APhA2017

MAKING AN IMPACT IN PATIENT CARE

San Francisco, CA | March 24–27
Annual Meeting & Exposition

APhA HOUSE OF DELEGATES
DELEGATE REFERENCE MATERIALS

15998

HOUSE OF DELEGATES
APhA AMERICAN PHARMACISTS ASSOCIATION

MEMORANDUM

TO: Delegates and Alternate Delegates to the APhA House of Delegates
FROM: Theresa Tolle, Speaker of the APhA House of Delegates
RE: Delegate Reference Materials and Important Information

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

Included within your Delegate Reference Materials, you will find:

- APhA House of Delegates Schedule At A Glance;
- 2016-2017 APhA House Rules Review Report;
- 2016-2017 APhA Policy Review Committee Report;
- 2016-2017 APhA Policy Committee Report; and
- 2016-2017 APhA New Business Items received to date.

Policy-Related Webinars Available

If you were unable to participate in one of the policy-related webinars, I encourage you to visit http://pharmacist.com/learn-about-0 to view an archived version of one of the webinars related to the policy topics, policy committee report, or the policy review committee report. These webinars will give you additional background information related to the subjects and provide insight of the questions raised by your fellow Delegates.

To provide an overview of the New Business Items to be discussed in this year's House, I will host two ***New Business Item Webinar*** **sessions from** 12:00-1:30pm on March 1, 2017 and from 6:00-7:30pm on March 8. Please try to participate in one of the two webinars. These webinars will give you an opportunity for you to learn more about the items submitted prior to the Annual Meeting and provides you adequate time to prepare for House discussions. You must register to participate in the webinars to go to register today at http://pharmacist.com/learn-about-0. If you find that you are unable to participate in one of the live webinars, an archived version will be available online soon after.

If you are new to the House of Delegates, or if you just want a refresher course on the rules and procedures of the APhA House, I encourage you to view the ***Delegate Orientation Webinar*** **recording.**

****Onsite Delegate Registration – Exhibit Hall ABC***

Registration for the First Session will open from **12:00pm-3:30pm on Friday**, **March 24, 2017.** This year delegate registration will be located inside **Exhibit Hall ABC of the Convention Center**. Registration for the Final session will be available in the same location, from **11:00am-2:00pm on Monday, March 27, 2017**. There is no need to check-in with the House of Delegates Office prior to these registration times.

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

Step 1 – Report to the Delegate registration area inside **Exhibit Hall ABC**. Please remember to bring your delegate reference materials and your name badge with you to registration.
Step 2 – Scan your name badge, pick up your Delegate ribbon (if needed), and pick up your electronic voter keypad from APhA staff. Note: you must return the keypad to staff at the conclusion of each House session.

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

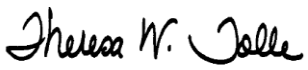
House of Delegates Office Hours
If you have specific questions regarding the policy development process or general House procedures, I encourage you to schedule an appointment to speak with me or the House Parliamentarian during the Annual Meeting. See your Schedule At-A-Glance for House of Delegates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

Planning for the 2018 House
It's never too early to plan ahead! In late April, APhA will begin the policy development process for 2018. With that in mind, I encourage you to begin thinking about the potential policy topics that should be addressed by the House of Delegates. Within this booklet, you will find a call for potential policy topics. I encourage you to bring your completed form to San Francisco, or submit the form electronically by **March 31, 2017** at http://fs3.formsite.com/apha/form220/index.html.

On a related note, there are a number of opportunities for you to serve APhA on one of the House of Delegates committees. If you are interested in serving during the 2017-2018 policy development process, I encourage you to complete the committee volunteer interest form **by May 17, 2017** at http://fs3.formsite.com/apha/form217/index.html.

Thank you again for your interest and service to the 2017 House of Delegates! I look forward to seeing you in San Francisco! If you have any questions about House activities, please visit http://www.pharmacist.com/apha-house-delegates or contact APhA staff at hod@aphanet.org.

Sincerely,



Theresa Tolle, BPharm
APhA Speaker of the House of Delegates

Thomas E. Menighan, BSPharm, MBA, ScD (Hon), FAPhA
Secretary, APhA House of Delegates
APhA Executive Vice President & Chief Executive Officer

Staff Liaisons:
Mitchel Rothholz, RPh, MBA, Chief Strategy Officer
Brian Wall, PharmD, Senior Manager, Governance
Wendy Gaitwood, Senior Administrative Manager, Policy & Governance

Online: http://www.pharmacist.com/apha-house-delegates *Email:* hod@aphanet.org

MAKING AN IMPACT IN PATIENT CARE

APhA 2017

San Francisco, CA | March 24–27
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House of Delegates Schedule At A Glance

FRIDAY, MARCH 24		
12:00 pm – 3:30 pm	Exhibit Hall ABC	Delegate Registration
1:00 pm – 2:30 pm	Room 274/276	APhA-APPM Delegate Caucus
1:00 pm – 2:30 pm	Room 272	APhA-APRS Delegate Caucus
3:00 pm – 5:00 pm	Gateway Ballroom	House of Delegates – First Session (Be seated by 2:45pm)

SATURDAY, MARCH 25		
1:00 pm – 2:30 pm	Room 124	New Business Review Committee Open Hearing

SUNDAY, MARCH 26		
1:00 pm – 3:00 pm	Room 124	Policy Committee Open Hearing

MONDAY, MARCH 27		
7:00 am – 9:30 am	Room 274/276	APhA-APPM Delegate Caucus
9:30 am – 11:00 am	Room 250/262	APhA-APRS Delegate Caucus
11:00 am – 2:00 pm	Exhibit Hall ABC	Delegate Registration
1:30 pm – 4:30 pm	Gateway Ballroom	House of Delegates – Final Session (Be seated by 1:15pm)

House of Delegates Office Hours - Hall Foyer A	
Thursday, March 23	3:00 pm – 6:00 pm
Friday, March 24	7:30 am – 3:00 pm
Saturday, March 25	8:00 am – 3:00 pm
Sunday, March 26	8:00 am – 3:00 pm
Monday, March 27	7:30 am – 1:00 pm

FRIDAY, MARCH 24

House of Delegates – First Session

Agenda

1. Call to Order
2. Review of Voting Procedures
3. Credentials Report*
4. Adoption of Agenda and Rules*
5. Introduction of Head Table
6. Report of the Speaker, APhA House of Delegates
7. APhA House Rules Review Committee Report*
8. New Business Procedure
9. APhA Policy Review Committee Report – (Received)
10. APhA Policy Committee Report (Received)
11. Adjourn to a Committee of the Whole for Discussion of the Policy Review Committee and Policy Committee Reports*
    a. APhA Policy Review Committee Report
    b. APhA Policy Committee Report
12. APhA Policy Review Committee Report Considerations*
13. APhA Policy Committee Report Considerations*
14. Recognition of APhA and Academy Officers – 2017 APhA Officers' Report
15. Meet the Candidates for the 2017 APhA Board of Trustees Election
16. Housekeeping Announcements
17. Adjournment of the First House Session

MONDAY, MARCH 27

House of Delegates – Final Session

Agenda

1. Call to Order
2. Review of Voting Procedures
3. Credentials Report*
4. Adoption of Agenda*
5. Consideration of Unfinished Business
    a. APhA Policy Committee Report*
    b. APhA Policy Review Committee Report*
6. Consideration of New Business*
7. Installation of the 2017-2019 Speaker
8. Installation of the APhA Board of Trustees
9. Installation of the 2017-2018 APhA President
10. Recommendations from APhA Members
11. Closing Announcements
12. Adjournment of the 2017 APhA House of Delegates

Please note: (*) asterisk indicates potential opportunities to cast votes.

Delegates Checklist

Prior to the Meeting:

- ☐ *Sign-up for the House sessions you wish to attend here*
- ☐ *Review 2017 posted House webinars*
- ☐ *Join in policy discussions via APhA Engage HOD communities*
- ☐ *Review Delegate Materials prior to the HOD meeting*
- ☐ *Prepare your amendment recommendations prior to House proceedings (Sample Amendment forms)*

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

- ☐ *Delegate Check-in located in **Exhibit Hall ABC** on Friday, March 24 between 12:00 pm – 3:30 pm to receive your Delegate ribbon and voting device (Must be seated by 2:45 pm)*
- ☐ *Saturday, March 25 - New Business Review Committee Open Hearing*
- ☐ *Sunday, March 26 - Policy Committee Open Hearing*
- ☐ *Delegate Check-in located in **Exhibit Hall ABC** on Monday, March 27 between 11:00 am - 2:00 pm to receive your Delegate ribbon and voting device (Must be seated by 1:15 pm)*

After the Meeting:

- ☐ *Submit 2017 Policy Topic Ideas online by **March 31, 2017** at* http://fs3.formsite.com/apha/form220/index.html
- ☐ *Volunteer to sit on a 2017 House Committee before **June 14, 2017** at https://fs3.formsite.com/apha/form217/index.html*
- ☐ *Contact your State, Academy or Recognized Organization to make sure you are listed as a delegate for 2017-2018!*

APhA House of Delegates Online: http://www.pharmacist.com/apha-house-delegates

APhA Email: hod@aphanet.org

AACP (*Delegates-2*)
Cynthia Boyle
Joseph DiPiro

AACP (*Alt. Delegates*)
Lynette Bradley-Baker

AAPS (*Delegates-1*)
Stacey May

ACA (*Delegates-2*)
DeAnna Leikach
Ryan Oftebro

ACA (*Alt. Delegates*)
Donnie Calhoun

ACCP (*Delegates-2*)
Marcia Buck
C Edwin Webb

ACCP (*Alt. Delegates*)
Samuel Johnson
Michael Maddux

AIHP (*Delegates-2*)
David Kreling
Anthony Palmieri

AIHP (*Alt. Delegates*)
Gregory Higby

AIR FORCE (*Delegates-2*)
Rodney Jorstad
Derek Larbie

AIR FORCE (*Alt. Delegates*)
Bernard Vanpelt

ALABAMA (*Delegates-4*)
Byrdena Dugan
Michael Hogue
Rebecca Sorrell
Ralph Sorrell

ALASKA (*Delegates-2*)
Amber Briggs
Tara Ruffner

AMCP (*Delegates-2*)
Marissa Schlaifer
April Shaughnessy

APhA-APPM (*Delegates-28*)
Jeffrey Baldwin
Jeffrey Bratberg
Andrew Bzowyckyj
Denise Clayton
Ron DeBellis
Joseph Fava
Brian Fingerson
Nicole Gattas
Ann Gorman
Nicki Hilliard
Mark Huffmyer
Duane Jones
Amy Kennedy
James Kirby
Phillip Lawrence
Jonathan Lee
Monali Majmudar
Bella Mehta
Wendy Mobley-Bukstein
Theresa Ofili
Sarah Ray
Blair Sarbacker
Michael Schuh
Sheila Seed
Larry Selkow
Bibi Wishart

APhA-APPM (*Alt. Delegates*)
Amanda Beck
Bin Deng
Sara Joe
Christopher Johnson
Ryan Lindenau
Brianne Porter

APhA-APRS (*Delegates-28*)
Jill Augustine
Edward Bednarczyk
Anthony Di Pasqua
Joseph Dikun
Kevin Farmer
Ronald Hadsall
Brandi Hamilton
Adriane Irwin
Eric Jarvi
Roger Lander
Eric Mack
Darius Mason
Joey Mattingly
Bill McLaughlin
Amanda Meeker
Jaclyn Myers
Karen Nagel-Edwards
Anthony Olson
Brent Reed
Melody Ryan
Kimberly Scarsi
Zia Shariat-Madar
Gary Smith
Michael Villalobos
Terri Warholak
Salisa Westrick

APhA-APRS (*Alt. Delegates*)
Julie Oestreich

APhA-ASP (*Delegates-28*)
Dylan Atkinson
Grace Baek
Scott Brewster
David Bunch
Nicole Clay
Evan Colmenares
Michelle Cottino
Alaina Darby
Amanda D'Ostroph
Jared Frye
Meryam Gharbi
Nicole Guist
Eileen Hang
Princy John
Michelle Leatherwood
Elissa Lechtenstein
Supannee Lertpaichaiyon
Derrick Lewis
Jordan Long
E. Michael Murphy
Megan O'Connor
Christine Rarrick
Allie Shipman
Adrienne Simmons
Mary Smith
Jeremy Sparks

APhA-ASP (*Alt. Delegates*)
Patrick Condon
Carla Figura
Jimmy Godwin
Olivia Johnson
Eric Kao
Wilhelmina Lord-Adem
Courtney McCaughey
Vivianne Nguyen
Autumn Petersen
Myriam Shaw Ojeda
Shannon Stittsworth
Charles Summerlin

ARIZONA (*Delegates-5*)
Laura Carpenter
Kelly Fine
Pamela Piotrowski
Whitney Rice
Lorri Walmsley

* The numbers reflect the allotted delegates per delegation, not the actual listed delegates.
* Individuals can only represent one delegation.

ARIZONA (*Alt. Delegates*)
Mark Boesen

ARKANSAS (*Delegates-3*)
Kevin Barton
Jeanie Monzingo Smith
Lanita White

ARKANSAS (*Alt. Delegates*)
Brenna Button-Neumann
Tiffany Diemer

ARMY (*Delegates-2*)
Jeffrey Neigh

ASCP (*Delegates-2*)
Nicole Brandt
Joseph Marek

ASCP (*Alt. Delegates*)
Arnold Clayman
Frank Grosso Rph

ASHP (*Delegates-1*)
Christina Martin

ASPL (*Delegates-2*)
Steven Gray
Giselle Willick

ASPL (*Alt. Delegates*)
John Jones
Holly Strom

BOARD (*Delegates-15*)
Nancy Alvarez
Tery Baskin
Lawrence Brown
Daniel Buffington
Robert DiCenzo
Gregory Fox
Kelsea Gallegos
Linda Garrelts MacLean
Jean-Venable Goode
Dennis Helling
Thomas Menighan
Bradley Tice
Wendy Weber
Theresa Wells-Tolle
Daniel Zlott

CALIFORNIA (*Delegates-11*)
Veronica Bandy
Sonya Frausto
Karl Hess
Douglas Hillblom
Ethan Huynh
Elizabeth Johnson
Vinson Lee
Sarah McBane
Edlen Wong
Chris Woo
George Yasutake

CALIFORNIA (*Alt. Delegates*)
Kathleen Besinque
Richard Dang
Patty Havard
Katherine Hillblom
Adrian Wong

COLORADO (*Delegates-3*)
Christine Feltman
Catherine Jarvis
Randy Knutsen

COLORADO (*Alt. Delegates*)
Jeannine Dickerhofe

CONNECTICUT (*Delegates-3*)
Valentino Caruso
Philip Hritcko
Meghan Wilkosz

CONNECTICUT (*Alt. Delegates*)
Margherita Giuliano

DELAWARE (*Delegates-2*)
Kevin Musto
Kimberly Robbins

DISTRICT OF COLUMBIA (*Delegates-2*)
Heather Free
Tamara McCants

FLORIDA (*Delegates-7*)
Goar Alvarez
Carol Motycka
Bob Parrado
Katherine Petsos
Norman Tomaka
Scott Tomerlin
Suzanne Wise

FLORIDA (*Alt. Delegates*)
Karen Whalen

FORMER PRESIDENTS (*Delegates-34*)
Lowell Anderson
Maurice Bectel
Marialice Bennett
J Bootman
Grover Bowles
Bruce Canaday
R David Cobb
Robert Davis
George Denmark
James Doluisio
Janet Engle
Robert Gibson
Harold Godwin
Charles Green
Ed Hamilton
Gary Kadlec
Calvin Knowlton
Winnie Landis
Eugene Lutz, FAPhA
James Main
Jacob Miller
Robert Osterhaus
Matthew Osterhaus
Marily Rhudy
Steven Simenson
Jenelle Sobotka
Kenneth Tiemann
Lisa Tonrey
Timothy Tucker
Timothy Vordenbaumen
William Whitten

FORMER SPEAKERS (*Delegates-18*)
Susan Bartlemay
Bethany Boyd
Leonard Camp
Betty Jean Harris
Lucinda Maine
Michael Mone
Craig Pedersen
Adele Pietrantoni
Hazel Pipkin
Valerie Prince
William Riffee
Michael Smith
Wilma Wong

GEORGIA (*Delegates-5*)
Lance Boles
Liza Chapman
Jonathan Marquess
Pamala Marquess
Mary Meredith

GEORGIA (*Alt. Delegates*)
Joshua Kinsey

GUAM (*Delegates-1*)
Karen Song

HAWAII (*Delegates-2*)
Hiromi Saito
Ronald Taniguchi

IACP (*Delegates-2*)
Erik Tosh

IDAHO (*Delegates-3*)
Jennifer Adams
Donald Smith

ILLINOIS (*Delegates-7*)
Ben Calcaterra
Starlin Haydon-Greatting
Miriam Mobley Smith
Garth Reynolds
Cynthia Russell
Lauren San Juan
Deanna Seiler

ILLINOIS (*Alt. Delegates*)
Henry Gould

INDIANA (*Delegates-4*)
Chelsea Anderson
Stephanie Arnett
Jackie Bowen
Lynn Fletcher

INDIANA (*Alt. Delegates*)
Bin Deng

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IOWA (*Delegates-4*)
Steve Firman
Rick Knudson
Stevie Veach
Susan Vos

IOWA (*Alt. Delegates*)
Brett Barker
Anthony Pudlo

KANSAS (*Delegates-4*)
Carl Benton
Robert Emerson
Emily Prohaska
Abigail Winter

KANSAS (*Alt. Delegates*)
Jessica Bates

KENTUCKY (*Delegates-4*)
Kimberly Croley
Patricia Freeman
Catherine Hanna
Chris Harlow

LOUISIANA (*Delegates-4*)
Aurdie Bellard
William Kirchain
Ben Orlando
Anthony Walker

LOUISIANA (*Alt. Delegates*)
Robert Toups

MAINE (*Delegates-3*)
Matthew Lacroix
Rodney Larson
Daniel Mickool

MAINE (*Alt. Delegates*)
Kenneth McCall

MARYLAND (*Delegates-6*)
G Hogue
Brian Hose
Anne Lin
Ashley Moody
Matthew Shimoda
Hoai-An Truong

MARYLAND (*Alt. Delegates*)
James Dvorsky

MASSACHUSETTS (*Delegates-5*)
Amit Hirani
Susan Holden
Nirali Rana
Kim Tanzer
Bridgette Tran

MICHIGAN (*Delegates-5*)
Mark Bomia
Jim Lile
Kimberly Proffer
Frederick Schmidt
Larry Wagenknecht

MICHIGAN (*Alt. Delegates*)
Dianne Malburg

MINNESOTA (*Delegates-5*)
Michelle Aytay
Kati Dvorak
Julie Freeman
Stephanie Gibbs
Natalie Roy

