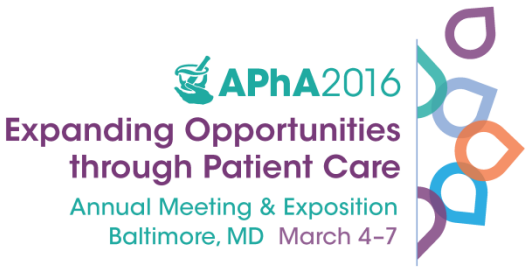


**Actions of the 2016 APhA House of Delegates**
**Baltimore, Maryland**
**March 4-7, 2016**

The following policies were adopted by the 2016 APhA House of Delegates and are now official Association policy:

***Biologic, Biosimilar, and Interchangeable Biologic Drug Products***

1. APhA urges the development of programs and policies that facilitate patient access to and affordability of biologic products.
2. APhA urges the Food and Drug Administration (FDA) to expedite the development of standards and pathways that will evaluate the interchangeability of biologic products.
3. APhA recognizes the Food and Drug Administration's (FDA) Purple Book as an authoritative reference about biologic product interchangeability within the United States.
4. APhA opposes interchangeable biologic product substitution processes that require authorization, recordkeeping, or reporting beyond generic product substitution processes.
5. APhA encourages scientific justification for extrapolation of indications for biologic products to ensure patient safety and optimal therapeutic outcomes.

***Point-of-Care Testing***

1. APhA recognizes the value of pharmacist-provided, point-of-care testing and related clinical services, and it promotes the provision of those tests and services in accordance with the Joint Commission of Pharmacy Practitioners Pharmacists' Patient Care Process.
2. APhA advocates for laws, regulations, and policies that enable pharmacist-provided, point-of-care testing and related clinical services that are consistent with the pharmacists' role in team-based care.
3. APhA opposes laws, regulations, and policies that create barriers to the tests that have been waived by the Clinical Laboratory Improvement Amendments (CLIA) and that are administered and interpreted by pharmacists.
4. APhA encourages use of educational programming and resources to facilitate practice implementation of pharmacist-provided, point-of-care testing and related clinical services.
5. APhA supports patients taking active roles in the management of their health, including their ability to request and obtain pharmacist-provided, point-of-care tests and related clinical services.
6. APhA advocates for access to, coverage of, and payment for both pharmacist-provided, point-of-care tests and any related clinical services.

***Adopted New Business Items***

The following items of New Business were adopted by the 2016 APhA House of Delegates and are now official Association policy:

***Substance Use Disorder Education*** *(modifies original policy language of 2003, 1987 Drug Abuse Education)*
APhA supports comprehensive substance use disorder education, prevention, treatment, and recovery programs.

***Substance Use Disorder***

1. APhA supports legislative, regulatory, and private sector efforts that include pharmacists' input and that will balance patient-consumers' need for access to medications for legitimate medical purposes with the need to prevent the diversion, misuse, and abuse of medications.
2. APhA supports consumer sales limits of nonprescription drug products, such as methamphetamine precursors, that may be illegally converted into drugs for illicit use.
3. APhA encourages education of all personnel involved in the distribution chain of nonprescription products so they understand the potential for certain products, such as methamphetamine precursors, to be illegally converted into drugs for illicit use. APhA supports patient-consumer education of consequences of methamphetamine use, misuse, and abuse.
4. APhA supports public and private initiatives to fund treatment and prevention of substance use disorders.
5. APhA supports stringent enforcement of criminal laws against individuals who engage in drug trafficking.

***Legalization or Decriminalization of Illicit Drugs*** *(modifies original policy language of 1990 Legalization or Decriminalization of Illicit Drugs)*

1. APhA opposes legalization of the possession, sale, distribution, or use of illicit drug substances for non-medical uses.
2. APhA supports the use of drug courts or other evidence-based mechanisms—when appropriate as determined by the courts—to provide alternate pathways within the criminal justice system for the treatment and rehabilitation of individuals who are charged with drug-related offenses and who have substance use or other related medical disorders.
3. APhA supports criminal penalties for persons convicted of drug-related crimes, including but not limited to drug trafficking, drug manufacturing, and drug diversion, whenever alternate pathways are inappropriate as determined by the courts.

***Medication Assisted Treatment***

APhA supports expanding access to Medication Assisted Treatment (MAT), including but not limited to pharmacist-administered injection services for treatment and maintenance of substance use disorders that are based on a valid prescription.

***Opioid Overdose Prevention***

1. APhA supports access to third-party (non-patient recipient) prescriptions for opioid reversal agents that are furnished by pharmacists.
2. APhA affirms that third-party (non-patient recipient) prescriptions should be reimbursed by public and private payers.

***Labeling and Measurement of Oral Liquid Medications***

1. APhA supports the use of the milliliter (mL) as the standard unit of measure for oral liquid medications.
2. APhA encourages the mandatory use of leading zeros before the decimal point for amounts of less than one on prescription-container labels for oral liquid medications.
3. APhA discourages the use of trailing zeros after the decimal point for amounts greater than one on prescription-container labels for oral liquid medications.
4. APhA supports access to and universal availability of dosing devices with numeric graduations that correspond to the unit of measure that is on the container's label for oral liquid medications.

***Policy Review Process***

As part of the continuing review of existing policy, the 2016 APhA House of Delegates adopted Parts 1 and 2 of the Policy Review Committee Report, thereby retaining, archiving, or rescinding existing Association policy on a range of topics.

The 2016 APhA House of Delegates RETAINED the following statements as shown below:

***1996 Brand-Name Line Extensions***

APhA opposes the use of the same brand name (or minor modifications of the same name) for prescription and nonprescription drug products containing different active ingredients.

(JAPhA NS36(6):396 June 1996) (Reviewed 2004) (Reviewed 2006)(Review 2011)(Reviewed 2016)

***2002, 1984 Depiction of Pharmacists in Public Media***

APhA supports the development of guidelines or standards to enhance the depiction of the pharmacy profession in all public media.

