More informed membership.

Barbara Poe (OK): Use of colognes and perfumes

Recommendation: That ASHP consider asking meeting participants (in meeting programs and announcements) to refrain from utilizing perfumes and colognes in deference to fellow colleagues with sensitivities and allergies to these substances.

Background: Self-explanatory.

David Santrock, Jr. (KY): Recognition of new officers to the board

Recommendation: The delegations from KY and OH wish to acknowledge and congratulate new officers to the board: President Max L. Hunt, and board members Jill E. Martin and Douglas J. Scheckelhoff and also to thank all for their participation in and contributions to each of our state organizations.

Background: All three have some important history either by getting a degree, practicing and/or serving in other state or state organization.

Teri Bair (TX) (endorsed by TX, DE, MN, MS, NJ, NY, MD, OK, VA): *Center on Patient Safety*

Recommendation: We would like to commend ASHP for establishing the Center on Patient Safety effective July 1, 2000, and for taking the lead on this very important component of pharmacy practice. In light of the importance and focus on patient safety in health care today, we request that ASHP report back to the House at the Annual Meeting in June 2001, on the progress, developments and specific accomplishments of the Center pursuant to its defined goals and objectives.

Background: The recent Institute of Medicine Report on medical errors has brought the critical issue of medication safety to the attention of the nation. For each of us, individually, as well as within our institutions, and professional associations this means that we must ensure that the problem and creative solutions receive ongoing focus and attention as our highest quality

improvement priority. Because of the important role of ASHP and its leadership in this process, a Texas ASHP member through the Texas delegation sought to recommend that ASHP establish a center dedicated to the principles of medication safety improvement for the benefit of patients consistent with recommendation 7.2, paragraph 2 (p. 134) of the IOM Report, "To Err Is Human" (a copy which is attached).

The purpose of such a center should be to ensure that ASHP provide support and assistance to its members in their continued quality improvement initiatives, research, and educational endeavors to reduce medical errors and adverse events in health-systems. The following areas of the medication use process should be a focus of the center:

1. prescribing and medication order entry;
2. dispensing of medications;
3. administration of medications;
4. clinical monitoring to assure appropriate drug therapy via pharmaceutical care;
5. pharmacy information systems safeguards;
6. drug information (to patients, practitioners, other health care providers and pharmacists).

Given the announcement of the opening of such a center by ASHP at its June 2000 Annual Meeting, the recommendation of the establishment of the center was no longer necessary. However, the Texas delegation believes that it is of considerable importance for the House to be kept informed of the activities, accomplishments, direction and focus of the Center to assure that our intended purposes, goals and objectives for such a center are met.

Suggested outcome: A report to be made at the House of Delegates Meeting June 2001.

Larry Engle (TX) (endorsed by TX, AK, DE, LA, MN, MS, MD, NM, NJ, NY, OK, OR, VA, WI): Establishment of a Timeline in Conjunction with Policy #9906, "Use of Machine-Readable Code Technology"

Recommendation: ASHP, in collaboration with other appropriate organizations, shall develop a deadline of not greater than two (2) years for the promotion and implementation of Policy #9906, "Use of Machine-Readable Code Technology", to include the market availability of a standardized, universally-accepted machine-readable code product from all pharmaceutical manufacturers.

Further, ASHP shall encourage its members to incorporate the use of machine-readable code technology in health systems to assist in the provision of accurate medication delivery.

In light of the importance and focus on patient safety in health care today, we request that ASHP report back to the House at the Annual Meeting in June, 2001, on the progress and specific actions taken toward accomplishing these goals.

Background: As a result of the recent publication of the Institute of Medicine Report; physicians and other health care professionals, administrators, politicians, lawyers, and our patients are all becoming more aware of the serious problem of medication errors. With such energy now focused on this problem at an unprecedented national level, we must capitalize on this attention and renew our personal and collective professional efforts regarding medication safety. In this spirit, today we

want to bring to the House the following facts and recommendations regarding medication error prevention:

- There **exists today** technology that has proven capability of virtually eliminating the incidence of wrong drug errors at both the point of dispensing and, in the case of hospitals, the point of administration to the patient at the bedside.
- Such technology utilizes computer scanning of machine-readable codes to verify accuracy of each individual drug product and the patient (via the arm-band, as an example).
- Studies have shown the use of such technology for other applications to be virtually error-free with less than one error in a million transactions.
- The pharmaceutical industry, for the most part, has failed to provide machine-readable coded individual drug packages which are fundamental to the use of such technology in pharmacy.
- A multitude of rationalizations and excuses have been given by pharmacy and industry for why this proven technology has not been adopted. But the fact remains that meanwhile other industries have quietly resolved their problems in this regard and thus we routinely see machine-readable code technology working well in parts stores, grocery stores, and almost every other business that must track inventory, costs, and charges.