MINNESOTA (*Alt. Delegates*)
Anjoli Punjabi

MISSISSIPPI (*Delegates-3*)
David Allen
Lauren Bloodworth
Jillian Foster

MISSISSIPPI (*Alt. Delegates*)
Olivia Strain

MISSOURI (*Delegates-5*)
Sandra Bollinger
Ashley Merritt
John Pieper
Elizabeth Rodman
Anne Rogers

MISSOURI (*Alt. Delegates*)
Fred Gattas

MONTANA (*Delegates-1*)
Lyndee Fogel

NAVY (*Delegates-2*)
Heather Hellwig
Tiffany Scott

NAVY (*Alt. Delegates*)
Benedict Baidoo
David Vera

NCPA (*Delegates-2*)
John Beckner
Robert Greenwood

NEBRASKA (*Delegates-4*)
Allison Dering-Anderson
Edward DeSimone
Jennifer Tilleman

NEVADA (*Delegates-3*)
Mark Decerbo
Christina Quimby
Eric Shalita

NEW HAMPSHIRE (*Delegates-2*)
Cheryl Abel
Jessica Marx

NEW HAMPSHIRE (*Alt. Delegates*)
Christopher Lopez

NEW JERSEY (*Delegates-5*)
Elise Barry
James Moore
Sandra Moore
Javier Rodriguez
Steven Zlotnick

NEW MEXICO (*Delegates-3*)
Michel Disco
Lynda Welage

NEW YORK (*Delegates-7*)
Bethany Abrahams
Karl Fiebelkorn
Sarah Lynch
Roxanne Richardson
Brian Richardson
Martha Rumore
Karl Williams

NORTH CAROLINA (*Delegates-6*)
Ashley Branham
Rebecca Chater
Cody Clifton
Stefanie Ferreri
Macary Marciniak
Cortney Mospan

NPhA (*Delegates-2*)
Lakesha Butler
Erica Hanesworth

NRPhA (*Delegates-1*)
Thomas Hanson

NRPhA (*Alt. Delegates*)
Moira Maroney

OHIO (*Delegates-8*)
Dana Bachmann
Kelli Barnes
Thad Franz
Stacey Frede
Brigid Groves
Jessica Hinson
Mitchell Howard
Catherine Kuhn

OHIO (*Alt. Delegates*)
Juanita Draime

OKLAHOMA (*Delegates-3*)
Eric Johnson
Katherine O'Neal
Steven Pryor

OREGON (*Delegates-3*)
Jill McClellan
Amy Valdez
Andrew Wash

OREGON (*Alt. Delegates*)
Marc Rizzo

PENNSYLVANIA (*Delegates-9*)
Howard Cook
Julie Gerhart-Rothholz
Daniel Hussar
Yardlee Kauffman
Nicholas Leon
Christina Maher
Mary McManus
Nancy Tang

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PENNSYLVANIA (*Alt. Delegates*)
Melissa Shiner

PHS (*Delegates-2*)
Patrick Harper
Garrette Martin-Yeboah

PHS (*Alt. Delegates*)
Kinbo Lee
Dorcas Taylor

PUERTO RICO (*Delegates-3*)
Milagros Morales
Nayda Rivera

RHODE ISLAND (*Delegates-2*)
Anita Jacobson
Lynn Pezzullo

RHODE ISLAND (*Alt. Delegates*)
Daniel Lefkowitz

SOUTH CAROLINA (*Delegates-4*)
Kayce Shealy
George Vess
Pamela Whitmire
William Wynn

SOUTH CAROLINA (*Alt. Delegates*)
Linda Reid

SOUTH DAKOTA (*Delegates-2*)
Trisha Hadrick

SPEAKER APPOINTED (*Delegates-10*)
Nicholas Dorich
Sean Jeffery
Dan Kennedy
Randal McDonough
Shannon Riggins
Scott Sexton

TENNESSEE (*Delegates-6*)
Lucy Adkins
McKenzie Calhoun
Jeremy Crain
Traci Poole
Leslie Shepard
Eleanor Twigg

TENNESSEE (*Alt. Delegates*)
Katelyn Alexander

TEXAS (*Delegates-8*)
Laura Beall
M. Lynn Crismon
Shara Elrod
Carole Hardin-Oliver
Mary Klein
Carol Reagan
L. Douglas Ried
May Woo

UTAH (*Delegates-2*)
Jonathan Magness
Buck Stanford

UTAH (*Alt. Delegates*)
Kyle Kitchen

VETERANS ADMIN (*Delegates-2*)
Anthony Morreale
Ronald Nosek

VETERANS ADMIN (*Alt. Delegates*)
Heather Ourth
Virginia Torrise

VIRGINIA (*Delegates-6*)
Lee Brower
Brandon Jennings
Johnny Moore
Dominic Solimando
Amy Sparkman
Krystalyn Weaver

VIRGINIA (*Alt. Delegates*)
William Lee

WASHINGTON (*Delegates-4*)
C A Leon Alzola
Collin Conway
Sara McElroy
Donald Williams

WEST VIRGINIA (*Delegates-3*)
Krista Capehart
Betsy Elswick
Karen Reed

WISCONSIN (*Delegates-5*)
Anthony Ball
Nicholas Capote
Audrey Kostrzewa

WYOMING (*Delegates-2*)
Reshmi Singh

WYOMING (*Alt. Delegates*)
Kem Krueger

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American Pharmacists Association House of Delegates

FIRST SESSION

Friday, March 24, 2017

3:00PM – 5:00PM

SEATING CHART

Speaker of the House

	15 IA-4 ID-3 (S)	30 MN-5 NH-2+	
1 AL-4 R-3 (S)	16 IL-7*	31 MO-5 ND-1	45 (S) PA-7
2 AZ-5* AK-2	17 IN-4 KS-4	32 (F) (S) NC-6	46 PA-2 PR-3* RI-2
3 CA-7	18 (F) KY-4 ME-3	33 (S) NE-4 NM-3	47 (F) SC-4 UT-2
4 CA-4 CT-3+	19 GU-1 MA-5	34 NJ-5 NV-3	48 SD-2 TN-6
5 CO-3 DE-2 DC-2	20 (S) MD-6	35 NY-7 (S)	49 TX-8
6 FL-7+	21 LA-4 MS-3 (S)	36 OH-8	50 VA-6+
7 GA-5 HI-2 (S)	22 MI-5 MT-1	37 (S) OK-3 OR-3	51 (S) WA-4 WV-3
8 AACP, AAPS, ACA, ACCP	23 AIHP, AMCP, ASHP, ASCP	38 ASPL, IACP, Speaker Appt-4	52 (F) WI-5 WY-2
9 APhA-APPM-7 (F)	24 APhA-ASP-7	39 (F) Speaker Appointed-6	53 NCPA, NPhA, NRPhA
10 APhA-APPM-7	25 APhA-ASP-7 (S)	40 APhA-APRS-7 (S)	54 Vet Admin, PHS
11 APhA-APPM-7	26 APhA-ASP-7	41 APhA-APRS-7	55 (S) Army, Air Force, Navy
12 APhA-APPM-7 (S)	27 APhA-ASP-7	42 APhA-APRS-7	56 Board of Trustees-3
13 Former Presidents-8	28 (S) Former Speakers-6	43 APhA-APRS-7	57 Board of Trustees-5
14 Former Presidents-8	29 Former Speakers-6	44 Former Speakers-6	58 (S) Board of Trustees-5

KEY

+ = Seat reserved for State Pharmacy Association Executive (Non-voting)

*** = Seat reserved for State Pharmacy Association Executive (Voting)**

(F) = APhA Former Speakers

(S) = APhA Staff Member

American Pharmacists Association House of Delegates
FIRST SESSION
Friday, March 24, 2017
3:00PM – 5:00PM

SEATING CHART BY DELEGATION NAME

Alabama – Table 1
Alaska – Table 2
Arizona – Table 2
Arkansas – Table 1
California – Tables 3 & 4
Colorado – Table 5
Connecticut – Table 4
Delaware – Table 5
District of Columbia – Table 5
Florida – Table 6
Georgia – Table 7
Guam – Table 19
Hawaii – Table 7
Idaho – Table 15
Illinois – Table 16
Indiana – Table 17
Iowa – Table 15
Kansas – Table 17
Kentucky – Table 18
Louisiana – Table 21
Maine – Table 18
Maryland – Table 20
Massachusetts – Table 19
Michigan – Table 22
Minnesota – Table 30
Mississippi – Table 21
Missouri – Table 31
Montana – Table 22
Nebraska – Table 33
Nevada – Table 34
New Hampshire – Table 30
New Jersey – Table 34
New Mexico – Table 33
New York – Table 35
North Carolina – Table 32
North Dakota – Table 31
Ohio – Table 36
Oklahoma – Table 37
Oregon – Table 37
Pennsylvania – Tables 45 & 46
Puerto Rico – Table 46
Rhode Island – Table 46
South Carolina – Table 47
South Dakota – Table 48
Tennessee – Table 48
Texas – Table 49
Utah – Table 47
Virginia – Table 50
Washington – Table 51
West Virginia - 51
Wisconsin – Table 52
Wyoming – Table 52
AAPS – Table 8
AACP – Table 8
ACA – Table 8
ACCP – Table 8
AIHP – Table 23
AMCP – Table 23
ASHP – Table 23
ASCP – Table 23
ASPL – Table 38
NCPA – Table 53
IACP – Table 38
National Pharmaceutical Assn. – Table 53
National Pharmacists Assn. – Table 53
Air Force – Table 55
Army – Table 55
Navy – Table 55
Public Health Service – Table 54
Veterans Administration – Table 54
APhA-APPM – Tables 9, 10, 11, & 12
APhA-APRS – Tables 40, 41, 42, & 43
APhA-ASP – Tables 24, 25, 26 & 27
APhA Board of Trustee – Tables 56, 57 & 58
APhA Former Presidents – Tables 13 & 14
APhA Former Speakers – Tables 28, 29 & 44
Speaker Appointed – Tables 38 & 39

American Pharmacists Association House of Delegates
FINAL SESSION
Monday, March 27, 2017
1:30PM – 4:30PM

SEATING CHART

Speaker of the House

	15 MI-5 MT-1 (S)	30 OK-3 OR-3	
1 GA-5 HI-2 (S)	16 LA-4 MS-3	31 OH-8	45 (S) WI-5 WY-2
2 FL-7+	17 (F) MD-6	32 (S) NY-7	46 (F) WA-4 WV-3
3 CO-3 DE-2 DC-2	18 GU-1 MA-5	33 NJ-5 NV-3	47 VA-6+
4 CA-4 CT-3+	19 (S) KY-4 ME-3	34 (F) NE-4 NM-3	48 TX-8
5 CA-7	20 IN-4 KS-4	35 NC-6 (S)	49 TN-6
6 AZ-5* AK-2	21 IL-7* (S)	36 MO-5 ND-1	50 SC-4 SD-2 UT-2
7 AL-4 AR-3 (S)	22 IA-4 ID-3	37 MN-5 NH-2+	51 (S) PA-2 PR-3* RI-2
8 AACP, AAPS, ACA, ACCP	23 AIHP, AMCP, ASHP, ASCP	38 ASPL, IACP, Speaker Appt-4	52 (F) PA-7
9 APhA-APPM-7 (F)	24 APhA-ASP-7	39 (F) (S) Speaker Appointed-6	53 NCPA, NPhA, NRPhA
10 APhA-APPM-7	25 APhA-ASP-7 (S)	40 APhA-APRS-7	54 Vet Admin, PHS
11 APhA-APPM-7	26 APhA-ASP-7	41 APhA-APRS-7	55 (S) Army, Air Force, Navy
12 APhA-APPM-7 (S)	27 APhA-ASP-7	42 (S) APhA-APRS-7	56 Board of Trustees-3
13 Former Presidents-8	28 (S) Former Speakers-6	43 APhA-APRS-7	57 Board of Trustees-5
14 Former Presidents-8	29 Former Speakers-6	44 Former Speakers-6	58 (S) Board of Trustees-5

KEY

+ = Seat reserved for State Pharmacy Association Executive (Non-voting)
* = Seat reserved for State Pharmacy Association Executive (Voting)

(F) = APhA Former Speakers
(S) = APhA Staff Member

American Pharmacists Association House of Delegates
FINAL SESSION
Monday, March 27, 2017
1:30PM – 4:30PM

SEATING CHART BY DELEGATION NAME

Alabama – Table 7
Alaska – Table 6
Arizona – Table 6
Arkansas – Table 7
California – Tables 4 & 5
Colorado – Table 3
Connecticut – Table 4
Delaware – Table 3
District of Columbia – Table 3
Florida – Table 2
Georgia – Table 1
Guam – Table 18
Hawaii – Table 1
Idaho – Table 22
Illinois – Table 21
Indiana – Table 20
Iowa – Table 22
Kansas – Table 20
Kentucky – Table 19
Louisiana – Table 16
Maine – Table 19
Maryland – Table 17
Massachusetts – Table 18
Michigan – Table 15
Minnesota – Table 37
Mississippi – Table 16
Missouri – Table 36
Montana – Table 15
Nebraska – Table 34
Nevada – Table 33
New Hampshire – Table 37
New Jersey – Table 33
New Mexico – Table 34
New York – Table 32
North Carolina – Table 35
North Dakota – Table 36
Ohio – Table 31
Oklahoma – Table 30
Oregon – Table 30
Pennsylvania – Tables 51 & 52
Puerto Rico – Table 51
Rhode Island – Table 51
South Carolina – Table 50
South Dakota – Table 50
Tennessee – Table 49
Texas – Table 48
Utah – Table 50
Virginia – Table 47
Washington – Table 46
West Virginia - 46
Wisconsin – Table 45
Wyoming – Table 45
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ACCP – Table 8
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AMCP – Table 23
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HOUSE OF DELEGATES
APhA AMERICAN PHARMACISTS ASSOCIATION

General Information for Delegates

DUTIES OF THE HOUSE OF DELEGATES	The APhA House of Delegates performs a major role in developing policy for the Association. With Delegates representing all segments of the profession, the House serves as a forum for discussion of key issues and articulation of positions reflecting input from a broad cross-section of pharmacy. The APhA House of Delegates is charged by the APhA Bylaws to serve as a legislative body in the development of Association policy. Policies adopted by the House guide the Association and its Board of Trustees in matters relating to educational, professional, scientific, and public health policy. These policies help to establish the role of the profession and its relationship with other elements of the contemporary health care system and set the objectives and future agenda of APhA in the continuous evolution of health care.
COMPOSITION OF THE HOUSE OF DELEGATES	The approximately 400-member APhA House of Delegates is composed of delegates representing state pharmacy associations, recognized national and federal organizations, APhA's Academies and Board of Trustees, former APhA Presidents, and former Speakers of the APhA House. Each state-affiliated organization appoints two Delegates, plus one additional Delegate for each 200 APhA Members residing in the state. Recognized national organizations and recognized Federal organizations appoint two Delegates each. Each of the Association's three Academies appoints 28 Delegates. Every member of the current APhA Board is a Delegate. Every Delegate must be an APhA member. Delegates are appointed to serve a term of one year, June 1-May 31of the following year. As a result, the appointment date for submitting delegates is June 1. In 2013, APhA amended its Bylaws (Article IV, Section 2) to increase member engagement in the Association's policy development process of the House of Delegates; delegations that have one or more seats unfilled during both House sessions for 3 consecutive years, shall have those seats removed from their delegate allocation. While the initial delegate allocations outlined in the APhA Bylaws will always stand, the actual number of delegate seats for each delegation may vary from year-to-year based on this change to the Bylaws (Article VI, Section 2, G).
CERTIFICATION OF DELEGATES	Organizations will be able to certify Alternate Delegates as Delegates upon notification to the Secretary of the APhA House of Delegates as late as 1:00PM on Monday. No Alternate Delegates will be seated after the Final Session of the House commences. The Secretary will announce the number of Delegates in attendance and whether a quorum has been reached based on the electronic system or roll call cards. Delegates who arrive after the quorum announcement should check in with APhA staff at the registration table.
OFFICERS OF THE HOUSE OF DELEGATES	The APhA Bylaws provide that the officers of the APhA House of Delegates shall be the Speaker, the Speaker-elect, and the Secretary. The Speaker and Speaker-elect are elected by the House. The Bylaws provide that the Executive Vice President of APhA shall serve as Secretary. The position of Speaker spans three years: the first year as Speaker-elect (a non-Trustee position) and the subsequent two years as Speaker and Trustee. Elections for Speaker-elect are held on even-numbered years. The Speaker, Speaker-elect, and the Secretary of the House are members of the APhA House of Delegates and, as such, may claim the floor and are entitled to vote.

DELEGATE ORIENTATION	Delegates and Alternate Delegates who are new to the policy process or want a refresher course on the rules and procedures of the APhA House of Delegates may review a posted webinar on the House website. For more in-depth information on the role of the Delegate review the "Delegate Toolkit".
APhA HOUSE RULES REVIEW COMMITTEE	The House Rules Review Committee is charged to review and establish rules and procedures for the conduct of business at each House session. The Committee meets via conference call at least twice a year: • Within 30 days after the conclusion of the Final Session of the House, to review and approve language of adopted House policy and to discuss observations of House operations for potential improvement. • To review and approve the House of Delegates Schedule, make recommendations regarding the proceedings of the House, and to issue a Final Report to the APhA House of Delegates. The Committee is comprised of 6 APhA members from diverse pharmacy practice backgrounds and is appointed prior to the beginning of the First Session of the House. The Committee's term concludes prior to the First Session of the House the following year.
APhA POLICY COMMITTEE	The Policy Committee is charged with analyzing specific topics assigned by the Board of Trustees and proposing policy on those topics for consideration by the House of Delegates. • Committee members meet in Washington, DC, to develop policy statements. • Committee members prepare a report of policy recommendations for presentation to the APhA House of Delegates. • The Committee is comprised of 7-10 APhA members from diverse pharmacy practice backgrounds.
APhA POLICY REFERENCE COMMITTEE	The APhA Policy Reference Committee is charged with providing greater participation in the policy development process and ensuring objective consideration of APhA member comments. • Committee members listen to Delegate comments during the First Session of the House of Delegates and during the Policy Committee Open Hearing at the APhA Annual Meeting. Following the Open Hearing, Committee members meet in an executive session to review comments and propose modifications to the original Policy Committee report language. The Committee then issues its final report during the Final Session of the House of Delegates. • The Committee is comprised of the Chair of the Policy Committee, two other members of the Policy Committee, and three or four new members.

APhA POLICY REVIEW COMMITTEE	The APhA Policy Review Committee is charged to ensure that adopted policy is relevant and reflects the opinion of the contemporary pharmacy community.
	• The Committee meets via conference call to determine whether adopted policy statements should be amended, retained, archived, or rescinded. The Committee can propose New Business Items for those statements needing an amendment.
	  ○ The Committee reviews adopted policy statements according to the schedule outlined in the House of Delegates Rules of Procedure.
	  ○ The Committee reviews adopted policy related to the policy topics assigned to APhA's Policy Committee.
	• The Policy Review Committee is comprised of 7-10 APhA members from diverse pharmacy practice backgrounds.