(Am Pharm NS24(7):60 July 1984) (JAPhA NS42(5: Suppl. 1:S62 September/October 2002) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***1999 Direct-to-Consumer Advertising of Medications***

1. APhA supports legislative and regulatory activities permitting direct-to-consumer advertising concerning medical or health conditions treatable by prescription or nonprescription drug products. These advertisements must conform to rules and regulations that assure complete, comprehensive and understandable information that informs consumers of potential benefits and risks of the product.
2. APhA opposes false or misleading advertising for prescription or nonprescription drugs or any promotional efforts that encourage indiscriminate use of medication.
3. APhA supports the availability of accurate information to consumers about medication use, and recognizes the responsibility of pharmacists to provide appropriate responses to consumer inquiries stimulated by direct-to-consumer advertising as a compensated pharmaceutical service. In addition, APhA recommends that healthcare professionals, including but not limited to pharmacists, receive new product information on direct-to-consumer advertising campaigns prior to this information being made available to consumers.

(JAPhA 39(4): 447 July/August 1999)(Reviewed 2004) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***2002 Investigation of Discount Card Issuer Practices***

APhA encourages the Federal Trade Commission, the US attorney general or other appropriate agency to investigate misleading and deceptive marketing practices of issuers of discount cards.

(JAPhA NS42(5):Suppl. 1:S61 September/October 2002) (Reviewed 2006)(Reviewed 2011)(Reviewed 2016)

***2004, 1977 Prescription Drug Advertising***

APhA does not oppose the dissemination of price information to patients, by advertising or by any other means.

(JAPhA NS17:448 July 1977)(JAPhA NS44(5):551 September/October 2004)(Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***2011, 2002, 1996 Health Mobilization***

APhA should continue to:

1. Emphasize its support for programs on disaster preparedness which involve the services of pharmacists (e.g., Medical Reserve Corps) and emergency responder registration networks [e.g., Emergency System for Advance Registration of Volunteer Health Professions (ESAR-VHP)].
2. Improve and expand established channels of communication between pharmacists, local, state and national pharmacy associations, boards and colleges of pharmacy and allied health professions.
3. Maintain its present liaison with the Office of the Assistant Secretary for Preparedness and Response (ASPR) of the Department of Health and Human Services and continue to seek Office of Preparedness and Emergency Operations (OPEO) assistance through professional service contracts to further develop pharmacy's activities in all phases of preparation before disasters
4. Encourage routine inspection of drug stockpiles and disaster kits by state boards of pharmacy.

(JAPhA N)S6:328. June, 1966) (JAPhA NS42(5) Suppl. 1:S62. September/October 2002) (Reviewed 2006) (JAPhA NS51(4) 483;July/August 2011)(Reviewed 2016)

***2006, 2002, 1971 Model Disaster Plan for Pharmacists***

1. The committee recommends that APhA develop a disaster plan for the guidance of pharmacy organizations in responding to the needs of pharmacists who experience losses from disasters and that this model plan be disseminated to state associations for their reference.
2. The committee recommends that APhA cooperate with associations representing pharmaceutical manufacturers, wholesale distributors, and others in the pharmaceutical supply system in developing a mechanism to facilitate the communication of information about the losses incurred by pharmacists as a result of disasters. Those firms that make it a practice to replace uninsured losses of inventories of their products could do so promptly and efficiently so that normal pharmaceutical services to the affected community are resumed as soon as possible.

(JAPhA NS11:256 May 1971) (JAPhA NS42(5): Suppl 1:S62, September/October 2002) (JAPhA NS46(5):562 September/October 2006)(Reviewed 2011)(Reviewed 2016)

***2004, 1984 Issuing of Drugs by Non-pharmacists***

APhA supports issuing drug products to patients by non-pharmacists under the control and direction of pharmacists.

(Am Pharm NS24(7):60 July 1984) (JAPhA NS44(5):551 September/October 2004) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***1979 Out of State Prescription Orders***

APhA supports the repeal of state laws, which prohibits the dispensing of an otherwise legal prescription order, issued by a prescriber licensed in another state.

(Am Pharm NS19(7):67 June 1979) (Reviewed 2004) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***1997 DEA Employment Waiver***

APhA urges the Drug Enforcement Administration, in processing employment waiver requests, to defer to the decisions of state boards of pharmacy related to the licensure of pharmacists suffering from alcohol and other chemical dependencies.

(JAPhA NS37(4):459 July/August 1997)(Reviewed 2003) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***2003 Drug Addiction/Chemical Dependency Education***

APhA urges pharmacists and pharmacy students to become educated in the recognition and treatment of drug addiction and chemical dependency.

(JAPhA NS43(5):Suppl. 1:S57 September/October 2003) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***1990 Drug Testing in the Workplace***

APhA endorses the concept of the "Drug Free Workplace" and recommends that where drug testing is performed in the workplace it be conducted in conjunction with an employee assistance program.

(Am Pharm NS30(6):45 June 1990)(Reviewed 2003) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***2011, 2005, 2002 Funding for Pharmacist Recovery Programs***

APhA supports and encourages a cooperative effort among state and national pharmacy associations, state boards of pharmacy, and state legislative bodies to authorize, develop, implement and maintain mechanisms for the comprehensive funding of state recovery programs for pharmacists, student pharmacists and pharmacy technicians.

(JAPhA NS42(5):Suppl. 1:S61 September/October 2002) (JAPhA NS45(5):559 September/October 2005) (Reviewed 2006)(Reviewed 2010) (JAPhA NS51(4) 483;July/August 2011) (Reviewed 2016)

***2003, 1972 Methadone Used as Analgesic and Antitussive***

APhA encourages developers of methadone programs to place pharmacists in charge of their drug distribution and control systems.

(JAPhA NS12:308 June 1972) (JAPhA NS43(5):Suppl. 1:S58 September/October 2003) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***2005, 2003, 1982 Pharmacists with Impairments that Affect Practice***

1. APhA advocates that pharmacists should not practice while subject to physical or mental impairment due to the influence of drugs -- including alcohol -- or other causes that might adversely affect their abilities to function properly in their professional capacities.
2. APhA supports establishment of counseling, treatment, prevention, and rehabilitation programs for pharmacists and student pharmacists who are subject to physical or mental impairment due to the influence of drugs – including alcohol – or other causes, when such impairment has potential for adversely affecting their abilities to function in their professional capacities.