In summary we believe the failure on the part of industry and pharmacy is no longer acceptable and recommend that ASHP take the recommended steps to immediately address this problem. With today's unprecedented attention on medication errors, there has never been a better time to resolve this issue.

Suggested outcome: We request that ASHP report back to the House at the Annual Meeting in June, 2001, on the progress and specific actions taken toward accomplishing these goals.

Don Johnson, Tracey Mosby (AR): The public relations image of ASHP

Recommendation: "What is ASHP known for"? As the Task Force on Reorganization considers this question to promote unity within the diverse membership, consider emphasizing the concept that ASHP be the "patient advocate pharmacist organization" to distinguish it from other pharmacist organizations.

Background: The question was posed at the Dallas RDC re how to provide focus/unity for the diverse membership of ASHP. E.g., ACCP wants to be the pharmacist organization that represents clinical pharmacists.

Suggested outcome: Unity of membership across the continuum of care. ASHP can be the pharmacist organization that best represents pharmacist's care for patients.

Board of Directors duly considered matters. The Board reported on one Board policy and four Council policy recommendations that were amended at the first House meeting. Pursuant to Bylaws Section 7.3.1.1, the Board met on the morning of June 7, 2000, to "duly consider" the amended policy recommendations. The Board presented its recommendations as follows.
Regarding the first item, from the Board of Directors, titled "ASHP Statement on Reporting Medical Errors," the Board agreed that the amendments were acceptable. However, the Board

made some editorial changes, including switing the order of the second and third paragraphs of the document, which do not affect the intent of the amendments. (See the report of the first meeting of this session, "Council reports.")

Regarding the second item, from the Council on Administrative Affairs, titled "Drug shortages," the Board agreed that the amendments were not acceptable and that the amended proposal would be referred for further consideration. (See the report of the first meeting of this session, "Council reports.")

Regarding the third item, from the Council on Educational Affairs, titled "Pharmacists Credentialing," the Board agreed that the amendment was acceptable. (See the report of the first meeting of this session, "Council reports.")

Regarding the fourth item, from the Council on Professional Affairs, titled "Internet and Telepharmacy," the Board agreed that the amendment was acceptable. (See the report of the first meeting of this session, "Council reports.")

Regarding the fifth item, from the Council on Professional Affairs, titled "Pharmacists' Role in Immunization," the Board agreed that the amendments were acceptable. (See the report of the first meeting of this session, "Council reports.")

It was then moved and seconded to reconsider Policy Recommendation B from the Council on Administrative Affairs. It was then moved and seconded to approve Policy Recommendation B as originally submitted to the House of Delegates. Following discussion, Policy Recommendation B was adopted. It reads as follows:

B. Drug shortages

To declare that pharmaceutical manufacturers, distributors, group purchasing organizations, and regulatory bodies, when making decisions that may create drug product shortages, should strive to prevent those decisions from compromising the quality and safety of patient care.

New Business. Chair Sheaffer announced that, in accordance with Article 7 of the Bylaws, there were two items of New Business to be considered. He noted that if an item of New Business is approved for referral to the Board, the delegates' discussion, ideas, and comments on the item become a part of the referral.

Chair Sheaffer called on Scott M. Mark (DC) to introduce the first item of New Business, titled "Member Designation of Affiliation for the Purpose of Delegate House Representation and Delegate Eligibility." After discussion , the item was approved for referral to the Board of Directors. It reads as follows:

Motion: That members of ASHP are given the opportunity to designate which Affiliated State Chapter, Fraternal body or Affiliated section they wish to represent them in the House of Delegates.

Background: ASHP Delegate eligibility is currently determined by the official address as registered at ASHP. This has been further defined as the official mailing address for ASHP publications (home vs. work). For members who work in one state and live in another, this has implications for where they are correspondingly considered delegate-eligible.