APhA NEW BUSINESS REVIEW COMMITTEE	The New Business Review Committee is charged to review proposed policy submitted by Delegates and recommend action on those items. • Committee members participate in the New Business Review Committee Open Hearing at the Annual Meeting and meet in an executive session to finalize their report to the House. • The Committee is comprised of 7 APhA members from diverse pharmacy practice backgrounds.

HOUSE OF DELEGATES COMMITTEE ON NOMINATIONS	The House of Delegates Committee on Nominations is charged to nominate candidates for the office of Speaker-elect of the House of Delegates each even-numbered year. • The Committee is appointed by the immediate former (non-incumbent) Speaker of the House and is comprised of 5 members. • The Committee only slates 2 candidates, but additional nominations may be made from the floor of the House. Candidates for Speaker-elect must be current Delegates to the APhA House. • The Committee presents its report, including the slate of candidates, during the First Session of the House. Each candidate is given 2 minutes to introduce him/herself to the Delegates. • At the Final Session of the APhA House, each candidate is given 3 minutes to address the APhA House. The election for the office of Speaker-elect is conducted electronically at the Final Session of the APhA House of Delegates.
COMMITTEE OF CANVASSERS	The Committee of Canvassers is charged to observe the administration of the electronic voting process for the election of Speaker-elect during the Final Session of the APhA House. APhA members are appointed each even-numbered year to perform the responsibilities of this position.
SUBMISSION OF NEW BUSINESS ITEMS	Items of New Business must be submitted to the Speaker of the House no later than 30 days before the start of the First Session of the House of Delegates. Consideration of urgent items can be entered with a "Suspension of House Rules" at the House Session where New Business will be acted upon.
DISTRIBUTION OF MATERIALS IN THE HOUSE OF DELEGATES	Materials may only be distributed in the APhA House of Delegates with the approval of the Secretary of the APhA House of Delegates. Individuals seeking to distribute material in the APhA House must submit a sample to the APhA House of Delegates Office prior to the start of the House Session. Materials to be distributed must relate to subjects and activities that are proposed for House action or information.
HOUSE OF DELEGATES RULES OF ORDER	The rules contained in *Robert's Rules of Order Newly Revised* govern the deliberations of the APhA House of Delegates in all cases in which they are applicable and not in conflict with special APhA House Rules or Bylaws. The Speaker of the APhA House appoints a Parliamentarian whose principal duty is to advise the Speaker. It is proper for the Parliamentarian to state his opinion to the APhA House of Delegates only when requested to do so by the Speaker. A parliamentary procedure reference guide is provided with the Delegate materials.
ACCESS TO THE FLOOR OF THE HOUSE OF DELEGATES	Each Delegate has the right to speak and vote on every issue before the APhA House of Delegates. The Speaker shall announce at the opening session of each House meeting the procedure he/she will follow in recognizing requests from the floor. During the APhA House sessions, the procedure for seeking recognition by the Speaker will be for the Delegate to approach a floor microphone and, when recognized by the Speaker, to state his/her name and delegation affiliation. Only Delegates or individuals recognized by the Speaker shall have access to the microphone.
AVAILABILITY OF REPORTS	The final report of the APhA Policy Committee will be sent electronically to members and hard copies can be obtained at the House of Delegates Office beginning at 8:00AM on Monday. The final report of the APhA New Business Review Committee will also be sent electronically to members and hard copies can be obtained at the House of Delegates Office beginning 8:00AM on Sunday.
VOTING PROCEDURES	Voting will occur via voice vote or by electronic tabulation. For action on Association policy and items of New Business, votes will be cast using voice votes. If the Speaker is unable to determine the outcome of the voice vote, or a Delegate calls for a vote count, the electronic voting system will be used. Voting for the election of Speaker-elect will occur using the electronic voting system.

American Pharmacists Association
House of Delegates
Rules of Procedure

Updated 2016

The following information reflects the final language adopted by the 2016 APhA House of Delegates.

Rule 1 Delegates and Voting

At the first session of a meeting of the House of Delegates, the Secretary shall report the number of accredited delegates who shall then compose the House of Delegates. Each delegate shall be entitled to one (1) vote. No delegate shall act as proxy of another delegate nor as delegate for more than one (1) association or organization. A member registered as an alternate may, upon proper clearance by the Credentials Committee, be transferred from alternate to delegate at any time during the continuance of business meetings.

Rule 2 Delegate Identification

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

Rule 3 Consideration of Committee Reports

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

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

Rule 4 New Business

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

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

The New Business Review Committee's report to the House of Delegates shall include one of the following recommended actions for each New Business Item considered:

(a) Adoption of the New Business Item
(b) Rejection of the New Business Item
(c) Referral of the New Business Item
(d) Adoption of the New Business Item as amended by the committee
(e) No action

If the New Business Review Committee recommends no action on a New Business Item, the Speaker of the House shall place the New Business item before the House of Delegates for consideration and action. Each whole-numbered statement within the New Business Item shall be considered separately. Consideration of the New Business Item in its entirety requires suspension of House rules.

Rule 5 Privilege of the Floor
Only delegates may introduce business on the floor of the House of Delegates. Any individual that is duly recognized by the Speaker and/or the House may have the privilege of the floor in order to address the delegates during a session of the House of Delegates. Any individual may present testimony during an open hearing.

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

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

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

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

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

Rule 7 Amendments to Resolutions
All amendments to Policy Committee recommendations or New Business Resolutions shall be submitted in writing to the Secretary on a form provided to Delegates. There are no 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 8 Amendments to House of Delegates Rules
Every proposed amendment of these rules shall be submitted in writing and will require a two-third vote for passage. A motion to suspend the rules shall require an affirmative vote of two-thirds of the total number of delegates present and voting.

Rule 9 Rules of Order
The procedures of the House of Delegates shall be governed by the latest edition of Robert's Rules of Order provided they are consistent with the APhA Bylaws and the House of Delegates Rules of Procedure.

Rule 10 Policy Review Committee
The House shall receive and consider the recommendations of the House Policy Review Committee to archive, rescind, retain, or amend existing policy at each Annual Meeting of the Association. A singular motion to archive, rescind, 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. 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.

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

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

Rule 12 Policy Reference Committee
The House of Delegates Policy Reference Committee shall consist of the chair of the Policy Committee, two members of the Policy Committee, and three or four new members appointed by the Speaker of the House of Delegates. The Policy Reference Committee will hear comments during the First Session of the House of Delegates and the Open Hearing of the Policy Committee at the APhA Annual Meeting and issue the Final Report of the House of Delegates.

Parlimentary Procedures At A Glance

To Do This:	*You Say This:*	*Must you interrupt speaker?*	*Must you be seconded?*	*Debatable?*	*Amendable?*	*Vote Required*
Introduce business (primary motion)	"I move that…"	No	Yes	Yes	Yes	Majority
Amend a motion	"I move that this motion be amended by…"	No	Yes	Yes	Yes	Majority
End debate	"I move the previous question."	No	Yes	No	No	Two-thirds
Request information	"Point of information."	Yes	No (urgent)	No	No	No vote
Verify a voice vote	"I call for division of the House."	No	No	No	No	No vote
Complain about noise, room temperature, smoking	"Question of privilege."	Yes	No	No	No	Chair decides
Object to procedure or to a personal affront	"Point of order."	Yes	No	No	No	Chair decides
Lay aside an issue temporarily because of emergency	"I move to lay on the table …"	No	Yes	No	No	Majority
Take up a matter previously tabled	"I move to take from the table…	No	Yes	No	No	Majority
Consider something out of scheduled order	"I move to suspend the rules to consider…"	No	Yes	No	No	Two-thirds
Vote on a ruling by the Chair	"I appeal the decision."	Yes	Yes	Yes	No	Majority
Postpone consideration of something	"I move we postpone this matter until…"	No	Yes	Yes	Yes	Majority
Reconsider something already disposed of	"I move to reconsider the vote on issue X…"	Yes	Yes	Yes	No	Majority
Have something studied further	"I move to refer this to…"	No	Yes	Yes	Yes	Majority

YOU COULD BE THE NEXT SPEAKER OF THE APhA HOUSE OF DELEGATES!

The APhA House of Delegates will be electing its next Speaker-elect at APhA2018
March 16-19, 2018
Nashville, TN

Consider serving your
Association and the Profession!

I am considering seeking the office of APhA Speaker of the House and Trustee. Please send me the Candidate Information and Application Booklet when it is available.

Name: _____

Address:_____

_____

E-mail:_____

Please submit all Speaker-elect Candidate applications electronically by **3pm (Eastern), Thursday, March 15, 2018**. This deadline is critical for scheduling candidate interviews.

For more information regarding the election process visit the House of Delegates website located at www.pharmacist.com/house-of-delegates.

HOUSE OF DELEGATES

APhA AMERICAN PHARMACISTS ASSOCIATION

We need your assistance in planning for the 2017-18 policy development process. Let us know what policy topics should be addressed by the 2017 House of Delegates.

Your recommendation will be considered by the Academies Joint Policy Standing Committee and the Board of Trustees for potential assignment to the 2017-18 APhA Policy Committee.

Delegate Name: _____

Delegation: _____

Proposed Policy Topic:

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

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

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

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

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

6. Other comments.

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

2017 House of Delegates

Report of the House Rules Review Committee

Committee Members

Bethany Boyd, Chair
Betsy Elswick
Cathy Kuhn
Eric Roath
Larry Selkow

Ex Officio
Theresa Tolle, Speaker of the House
Michael Hogue, Speaker-elect of the House

2016-2017
APhA House Rules Review Committee Report

The 2016-2017 APhA House Rules Review Committee (HRRC) consists of the following APhA members and long-time Delegates:

Bethany Boyd, Chair
Allen, TX

Betsy Elswick
Morgantown, WV

Eric Roath
Lansing, MI

Cathy Kuhn
Plain City, OH

Larry Selkow
La Quinta, CA

Overall Charge and Duties

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

2016-2017 Specific Charges / Work Plan

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

1. Observe the 2016 APhA House of Delegates proceedings, review House-related feedback, and make recommendations for improvement.
2. Review and approve, from a grammatical and copy-editing perspective, adopted policy from the 2016 APhA House of Delegates.
3. Review and approve the 2017 APhA House of Delegates schedule and make recommendations for improvement.
4. Review the APhA House of Delegates Rules of Procedure and make recommendations for improvement.
5. Reviewed seat allotments and procedures for delegations.

The HRRC met via conference call on March 23, 2016, April 25, 2016, and May 24, 2016, and made the following recommendations.

1. Observation of the 2016 APhA House of Delegates

Upon completing its review of the proceedings of the 2016 APhA House of Delegates, the Committee took the following action:

> **By CONSENT, the House Rules Review Committee observed no violations of the House Rules during the proceedings of the 2016 APhA House of Delegates. The Committee observed, reviewed, and discussed challenges and opportunities to maximize the efficiency of House operations. One change to the APhA House of Delegates Rules was suggested for consideration by Delegates (see Sections 3 and 5).**

2. Review of Policy Adopted by the 2016 APhA House of Delegates

The HRRC reviewed, from a grammatical and copy-editing perspective, the policy language approved by the 2016 House of Delegates. Upon completing its review, the HRRC took the following action:

> **By CONSENT, the House Rules Review Committee approved the 2016 Report of the APhA House of Delegates Report as prepared by APhA staff.**

3. Recommendations to the APhA House of Delegates

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

- Unfilled Delegate Seats
    - The HRRC reviewed the report of unfilled delegate seats prepared by APhA staff. In accordance with APhA Bylaws, staff began tracking the number of unfilled seats in 2014.
    - The HRRC discussed the need for active delegates and other options for delegate appointments. After discussion by the HRRC, and consideration by the APhA Board of Trustees, the decision was made to not make any changes to the current APhA Bylaws and House Rules regarding inactivation of delegate seats.
    - The HRRC approved the process to guide staff on the implementation of the current House policy related to delegate seat allocation.
- Secondary Amendments
    - The HRRC reviewed and discussed recent changes to House Rule 7 involving no secondary amendments to be allowed. Based on observations in the 2016 House, the HRRC recommends the continuation of not allowing secondary amendments in future House proceedings.
- Committee of the Whole
    - The HRRC recommends continuing the use of the Committee of the Whole proceedings during the first House of Delegates session. The HRRC recommends additional instruction by staff and the Speaker, as appropriate, to clarify the purpose of the Committee of the Whole and make sure non-delegates know they are able to speak in the House sessions during this time.
- Delegate Education
    - The HRRC recommends the continued use of webinars to educate and engage APhA members in the Association's policy development process. The HRRC recommends additional marketing to members and Delegates regarding upcoming webinars, the scheduling of webinars outside of normal business hours, and the availability of webinars on-demand.

- Policy Review Process
    - The HRRC reviewed and discussed House Rule 10 (Policy Review Committee), including the Policy Review Committee's scope and Part 2 activities. Based on the discussion, the HRRC recommends a change to House Rule 10 (see **Section 5**).
    - The HRRC recommends Part 2 of the Policy Review Committee report be discontinued. The review of policies related to current topics in the Policy Development Process is confusing since the final adopted policies may look different than the policies used to draft Part 2 of the report. Instead of Part 2, all policy related to statements adopted in the previous House session will be reviewed and included in the main report.
- Electronic Voting (*for votes requiring a 2/3 majority*)
    - The HRRC recommends that the electronic keypads continue to be used as the primary method of voting for votes requiring a 2/3 majority during House proceedings. It is also recommended that the number of votes cast continue to be displayed on the screen and announced by the Speaker.
- House of Delegates Materials
    - The HRRC recommends that all Delegate materials continue to be provided electronically unless otherwise requested by a Delegate. A limited number of Delegate materials will be made available onsite. Robert's Rules "cheat sheets" will be placed at each Delegate seat.
    - The HRRC encourages APhA staff to explore opportunities to make House documents available within the APhA app.
- Board of Trustee Speeches
    - The HRRC recommends the continuation of speeches from Board of Trustee candidates.
    - The HRRC encourages APhA staff to provide additional opportunities to hear Board of Trustee candidate information including improved use of the meet the candidate's area, video formats, and organized caucus information.

4. Review of 2017 APhA House of Delegates Activities Schedule

The HRRC reviewed and evaluated the 2016 APhA House of Delegates Schedule and other newly revised Delegate materials. Upon completing its review, the HRRC took the following action:

By CONSENT, the House Rules Review Committee approved the schedule and Delegate materials for the 2017 APhA House of Delegates.

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

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

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, 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. The Policy Review Committee shall meet annually and review any policy that has not been reviewed or revised ~~had policies added~~ in the past 4 years and policy related to statements adopted in the previous House session.

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

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

This report is presented for approval by the APhA House of Delegates by Bethany Boyd, Chair of the House Rules Review Committee.

2017 House of Delegates
Report of the Policy Review Committee

Policies last reviewed in 2012

- Statements Organized by Recommendation
- Newly Adopted Policies Related to 2016 HOD

Committee Members

May Woo, Chair
Daniel Bell
Heather Free
Brigid Groves
Heather Hellwig
Dixie Leikach
Sara McBane
Anthony Olson
Norman Tomaka

Ex Officio
Theresa Tolle, Speaker of the House
Michael Hogue, Speaker-elect of the House

This report is disseminated for consideration by the APhA House of Delegates and does not represent the position of the Association. Only those statements adopted by the House are considered official Association policy.

RETAINED POLICY STATEMENTS

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

2007, 2002, 1968 Directory Listings for Pharmacies

APhA encourages the listing of all pharmacies in telephone, Internet and other directories under "Pharmacies."

(JAPhA NS8:380 July 1968) (JAPhA NS42(5 Suppl 1:S62 September/October 2002)(Reviewed 2006) (JAPhA NS45(5):580 September-October 2007)(Reviewed 2012)

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

2000 Use of the phrase "Community Pharmacy"

APhA supports use of the phrase "community pharmacy" rather than "retail pharmacy."

(JAPhA NS40(5):Suppl. 1:S8 September/October 2000) (Reviewed 2002) (Reviewed 2007)(Reviewed 2012)

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

2012, 2007 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 drugs products.

(JAPhA NS40(5):Suppl. 1:S8 September/October 2000) (Reviewed 2002) (Reviewed 2007)(Reviewed 2012)

COMMENTS: This item is included in both the RETAINING and ARCHIVING sections of this report. The Policy Review Committee recommends RETAINING statement #4 as this item is still relevant and not covered specifically in other policy statements. The Policy Review Committee recommends ARCHIVING statements #1, 2 and 3 as the committee feels more contemporary and comprehensive policy exists as part of APhA **2016 Biologic, Biosimilar, and Interchangeable Biologic Products**. Items #1, 2 and 3 are shown in the ARCHIVED section of this report.

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

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 2015)

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

1991 Biotechnology

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

(Am Pharm NS31(6):29 June 1991) (Reviewed 2004) (Reviewed 2007) (Reviewed 2010) (Reviewed 2015)

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

2005, 1998 Administration of Medications

1. APhA recognizes and supports pharmacist administration of prescription and non-prescription drugs as a component of pharmacy practice.
2. APhA supports the development of educational programs and practice guidelines for student pharmacists and practitioners for the administration of prescription and non-prescription drugs.
3. APhA supports pharmacist compensation for administration of prescription and non-prescription drugs and services related to such administration
4. APhA urges adoption of state laws and regulations authorizing pharmacist administration of prescription and non-prescription drugs.

(JAPhA 38(4): 417 July/August 1998) (JAPhA NS45(5):559 September/October 2005) (Reviewed 2006)(Reviewed 2011)(Reviewed 2012)

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

1979 Dispensing and/or Administration of Legend Drugs in Emergency Situations

1. APhA supports making insect sting kits and other, life-saving, emergency, treatment kits available for lawful dispensing by pharmacists without a prescription order, based on the pharmacist's professional judgment.
2. APhA supports permitting pharmacists to lawfully dispense and administer legend drugs in emergency situations, without an order from a licensed prescriber, provided that
(a) There is an assessment on the part of the pharmacist and the patient that the drug is needed immediately to preserve the well-being of the patient, and;
(b) The normal legal means for obtaining authorization to dispense the drug must not be immediately available, such as in cases where the patient's physician is not available, and;
(c) The quantity of the drug, which can be dispensed in an emergency situation, is enough so that the emergency situation can subside and the patient can be sustained for the immediate emergency, as determined by the pharmacist's professional judgment.
3. APhA supports expansion of state Good Samaritan Acts to provide pharmacists immunity from professional liability for dispensing in emergency situations without order from a licensed prescriber.
4. APhA supports permitting pharmacists to lawfully dispense and/or administer legend drugs without an order from a licensed prescriber during disaster situations.