(Am Pharm NS22(7):32 July 1982) (JAPhA NS43(5):Suppl. 1:S58 September/October 2003) (JAPhA NS45(5:)559 September/October 2005)(Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***1981 Removal of Hallucinogenic Solvents from Paints, Sprays, and Glues***

APhA supports the denaturing of abused products containing hallucinogens by appropriate means, such as the addition of harmless chemicals with obnoxious scents or with the ability to produce nausea when the products are abused, but not when used as directed.

(Am Pharm NS21(5):40 May 1981)(Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***2003, 1971 Security — Pharmacists' Responsibility***

APhA encourages pharmacists to voluntarily remove all proprietary drug products with potential for abuse or adverse drug interactions from general sales areas and to make their dispensing the personal responsibility of the pharmacist.

(JAPhA NS11:267 May 1971)(JAPhA NS43(5):Suppl. 1:S58 September/October 2003)(Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***2004, 1966 Distribution Programs: Circumvention of the Pharmacist***

APhA opposes distribution programs and policies by manufacturers, governmental agencies, and voluntary health groups which circumvent the pharmacist and promote the dispensing of prescription, legend drugs by non-pharmacists. These programs and policies should, in the public interest, be eliminated.

(JAPhA NS6:293 June 1966) (JAPhA NS44(5):551 September/October 2004) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***2004, 1968 Manufacturers' Pricing Policies***

APhA supports pharmaceutical industry adoption of a "transparent pricing" system which would eliminate hidden discounts, free goods, and other subtle economic devices.

(JAPhA NS8:362 July 1968) (JAPhA NS44(5):551 September/October 2004) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***1985 Pharmaceutical Pricing***

APhA supports a system of equal opportunity with the same terms, conditions, and prices available for all pharmacies.

(Am Pharm NS25(5):52 May 1985) (Reviewed 2004) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***1978 Post-Marketing Requirements (Restricted Distribution)***

APhA opposes any legislation that would grant FDA authority to restrict the channels of drug distribution for any prescription drug as a condition for approval for marketing the drug under approved labeling.

(Am Pharm NS18(8):30 July 1978) (Reviewed 2004) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***1994 Product Licensing Agreements and Restricted Distribution***

APhA opposes any manufacturer-provider relationship which involves product licensing agreements and/or restricted distribution arrangements which infringe on pharmacists' rights to provide pharmaceuticals and pharmaceutical care to their patients.

(Am Pharm NS34(6):55 June 1994) (Reviewed 2004) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***2004, 1971 Single Dose Containers for Parenteral Use***

APhA supports packaging all drugs intended for parenteral use in humans in single-dose containers, except where clearly not feasible.

JAPhA NS11:270 May 1971) (JAPhA NS44(5):551 September/October 2004) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***1983 Pharmaceutical Alternates***

APhA supports recognition of the pharmacist's role in the selection of pharmaceutical alternates (i.e., drug products containing the same therapeutic moiety, but differing in salt, ester, or comparable physical/chemical form or differing in dosage form)

(Am Pharm NS23(6):52 June 1983) (Reviewed 2004) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***2011 Potential Conflicts of Interest in Pharmacy Practice***

1. APhA reaffirms that as healthcare professionals, pharmacists are expected to act in the best interest of patients when making clinical recommendations.
2. APhA supports pharmacists using evidence-based practices to guide decisions that lead to the delivery of optimal patient care.
3. APhA supports pharmacist development, adoption, and use of policies and procedures to manage potential conflicts of interest in practice.
4. APhA should develop core principles that guide pharmacists in developing and using policies and procedures for identifying and managing potential conflicts of interest.

(JAPhA NS51(4) 482;July/August 2011) (Reviewed 2016)

***2011, 2004, 1995 Product Recall Policy***

1. APhA supports:
    a. the use of contemporary communications technologies to enhance communication of recall information to all relevant parties,
    b. developing and promoting strategies to identify and communicate with patients who may have received recalled products, when appropriate,
    c. identifying compensation mechanisms for resources expended in responding to recalls, and
    d. maintaining the FDA recall program, which ensures that appropriate promptness of action can be taken based on the depth and severity of the recall.

(Am Pharm NS35(6):38 June 1995) (JAPhA NS44(5):551 September/October 2004) (Reviewed 2006) (JAPhA NS51(4) 483;July/August 2011) (Reviewed 2016)

***2003, 1997 Continued Competence Assessment Examination***

1. APhA should develop, in cooperation with other state and national associations, a voluntary process for self-assessing pharmaceutical care competence.
2. APhA opposes regulatory bodies utilizing continuing competence examinations as a requirement for renewal of a pharmacist's license.
3. APhA supports programs that measure and evaluate pharmacist competence based on established, valid standards.

(JAPhA NS37(4): 460 July/August 1997) (JAPhA NS43(5):Suppl. 1:S58 September/October 2003)(Reviewed 2005) (Reviewed 2006)(Reviewed 2008)(Reviewed 2011) (Reviewed 2016)

***2003, 1974 Continuing Education***

APhA strongly endorses continuing education for pharmacists.

(JAPhA NS14:494 September 1974) (JAPhA NS43(5): Suppl. 1:S58 September/October 2003) (Reviewed 2005) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***2005, 1992 Cross-Discipline Accreditation of Continuing Education***

1. APhA supports the acceptance, for pharmacy continuing education credit, of relevant, quality programs offered by other health-related continuing education providers.
2. APhA supports the acceptance of relevant programs offered by the Accreditation Council for Pharmacy Education (ACPE)-accredited providers to meet continuing education requirements in other health disciplines.

(Am Pharm NS32(6):515 June 1992) (Reviewed 2003) (JAPhA NS45(5):560 September/October 2005) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***2011, 2003 Distance Education in First Professional Pharmacy Degree Programs***

1. Distance education components of first professional pharmacy degree programs must be constructed in a way to assure socialization into the profession and understanding the ethos and essence of the profession, as such development is primarily derived through practical experience and interaction with faculty, colleagues and patients.
2. APhA expects the Accreditation Council for Pharmacy Education to develop, maintain, and enforce applicable standards to ensure students trained in distance education programs achieve the same educational and professional competencies as students in on-site programs.