Currently, members of some Affiliated State Chapters are not eligible to become a delegate or vote for the chapter delegate in the state in which they are active. This is because they do not work in the given state and do not live in the given state. This issue is frequently encountered when a major metropolitan area encompasses more than one state. Often, these members have chosen membership in that given state because geographically, they live or work in closer proximity to that

state than the state in which they live. For example, in the DC area, many members live just outside DC and have chosen to be active in WMSHP rather than MSHP as they live closer to DC (the center of WMSHP) than Baltimore (the center of MSHP). As a result, they are not eligible as delegates of DC nor are they eligible to vote for the delegates of DC.

This issue has the ability to be further complicated if the Fraternal Delegates and Section chairs are given voting rights in the House of Delegates. It would be possible for a member to live in one state, work at federal facility in another state and be a member of a section thus giving them four delegates in which they could conceivability be represented.

Allowing each member to designate which delegate best represents their interests will increase the true representation of member issues, increase their ability to become active in their chosen Affiliate and eliminate the potential for dual representation in the House.

Suggested Outcome: To amend and restate the ASHP Bylaws to allow members to designate the region from which they wish to be aligned for the purpose of voting and delegate representation.

The second item of New Business, "Support of genetic and gene therapy research," was introduced by Delegate Dennis Williams (NC) on behalf of the ASHP Section of Clinical Specialists. Following discussion, it was approved for referral to the Board of Directors. It reads:

Support of genetic and gene therapy research

Motion: To support the responsible and ethical conduct of genetic research, including gene and gene-based therapy, to improve the understanding of diseases and variable responses to treatment, and to identify potential therapies and cures.

Background: The Executive Committee of the Section of Clinical Specialists voted to support this new business item on June 4, 2000.

Major advances have been made in the Human Genome Project, and a working draft of mapping of the human genome is expected later this summer. Enhanced knowledge of genetics and pharmacogenomics will significantly influence medical diagnosis and management.

An individual's genetic makeup influences susceptibility to or presence of a disease, and can impact dosage requirements and response to treatment (pharmacodynamics and pharmacokinetics). There are potential applications for optimizing drug therapy for both efficacy and toxicity.

Many new and existing medications work mechanistically by initiating, suppressing or modifying gene expression.

Genetic and pharmacogenomic research r3equires consideration of numerous factors including scientific, social, economic, and ethical issues. There is a necessity for balance in considering these issues.

Genetic research is in the public and regulatory spotlight. Public awareness and concerns have been enhanced due to recent events and reports of safety of these therapies. In some cases, the regulatory body (OPRR) has halted studies pending further investigation.

Suggested Outcome: Current policy addresses the pharmacist's role in the handling of biologics; however, due to the intensity of scrutiny and widespread implications and applications, specific policy should focus on genetic research and therapies.

Numerous policy proposals from councils, educational activities, and products may emanate from this item of new business. We benefit from specific policy addressing the importance of continued advancement o genetic research and therapies. Additionally, positions may be developed addressing specifics about the pharmacist's role in providing, managing, and monitoring gene-based therapies, as well as our role in ensuring appropriate consideration of social, economic and ethical issues in their use. There will be a continuing need for educational programs and products

to ensure adequate knowledge and core competencies of pharmacists in handling, preparing, and monitoring gene-based therapies.

Election of House Chair. Chair Sheaffer conducted the election for Chair of the House of Delegates. He called delegates to present completed official ballots to tellers, who certified the eligibility of delegates to vote. After the balloting, the tellers counted the ballots.

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

As a token of appreciation on behalf of the Board of Directors and members of ASHP, Chair Sheaffer presented President Scott with an inscribed gavel commemorating his term of office.

President Scott recognized the service of Chair Sheaffer as Chair of the House of Delegates and a member of the Board of Directors.

Chair Sheaffer recognized Bruce R. Canaday's years of service as a member of the Board, in various presidential capacities, as Chair of the Board, and as Vice Chair of the House of Delegates.

Installation. Chair Sheaffer received the tellers' certified report and announced that Roland A. Patry was the newly elected Chair of the House of Delegates. Chair Sheaffer then installed Max L. Hunt, Jr., as President of ASHP, Douglas J. Scheckelhoff and Jill E. Martin as members of the Board of Directors, and Roland A. Patry as Chair of the House of Delegates. He introduced the families of President Hunt, Board member Scheckelhoff and Chair Patry.

Inaugural address. President Max. L. Hunt, Jr., presented his inaugural address, titled "Building the fire within."