(Am Pharm NS19(7):68 June 1979) (Reviewed 2002) (Reviewed 2006) (Revised 2007)(Reviewed 2012)(Reviewed 2012)

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

2012 Drug Supply Shortages and Patient Care

1. APhA supports the immediate reporting by manufacturers to the U.S. Food and Drug Administration (FDA) of disruptions that may impact the market supply of medically necessary drug products to prevent, mitigate, or resolve drug shortage issues and supports the authority for FDA to impose penalties for failing to report.
2. APhA supports revising current laws and regulations that restrict the FDA's ability to provide timely communication to pharmacists, other health care providers, health systems, and professional associations regarding potential or real drug shortages.
3. APhA encourages the FDA, the Drug Enforcement Administration (DEA), and other stakeholders to collaborate in order to minimize barriers (e.g., aggregate production quotas, annual assessment of needs, unapproved drug initiatives) that contribute to or exacerbate drug shortages.
4. APhA should actively support legislation to hasten the development of an efficient regulatory process to approve therapeutically equivalent generic versions of biologic drug products.

5. APhA encourages pharmacists and other health care providers to assist in maintaining continuity of care during drug shortage situations by:
(a) creating a practice site drug shortage plan as well as policies and procedures,
(b) using reputable drug shortage management and information resources in decision making,
(c) communicating with patients and coordinating with other health care providers,
(d) avoiding excessive ordering and stockpiling of drugs,
(e) acquiring drugs from reputable distributors, and
(f) heightening their awareness of the potential for counterfeit or adulterated drugs entering the drug distribution system.
6. APhA encourages accrediting and regulatory agencies and the pharmaceutical science and manufacturing communities to evaluate policies/procedures related to the establishment and use of drug expiration dates and any impact those policies/procedures may have on drug shortages.
7. APhA encourages the active investigation and appropriate prosecution of entities that engage in price gouging and profiteering of medically necessary drug products in response to drug shortages.
(JAPhA NS52(4) 457 July/August 2012)

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

1989 Impact of Drug Distribution Systems on Integrity and Stability of Drug Products
APhA encourages the development and use of quality-control procedures by all persons or entities involved in the distribution and dispensing of drug products. Such procedures should assure drug product integrity and stability in accordance with official compendia standards.
(Am Pharm NS29(7):464 July 1989) (Reviewed 2004) (Reviewed 2006) (Reviewed 2007)(Reviewed 2012)

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

2012 Drug Product Packaging
APhA supports the use of tamper-evident packaging on pharmaceutical products throughout the supply chain before dispensing to reduce the potential of counterfeit and/or adulterated medications reaching patients.
(JAPhA N552(4) 458 July/August 2012)

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

2012 Medication Verification
APhA encourages including a description of a medication's appearance on the pharmacy label or receipt as a means of reducing medication errors and distribution of counterfeit medications.
(JAPhA NS52(4) 458 July/August 2012)

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

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)

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

1987 Therapeutic Equivalence

1. APhA encourages continuing dialogue with other health care organizations with regard to the role of the pharmacist in therapeutic interchange, including the formation of a task force to include representatives of pharmacy, industry, government, and medicine for the purpose of adoption of uniform terminology and definitions related to chemical, biological, and therapeutic equivalence.
2. APhA supports the concept of therapeutic interchange of various drug products by pharmacists under arrangements in which pharmacists and authorized prescribers interrelate on behalf of the care of patients.

(JAPhA NS27:424 June 1987) (Reviewed 2003) (Reviewed 2006)(Reviewed 2011)(Reviewed 2012)

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

2001, 1989 Uniform Designation for Drug Product Selection Authority

APhA supports a uniform procedure nationwide for designating on a prescription order that drug product selection by the pharmacist is precluded by the prescriber.

(Am Pharm. NS29(1):67. January 1989) (JAPhA NS41(5) Suppl. 1:58, September/October, 2001) (Reviewed 2004) (Reviewed 2006)(Reviewed 2011)(Reviewed 2012)

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

2012, 1981 Pharmacist Training in Nutrition

1. APhA advocates that all pharmacists become knowledgeable about the subject of nutrition.
2. APhA encourages schools and colleges of pharmacy as well as providers of continuing pharmacy education to offer education and training on the subject of nutrition.

(Am Pharm NS21(5):40 May 1981) (Reviewed 2003) (Reviewed 2006) (Reviewed 2007) (JAPhA NS52(4) 458 July/August 2012)

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

2012, 1981 Pharmacist Training in Physical Assessments

APhA supports education and training by schools and colleges of pharmacy, as well as providers of continuing pharmacy education, to prepare pharmacists to perform physical assessments of patients.

(Am Pharm NS21(5):40 May 1981) (Reviewed 2003) (Reviewed 2006) (Reviewed 2007) (JAPhA NS52(4) 458 July/August 2012)

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

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)

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

2012, 1999 Collective Bargaining/Unionization

1. APhA supports pharmacists' participation in organizations that promote the discretion or professional prerogatives exercised by pharmacists in their practice, including the provision of patient care.
2. APhA supports the rights of pharmacists to negotiate with their respective employers for working conditions that will foster compliance with the standards of patient care as established by the profession

(JAPhA 39(4): 447 July/August 1999) (Reviewed 2001) (Reviewed 2007) (JAPhA NS52(4) 458 July/August 2012)

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

2012, 2007, 1970 Employment Standards Policy Statement

The employment relationship between pharmacists and their employers must start with the principle that pharmacists have a professional, inherent right to practice in a manner which will engender self-respect in pursuit of their professional and economic objectives.
It is the policy of APhA to further the following basic employment standards:
1. Employers are obligated to respect the professional status, privileges, and responsibilities of employed pharmacists.
2. Employers are obligated to provide working conditions that enhance the ability of employed pharmacists to utilize their full professional capacity in providing patient care service to the public.
3. Employers are obligated to provide employed pharmacists opportunities to increase their professional knowledge and experience.
4. Employers are obligated to fairly compensate employed pharmacists commensurate with their duties and performances. Such compensation should include benefits generally available to other professionals including, but not limited to, vacation, sick leave, insurance plans, and retirement programs.
5. Employed pharmacists are obligated to use their best efforts to further the services offered to the public by their employers.
6. Employed pharmacists are obligated to unhesitantly bring to the attention of their employers all matters which will assist the employers in maintaining professional standards and successful practices.
7. Employed pharmacists are obligated, when negotiating compensation, to consider not only prevailing economic conditions in their community, but also their economic position relative to other health care professionals.
8. Employed pharmacists are obligated to recognize that their responsibility includes not depriving the public of their patient care services by striking in support of their economic demands or those of others.
9. Both employers and employed pharmacists are obligated to reach and maintain definite understandings with regards to their respective economic rights and duties by resolving employment issues fairly, promptly, and in good faith.

It is the policy of APhA to support these basic employment standards by:

1. Encouraging and assisting state pharmacists associations and national specialty associations to establish broadly representative bodies to study the subject of professional and economic relations and to establish locally responsive guidelines to assist employers and employed pharmacists in developing satisfactory employment relationships.
2. Encouraging and assisting state pharmacists associations and national specialty associations to use their good offices, whenever invited, to resolve specific issues which may arise.
3. Assisting state pharmacists associations and national specialty associations to use their good offices, whenever invited, to resolve specific issues which may arise.
4. Assisting state pharmacists associations and national specialty associations to develop procedures for mediation or arbitration of disputes which may arise between employers and employed pharmacists so that pharmacists can call on their profession for such assistance when required.
5. Increasing its activities directed towards educating the profession about the mutual employment responsibilities of employers and employed pharmacists.

6. Developing benefits programs wherever possible to assist employers in providing employed pharmacists with economic security.
7. Continuously reminding pharmacists that the future development and status of pharmacy as a health profession rests in their willingness and ability to maintain control of their profession.

(JAPhA NS10:363 June 1970) (Reviewed 2001) (JAPhA NS45(5):580 September-October 2007)(JAPhA NS52(4) 458 July/August 2012)

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

2012, 2007, 2001, 1995 Impact of the Pharmacists' Working Conditions on Public Safety

1. APhA recognizes that the quality of a pharmacist's work-life affects public safety and that a working environment conducive to providing effective patient care is essential.
2. APhA opposes the practice of imposing minimum numbers of prescriptions which pharmacists are to dispense in a given period of time. Further, APhA opposes employment practices that evaluate a pharmacist's performance on the basis of set quotas of work performed.
3. APhA opposes employment practices that limit a pharmacist's ability to provide effective patient care.

(Am Pharm NS35(6):36 June 1995) (JAPhA NS4(5):Suppl. 1:58 September/October 2001) (Reviewed 2001) (JAPhA NS45(5):580 September-October 2007)(JAPhA NS52(4) 459 July/August 2012)

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

2012, 2001, 1969 Pharmacist Workforce Census

1. APhA recognizes the need for an ongoing census of pharmacists to establish and track changes in workforce demographics and practice characteristics.
2. APhA urges the federal government or other stakeholders to establish funding mechanisms to conduct an ongoing census of pharmacists to establish and track changes in workforce demographics and practice characteristics.

(JAPhA NS9:361 July 1969) (JAPhA NS41(5):Suppl.1:S9 September/October 2001) (Reviewed 2007) (JAPhA NS52(4) 458 July/August 2012)

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

2004, 1977 Pharmacy Practice: Professional Judgment

1. APhA supports a pharmacist's right, regardless of place or style of practice, to exercise individual professional judgment and complete authority for those individual professional responsibilities assumed.
2. APhA supports decision-making processes that ensure the opportunity for input by all pharmacists affected by the decisions.

(JAPhA NS17:463 July 1977) (JAPhA NS44(5):551 September/October 2004) (Reviewed 2007)(Reviewed 2012)

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

2011 Requiring Influenza Vaccination for All Pharmacy Personnel

APhA supports an annual influenza vaccination as a condition of employment, training, or volunteering within an organization that provides pharmacy services or operates a pharmacy or pharmacy department (unless a valid medical or religious reason precludes vaccination)

JAPhA NS51(4) 482;July/August 2011)(Reviewed 2012)

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

2001 Stress and Conflict in the Workplace

APhA encourages employers to provide pharmacists with the tools required to manage stress and conflict within the workplace.

(JAPhA NS41(5):Suppl.1:S9 September/October, 2001) (Reviewed 2007)(Reviewed 2012)

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

1999, 1971 Unionization of Pharmacists

1. The committee recommends that no change be made in the present policy of APhA with regard to becoming a collective bargaining unit.
2. The committee recommends that APhA continue its educational efforts concerning the mutual responsibilities of the employer and employee pharmacist inherent in the employment relationship.
3. The committee recommends that APhA continue to urge state associations to develop employee/employer relations committees to:
(a) Study all aspects of both the professional and employment relationships that exist between the employer and the employee;
(b) Develop and recommend guidelines to provide direction and guidance to both the employed pharmacist and the employer in developing a mutually acceptable relationship;
(c) Conduct necessary surveys designed to provide information on salaries, benefits, and specific problems with attention given to possible regional variations in the data obtained, and;
(d) Consider the establishment of an employment standards committee where feasible in each appropriate area of the state to act in an advisory and/or arbitrating capacity on matters pertaining to employment standards and employment grievances
4. The committee recommends that colleges of pharmacy include the subject of employer/ employee relations within an appropriate course of the curriculum.

(JAPhA NS11:273 May 1971) (JAPhA 39(4):447 July/August 1999) (Reviewed 2001) (Reviewed 2007)(Reviewed 2012)

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

1999, 1970 Unionization of Pharmacists: State Participation in Employer/Employee Relations

The committee endorses the recommendations in the Provisional Policy Statement on Employment Standards submitted by the Board of Trustees at the special meeting of the House of Delegates in November, 1969. The committee recommends that any change in this statement to provide that APhA function as a collective bargaining unit be rejected.

(JAPhA NS10:353 June 1970) (JAPhA 39(4):447 July/August 1999) (Reviewed 2001) (Reviewed 2007)(Reviewed 2012)

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

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

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

(Am Pharm NS30(6):45 June 1990) (Reviewed 2004) (Reviewed 2007)(Reviewed 2012)

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

2007, 1992 Recycling of Pharmaceutical Packaging

APhA supports aggressive research and development by pharmacists, pharmaceutical manufacturers, waste product managers, and other appropriate parties of mechanisms to increase recycling of non-hazardous, pharmaceutical, packaging materials, to reduce unnecessary waste in pharmaceutical product packaging, and to minimize the opportunity for counterfeiters to use discarded packaging

(Am Pharm NS32(6):516 June 1992) (Reviewed 2004) (JAPhA NS45(5):580 September-October 2007)(Reviewed 2012)

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

2007 Re-Distribution of Previously Dispensed Medications

1. As a matter of patient safety, APhA opposes the re-dispensing of a previously dispensed medication once it has been out of the control of a health care professional.
2. APhA supports a public awareness program to explain why the re-dispensing of a previously dispensed medication once it is out of the control of the healthcare professional is a public health safety concern.

(JAPhA NS45(5):580 September-October 2007)(Reviewed 2012)

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

2001 Syringe Disposal

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

(JAPhA NS41(5): Suppl.1:S9 September/October 2001)(Reviewed 2007)(Reviewed 2012)

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

1997 Collaborative Practice Agreements

1. APhA supports the establishment of collaborative practice agreements between pharmacists and other health care professionals designed to optimize patient care outcomes.
2. APhA shall promote the establishment and dissemination of guidelines and information to pharmacists and other health care professionals to facilitate the development of collaborative practice agreements.

(JAPhA NS37(4):459 July/August 1997) (Reviewed 2003)(Reviewed 2007)(Reviewed 2009)(Reviewed 2011)(Reviewed 2012)

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

1967 State and Local Boards of Health

Because of the broad implications of the pharmacist's role in public health, the committee recommends that pharmacists and pharmacy associations seek to have the state laws amended to require that a pharmacist serve on the state and local boards of health. One part of this effort should be an increased interest on the part of the pharmacist in his local health boards and commissions.

(JAPhA NS7:324 June 1967) (Reviewed 2002) (Reviewed 2007)(Reviewed 2012)

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

2004, 1989 "Beyond-use Dating" by Pharmacists

APhA recommends that all pharmacists place a "beyond-use-date" on the labeling of all medications dispensed to patients as recommended by the United States Pharmacopeia-National Formulary or manufacturer.

(Am Pharm NS29(7):465 July 1989) (JAPhA NS44(5):551 September/October 2004) (Reviewed 2007)(Reviewed 2012)

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

2004, 1971 Expiration Dating

APhA supports manufacturers of prescription and non-prescription drugs including on the package label adequate information regarding storage requirements and a date after which the product should not be used.

(JAPhA NS11:271 May 1971) (JAPhA NS44(5):551 September/October 2004) (Reviewed 2007)(Reviewed 2012)

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

2000 Regulation of Dietary Supplements

1. APhA shall work with Congress to modify the Dietary Supplement Health and Education Act or enact other legislation to require that dietary supplement manufacturers provide evidence of efficacy and safety for all products, including products currently in the marketplace.
2. APhA supports the establishment and implementation of clear and effective enforcement policies to remove promptly unsafe or ineffective dietary supplement products from the marketplace.
3. APhA shall work with the FDA to improve dietary supplement product labeling to ensure full disclosure of all product components and their source with associated strengths and recommendations for use in specific patient populations.
4. APhA supports the development and enforcement of dietary supplement good manufacturing practices (GMPs) and compliance with USP/NF standards to assure quality, safe, contaminant-free products.
5. APhA encourages health care professionals, manufacturers, and consumers to report adverse health events associated with dietary supplements. APhA encourages the FDA to create a database with this information and make it available to all interested parties.

(JAPhA NS1(9):40 September/October 2000)(Reviewed 2005)(Reviewed 2007)(Reviewed 2012)

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

2007 Privacy of Pharmacists' Personal Information

1. APhA supports protecting pharmacist, student pharmacist, and pharmacy technician personal information (e.g. home address, telephone, and personal email address).
2. APhA opposes legislative or regulatory requirements that mandate the publication of pharmacist, student pharmacist and pharmacy technician personal information (e.g. home address, telephone, and personal email address).
3. APhA encourages state boards of pharmacy to remove from their Web sites personal addresses, phone numbers, email, and other non-business contact information of pharmacists, student pharmacists, and pharmacy technicians.

(JAPhA NS45(5):580 September-October 2007)(Reviewed 2012)

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

2012 Registration of Facilities

APhA supports state and federal laws and regulations that require registration with the state boards of pharmacy of all facilities involved in the storage, wholesale distribution, and issuance of legend drugs to patients, provided that such registration does not restrict the pharmacists from providing professional services independent of a facility.

(JAPhA NS52(4) 458 July/August 2012)

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

2004, 1991 Updating of State Pharmacy Practice Acts

1. APhA recommends and supports enactment of state pharmacy practice act revisions enabling pharmacists to achieve the full scope of APhA's Mission Statement for the Pharmacy Profession.
2. APhA supports standards of pharmacy practice reflecting the APhA Mission Statement for the Pharmacy Profession.

(Am Pharm NS31(6):28 June 1991) (JAPhA NS44(5):(551 September/October 2004) (Reviewed 2007)(Reviewed 2012)

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

2012, 1992 Patient Care and Medication Distribution System

APhA encourages those responsible for practice environments without direct patient/pharmacist contact to use methods to enhance communication, face-to-face interaction, and patient care.

(Am Pharm NS32(6):515 June 1992) (Reviewed 2001) (Reviewed 2007) (JAPhA NS52(4) 459 July/August 2012)

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

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 20088) (JAPhA 53(4):366 July/August 2013)

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

2001 Pharmacist Counseling on Administration Devices

APhA encourages patient and caregiver education by a pharmacist on the appropriate use of drug administration devices.

(JAPhA NS41(5):Suppl.1:S9 September/October 2001)(Reviewed 2007)(Reviewed 2012)

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

2012, 1989 Equal Employment Opportunity for Pharmacists

APhA reaffirms its unequivocal support of equal opportunities for professional employment and advancement, compensation, and organizational leadership positions for all pharmacists regardless of gender, race, color, religion, national origin, age, disability, genetic information, sexual orientation, or any other category protected by federal or state law.

(Am Pharm NS 29(7):464 July 1989) (Reviewed 2001) (Reviewed 2007)(JAPhA NS52(4) 459 July/August 2012)

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

2012, 1991 Recruitment of a Diverse Population into Pharmacy

1. APhA supports a vigorous long term program for the recruitment of a diverse population of student pharmacists into the pharmacy profession.
2. APhA encourages the development and regular updating of comprehensive recruitment materials, directed toward diversity and inclusion, that address such issues as pharmacy career opportunities, financial aid, and educational prerequisites, and that highlight professional diverse role models.
3. APhA encourages national, state, and local association; schools; students; and industry to create a network of pharmacists who would serve as role models for a diverse population of student pharmacists.
4. APhA supports the development of guidelines that assist schools of pharmacy in implementing diversity and inclusion initiatives into student pharmacist recruitment programs.

(Am Pharm NS31(6):28 June 1991) (Reviewed 2001) (Reviewed 2007) (JAPhA NS52(4) 459 July/August 2012)

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

1971 Communications with Patients: Drug Delivery Practice

APhA supports the Academy of General Practice of Pharmacy statement on drug delivery practice that reads as follows: "When requested by a patient or a prescriber to deliver medication to the home of a patient, the pharmacist will communicate directly with the patient, or his representative, instructions and warnings concerning the medication and ascertain that a responsible individual will receive the medication or determine that the medication will be left in a safe place."