(JAPhA NS43(5):Suppl.1:S56 September/October 2003) (Reviewed 2006) (JAPhA NS51(4) 482;July/August 2011) (Reviewed 2016)

***1991 Doctor of Pharmacy Attainment through Non-traditional Mechanisms***

1. APhA encourages schools and colleges of pharmacy to consider, in their strategic planning process, offering non-traditional, post-baccalaureate, doctor of pharmacy degree programs. Issues to be considered in such planning should include at least the following:
   (a) entry requirements;
   (b) educational and financial resources; and
   (c) competency evaluation for course credit.
2. APhA recommends that non-traditional, doctor of pharmacy degree programs have competency outcomes for graduates equal to those in traditional programs.

(Am Pharm NS31(6):28 June 1991) (Reviewed 2003) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***1993 Payment System Reform Curriculum***

APhA encourages the colleges and schools of pharmacy to incorporate the concept of payment system reform throughout the curricula for all professional programs, and should work with pharmacy organizations to ensure the integration of these concepts into practitioners' continuing development.

(Am Pharm NS33(7):54 July 1993) (Reviewed 2003) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***1975 Pharmacists' Responsibility for Continuing Competence***

APhA advocates that pharmacists maintain their professional competence throughout their professional careers.

(JAPhA NS15:336. June, 1975) (Reviewed 2001) (Reviewed 2003)(Reviewed 2005) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***1984 Primary and Secondary Education in Science, Mathematics, and English***

APhA supports efforts to improve education at the primary and secondary school levels, particularly in the areas of science, mathematics, and English.

(Am Pharm NS24(7):60 July 1984) (Reviewed 2003) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***1988 Professional Ethics in Educational Curricula and Practice***

APhA supports the incorporation of professional ethics instruction in pharmacy curricula and post-graduate continuing education and training.

(Am Pharm NS28(6):394 June 1988) (Reviewed 2003) (Reviewed 2005) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***1982 Use of Academic and Continuing Education Credit***

1. APhA supports the award of continuing education credit for the successful completion of academic credit courses within the scope of pharmacy practice under circumstances which preserve the integrity of both the academic and the continuing education credit.
2. APhA endorses the development and implementation by colleges of pharmacy and other appropriate organizations, of standards and mechanisms by which academic credit can be awarded for successful completion of continuing education courses under circumstances which preserve the integrity of the academic credit.

(Am Pharm NS22(7):33 July 1982) (Reviewed 2003) (Reviewed 2005) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***1994 The Scientific Implications of Health Care Reform***

1. APhA advocates that the public and private sectors maintain or increase their level of commitment to assure adequate resources for both basic and applied research within a reformed health care system.
2. APhA encourages the public and private research communities to preferentially expend resources for the discovery and development of new drugs and technologies that provide substantive, innovative therapeutic advances.
3. APhA advocates an increased emphasis on outcomes research in all areas of health services, including drug and disease-specific research encompassing clinical, economic, and humanistic dimensions (e.g., quality of life, patient satisfaction, ethics) and advocates for action related to conclusions for such research.
4. APhA encourages interdisciplinary collaboration in research efforts within and between the public and private research communities.

(Am Pharm NS34(6):55 June 1994)(Reviewed 2004)(Reviewed 2005)(Reviewed 2010)(Reviewed 2011) (Reviewed 2016)

***2004, 1965 Guidelines for Physician Ownership***

APhA supports efforts to develop guidelines on physician ownership of pharmacies due to the inherent conflict of interest.

(JAPhA NS5:276 May 1965) (JAPhA NS44(5):551 September/October 2004) (Reviewed 2010) (Reviewed 2011) (Reviewed 2016)

***2011, 2004, 1963 Pharmacists and Other Health Practitioners: Relationships and Compensation Among Health Care Practitioners***

APhA opposes any method which provides an inappropriate sharing of compensation between the prescriber and dispenser.

(JAPhA NS3:298 June 1963) (JAPhA NS44(5):551 September/October 2004) (Reviewed 2010) (JAPhA NS51(4) 484;July/August 2011) (Reviewed 2016)

***2004, 1975 Other Health Care Professional Organizations***

APhA supports continuing joint action with other health care and professional organizations.

(JAPhA NS15:331-333 June 1975) (JAPhA NS44(5):551 September/October 2004) (Reviewed 2010)(Reviewed 2011) (Reviewed 2016)

***1989 The Joint Commission***

1. APhA supports increased interaction with The Joint Commission regarding accreditation standards and procedures pertaining to pharmacy and therapeutics.
2. APhA supports pharmacy representation on appropriate The Joint Commission professional and technical advisory committees.

(Am Pharm NS29(7)464 July 1989) (Reviewed 2004) (Reviewed 2009) (Modified 2010)(Reviewed 2011) (Reviewed 2016)

***2008 Pharmacy Compounding Accreditation***

1. APhA reaffirms the 1992 Compounding Activities of Pharmacists policy, which states that APhA affirms that compounding pursuant to or in anticipation of a prescription or diagnostic preparation order is an essential part of health care that is the prerogative of the pharmacist.
2. APhA supports compounding as defined by the Pharmacy Compounding Accreditation Board (PCAB) as a means to meet patient drug therapy needs.
3. APhA opposes compounding when identical medications are commercially and readily available in strength and dosage form to meet patient drug therapy needs.
4. APhA asserts that compounding is subject to regulations and oversight from state boards of pharmacy. APhA urges state boards of pharmacy to identify and take appropriate action against entities who are illegally manufacturing medications under the guise of compounding.
5. APhA supports accreditation of compounding sites by PCAB to ensure patient safety. APhA encourages state boards of pharmacy to recommend accreditation for those sites that engage in more than basic non sterile compounding as defined by PCAB.
6. APhA supports the development of education, training and recognition programs that enhance pharmacist and student pharmacist knowledge and skills to engage in compounding beyond basic, non sterile preparations as defined by PCAB.
7. APhA encourages the exploration of a specialty certification in the area of compounding through the Board of Pharmaceutical Specialties (BPS).