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

Adjournment. The 52nd annual session of the House of Delegates adjourned at 5 p.m.

aThe Committee on Nominations included William H. Puckett, Chair; Sara J. White, Vice Chair; and Kevin J. Colgan, Catherine L. Hansen, Lynnae M. Mahaney, Joseph J. McVety and Phillip J. Schneider.

bWhen the House of Delegates amends a professional policy recommendation submitted to it by the Board, the ASHP Bylaws (Section 7.3.1.1) require the Board to review the amended action and make a recommendation to the House on final disposition of the issue.

ASHP Statement on Reporting Medical Errors

Position

The incidence of death and serious harm caused by mistakes and accidents in health care is unacceptable.[1] This serious public health problem merits top-priority national attention. Addressing this issue will require major reforms and sizable investment of resources throughout the health care system, including the medication use process, which is a particular focus of the American Society of Health-System Pharmacists (ASHP).

ASHP believes that the following steps should be taken as part of a comprehensive national solution to the problem: (1) The establishment of a standardized, uniform nationwide system (with the characteristics noted below) of mandatory reporting of adverse medical events that cause death or serious harm, (2) continued development and strengthening of systems for voluntary reporting of medical errors, and (3) strengthening efforts to implement process changes that reduce the risk of future errors and improve patient care.

The fundamental purpose of reporting systems for medical errors is to learn how to improve the health care delivery process to prevent these errors. Reporting of medical errors must become culturally accepted throughout health care. A major investment of resources will be required in the health care system to apply the lessons derived from the reporting of medical errors. Marshaling those resources is an urgent issue for the governing boards of health care institutions, health care administrators, health professionals, purchasers of health care (including federal and state governments), third party payers, public policy makers, credentialing organizations, the legal profession, and consumers.

Requirements

The primary goal of *mandatory reporting* of adverse medical events that cause death or serious harm should be to foster accountability for health care delivery process changes to prevent errors or adverse medical events. If a patient dies or is seriously harmed because of a mistake or accident in the health care system, the practitioner or institution responsible for the patient's care should report the incident to a designated state health body. Further, states should be obligated to share information based on these reports promptly with a national coordinating body and with national programs that are designed to improve the quality and enhance the safety of patient care.

ASHP's support of a mandatory reporting system is contingent upon the system having the following characteristics:

1. An overall focus on improving the processes used in health care, with the proper application of technical expertise to analyze and learn from reports,
2. Legal protection of confidentiality of patients, health care workers, and the information submitted to the extent feasible while preserving the interest of public accountability,
3. Nonpunitive in the sense that the submission of a report, per se, does not engender a penalty on the reporting institution or practitioner or others involved in the incident,
4. A definition of "serious harm" that concentrates on long-term or irreversible patient harm, so as not to overburden the reporting system,
5. National coordination and strong federal efforts to ensure compliance with standardized methods of reporting, analysis, and follow up, that emphasize process improvement and avoid a culture of blame,
6. Adequate resources devoted to report analysis, timely dissemination of advisories based on report analysis, and development of appropriate quality improvement efforts, and
7. Periodic assessment of the system to ensure that it is meeting its intent and not having serious undesired consequences.

Experience associated with current mandatory state reporting of adverse medical events and mandatory public health reporting of certain infectious diseases should be assessed, and the best practices of such programs should be applied to the new system of mandatory reporting of adverse medical events that cause death or serious harm.

The primary goals of *voluntary reporting* of medical errors should be quality improvement and enhancement of patient safety. Reports by frontline practitioners of errors and "near misses" are a strength of such programs when report analysis and communication lead to prevention of similar occurrences. The public interest will be served if protection is granted to individuals who submit reports to voluntary reporting programs. The Medication Errors Reporting Program

operated by the United States Pharmacopeia in cooperation with the Institute for Safe Medication Practices is an important initiative that merits strengthening; this program may be a model for voluntary reporting of other types of medical error.

1. Institute of Medicine Division of Health Care Services Committee on Quality of Health Care in America. To err is human: building a safer health system. Washington, DC: National Academy Press; 1999.

Approved by the ASHP House of Delegates, June 5, 2000.

[Other relevant ASHP policies are the ASHP Guidelines on Preventing Medication Errors in Hospitals and policy positions 8614, 9007, 9206, 9609, 9805, and 9918.]

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