(JAPhA NS11:272 May 1971) (Reviewed 2001) (Reviewed 2007)(Reviewed 2012)

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

2012, 2003 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 tests 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)

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

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 2012)(Reviewed 2013)

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

2004, 1979 Drug Regimen Review (DRR) by Pharmacists

APhA endorses adequate compensation for pharmacists by the patient, the government, and/or all other third-party programs for performing drug regimen review in all settings where drug therapy is used.

(Am Pharm NS19(7):61 June 1979) (APhA NS44(5):551 September/October 2004)(Reviewed 2007)(Reviewed 2012)

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

2004, 1971 Drug Storage and Return Goods Policy

1. APhA recommends that all practitioners and wholesalers provide controlled, room temperature, storage conditions as defined in the official compendia to adequately store drug products.
2. APhA recommends that manufacturers adopt return goods policies that allow the return of drug products even if the expiration date has not yet occurred.
3. APhA shall continue to study the problem of drug storage at all levels of distribution including in transit, in the pharmacy, and in the home and provide guidance for the profession and public in these areas.

(JAPhA NS11:271 May 1971) (JAPhA NS44(5):551 September/October 2004)(Reviewed 2007)(Reviewed 2012)

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

1993 Patient Counseling Environment

APhA encourages the development and use of responsible and effective design of pharmacy facilities to allow for convenient, comfortable, and private pharmacist-patient communications.

(Am Pharm NS33(7):56 July 1993)(Reviewed 2002)(Reviewed 2007)(Reviewed 2012)

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

2001, 1990 Regulatory Infringements on Professional Practice

1. APhA, in cooperation with other national pharmacy organizations, shall take a leadership role in the establishment and maintenance of standards of practice for existing and emerging areas in the profession of pharmacy.
2. APhA encourages a cooperative process in the development, enforcement, and review of rules and regulations by agencies that affect any aspect of pharmacy practice, and this process must utilize the expertise of affected pharmacist specialists and their organizations.
3. APhA supports the right of pharmacists to exercise professional judgment in the implementation of standards of practice in their practice settings.

(Am Pharm NS30(6):45 June 1990) (JAPhA NS4(5)Suppl.1:S7 September/October, 2001)(Reviewed 2007)(Reviewed 2012)

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

2010, 2001 Prescription Order Requirements

1. APhA supports the use of technology to facilitate the transmission of prescription order information from the prescriber to the pharmacist of the patient's choice at no additional cost to the pharmacy.
2. APhA supports the use of technology where appropriate standards for patient confidentiality and prescriber and pharmacist verification are established.
3. APhA supports the transmission of complete prescriber information on or with the prescription order that enables the pharmacist to readily identify and facilitate communication with the prescriber.
4. APhA supports the use of specific instructions with prescription orders. Use of potentially confusing terminology (such as "as directed", unclear use of Latin phrases, confusing abbreviations, etc.) should be avoided.

5. APhA supports the inclusion of the diagnosis or indication for use for which the medication is ordered on or with the transmission of the prescription order by use of standard diagnosis codes or within the directions for use. APhA further supports the inclusion of patient-specific information on or with the prescription order where appropriate.
6. APhA supports public education about the benefits and risks of technological advances in pharmacy practice.

(JAPhA NS41(5):Suppl.1:S8 September/October 2001) (Reviewed 2007)(Reviewed 2009)(Reviewed 2010)(Reviewed 2012)

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

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.

(Am Pharm NS35(6):37 June 1995) (Reviewed 2006)) (JAPhA NS51(4) 484;July/August 2011)

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

2012, 2005, 1992 The Role of Pharmacists in Public Health Awareness

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

(Am Pharm NS32(6):515 June 1992) (Reviewed 2005) (Reviewed 2009)(Reviewed 2010) (JAPhA NS52(4) 460 July/August 2012)

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

2007 WHO Policy on Infectious Diseases

1. APhA supports the World Health Organization's (WHO) requirements for accurate and expeditious reporting of infectious diseases from all countries, including unrestricted sharing of infectious substance samples with WHO.
2. APhA supports access to affordable vaccines in all countries.

(JAPhA NS45(5):580 September-October 2007)(Reviewed 2012)

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

2012, 2002, 1964 Health Education: Selection of Pharmacist

APhA supports education of consumers about the importance of selecting their personal pharmacist to assist them in the proper use of all medications and medical devices.

(JAPhA NS4:429 August 1964) (JAPhA NS42(5):Suppl. 1:S62 September/October 2002) (Reviewed 2007)(JAPhA NS52(4) 459 July/August 2012)

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

2002, 1971 Promotion of Pharmacists' Value

APhA encourages a coordinated effort by state and national associations, individual pharmacists, pharmacy employers and stakeholders to promote public understanding about the nature, value and necessity of pharmacists' services.

(JAPhA NS11:264 May 1971) (JAPhA NS42(5):Suppl. 1:S62 September/October 2002)(Reviewed 2007)(Reviewed 2012)

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

1986 Use of the Title "Pharmacist"

APhA encourages the use of the title "Pharmacist" in communications and all public media.

(Am Pharm NS26(6):421 June 1986)(Reviewed 2007)(Reviewed 2012)

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

2005, 1977 Government-Financed Reimbursement

1. APhA supports only those government-operated or -financed, third-party prescription programs which ensures that participating pharmacists receive individualized, equitable compensation for professional services and reimbursement for products provided under the program.
2. APhA regards equitable compensation under any government-operated or -financed, third party prescription programs as requiring payments equivalent to a participating pharmacist's prevailing charges to the self-paying public for comparable services and products, plus additional, documented, direct and indirect costs which are generated by participation in the program.
3. APhA supports those government-operated or -financed, third-party prescription programs which base compensation for professional services on professional fees and reimbursement for products provided on actual cost, with the provision of a specific exception to this policy in those instances when equity in professional compensation cannot otherwise be attained.

(JAPhA NS17:452 July 1977) (JAPhA NS45(5):558 September/October 2005) (Reviwed 2009(Reviewed 2011)(Reviewed 2012)

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

2005, 1980 Inclusion of Pharmacist-Provided Patient Care Services in Health Programs

APhA supports the inclusion of pharmacist-provided patient care services in health care programs that are developed and/or funded by governments and private agencies and organizations.

(Am Pharm NS20(7):69 July 1980) (JAPhA NS45(5):558 September/October 2005)(Reviewed 2009)(Reviewed 2010)(Reviewed 2011)(Reviewed 2012)

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

2012, 2005, 1969 Medicare and Patient Care Service

1. APhA believes that Health care, including the essential component of patient care services, should be made available to as many people as possible in our society through the most economical system compatible with an acceptable standard of quality.
2. APhA should support the Part B mechanism which is the voluntary supplementary medical insurance program financed equally by beneficiaries and the government.
3. APhA should oppose legislation which would restrict the Medicare drug benefit to specific, chronic diseases.
4. APhA should support the inclusion of patient care services under Medicare or any other federal financing mechanism, providing the program is designed to help persons who need it most and is administratively efficient and economical.

(JAPhA NS9:363 July 1969) (JAPhA NS45(5):558 September/October 2005) (Reviewed 2009) (JAPhA NS52(4) 460 July/August 2012)

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

1993 Pharmacists' Services

1. APhA supports development of pharmacy payment systems that include reimbursement of the cost of any medication or device provided;the cost of preparing the medication or device;the costs of administrative services;return on capital investment;and payment for both the dispensing-related and non-dispensing-pharmacy services.
2. APhA believes that appropriate incentives for the pharmacist providing care should be part of any payment system.

(Am Pharm NS33(7):53 July 1993) (Reviewed 2005) (Reviewed 2007) (Reviewed 2009) (Reviewed 2010)(Reviewed 2011)(Reviewed 2012)

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

2002, 1993 Traditional Sampling and Pharmacy-Based, Starter Dose Programs

1. APhA encourages the use of pharmacy-based, starter dose programs.
2. APhA recommends that pharmacy-based, starter dose programs should promote patient access, be cost effective, ensure product integrity, maximize patient outcomes and provide appropriate compensation to the pharmacist.
3. APhA recommends that patients and prescribers communicate with pharmacists regarding the use of traditional drug samples to promote safe and effective medication use.
4. APhA encourages that sampling and starter dose programs limit the quantity of medications involved to amounts sufficient for beginning doses only.

(Am Pharm NS33(7):55 July 1993) (JAPhA NS42(5):Suppl. 1:S60 September/October 2002)(Reviewed 2007)(Reviewed 2012)

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

2012, 1989 Recognition of Pharmacy Practice Specialties

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

(Am Pharm NS29(7):464 July 1989) (Reviewed 2001) (Reviewed 2007) (JAPhA NS52(4) 460 July/August 2012)

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

1981 "P.D." (Pharmacy Doctor) Designation for Pharmacists

APhA opposes the term "P.D." (Pharmacy Doctor) as the uniform designation for pharmacists.

(Am Pharm NS21(5):40 May 1981) (Reviewed 2002) (Reviewed 2007)(Reviewed 2012)

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

1977 Uniform Designation for Pharmacists

1. The profession of pharmacy should establish and use a uniform designation to identify an individual as a pharmacist.
2. The profession should adopt and use the designation "Pharmacist" following an individual's name as the uniform designation identifying that individual as a pharmacist.
3. At the discretion of individual pharmacists, earned academic degrees or state licensure designation may be indicated following the uniform designation.

(JAPhA NS17:454 July 1977) (Reviewed 2002) (Reviewed 2007)(Reviewed 2012)

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

1999 Use of Titles

APhA opposes the use of titles such as "Pharmaceutical Specialist" and "Pharmaceutical Consultant" by sales representatives of pharmaceutical manufacturers.

(JAPhA 39(4):447 July/August 1999)(Reviewed 2006) (Reviewed 2007)(Reviewed 2012)

AMENDED POLICY STATEMENTS

67. The Committee recommends **AMENDING** the following policy statement as written.

1982 Legislative Restrictions on ~~Therapeutic~~ Clinical Judgment

APhA opposes the enactment of legislation which would act to restrict the ~~therapeutic~~ clinical judgments of medical practitioners and other health professionals.

(Am Pharm NS22(7):32 July 1982) (Reviewed 2004) (Reviewed 2006) (Reviewed 2007)(Reviewed 2012)

COMMENTS: The Policy Review Committee recommends AMENDING this policy statement to replace "Therapeutic" with "Clinical" to reflect contemporary terminology.

68. The Committee recommends **AMENDING** the following policy statement as written.

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 toward ~~that lead to the establishment of~~ establishing a consistent and accurate perception ~~by the public, lawmakers, regulators, and other health care professionals~~ of the contemporary role and ~~contemporary~~ practice of pharmacists by the general public, patients, and all persons and institutions engaged in health care policy, administration, payment, and delivery.
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 continued 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)

COMMENTS: The Policy Review Committee recommends AMENDING policy statement #2 to read as follows: APhA supports continuing efforts toward establishing a consistent and accurate perception of the contemporary role and practice of pharmacists by the general public, patients, and all persons and institutions engaged in health care policy, administration, payment, and delivery. These modifications are to incorporate additional individuals or organizations involved in policy development. The Policy Review Committee also recommends AMENDING policy statement #5 to add the word "continued" as some of the documents mentioned in the policy statement have been completed, but additional development may still be necessary.

ARCHIVED POLICY STATEMENTS

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

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.

(JAPhA NS40(5):Suppl. 1:S8 September/October 2000) (Reviewed 2002) (Reviewed 2007)(Reviewed 2012)

COMMENTS: This item is included in both the RETAINING and ARCHIVING sections of this report. The Policy Review Committee recommends ARCHIVING statements #1, 2 and 3 as the committee feels more contemporary and comprehensive policy exists as part of APhA **2016 Biologic, Biosimilar, and Interchangeable Biologic Products**. The Policy Review Committee recommends RETAINING statement #4 as this item is still relevant and not covered specifically in other policy statements.

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

2012, 1995 Assuring Pharmacists' Continuing Competence in Contemporary Practice

1. APhA reaffirms its policy, adopted in 1975, which advocates that pharmacists maintain their professional competence throughout their professional careers.
2. APhA recommends that employers evaluate prospective and current pharmacist employees based on demonstrated competencies in patient care and experience, in addition to education.
3. APhA will develop and implement curricular-based continuing education programs leading to certificates of competence in patient care.
4. APhA will convene a task force to develop and implement a voluntary program which enables pharmacists to assess and improve their continuing professional competence.

(Am Pharm NS35(6):36 June 1995) (Reviewed 2001) (Reviewed 2007)(Reviewed 2011) (JAPhA NS52(4) 460 July/August 2012)

COMMENTS: The Policy Review Committee recommends ARCHIVING this policy statement as there is no longer a task force in operation and **APhA 2005 Continuing Professional Development** policy language encompasses the intent of these items.

The Policy Review Committee identified the following policy statement as needing an amendment that changes the intent. If the associated NBI is not adopted by the House then the recommendation in this report stands, as approved by the House of Delegates.

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

2001 Work Schedules

1. APhA supports a work environment in which innovative work schedules are available to pharmacists and encourages employers to allow meal breaks and rest periods.
2. APhA encourages employers to offer benefit packages that provide dependent-care benefits, including, but not limited to, flexible spending accounts, voucher systems, referral services, on-site dependent care, and negotiated discounts for use of day care facilities, to improve workforce conditions.

(JAPhA NS(5):Suppl.1:S10 September/October 2001)(Reviewed 2007)(Reviewed 2012)

COMMENTS: The Policy Review Committee (PRC) intends to submit a New Business Item (NBI) to add language to replace "including, but not limited to" with "such as" as smaller pharmacies may not be able to adhere to the original policy language that includes all items listed. The Committee recommends **RETAINING** this policy statement as written unless a revised statement is adopted as a NBI by the House. If the policy statement is **RETAINED** then the PRC recommends referring this policy to the 2017-18 Policy Review Committee for additional review.

HOUSE OF DELEGATES
APhA AMERICAN PHARMACISTS ASSOCIATION

2017 House of Delegates
Report of the Policy Committee

- Patient Access to Pharmacist-Prescribed Medications
- Pharmacists' Role within Value-Based Payment Models
- Pharmacy Performance Networks

Committee Members
Kevin Musto, Chair
Nicholas Dorich
Sean Jeffery
Dan Kennedy
Jim Kirby
Randy McDonough
Marissa Schlaifer
Scott Sexton
Krystalyn Weaver

APhA2017 MAKING AN IMPACT IN PATIENT CARE
San Francisco, CA | March 24–27
Annual Meeting & Exposition

Ex Officio
Theresa Tolle, Speaker of the House
Michael Hogue, Speaker-elect of the House

This report is disseminated for consideration by the APhA House of Delegates, but does not represent the position of the Association. Only those statements adopted by the House are official Association policy.

2016–2017 APhA Policy Committee Report

Patient Access to Pharmacist-Prescribed Medications

The committee recommends that the association adopt the following statements:

1. APhA asserts that pharmacists' patient care services and related pharmacist prescribing are beneficial to improving patient access to care, patient outcomes, and community health and align with coordinated, team-based care.
   [Refer to Summary of Discussion Items 2, 3.]

2. APhA supports increased patient access to care through pharmacist prescriptive authority models including, but not limited to, collaborative practice agreements and statewide protocols.
   [Refer to Summary of Discussion Items 3, 4, 5, 6, 7, 8.]

3. APhA opposes requirements and restrictions impeding patient access to pharmacist-provided patient care services and related pharmacist prescribing that do not improve quality, safety, and efficiency.
   [Refer to Summary of Discussion Items 9, 10, 11, 12.]

4. APhA urges prescribing pharmacists to coordinate care with patients' other health care providers through appropriate documentation, communication, and referral.
   [Refer to Summary of Discussion Items 3, 13, 14, 15, 16]

5. APhA advocates that medications and services associated with prescribing by pharmacists must be covered and compensated in the same manner as other prescribers.
   [Refer to Summary of Discussion Items 17, 18.]

6. APhA supports the right of patients to fill pharmacist-prescribed medications at a pharmacy of their choice.
   [Refer to Summary of Discussion Item 19.]

Summary of Discussion

1. The committee discussed the use of the terms *initiate*, *furnish*, and *prescribe* and the way *initiate* and *furnish* may create barriers to payment to pharmacists for prescriptive authority and appropriate reimbursement for the medication (if not prescribed). In some states, the term *initiate* does not have the same legal meaning as *prescribe* and also may be unfamiliar to patients. The committee agreed that using a term other than *prescribe* would not be beneficial to describe a patient care function that is already being performed by other health care professionals.

2. The committee discussed how the focus and intent of statement 1 is access to the pharmacists who are able to prescribe and those associated services as opposed to focusing on only access to medications.

3. The committee agreed that circumstances exist where pharmacist prescribing is not appropriate because pharmacists are not being formally trained as diagnosticians. The committee also discussed specific cases where a diagnosis would not be required, such as preventive care, travel medicine, immunizations, etc.

4. The committee reviewed all existing forms of pharmacist prescriptive authority models. The committee discussed including standing orders in the policy statement itself, but chose not to keep this item in the statement because it does not explicitly belong in the area of prescribing practices.

5. The committee discussed the need for prescriptive authority models that do not limit pharmacists' role in prescribing practices.

6. The committee discussed the education and training related to pharmacist prescribing and did not intend to identify any special training measures beyond the curriculum for the Doctor of Pharmacy degree.

7. The committee referenced the document "Pharmacist Collaborative Practice Agreements: Key Elements for CPA Legislative and Regulatory Authority,"[1] when discussing the current landscape of prescriptive authority models. This document was developed by the Collaborative Practice Workgroup, which was convened by the National Alliance of State Pharmacy Associations.

8. The committee specifically included the term *models* because it is used by the Center for Medicare and Medicaid Innovation and also encompasses existing models while including potential future models.

9. The committee reviewed potential forms of restrictions such as practice setting, additional education requirements, specific prescribers, specific pharmacists, or specific patients and chose the verb *oppose* to highlight the importance of advocating against these types of legislative barriers and administrative restrictions.

10. The committee acknowledged that a legitimate reason for requirements or restrictions on pharmacist prescribing practices may exist. However, the committee agreed that any requirements and restrictions should be evidence based and not be arbitrary and also should not impede patient access. The committee initially chose the term *unsubstantiated* in place of *arbitrary*, but chose not to use *unsubstantiated* because *arbitrary* was clearer.

11. The committee discussed the importance of having statement 3 as guidance for state-level implementation. The committee intends to support the removal of legislative, regulatory, or policy barriers, such as practice restrictions or limitations on which and how many prescribers may collaborate with pharmacists under a CPA, that would limit patient access to medications prescribed by pharmacists.

12. The committee discussed the importance of pharmacists in their respective states working with state boards of pharmacy, state pharmacy associations, and other state-level legislative and regulatory bodies to advance pharmacists' role as prescribers in a state scope of practice act.