(JAPhA NS48(4):470 July/August 2008) (Reviewed 2009)(Reviewed 2011) (Reviewed 2016)

***2011 Pharmacy Practice Accreditation***

1. APhA should lead the creation of consensus-based, pharmacy profession-developed accreditation standards and methods of evaluation to optimize the quality and safety of patient care and promote best practices.
2. APhA urges that accrediting bodies use profession-developed standards for pharmacy.
3. APhA supports only those pharmacy accreditation processes that are voluntary, transparent, consensus-based, reasonably executable, and affordable, while avoiding duplication and barriers to patient care.
4. APhA opposes mandatory pharmacy accreditation.
5. APhA shall assume the leadership role among stakeholders on the design and implementation of an appropriate process for any new pharmacy accrediting program.
6. APhA supports the appropriate use of data gathered from pharmacy practice monitoring processes to facilitate the advancement of pharmacy practice and quality of patient care.

(JAPhA NS51(4) 482;July/August 2011) (Reviewed 2016)

***2002 Professional Practice Regulation***

1. APhA encourages the revision of pharmacy laws to assign the responsibility and accountability to the pharmacy license holder for the operations of the pharmacy, including but not limited to quality improvement, staffing, inventory, and financial activities. Further, APhA supports the responsibility and accountability of the pharmacist for dispensing of the pharmaceutical product and for the provision of pharmaceutical care services.
2. APhA encourages the pharmacy license holder to provide adequate resources and support for pharmacists to meet their professional responsibilities, and for pharmacists to utilize the resources and support appropriately and efficiently. APhA encourages state boards of pharmacy to hold pharmacy license holders accountable for failure to provide such adequate resources and support.

(JAPhA NS42(5):Suppl. 1:S60 September/October 2002) (Reviewed 2007) (Reviewed 2008)(Reviewed 2011) (Reviewed 2016)

***1979 Child Abuse Reporting***

APhA urges pharmacists to report all suspected cases of child abuse to proper authorities.

(Am Pharm NS19(7):69 June 1979) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***1995 Continuum of Patient Care***

1. APhA advocates and will facilitate pharmacists' participation in the continuum of patient care. The continuum of patient care is characterized by the interdisciplinary care provided a patient through a series of organized, connected events or activities independent of time and practice site, in order to optimize desired therapeutic outcomes.
2. APhA will facilitate pharmacists' participation in the continuum of patient care by:
    a. Achieving recognition for the pharmacist as a primary care provider;
    b. Securing access for pharmacists to patient information systems, including creation of the necessary software for the purpose of record maintenance of cognitive services provided by pharmacists;
    c. Developing means and methods to establish and enable pharmacists' direct participation in the continuum of patient care.

(Am Pharm NS35(6):36 June 1995) (Reviewed 2004) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***1987 Cost-effectiveness of Drug Products and Pharmacy Services***

APhA supports the development of programs which educate pharmacy's several publics about the cost-effectiveness of drug products and related comprehensive pharmacists services.

(Am Pharm NS27(6):422 June 1987) (Reviewed 2004) (Reviewed 2010)(Reviewed 2011) (Reviewed 2016)

***2005 Cultural Competence***

1. Recognizing the diverse patient population served by our profession and the impact of cultural diversity on patient safety and medication use outcomes, APhA encourages pharmacists to continually strive to achieve and develop cultural awareness, sensitivity, and cultural competence.
2. APhA shall facilitate access to resources that assist pharmacists and student pharmacists in achieving and maintaining cultural competence relevant to their practice.

(JAPhA NS45(5):554 September/October 2005) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***2005 Patient Safety***

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

(JAPhA NS45(5):554 September/October 2005) (Reviewed 2009)(Reviewed 2011) (Reviewed 2016)

***2003, 1992 The Pharmacist's Role in Therapeutic Outcomes***

1. APhA affirms that achieving optimal therapeutic outcomes for each patient is a shared responsibility of the healthcare team.
2. APhA recognizes that a primary responsibility of the pharmacist in achieving optimal therapeutic outcomes is to take an active role in the development and implementation of a therapeutic plan and in the appropriate monitoring of each patient.

(Am Pharm NS32(6):515 June 1992) (JAPhA NS43(5):Suppl. 1:S57 September/October 2003) (Reviewed 2007) (Reviewed 2009) (Reviewed 2010)(Reviewed 2011) (Reviewed 2016)

***1971 Prescription Department Security***

The committee recommends that APhA support state legislation to require that a prescription department must be secured whenever the pharmacist or persons authorized by the pharmacist are not present.

(JAPhA NS11:267 May 1971)(Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***1996 Quality Assurance and Improvement in Pharmacy Practice***

1. APhA recommends that all pharmacists incorporate principles and tools available to continually improve the quality of patient care and management activities in their practices.
2. APhA recommends that content on principles and tools available to continually improve the quality of patient care and management practices be incorporated into pharmacy school curricula and into post-graduate education for pharmacists.
3. APhA supports appropriate evaluation and recognition of providers of pharmaceutical care.

(JAPhA NS36(6):395 June 1996) (Reviewed 2004) (Reviewed 2010)(Reviewed 2011) (Reviewed 2016)

***2003, 1993 The Pharmacist's Role with Diagnostic Drugs in Therapeutic Outcomes***

APhA recognizes that it is a responsibility of the pharmacists to take an active role in the selection and use of diagnostic drugs as an integral component in the development and implementation of a patient's therapeutic plan.

(Am Pharm NS33(7):56 July 1993) (JAPhA NS43(5):Suppl. 1:S57 September/October 2003) (Reviewed 2007) (Reviewed 2009)(Reviewed 2010)((Reviewed 2011) (Reviewed 2016)

***2011, 1996 Fluoridation of Water Supplies***

APhA reaffirms its 1954 position in support of appropriate fluoridation of water supplies and encourage pharmacists to assist in implementing such programs in their local communities.

(JAPhA NS6:293 June 1966) (Reviewed 2005) (Reviewed 2009)(JAPhA NS51(4) 484;July/August 2011) (Reviewed 2016)

***1986 Reye Syndrome***

APhA supports all initiatives which enhance public education about the potential relationship between Reye Syndrome and oral and rectal salicylate-containing products, including settings where pharmacists are not available for consultation.

(Am Pharm NS26(6):419 June 1986) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***2011, 1995 Measuring the Quality of Patient Care***

1. APhA believes that quality assessment measures must evaluate the accessibility, acceptability, and technical quality of pharmacy services, as well as the patient-centered and economic outcomes of patient care. These measures must consider the perspectives of patients, pharmacists, and other healthcare providers.
2. APhA believes quality assessment measures of patient care should be tested for validity and reliability in various pharmacy practice settings prior to widespread application.
3. APhA should develop tools and/or programs that enable pharmacists to apply quality assessment measures to their delivery of patient care.
4. APhA should promote efforts to educate patients, pharmacists, other healthcare providers, payers, policy makers, and other interested parties on the appropriate use of quality assessment measures to evaluate and improve the delivery of patient care.

(Am Pharm NS35(6):37 June 1995) (Reviewed 2006 – Statement 1 archived in 2006)((JAPhA NS51(4) 484;July/August 2011) (Reviewed 2016)

***2011, 1994 APhA's Role in the Development and Support of New Payment Systems***

1. APhA should continue its work with pharmacy benefits' managers and other private and public payers to develop innovative pharmacy benefit designs and compensation strategies for pharmacists' services.
2. APhA will endorse benefit design concepts that recognize and compensate pharmacists for their cognitive services to maximize therapeutic outcomes.

(Am Pharm NS34(6):58 June 1994) (Reviewed 2005)(Reviewed 2009) (Reviewed 2010((JAPhA NS51(4) 484;July/August 2011) (Reviewed 2016)

***2005, 1993 Payment System Reform***

1. APhA must advocate reform of pharmacy payment systems to enhance the delivery of comprehensive medication-use management services.
2. APhA must assume a leadership role, in cooperation with other pharmacy organizations, patients, other providers of health services, and third-party payers, in developing a payment system reform plan.
3. APhA should encourage universal acceptance of all components of pharmaceutical care and their integration into pharmacy practice to support payment for services.

(Am Pharm NS33(7):53 July 1993) (Reviewed 2005) (Reviewed 2009)(Reviewed 2011) (Reviewed 2016)

***1980 Nuclear Pharmacy Regulations***

1. APhA supports the concept of state boards of pharmacy retaining their authority to regulate all aspects of professional pharmacy practice including nuclear pharmacy practice.
2. APhA urges state boards of pharmacy to promptly adopt appropriate rules and regulations for the practice of nuclear pharmacy, using the NABP Model Regulations for the Licensure of Nuclear Pharmacies as a model.

(Am Pharm NS20:69 July 1980) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***2011, 1995 Adequacy of Directions for Use on Prescriptions and Prescription Orders***

1. APhA recommends that all professions with prescriptive authority address the issue of prescribers' responsibility for specific instructions to the pharmacist and the patient in all prescription orders.
2. APhA affirms the pharmacist's responsibility, as the patient's advocate, to obtain and communicate adequate directions for use of medications.

(JAPhA NS51(4) 484;July/August 2011) (Reviewed 2016)

***2012, 2007 Biologic Drug Products***

1. APhA encourages the development of safe, effective, and affordable therapeutically equivalent generic/biosimilar versions of biologic drug products, including clinical trials that assess safety.

2. APhA encourages the FDA to develop a scientifically based process to approve therapeutically equivalent generic/biosimilar versions of biologic drug products.

3. APhA should actively support legislation to hasten the development of an efficient regulatory process to approve therapeutically equivalent generic versions of biologic drug products.

4. APhA should initiate educational programs for pharmacists and other health care professionals concerning the determination of therapeutic equivalence of generic/biosimilar versions of biologic drug products.

(JAPhA NS45(5):580 September-October 2007))(JAPhA NS52(4) 458 July/August 2012) (Reviewed 2016)

***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.

(Am Pharm NS31(6):29 June 1991)(Reviewed 2004)(Reviewed 2007)(Reviewed 2010) (Reviewed 2016)

***2005, 1988 Pharmaceutical Biotechnology 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 products. APhA, therefore, supports the continuing development and implementation of such education and training.

(Am Pharm NS28(6):394 June 1988) (JAPhA NS45(5):559 September/October 2005)(Reviewed 2006) (Reviewed 2007) (Reviewed 2010) (Reviewed 2016)

***2004, 1971 Anti-substitution Laws: Pharmacists' Responsibility***

APhA supports state substitution laws which emphasize the pharmacists' professional responsibility for determining, on the basis of available evidence, including professional literature, clinical studies, drug recalls, manufacturer reputation and other pertinent factors, that the drug products they dispense are therapeutically effective.

(JAPhA NS11:260. May, 1971) (JAPhA NS 44(5):551 September/October 2004) (Reviewed 2006)(Reviewed 2011) (Reviewed 2016)

***2013, 2008, 1987 Sale of Home-use Diagnostic and Monitoring Products***

1. APhA supports the need to protect the health of the American people through proper instruction in the safe and effective use of the more complex home-use diagnostic and monitoring products.
2. APhA supports the promotion of the pharmacist as a widely available and qualified health care professional to advise patients in the use of home-use diagnostic and monitoring products.
   (Am Pharm NS27(6):424 June 1987) (Reviewed 2003) (JAPhA NS48(4):470 July/August 2008) (JAPhA 53(4):366 July/August 2013) (Reviewed 2016)

***2012, 20013 The Pharmacist's Role in Laboratory Monitoring and Health Screening***

1. APhA supports pharmacist involvement in appropriate laboratory testing and health screening, including pharmacists directly conducting the activity, supervising such activity, ordering and interpreting such tests, and communicating such test results.
2. APhA supports revision of relevant laws and regulations to facilitate pharmacist involvement in appropriate laboratory testing and health screening as essential components of patient care.
3. APhA encourages research to further demonstrate the value of pharmacist involvement in laboratory testing and health screening services.
4. APhA supports public and private sector compensation for pharmacist involvement in laboratory testing and health screening services.
5. APhA supports training and education of pharmacists and student pharmacists to direct, perform, and interpret appropriate laboratory testing and health screening services. Such education and training should include proficiency testing, quality control, and quality assurance.
6. APhA encourages collaboration and research with other health care providers to ensure appropriate interpretation and use of laboratory monitoring and health screening results.