13. The committee further reviewed situations where a diagnosis may already exist (diabetes, etc.) and commented that the medications associated with conditions already being treated can be appropriately managed by pharmacists, but that such management should be performed in coordination with patients' other health care providers.

14. The committee reviewed the full spectrum of coordinated care and discussed the importance of monitoring and follow-up after the actions of prescribing.

15. The committee recognized that a pharmacist may be the health care system entry point for many patients, and pharmacists should be aware of potential situations that necessitate referral. The committee also discussed the importance for a patient to visit not only with a pharmacist but also with other members of the health care team when appropriate.

16. The committee discussed that coordination of care applies not only to prospective communication but also to retrospective communication with other members of the health care team.

17. The committee discussed that when a pharmacist issues a prescription, the pharmacist is then recognized as the prescriber on record and also recognized for coverage and compensation in the same way as other prescribers.

18. The committee reviewed existing billing codes used by prescribers and asserted that pharmacists should be able to use those same billing codes for pharmacist-prescribed medication and service.

19. The committee reviewed the APhA **2011 Potential Conflicts of Interest in Pharmacy Practice** policy statement when discussing issues related to conflicts of interest. The committee decided to further emphasize patients' autonomy to choose where they may fill their prescriptions in addition to existing policy on the subject.

20. The committee reviewed existing Washington State Administrative Code, specifically the definition of pharmacy practice (item 28 under the **RCW 18.64.011: Definitions** section) and **WAC 246-863-100, Pharmacist prescriptive authority—Prior board notification of written guideline or protocol required**.

21. The committee reviewed Oregon legislation (Oregon Revised Statutes, Chapter 689, Pharmacists; Drug Outlets; Drug Sales—Miscellaneous, 689.683 Prescription and dispensation of certain contraceptives; rules; insurance coverage) regarding hormonal contraceptive assessment, prescribing, dispensing, and referral by a pharmacist.

22. The committee discussed the importance of education and training but believes that pharmacists' current education prepares them for the authority to prescribe. The committee also reviewed the APhA **1975 Pharmacist's Responsibility for Continuing Competence** policy statement, which highlights the importance of pharmacists retaining their level of competence throughout their career.

23. The committee discussed that pharmacists should inherently understand that they have the professional responsibility to practice within their level of education and training as mentioned in the pharmacists' code of ethics.

24. The committee discussed the importance of sharing these practices with consumers and the public, but it assumed that information sharing would occur on the practice, state, and national level once approval of authority was obtained.

Reference

1. Collaborative Practice Workgroup, National Alliance of State Pharmacy Associations. *Pharmacist Collaborative Practice Agreements: Key Elements for Legislative and Regulatory Authority*. 2015. Available at: http://naspa.us/wp-content/uploads/2015/07/CPA-Workgroup-Report-FINAL.pdf. Accessed August 8, 2016.

Patient Access to Pharmacist-Prescribed Medications

Background Paper Prepared for the 2016–2017 APhA Policy Committee

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2016–2017 Executive Resident

American Pharmacists Association Foundation

Issue

Many states across the country have expanded the role of the pharmacist through statewide protocols, collaborative practice agreements (CPAs), or legislative and regulatory changes that allow a pharmacist to assess, monitor, modify, initiate, and dispense specific medications. While the various activities that are often included under the scope of "prescribing" can include selecting, initiating, monitoring, continuing, modifying, and administering, this paper will focus on the initiation of therapy. Authority to initiate therapy can vary widely from state to state.

These innovative practice models have begun to gain even more traction recently due to increased attention directed toward various public health issues—for example, patient access to naloxone for treatment of opioid overdose. Naloxone is not the only type of medication for which pharmacists can provide additional services. Smoking cessation products, hormonal contraception medications, and international travel medications have also become more accessible to patients because many states are using pharmacists more extensively and equipping them with the authority to assess, monitor, modify, initiate, and dispense these medications. Enabling pharmacists to expand their roles on the health care team by enhancing their ability to provide patients with access to necessary medications and expanded health care services is essential to maximizing the value of our nation's health care system.

Summary of Key Concepts

- A national shortage in the number of primary care professionals is resulting in many medically underserved populations and limiting patients' access to health care services.
- Pharmacists are highly qualified, trained, and accessible health care professionals who improve patient outcomes through the services they provide.
- Pharmacists are key members of health care teams, which is increasingly apparent as treatment and payment models shift toward coordinated care.

- Many states have begun allowing pharmacists to initiate certain medications through statewide protocol implementation and legislative or regulatory changes that permit or encourage CPAs and standing orders.
- Pharmacists are in a position to address unmet public health needs by providing care for chronic disease states, addressing public health initiatives, and offering preventive care services.
- Communication with patients' primary health care providers and documentation of services delivered are essential to ensuring the highest quality of care for patients.
- Practicing within the appropriate scope and identifying patient situations that necessitate referral are fundamental elements involved in the various prescriptive authority models.
- Several stakeholders and organizations outside the pharmacy profession have developed guidance documents referencing expanded roles for pharmacists and supporting broad collaborative authority.

Background

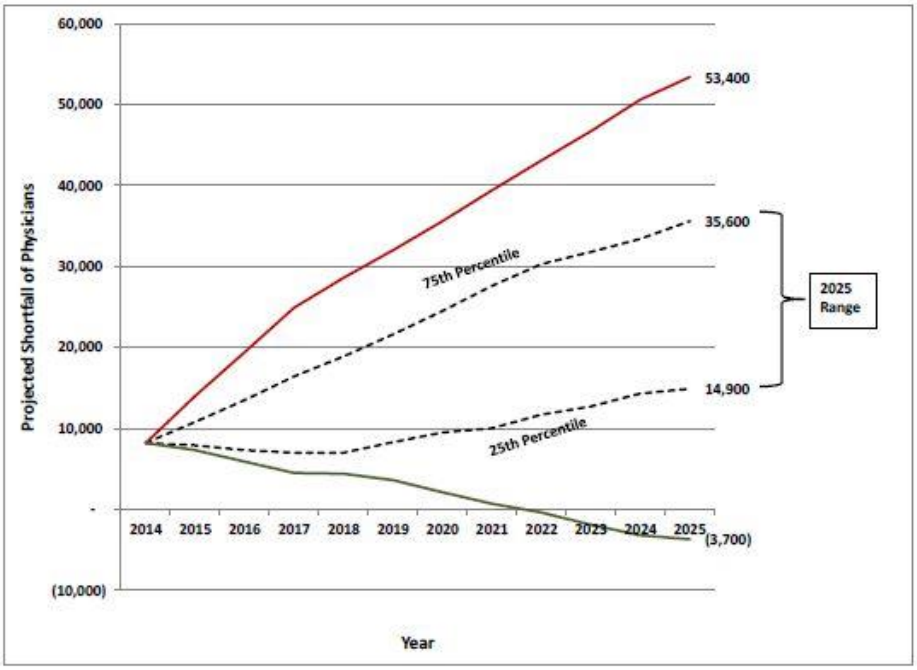
Introduction

Although the overall physician-to-population ratio in the United States has increased steadily over the past several decades, a growing trend toward physician specialization has not allowed for improvement in meeting the demand for primary care.[1] This reallocation of health care providers has left many patient populations without adequate and timely access to appropriate care. The need for appointments and the general lack of convenience pose additional barriers for patients attempting to gain access to care. Expanded implementation of prescriptive authority models that facilitate increased patient access to pharmacist-initiated medications is a viable solution to address this critical deficiency in patient access to primary care services.

Although pharmacists continue to expand the health care services they can deliver, shortages in the total number of physicians and in the number of primary care physicians are projected to worsen.[2] Immediate physician shortages highlight a greater need for health care stakeholders to routinely evaluate and assess our nation's pool of available resources. In 2015, the Association of American Medical Colleges (AAMC) committed to developing annual reports on physician supply-and-demand projections for this reason. The 2016 annual report published by AAMC reiterated and expanded on previous findings—an increasing deficit in physician supply in regard to physician demand.[2] Reports are driven by the most current research practices and by key trends in the profession that are most likely to affect the future supply and demand of physicians. Figure 1 depicts the projected shortfall of primary care physicians by 2025. Because the report weighs multiple potential supply-and-demand scenarios, projecting a specific number

with certainty is impossible. Instead, the projected shortfall is provided as a range that AAMC believes to be the most adequate representation of the primary care physician deficit by 2025—a projected deficit of 14,900 to 35,600 primary care physicians.

Figure 1. Total Projected Shortfall of Primary Care Physicians, 2014–2025

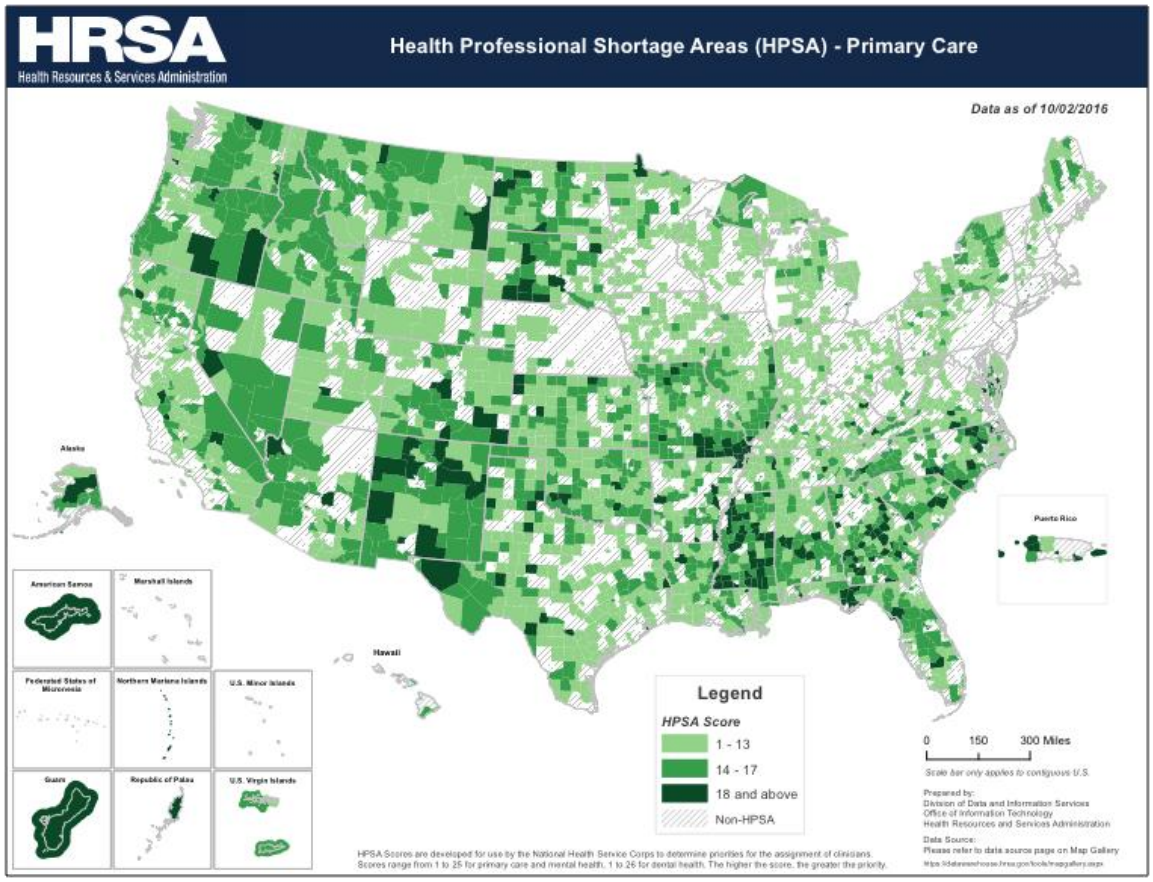


Source: (Dall et al., 2016)[2]

To supplement this research projecting the growing physician deficit, physician census data are also readily available. Data collected by the Federation of State Medical Boards (FSMB) document the number of licensed physicians per state, individual state population figures, and physicians per capita (per 100,000 population). The most recent data indicate a physician shortage in the near future. The authors of the census report also reference several studies to indicate that the future demands for primary care may be met by more active utilization of non-physician clinicians.[3] The data also allow for the determination of whether a state can be classified as a health professional shortage area (HPSA). Shortage designation criteria are established by the Health Resources and Services Administration (HRSA), an agency of the United States Department of Health and Human Services (HHS). In general, classification as a primary care HPSA is based on a physician-to-population ratio of 1:3,500.[4] A population in excess of 3,500 individuals per primary care physician would thus qualify as an HPSA. In 2014, approximately 6,100 areas in the United States were designated as primary care HPSAs.[5]

Figure 2 demonstrates the prevalence of HPSAs across the United States. HPSA scores indicate a priority for the assignment of clinicians in the corresponding area. The complete scoring process and criteria involved are accessible on the Health Resources and Services Administration website. The higher the score (and darker the shade of green), the greater the priority for clinician assignment. As evidenced in the data and Figure 2, a sizable percentage of the country is experiencing a shortage of primary care physicians.

Figure 2. Health Professional Shortage Areas (HPSA) – Primary Care



Source: (HRSA, 2016)[5]

Terminology

Several different terms are used in the marketplace to describe the initiation of medication therapy by a pharmacist. Commonly used terms include *prescribe*, *initiate*, and more recently, with respect to medications provided through state-based protocols, *furnish*. Traditionally, the majority of the profession has used the term *initiate* to describe pharmacist-prescribing activities. However, broad language should be encouraged to avoid restricting or limiting the services pharmacists can provide. When language

related to prescribing is used, it is important to emphasize to other providers that the pharmacist is working with the providers, not independent of them, to improve patient outcomes. As states continue to embrace prescriptive authority models, careful consideration should be given to addressing and describing terminology to avoid further segmentation or contribution to barriers impeding nationwide uptake.

Coordinated Care Approach

Over the past several years, the health care sector has seen several related trends emerge. These trends have begun to place focus on value-based patient care models rather than volume-based patient care models.[6] As a result, many health care providers, prescription drug plans, and other stakeholders are now being guided and assessed by performance metrics. These metrics are evaluated on the basis of predetermined quality measures. This shift toward a value-based health care system is furthermore facilitating a shift within the various practice settings toward a more team-based, interdisciplinary care approach.[7] The overall impact of these shifts has allowed for a natural progression toward a coordinated care model, with the patient's holistic health being at the forefront.

As health care practitioners are now being directly assessed on the quality of care they provide, hospitals and other providers are beginning to express a greater appreciation for health care teams.[7] The changing landscape of the health care environment has affected not only the way that providers approach the facilitation and delivery of patient care, but also the roles and responsibilities of patients and other health care professionals within these models. Through patient-centered, team-based care models, patients are becoming more engaged in the decision-making process related to their health care and receiving more transparent information about the quality of care delivered by their providers. As a result of this increased transparency, patients are better equipped to select providers and health plans that will best suit their individual health care needs.

Changes in the health care landscape are also providing opportunities for pharmacists to play a greater role in the delivery of care services to patients. Pharmacists are increasingly being integrated into health care teams for their medication expertise and their focus on wellness and prevention and chronic disease management.

Coordinated, team-based care is often referred to as collaborative care and can serve as the foundation for more formal agreements and protocols that expand the types of services pharmacists can deliver. Many states have passed legislation allowing pharmacists to initiate certain medications under various prescriptive authority models, an expansion in scope of practice that allows pharmacists to take on additional patient care responsibilities. As the health care arena continues to progress in the direction of coordinated care, pharmacists will need to be vigilant in the documentation of services delivered and the

communication of this information to appropriate members of the health care team. Pharmacists should also refer patients to their primary care physician (if assigned) whenever deemed appropriate.

Prescriptive Authority Models

Pharmacist initiation of medications and pharmacist prescriptive authority models have been in place for years, steadily gaining traction since the 1970s. The Indian Health Service (IHS) was one of the first groups to institute the idea of coordinated care. Pharmacists were granted post-diagnostic prescriptive authority that allowed them to provide certain prescription legend drugs without a physician prescription.[8] The Department of Veterans Affairs (VA) implemented a similar directive in 1995, allowing pharmacists prescriptive authority with the scope of practice established by local VA facilities.[9] At the state level, Washington was the first state to pass legislation granting pharmacists collaborative prescriptive authority in 1979. "Today, 49 states and the District of Columbia enable pharmacist prescriptive authority under CPAs, standing orders, or statewide protocols."[10]

Collaborative practice agreements are formal agreements in which a licensed provider makes a diagnosis, supervises patient care, and refers the patient to a pharmacist under a protocol or agreement that allows the pharmacist to perform specific patient care functions. The terminology used for CPAs can vary from state to state and may include collaborative drug therapy management agreement, collaborative pharmacy practice agreement, consult agreement, physician-pharmacist agreement, standing order or protocol, or, simply, physician delegation.

The term *statewide protocol* refers to a state regulatory framework under which qualified pharmacists are authorized by an empowered state body to initiate a specified medication or category of medications. Each protocol specifies the conditions under which a pharmacist may initiate and the general procedures that must be followed, while allowing the pharmacist to exercise clinical judgment in product selection. Generally, protocols are used to address patient care needs that do not require a diagnosis (i.e., preventive care) or for which a diagnosis already exists or can be easily obtained (i.e., through the use of a rapid diagnostic test).

A *standing order* is an order issued by a specific prescriber that can be carried out by other health care providers. Standing orders do not require an agreement with a collaborating provider. They may be used in several different settings and for different purposes. In institutional settings, standing orders are commonly incorporated into the general operations. Although standing orders have uses at the organizational level (typically in institutions, such as long-term care facilities and hospitals), they may also be implemented at the state level. A statewide standing order is typically issued by a state health official (or department) or attorney general. Statewide standing orders allow the designated individuals and/or others who meet the criteria to carry out an order throughout the entire state.[11]

Patient-Specific Collaborative Practice Agreements[10]

Patient-specific CPAs are formal relationships between participating patients, a provider or group of providers, and a pharmacist or group of pharmacists. Notably, some states allow pharmacists to enter into CPAs with nurse practitioners and/or physician assistants. Patient-specific CPAs are more restrictive than population-specific CPAs in terms of the patients served by the agreement, limiting services to either a single patient or group of patients, only patients who are under the care of the collaborating provider(s), or patients receiving only post-diagnostic follow-up services. Currently, 19 states restrict collaborative practice to the these patient-specific limitations.[10]

Patient-specific CPAs often are used by pharmacists to manage chronic disease states, such as diabetes, hypertension, and dyslipidemia.[12] Terms are negotiated between the provider(s) and the pharmacist(s). The pharmacist often then is able to initiate new medications, adjust medication therapies, and/or order laboratory tests.

Population-Specific Collaborative Practice Agreements[10]

Population-specific CPAs, in contrast with patient-specific CPAs, are regulated by broad inclusion criteria. Under this prescriptive authority model, patients who meet the inclusion criteria are eligible to receive services regardless of whether they are under the care of the collaborating provider(s) participating in the agreement. Population-specific CPAs have a collaborating prescriber, such as a medical director at a department of health, but that collaborating prescriber may not be the patient's personal physician. Currently, 17 states allow population-specific CPAs. By default, these states also allow patient-specific CPAs, because providers could also restrict certain agreements to specific patients or groups of patients.