(JAPhA NS43(5)Suppl. 1:S58 September/October 2003) (Reviewed 2007) (Reviewed 2009) (Reviewed 2010) (JAPhA NS52(4) 460 July/August 2012) (Reviewed 2013) (Reviewed 2016)

***2011 The Role and Contributions of the Pharmacist in Public Health***

In concert with the American Public Health Association's (APHA) 2006 policy statement, "The Role of the Pharmacist in Public Health," APhA encourages collaboration with APHA and other public health organizations to increase pharmacists' participation in initiatives designed to meet global, national, regional, state, local, and community health goals.

(JAPhA NS52(4) 482 July/August 2011) (Reviewed 2012) (Reviewed 2016)

***1981 Pharmacist Training in Medical Technology***

1. APhA supports the education and training of pharmacists in the ordering and interpretation of laboratory tests as they may relate to the usage, dosing, and administration of drugs.
2. APhA opposes requiring certification of pharmacists as medical technologists for the practice of pharmacy.

(Am Pharm NS21(5):40 May 1981) (Reviewed 2003) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016)

***2012 Contemporary Pharmacy Practice***

1. APhA asserts that pharmacists should have the authority and support to practice to the full extent of their education, training, and experience in delivering patient care in all practice settings and activities.
2. APhA supports continuing efforts that lead to the establishment of a consistent and accurate perception by the public, lawmakers, regulators, and other health care professionals of the role and contemporary practice of pharmacists.
3. APhA supports continued collaboration with stakeholders to facilitate adoption of standardized practice acts, appropriate related laws, and regulations that reflect contemporary pharmacy practice.
4. APhA supports the establishment of multistate pharmacist licensure agreements to address the evolving needs of the pharmacy profession and pharmacist-provided patient care.
5. APhA urges the development of consensus documents, in collaboration with medical associations and other stakeholders that recognize and support pharmacists' roles in patient care as health care providers.
6. APhA urges universal recognition of pharmacists as health care providers and compensation based on the level of patient care provided using standardized and future health care payment models.

(JAPhA NS52(4) 457 July/August 2012) (Reviewed 2016)

***2011 Pharmacist's Role in Healthcare Reform***

1. APhA affirms that pharmacists are the medication experts whose accessibility uniquely positions them to increase access to and improve quality of health care while decreasing overall costs.
2. APhA asserts that pharmacists must be recognized as the essential and accountable patient care provider on the health care team responsible for optimizing outcomes through medication therapy management (MTM).
3. APhA asserts the following: (a) Medication Therapy Management Services: Definition and Program Criteria is the standard definition of MTM that must be recognized by all stakeholders. (b) Medication Therapy Management in Pharmacy Practice: Core Elements of an MTM Service Model, as adopted by the profession of pharmacy, shall serve as the foundational MTM service model.
4. APhA asserts that pharmacists must be included as essential patient care provider and compensated as such in every health care model, including but not limited to, the medical home and accountable care organizations.
5. APhA actively promotes the outcomes-based studies, pilot programs, demonstration projects, and other activities that document and reconfirm pharmacists' impact on patient health and well-being, process of care delivery, and overall health care costs.

(JAPhA NS51(4) 482;July/August 2011) (Reviewed 2016)

***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.
3. APhA encourages pharmacists to use the American Medical Association (AMA) Current Procedural Terminology (CPT) codes for billing of MTM services.
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) (Reviewed 2015) (Reviewed 2016)

***2003, 1992 The Pharmacist's Role in Therapeutic Outcomes***

1. APhA affirms that achieving optimal therapeutic outcomes for each patient is a shared responsibility of the health care team.
2. APhA recognizes that a primary responsibility of the pharmacist in achieving optimal therapeutic outcomes is to take an active role in the development and implementation of a therapeutic plan and in the appropriate monitoring of each patient.

(Am Pharm NS32(6):515 June 1992) (JAPhA NS43(5):Suppl. 1:S57 September/October 2003) (Reviewed 2007) (Reviewed 2009) (Reviewed 2010)(Reviewed 2011) (Reviewed 2016)

***2013, 1978 Pharmacists Providing Health Care Services***

APhA supports the study and development of new methods and procedures whereby pharmacists can increase their abilities and expand their opportunities to provide health care services to patients.

(Am Pharm NS18(8):47 July 1978) (Reviewed 2007) (Reviewed 2008) (JAPhA 53(4):366 July/August 2013) (Reviewed 2016)

**The 2016 APhA House of Delegates AMENDED the following statements as shown underlined and struck through below:**

***2016, 2011, 2002, 1963 Role of the Pharmacist in National Defense***

APhA endorses the position that the pharmacist, as a member of the healthcare 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 (e.g., ~~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~~ their position as a member of the health team.

(JAPhA NS3:330 June 1963) (JAPhA NS42(5): Suppl. 1:S62 September/October 2002) (Reviewed 2006)(Reviewed 2010) (JAPhA NS51(4) 483;July/August 2011) (Amended 2016)

***2016, 2005, 1995 Professional Development of Student Pharmacists***

1. APhA believes that it is essential to integrate professionalism throughout a student pharmacist's educational experience.
2. APhA will assist schools and colleges of pharmacy to develop and utilize recruitment materials that emphasize the professional role and responsibilities associated with the provision of pharmaceutical care.
3. APhA ~~encourages~~ supports schools and colleges of pharmacy ~~to~~ interviewing candidates during the admissions process to assess their characteristics for the potential for development of professional attitudes and behaviors.
4. APhA recommends that schools and colleges of pharmacy administer the model pledge of professionalism, as developed by the APhA-ASP/American Association of Colleges of Pharmacy Council of Deans Task Force on Professionalism, to all student pharmacists.
5. APhA encourages schools and colleges of pharmacy and the American Association of Colleges of Pharmacy to develop and implement ongoing programs for faculty, staff, preceptors, and other mentors to enhance their ability to serve as role models and teach professionalism.
6. APhA supports the continuation of ~~will develop and institute~~ a forum for faculty, students, preceptors, and others to establish and foster mentor relationships.

(Am Pharm NS35(6):36 June 1995) (Reviewed 2003) (JAPhA NS45(5):554 September/October 2005) (Reviewed 2006)(Reviewed 2011) (Amended 2016)

***2016, 2011 Pharmacists as Providers Under the Social Security Act***

APhA supports changes to the Social Security Act to allow pharmacists to be recognized and paid as providers of patient care services~~, including but not limited to medication therapy management~~.

(JAPhA NS51(4) 482;July/August 2011) (Amended 2016)

***2016, 1994 Pharmacy Services Benefits in Health Care Reform***

APhA supports reform of the U.S. health care system and believes that any reform at the state or national level must provide for the following

1. Universal coverage for pharmacy service benefits that include both medications and pharmacists' patient care services;
2. Specific provisions for the access to and payment for pharmacists' patient care services ~~pharmaceutical care services, including, but not limited to, patient compliance and preventive care, medication therapy management (MTM) of complex and high-risk patients, health education, drug regimen review, and drug utilization review~~;
3. A single set of pricing rules, eliminating class-of-trade distinctions, for medications, medication delivery systems, and other equipment so that no payer, patient, or provider is disadvantaged by cost shifting;
4. The right for every American to choose his/her own provider of medications and pharmacists' patient care services and for all pharmacists to participate in the health plans of their choice under equally applied terms and conditions;
5. Quality assurance mechanisms to improve and substantiate the effectiveness of medications and health services;
6. Information and administrative systems designed to enhance patient care, eliminate needless bureaucracy, and provide patients and providers price and quality information needed to make informed patient care decisions;
7. Relief from antitrust laws and regulations to enable pharmacists to establish systems that balance provider needs relative to corporate and governmental interests;
8. Reform in the professional liability system, including caps on non-economic damages, attorneys' fees, and other measures;
9. Representation on the controlling board of each plan by an active healthcare practitioner from each discipline within the scope of the plan; and
10. Recognition of the pharmacist's role in delivering primary healthcare services.

(Am Pharm NS34(6):58 June 1994) (Reviewed 2004) (Reviewed 2010) (Reviewed 2011) (Amended 2016)

***2016, 2006 Tobacco/Nicotine Use Data Entry Field in Pharmacy Patient Records***

APhA supports standardizing patient records and clinical decision support tools (including pharmacy dispensing systems) to collect, document, and utilize information regarding the patient's tobacco/nicotine use.

(JAPhA NS46(5):561 September/October 2006)(Reviewed 2011) (Amended 2016)

***2016, 1997 Use of the Word "Pharmacy" in Non-licensed Environments***

APhA supports the establishment and enforcement of regulations through Boards of Pharmacy that restrict the use of the words "pharmacy", "drug store", "apothecary" or any other words or symbols of similar meaning or ~~type in~~ signage and ~~or the name of a~~ business names to entities in which the practice of pharmacy is conducted.

(JAPhA NS37:460 July/August 1997) (Reviewed 2002) (Reviewed 2006)(Reviewed 2011) (Amended 2016)

**The 2016 APhA House of Delegates ARCHIVED the following statements as shown below:**

***1980 Non-prescription Drug Advertising***

1. APhA supports a legislative or regulatory requirement that advertising of non-prescription drugs directed to the health care professions identify all active and inactive ingredients, including disclosure of the quantitative amounts of all physiologically active ingredients.
2. APhA supports disclosure of all therapeutically active ingredients of non-prescription drugs in advertising directed to the public

(Am Pharm NS20(7):62 July 1980) (Reviewed 2004) (Reviewed 2006)(Reviewed 2011) (Archived 2016)

***1992 Balanced Education for Pharmacists***

1. APhA encourages schools and colleges of pharmacy to continue to develop educational requirements to ensure the provision of a balanced, general education in order to graduate educated citizens and competent, health care professionals.
2. APhA supports development of admission processes by schools and colleges of pharmacy that ensure ~~assure~~ that students possess qualities necessary to become educated citizens and competent, health care professionals.

(Am Pharm NS32(6):515 June 1992) (Reviewed 2001) (Reviewed 2003) (Reviewed 2005) (Reviewed 2006)(Reviewed 2011) (Archived 2016)

***2006 Conversion of Nonprescription Products Into Drugs of Abuse***

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

(JAPhA N46(5):561 September/October 2006)(Reviewed 2011) (Archived 2016)

***1989 Pharmacy-based Screening and Monitoring Services***

APhA supports projects that demonstrate and evaluate various pharmacy-based screening and monitoring services.

(Am Pharm NS29(7):463 July 1989) (Reviewed 2006) (Reviewed 2007)(Reviewed 2013) (Archived 2016)

***2005 Efforts to Limit Methamphetamine Access***

1. APhA supports legislation that balances the need for patient/consumer access to medications for legitimate medical purposes with the need to prevent diversion and abuse.
2. APhA supports stringent enforcement of criminal laws against individuals who engage in the illegal trafficking of methamphetamine and methamphetamine precursors.
3. APhA supports retail sales limits of non-prescription products that contain methamphetamine precursors to prevent diversion.
4. APhA supports education of employees involved in the distribution chain of methamphetamine precursors about diversion, methamphetamine abuse and prevention of abuse. APhA supports patient/consumer education of consequences of methamphetamine abuse.
5. APhA supports public and private initiatives that result in increased funding to address the escalating needs for drug abuse treatment and prevention.

(JAPhA NS45(5):555 September/October 2005)(Reviewed 2006)(Reviewed 2011) (Archived 2016)

***APhA House Rules Review Process***

The 2016 APhA House of Delegates adopted the report of the 2015–2016 APhA House Rules Review Committee, making the following modifications to House operations (approved additions are shown underlined below and deletions are shown ~~struck through~~).

***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 secondary amendments or "friendly" amendments. The Speaker will rule any Delegates out of order who express a desire to make a secondary amendment or "friendly amendment."

***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, or amend, all such existing policy, with limited debate, shall be in order. Items identified by the Policy Review Committee as needing amendment shall be reviewed by the Committee and Speaker of the House to determine that the amendment does not change the intent of the original policy and included in a separate section of the Policy Review Committee report provided to Delegates at the Annual Meeting. Any substantive amendments or those that change the intent of the original policy should be submitted by the Policy Review Committee 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 Re-view Committee, and every 4 years from there (not on an even year when there is a Speaker election),~~ The Policy Review Committee shall meet annually and review any policy that has not been reviewed or had policies added in the past 4 years.