Population-specific CPAs often are used by pharmacists to provide prevention and wellness services and to address certain acute conditions. They may also be used to manage chronic disease states. Under this model, pharmacists may administer certain vaccines pursuant to predetermined inclusion criteria. In several states, pharmacists are working under the terms of population-based CPAs to initiate an influenza medication after performing a flu test. Documentation of delivered services and communication with providers are imperative for pharmacists choosing to practice under these models.

Statewide Protocols[10]

Statewide protocols and unrestricted category-specific prescribing are both examples of autonomous prescribing models. Though pharmacists are still collaborating with providers to deliver services, autonomous prescribing allows for alternative models of care. One of the primary differences between statewide protocols and population-specific CPAs is that statewide protocols do not require pharmacists to practice under the delegation of functions by a specific provider or set of providers, as seen in Table 1.

An empowered state body, not a prescriber, establishes statewide protocols. The two models are similar, however, in that both are designed to facilitate delivery of care to populations, rather than individual patients.

Statewide protocols often address broad public health initiatives or are used to treat conditions that do not require a specific diagnosis. Typically, they are established by a public health department or state board of pharmacy. Statewide protocols issued to date have focused narrowly on specific medications or classes of medications. Examples of medications initiated by pharmacists under such protocols include tobacco cessation products, hormonal contraceptives, immunizations, and opioid reversal agents. The prescription opioid epidemic is a recent example of a public health initiative that has led many states to pass legislation allowing pharmacists to furnish naloxone. Currently, 19 states have passed statewide protocols for the issuance of naloxone.[13] In addition, statewide protocols also exist for tuberculosis testing and travel medications.[14] Many states with protocols in place also require patient counseling and education, some form of continuing pharmacist education component, and communication with the patient's primary care provider.

Unrestricted Category-Specific Prescribing[10]

Unrestricted category-specific prescribing models afford pharmacists autonomous prescribing authority and do not require the supervision of a collaborating provider or a state organization or agency. Medications that may be prescribed under this model do not require a specific diagnosis. This model includes a very narrow spectrum of medications, including immunizations, epinephrine autoinjectors, fluoride supplements, and opioid reversal agents.

Unrestricted category-specific models of prescribing do not dictate certain protocols for pharmacists to follow. Instead, they often reference prevailing treatment guidelines or professional association recommendations. For example, pharmacists in Idaho may prescribe dietary fluoride supplements if they follow the recommendations set by the American Dental Association (ADA).[15] This model is the least restrictive for pharmacists because changes in parameters associated with authority, such as changes to treatment guidelines, likely will not necessitate any type of statute or regulatory change.

Table 1. Side-By-Side Comparison of Collaborative Practice Agreements and Statewide Protocols

Collaborative Practice Agreement	Statewide Protocol
Individual agreement is negotiated between prescriber(s) and pharmacist(s).	Standardized agreement applies to any willing and qualified pharmacist in the state.

Pharmacist(s) must identify collaborating physician(s).	A pharmacist is not required to identify a collaborating physician.
The agreement applies to a pharmacist or group of pharmacists specifically defined in the agreement.	The protocol could apply to all pharmacists in the state who meet the requirements of the protocol.
The agreement can be patient-specific, disease state-specific, or patient population-specific, depending on state regulations and the conditions of the agreement.	Rather than being specific to the patient, pharmacist, or provider, the protocol defines the patient populations eligible for services, as well as the minimum qualifications needed by pharmacists to participate.
49 states and the District of Columbia allow CPAs.	25 states have established protocols in place.[14]
Services may be broad and may address a variety of conditions, both acute and chronic.	Protocols tend to focus on discreet services or conditions, such as dispensing naloxone, hormonal contraception, or smoking cessation therapies.
Pharmacist authority under the agreement may or may not be protocol-driven.	Pharmacist authority is protocol-driven.
Authority provided in the agreement is at the discretion of the collaborating practitioner(s), based on local clinical needs.	A pharmacist follows a protocol that is usually developed by a state board of pharmacy, board of medicine, board of public health, or that is jointly developed.
Parameters are modifiable on the basis of negotiations with the collaborating practitioner(s).	Parameters are not modifiable by individual pharmacists.

(Adapted from: Adams AJ, 2016)[16]

Education and Training

As of 2004, the Accreditation Council on Pharmacy Education (ACPE) requires that all students attending schools of pharmacy complete a Doctor of Pharmacy (PharmD) degree in order to be eligible to become a licensed pharmacist.[17] ACPE is the national agency for the accreditation of professional degree programs in pharmacy and providers of continuing pharmacy education.[18] The PharmD degree program encompasses rigorous educational curricula and clinical training requirements. Schools of pharmacy are required to meet specific standards established and outlined by ACPE in order to achieve and maintain ACPE accreditation.

As of 2015 (implemented in July 2016), ACPE accreditation standards have been updated to reflect the evolving role of pharmacists in team-based care settings. The standards have been refined to ensure that graduating students are prepared to achieve advanced clinical outcomes and collaborate with other health care providers to deliver the highest quality of patient care. Graduates are now assessed on key elements, such as foundational science knowledge, patient-centered and population-based care, medication use systems management, and health and wellness prevention and intervention strategies.[18]

The accreditation standards also require that graduates receive the skills training and professional development necessary to deliver care effectively. Curricula include skills training in areas such as problem solving, interprofessional collaboration, cultural sensitivity, and communication, as well as professional development in the areas of leadership, self-awareness, and innovation.[18] Thus, PharmD program graduates receive the education, training, and professional skills needed to provide high quality patient care in concert with other members of the health care team. As the health care landscape continues to change and needs continue to shift, routine refinement of accreditation standards should remain a priority to ensure that pharmacists' skills and training are aligned with the contemporary health care system.

In addition to the ACPE accreditation requirements that must be met by PharmD programs, some states require pharmacists to complete some form of additional training before entering into CPAs or administering protocols. To date, the majority of statewide protocols adopted require pharmacists to complete continuing education (CE) programs before engaging in the protocol. The training and/or practice designation requirements to enter into CPAs, however, vary widely from state to state.[19]

In some states, such as Minnesota and Washington, pharmacists are permitted entry into CPAs without any additional education or training beyond that of a PharmD program.[20,21] Other states, such as California and North Carolina, require pharmacists to obtain an advanced practice designation before they are eligible to enter into CPAs.[17] Pharmacists seeking recognition in California as an "advanced practice pharmacist (APP)" must fulfill at least two of the following qualifications: earn certification in a relevant area of practice, complete a postgraduate residency, or have provided clinical services to patients for at least one year under a CPA or protocol with another practitioner. Similarly, pharmacists seeking recognition in North Carolina as a "clinical pharmacist practitioner (CPP)" must meet certain criteria and receive approval from both the state pharmacy and the state medical boards.[17] Still, other states allow pharmacists entry into CPAs without an advanced practice designation but with additional training.

Documentation and Communication

Two key components involved in the different prescriptive authority models are documentation of delivered services and communication with the collaborating provider(s). Though many states have laws

explicitly outlining what should be documented, appropriate documentation should be standard practice.[22] Comprehensive access to electronic health records (EHRs) and other health information technology (HIT) can aid pharmacists in this process. Although documentation of services delivered can be completed through paper charting or electronic software systems, EHR access may allow pharmacists to view nurse and physician notes, patient vitals and laboratory results, care plans, and other important information needed to deliver patient care.[12] In addition, it assists pharmacists in communicating patient care activities to other members of the health care team. Pharmacist access to EHRs may also potentially help reduce hospital or long-term care readmission rates, facilitate enhanced medication reconciliation, and improve quality measures and patient outcomes.[23,24]

Identifying the appropriate documentation and record keeping requirements in any CPA or protocol is recommended to ensure that all participating parties meet the standards of expectation. Delivered services may be documented by use of a Subjective, Objective, Assessment, and Plan (SOAP) note or forms tailored specifically to the patient care service being provided. Structured electronic documents, such as the pharmacist e-care plan, are being developed to standardize documentation formats that will be shared electronically between health care professionals and organizations as part of the EHR infrastructure.

Effective communication among team members is at the core of the coordinated care approach. Efficient communication strategies allow health care team members to build trust with one another and to deliver care in a more cohesive fashion. Information may be exchanged via email, fax, telephone, text messaging, live conversation, and so on.[25] Similar to the previously mentioned documentation requirements, some states also have specific regulations regarding communication, such as the scope of information and the time frame in which it is communicated. When necessary, pharmacists practicing under prescriptive authority models should communicate therapeutic interventions with the patient's collaborating primary care provider. In addition, any other relevant patient information or changes in any of the patient's conditions should also be communicated. Appropriate and efficient communication will facilitate continuity of care, build trusting relationships, and contribute to meeting quality metrics.

Referral

In addition to routinely communicating with the primary care provider and documenting all patient interactions and therapy changes, pharmacists should also be diligent in ensuring that patients are referred back to the physician in any situations that necessitate referral. CPAs may include a visit protocol, which pharmacists may use to guide their interactions with patients. Algorithms for treatment may also be included in the agreement. Alternatively, other agreements may simply advise referencing and following evidence-based guidelines.

Pharmacists are responsible for ensuring that they are practicing within the scope of the CPA and/or statewide protocol being administered. For example, if a pharmacist is managing a patient's blood pressure according to a treatment algorithm defined in a CPA, that algorithm likely has a step recommending referral if the patient's blood pressure continued to remain uncontrolled. The pharmacist would also want to refer if he or she suspected some underlying cause of hypertension, if the patient's hypertension appeared resistant, or if some new symptom or complication suddenly presented that was outside the scope of the pharmacist's expertise and/or the CPA.

Although patient referral because of situations beyond the scope of the agreement is important, the pharmacist should also encourage the patient to see the collaborating provider routinely, however often the physician deems necessary. The time frame for routine referral should be discussed between the pharmacist and collaborating provider prior to the development of the CPA. The time frame for routine referral will likely vary among agreements, and may depend on such factors as physician preference, condition(s) being managed, and care setting.

Supporting Organizations

While numerous pharmacy organizations and associations have published literature on the expanding role of pharmacists in patient care, it is important to note that there is also additional support from outside stakeholders. As research data and study results continue to become more readily available, a growing number of stakeholders have begun to acknowledge the impact pharmacists can make when integrated into health care teams. Studies have demonstrated improved medication adherence, increased health care savings, and higher quality care overall.[26,27]

One such advocate for the profession, the National Governors Association (NGA), recently published a resource on pharmacist integration into health care teams. In an evolving health care landscape, NGA recognizes the importance of leveraging the third-largest group of health care practitioners to bridge some of the chasms facing the health care system today. NGA highlights medication management and chronic disease management as high priority areas in need of pharmacists' services.[17] The resource also identifies potential barriers impeding pharmacist integration, as well as viable solutions. Examples of different state CPAs are provided, and the resource encourages quality review and process improvement in terms of state board of pharmacy approval. States are encouraged to identify the most significant challenges impeding pharmacist integration and to examine other states' existing practice models for potential solutions.

Similar to NGA, the National Center for Chronic Disease Prevention and Health Promotion of the Centers for Disease Control and Prevention (CDC) published a resource to assist pharmacists in generating CPAs

and promoting team integration. The resource identifies specific strategies and measures that pharmacists can leverage to develop rapport with other health care practitioners and stakeholders involved.[12]

Barriers

Variability in the implementation, scope of practice, and patients and populations served in the prescriptive authority models creates a challenging atmosphere for broad-scale national uptake. Though all pharmacists receive the same education through PharmD programs, some states still restrict participation in CPAs to certain practice settings. As discussed earlier, significant variability also exists among states regarding the designation and training requirements related to entry into CPAs. These interstate regulatory discrepancies prevent chain pharmacies operating in multiple states from implementing expanded health care services at a national level.[22]

Concerns from other health care providers and a lack of financial resources to support pharmacists providing care under these models pose additional challenges. Pharmacists can play an active role by educating other health care practitioners about the services patients can receive through these models. In addition to the barriers created by concerns from other providers, financial challenges exist because clear guidance or understanding as to whether pharmacists receive payment for the initiation of medications is lacking currently. As pharmacist prescriptive authority models continue to become more prevalent, focus should be directed toward the development of standardized guidelines related to payment for pharmacists' services, and potentially the establishment of payment methodologies that recognize and compensate for "degree of efforts" and contributions to the patient's overall care outcomes.

Conclusion

As the most accessible health care practitioners to patients in the United States, pharmacists are conveniently positioned to bridge many of the gaps in the health care system today. In addition to the vast number of areas and populations that are already classified as medically underserved, projections estimate that the nationwide shortage in the number of primary care physicians will continue to worsen. As the degree requirements, education, and training for pharmacists have progressively evolved over the years, the patient assessment skills and health care services that pharmacists are able to provide have also expanded.

Trends in the health care sector toward value-based patient care models are creating additional opportunities for pharmacists to practice in team-based settings through a coordinated care approach. These opportunities further allow pharmacists to demonstrate their value and the impact they can make as members of the health care team. The pharmacist-physician relationship is extended through CPAs, which expand pharmacists' authority to initiate, modify, and discontinue medication therapy and also order

laboratory tests to manage chronic disease conditions and, in some cases, certain acute conditions. Autonomous prescribing models addressing public health initiatives, such as statewide protocols, are also increasing patient access to care. Although many states have already begun to allow pharmacists to initiate medications through prescriptive authority models, much opportunity exists for implementation in states that lack legislation granting pharmacists prescriptive authority, as do additional opportunities related to expanded implementation in states that have such legislation in place.

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Relevant APhA Policies

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

1. APhA supports education for pharmacists and student pharmacists to address issues of pain management, palliative care, appropriate use of opioid reversal agents in overdose, drug diversion, and substance-related and addictive disorders.
2. APhA supports recognition of pharmacists as the health care providers who must exercise professional judgment in the assessment of a patient's conditions to fulfill corresponding responsibility for the use of controlled substances and other medications with the potential for misuse, abuse, and/or diversion.
3. APhA supports pharmacists' access to and use of prescription monitoring programs to identify and prevent drug misuse, abuse, and/or diversion.

4. APhA supports the development and implementation of state and federal laws and regulations that permit pharmacists to furnish opioid reversal agents to prevent opioid-related deaths due to overdose.
5. APhA supports the pharmacist's role in selecting appropriate therapy and dosing and initiating and providing education about the proper use of opioid reversal agents to prevent opioid-related deaths due to overdose.
(JAPhA 54(4) July/August 2014) (Reviewed 2015)

2005, 1971 Cigarette Sales in Pharmacies

1. APhA recommends that tobacco products not be sold in pharmacies.
2. APhA recommends that state and local pharmacist associations develop similar policy statements for their membership and increase their involvement in public educational programs regarding the health hazards of smoking.
3. APhA recommends that individual pharmacists give particular attention to educating young people on the health hazards of smoking.
4. APhA recommends that APhA-ASP develop projects aimed at educating young people on the health hazards of smoking, such as visiting schools and conducting health education programs.
(JAPhA NS11:270 May 1971) (JAPhA NS45(5):555 September/October 2005) (Reviewed 2009) (Reviewed 2014)

2013 Revisions to the Medication Classification System

1. APhA supports the Food and Drug Administration's (FDA's) efforts to revise the drug classification paradigms for prescription and nonprescription medications to allow greater access to certain medications under conditions of safe use while maintaining patients' relationships with their pharmacists and other health care providers.
2. APhA supports the implementation or modification of state laws to facilitate pharmacists' implementation and provision of services related to a revised drug classification system.
3. APhA supports a patient care delivery model built on coordination and communication between pharmacists and other health care team members in the evaluation and management of care delivery.
4. APhA affirms that pharmacists are qualified to provide clinical interventions on medications under FDA's approved conditions of safe use.
5. APhA urges manufacturers, FDA, and other stakeholders to include pharmacists' input in the development and adoption of technology and standardized processes for services related to medications under FDA's defined conditions of safe use.

6. APhA supports the utilization of best practices, treatment algorithms, and clinical judgment of pharmacists and other health care providers to guide the evaluation and management of care delivery related to medications under FDA's approved conditions of safe use.
7. APhA encourages the inclusion of medications and services provided under FDA's defined conditions of safe use within health benefit coverage.
8. APhA supports compensation of pharmacists and other health care professionals for the provision of services related to FDA's defined conditions of safe use programs.
(JAPhA 53(4): 365 July/August 2013)

2006 Drug Classification System

1. APhA supports restructuring the current drug classification system and drug approval process. Evidence should drive the restructuring beyond the current prescription and nonprescription classes to ensure appropriate access to medications and pharmacist services and improve medication use and outcomes.
2. APhA encourages pharmacists to exercise their professional judgment to manage access to nonprescription medications and dietary supplements to facilitate patient/caregiver interaction with their pharmacist.
(JAPhA NS46(5):561 September/October 2006) (Reviewed 2011) (Reviewed 2013)

2003, 2000 Emergency Contraception

APhA supports the voluntary involvement of pharmacists, in collaboration with other health care providers, in emergency contraceptive programs that include patient evaluation, patient education, and direct provision of emergency contraceptive medications.
(JAPhA NS40(5):Suppl.1:S8 September/October 2000) (JAPhA NS43(5):Suppl. 1:S58 September/October 2003) (Reviewed 2006) (Reviewed 2008) (Reviewed 2009) (Reviewed 2014)

2013, 2009 Independent Practice of Pharmacists

1. APhA recommends that health plans and payers contract with and appropriately compensate individual pharmacist providers for the level of care rendered without requiring the pharmacist to be associated with a pharmacy.
2. APhA supports adoption of state laws and rules pertaining to the independent practice of pharmacists when those laws and rules are consistent with APhA policy.
3. APhA, recognizing the positive impact that pharmacists can have in meeting unmet needs and managing medical conditions, supports the adoption of laws and regulations and the creation of payment mechanisms for appropriately trained pharmacists to autonomously provide patient care services, including prescribing, as part of the health care team.

(JAPhANS 49(4):492 July/August 2009) (Reviewed 2012) (JAPhA 53(4):366 July/August 2013)

2013, 1980 Medication Selection by Pharmacists

APhA supports the concept of a team approach to health care in which health care professionals perform those functions for which they are educated. APhA recognizes that the pharmacist is the expert on drugs and drug therapy on the health care team and supports a medication selection role for the pharmacist, based on the specific diagnosis of a qualified health care practitioner.

(Am Pharm NS20(7):62 July 1980) (Reviewed 2003) (Reviewed 2007) (Reviewed 2008) (Reviewed 2009) (Reviewed 2011) (Reviewed 2012) (JAPhA 53(4):366 July/August 2013)

2016–2017 APhA Policy Committee Report

Pharmacists' Role within Value-Based Payment Models

The committee recommends that the association adopt the following statements:

1. APhA supports value-based payment models that include pharmacists as vital health care team members and that promote coordinated care, improve health outcomes, and lower total costs of health care.
   [Refer to Summary of Discussion Items 3, 4.]

2. APhA advocates for the development and implementation of meaningful quality measures within value-based payment models that achieve optimal health and medication outcomes that pharmacists can impact.
   [Refer to Summary of Discussion Items 5, 6.]

3. APhA advocates for mechanisms to recognize and compensate pharmacists for their contributions toward meeting quality measures and reducing total costs of care in value-based payment models.
   [Refer to Summary of Discussion Items 5, 6, 7, 8, 9, 10.]

4. APhA advocates that pharmacists must have the ability to access and exchange electronic health record data within value-based payment models in order to achieve optimal health and medication outcomes.
   [Refer to Summary of Discussion Item 11.]

5. APhA supports education, training, and resources that help pharmacists transform and integrate their practices with value-based payment models and programs.
   [Refer to Summary of Discussion Items 12, 13.]

Summary of Discussion

1. The committee considered the terminology *value-based care models* but used instead the terminology *value-based payment models* because it more accurately reflects current and familiar terminology without limiting the scope of policy statements to existing models.

2. The committee reviewed current definitions and explanations for value-based payment models from the Centers for Medicare and Medicaid Services (CMS) and specifically reviewed the concepts described in CMS's Quality Payment Program. The committee also reviewed a white paper developed by Optum, titled "Can Value-Based Reimbursement Models Transform Health Care?"[1] and released in August 2013, to gain additional guidance when discussing value-based payment models.

3. The committee discussed the importance of concepts behind value-based payment models (coordinated care, improved health outcomes, and lower costs) and wanted to support the direction in which value-based payment models are leading patient care. The committee also wanted to ensure that pharmacists are recognized as a part of the health care team in value-based payment models.

4. The committee reviewed existing APhA policy on the topic of team-based care and believed a policy statement should support a pharmacist's role on the health care team within existing and future value-based payment models, regardless of setting.

5. The committee does not intend for this statement to require the creation of additional pharmacist-only measures, but rather to assist in identifying measures where a pharmacist can assist other providers within a value-based payment model.

6. The committee discussed specifically including only *patient care quality measures*, but it did not want to limit the statement to only patient care measures because pharmacists may have a broader effect on organizational quality or other measures.

7. The committee recognized the need for a pharmacist to be recognized as a provider and reviewed the APhA **2013 Pharmacists Providing Primary Care Services** and **2013 Ensuring Access to Pharmacy Services** policy statements. The committee discussed how recognition as a provider supports the economic standing of a value-based payment model.

8. The committee recognized that value-based payment models are measured through multiple metrics and that identification of the specific measures in which pharmacists have an effect on patient care is important.

9. The committee recognized that as outcomes become broader, attributing a pharmacist's role in meeting a measure will be increasingly difficult. The committee believed, regardless of the type of measure, that determining how pharmacists assist in meeting measures is imperative.

10. The committee discussed including the terminology *team-based care* within statement 4, but determined it was not necessary because a pharmacist will be practicing as part of the team within a value-based payment model.

11. The committee recognized the importance of health information technology (HIT) and reviewed the APhA **2009 Health Information Technology** and **2015 Interoperability of Communications Among Health Care Providers to Improve Quality of Patient Care** policy statements. Because patient data are essential to the success of a value-based payment model, the committee developed an additional policy statement regarding HIT to reiterate the importance of HIT not being a barrier.

12. The committee discussed the importance of continuing education providers and colleges and schools of pharmacy providing education related to value-based payment models.

13. The committee discussed that education, training, and resources should cover all aspects of specific payment models used within value-based payment models. Specifically, the committee recognized that risk-based contracting is an important strategy within value-based payment models that pharmacists need to understand.

14. The committee discussed the existing role of fee-for-service payments as part of existing models in the health care landscape. However, the committee did not address fee-for-service models because it wanted policy statements under this topic to focus on future value-based payment models.

15. The committee recognized the incentive measurements used in the Merit-based Incentive Payment System (MIPS) developed by CMS, Advancing Care Information, which outlines objectives and measures related to HIT services within value-based payment models. The committee discussed the importance of pharmacists' inclusion in the implementation of the following objectives: access to protected health information, electronic prescribing, patient electronic access, coordination of care through patient engagement, health information exchange, and public health and clinical data registry reporting. These objectives and measures are outlined in a Notice of Proposed Rule Making titled "Merit-based Incentive Payment System: Advancing Care Information," a document published by CMS.[2]

16. The committee discussed the concept of pharmacy group practices as a strategy for participation in value-based payment models, but it did not believe this strategy needed a specific policy statement because this concept is still in the early stages of development.

References

1. Optum. *Can Value-Based Reimbursement Models Transform Health Care?* 2013. Available at: https://www.optum.com/content/dam/optum/resources/whitePapers/can-value-base-reimburesment-models-transform.pdf.
2. Centers for Medicare and Medicaid Services. Merit-based Incentive Payment System—Advancing Care Information. Notice of Proposed Rule Making. Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Advancing-Care-Information-Fact-Sheet.pdf.

Pharmacists' Role within Value-Based Payment Models
Background Paper Prepared for the 2016–2017 APhA Policy Committee

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Issue

The American Pharmacists Association (APhA) Board of Trustees has directed the 2016–2017 Policy Committee to recommend policy to the APhA House of Delegates related to pharmacists' role in value-based care models.

Summary of Key Concepts

- An objective recent revision to the U.S. health care system provided health care access to all patients, while also addressing the cost and quality of health care. This approach has provided more opportunities for all health care professionals to better use their knowledge in serving patient health care needs. These changes have led to an increasing need for health care providers of all types to be more involved in the care of patients and assume greater roles and responsibilities.
- The current fee-for-service (FFS) model of health care delivery differs from value-based health care delivery in its overall approach and philosophy, but elements of the FFS model continue to be used in the model transition.
- The Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare and Medicaid Services (CMS) supports the development and testing of innovative health care payment and service delivery models, including value-based care models.
- Certain structural components must be put in place in order to maintain a successful value-based care model. A patient-centered, multidisciplinary approach to care is an important component of value-based health care delivery.
- Pharmacists already serve roles that fit into a value-based health care model. However, acknowledgment of a pharmacist as part of a multidisciplinary team is important in achieving a comprehensive team approach.
- Pharmacists' roles and scope of activities are typically regulated by their respective state board of pharmacy. Optimizing pharmacists' scope of practice in accordance with their training and knowledge is pertinent in adding value to the health care system.
- The Doctor of Pharmacy degree provides the majority of tools necessary to develop roles within value-based care models, and in some instances, additional training may be necessary.
- Patients see pharmacists as trustworthy members of the health care team who can add value to patients' overall health. Gaining the trust and recognition of patients and colleagues rests on pharmacists' demonstration of their value through their actions.
- Pharmacists affect patients' health care outcomes throughout the health care continuum, including the community and inpatient settings. Metrics will always be needed to help define these outcomes regardless of the health care delivery model.

- Currently, value-based care model examples exist where pharmacists are integrated and are serving the needs of their health care system.
- The pharmacy profession is working persistently to develop a comprehensive, structured plan to obtain compensation for the services it provides.

Introduction

The means by which patients access and use health care in the United States is ever expanding. The most significant legislative and regulatory overhauls of the U.S. health care system were the enactment of Medicare and Medicaid in 1965; the Medicare Prescription Drug, Improvement, and Modernization Act on December 8, 2003; the Patient Protection and Affordable Care Act on March 23, 2010; the Health Care and Education Reconciliation Act on March 30, 2010; and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) on April 16, 2015. Overall, expectations for health care systems have shifted to convert from supply-driven systems to patient-centered systems. Within these changes, a major objective has been to provide increased health care access to patients.[1] Pharmacists have always provided specific services to patients. However, the current attempts to increase access to health care have generated opportunities for pharmacists to step up and provide expanded patient care services in a variety of ways. In order for pharmacists to provide additional services, sustainable mechanisms for reimbursement and compensation must be established. Value-based care models have evolved rapidly. However, an outline defining a role for pharmacists and the care they can provide does not exist. This paper will discuss pharmacists' role within value-based care models.

Definitions

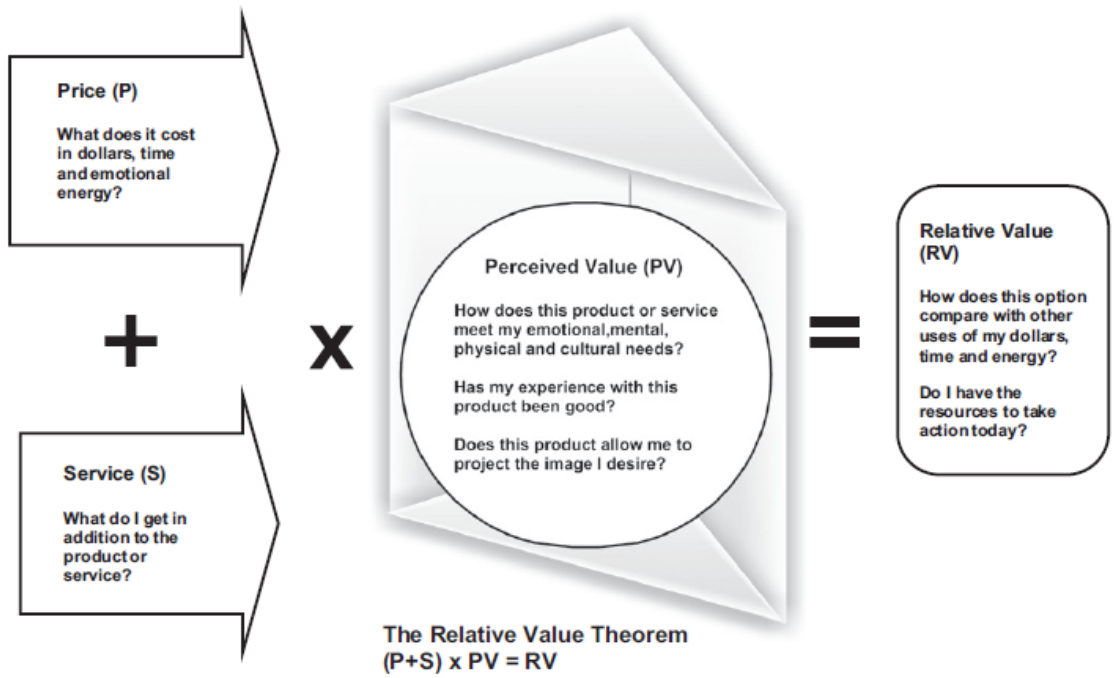
Defining the current health care model, fee-for-service (FFS) and the value-based care model will help define pharmacists' roles in a health care setting. CMS is transitioning away from FFS, the current central payment model in the United States, for physicians and other eligible professionals. Under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), reporting for two separate payment tracks—the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models—will go into effect in 2017. In the FFS model, services are unbundled and paid for separately. Essentially, FFS is a process in which physicians and other health care providers receive payment for each service performed (e.g., tests, laboratory tests, and office visits).[2]

Value-based care can present itself in a variety of models. To define value-based care, one must first consider the definition of *value* in relation to health care as well as the value equation (Value = Outcome/Cost). According to Professor Michael Porter of the Harvard Business School, value is "neither an abstract ideal nor a code word for cost reduction"; however, it "should define the framework for performance improvement in health care." Value is defined as patient health outcomes achieved relative to the costs of care. It is measured by outputs. Value depends on the actual patient health outcomes, not the volume of services provided.[3]

The concepts of value and perceived value have been defined by Zeithaml. She proposed that value is a utility of the consumer's desire to obtain high-quality goods and services that meet the consumer's needs and wants, as well as the sacrifices made by the consumer to obtain those goods and services. These sacrifices are typically a resource such as money (cost). The perceived value is the patient's "overall assessment of the utility of a product based on perceptions of what is received and what is given."[4] Alston

and Blizzard define value as it relates to relative value (RV). RV can be expressed by a mathematical equation: [RV = (P+S) × PV], where P is price, S is service, and PV is perceived value. Figure 1, the Relative Value Theorem, as described by Alston, illustrates a more extensive definition of this concept.[5]

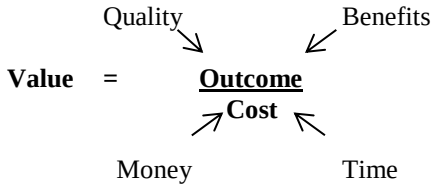
Figure 1. Relative Value Theorem



Source: Reference 5.

In a thriving health care system, value should always be centered on patients. The value equation can be viewed several ways, but the result is the same. Simply, value equals outcome over cost (Figure 2).[3] Outcome, the numerator, takes into consideration a bundle of services that achieve quality and benefits. The outcome is what a patient receives from a health care provider as a result of care. Outcomes are condition specific and multidimensional. Cost, the denominator, refers to the total costs for the full cycle of care for a patient. Cost includes aspects of care such as time, which then relates to efficiency.[1] To increase value, one must increase the outcome (quality and/or benefits), lower the cost (money and/or time), or both. Value-based health care delivery is a model that is centered on patients and their condition and that considers value, not volume. Value should be universally measured and reported. Finally, the reimbursement component should be aligned with value and reward innovation.[6]

Figure 2. Value Equation



Source: Reference 6.

How Do Value-Based Care Models Differ from Fee-for-Service Models?

In the current FFS model of reimbursing providers for health care services, providers and organizations have incentives to do more. The more patients seen, tests ordered, and procedures performed, the more money the provider or organization generates. Sometimes, this model can prove effective. However, a volume-driven model often comes with abundant variation in the number of procedures and tests performed and patients seen. In health care, the FFS model incentivizes physicians to provide more treatments because payment depends on the quantity of care, rather than the quality of care. When patients are shielded from cost sharing by health insurance coverage, they are incentivized to seek any medical service that may do some good. Unfortunately, this course of action can raise costs of health care and discourage the delivery of efficient, effective, coordinated evidence-based care.[7] In this model, as health plans try to control costs, often the compensation for services decreases, causing providers to try to see more patients, thereby spending less time per visit with patients. The result is that quality and continuity of care can suffer, leading to fragmented, inefficient care. Regarding the value equation, this model has the potential to decrease value.

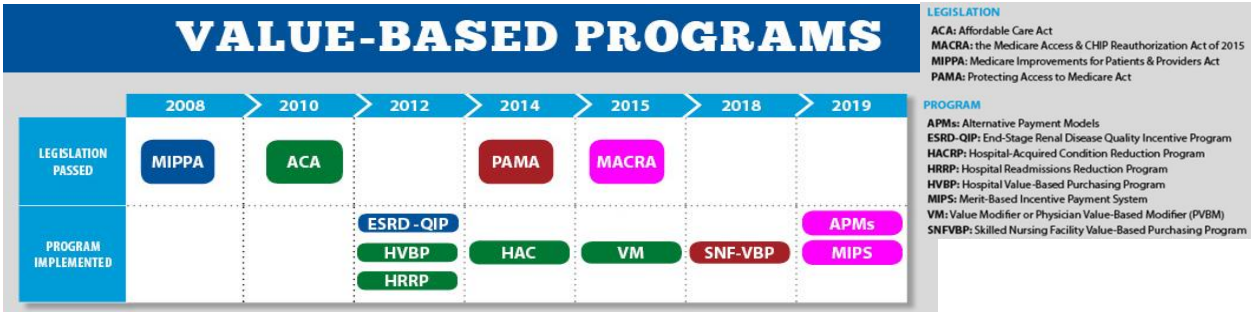
If value-based care models are successful, they can become very attractive to health care providers and organizations because they provide proof of enhanced quality and reduced cost of care. Ideally, quality is one of the most pertinent principles in health care. Patients' ultimate goals are to be treated appropriately (quality) and to become healthy (outcomes). If a health care model is aligned in a way that satisfies patients and providers alike, then health care is moving in the proper direction. For patients, this means safe, appropriate, and effective care with lasting results, at a justifiable cost. For providers, it means using evidence-based medicine with proven treatments and processes while taking into account patients' desires.[8] The value-based care model uses a collaborative approach to treat patients whereby every team member works together for the same goal—making patients better and decreasing the possibility of their becoming sick again.

CMS Guidance for Value-Based Care Models

CMS has initiated programs that are part of the quality strategy to reform how health care is delivered. These programs align the goals of providing better care for individuals, better health for populations, and lower costs.[9–11] The intent is to move provider compensation from FFS to provider compensation based on quality, rather than quantity. CMS initiated four original value-based programs: the Hospital Readmissions Reduction Program (HRRP), the Hospital Value-Based Purchasing Program (HVBP), the Value Modifier (VM), and the Hospital Acquired Condition Reduction Program (HACRP). CMS has also initiated other value-based programs, including the End-Stage Renal Disease Quality Initiative Program (ESRD-QIP), the

Skilled Nursing Facility Value-Based Purchasing Program (SNFVBP), and the Home Health Value-Based Program (HHVBP). See Figure 3 for the timeline for these programs.[12]

Figure 3. Timeline for CMS Value-Based Programs



Source: Reference 12.

Pharmacists' roles within each of these programs will evolve into more direct involvement in patient care and population health. To improve outcomes in the HRRP, pharmacists will need to be involved in patients' transitions of care. This approach will include focusing on management of medications during care transitions, improved coordination of care through communication with all providers involved, enhanced discharge education and follow-up, and the ability to view and document information using a shared electronic medical record to provide continuity of care. To improve outcomes in the HVBP, pharmacists could be involved in the formulary management and in committees outlining specific structures for each organization. The VM program lists physicians, practitioners, and therapists as eligible professionals. The pharmacist can fit into this model by helping providers meet the required quality metrics within the program. Pharmacists could aid in the safety, quality, care coordination, and medication costs of patients seen by each of these health care providers because this program is incorporated under the MIPS. The MIPS is a new program that merges the Physician Quality Reporting System (PQRS), the VM, and the Medicare Electronic Health Record (EHR) incentive program into a single program that measures Eligible Professionals (EPs) on quality, resource use, clinical practice improvement, and meaningful use of certified EHR technology.[13] For 2017, the HACRP has a scoring system for a Total HAC (hospital acquired condition) Score, which is based on data for the six quality measures of Patient Safety Indicator (PSI) 90 Composite, Central Line-Associated Bloodstream Infection (CLABSI), Catheter-Associated Urinary Tract Infection (CAUTI), Surgical Site Infection (SSI)—colon and hysterectomy, Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia, and *Clostridium difficile* Infection (CDI).[14] Pharmacists' roles in this model could include antibiotic susceptibility monitoring, antibiotic stewardship, and outpatient follow-up. Under each of these models, pharmacists are dependent on another provider allowing them to participate and share compensation for the services they provide.

Structuring the Components of a Successful Value-Based Health Care Model

Restructuring the mechanism by which health care is delivered requires defining aspects of care to build structure and accountability within a system. According to the work of Professor Michael Porter of the Harvard Business School, there are several key components to the success of a value-based health care delivery model:[15]

1. Organization of care around patient medical conditions and distinct segments by a multidisciplinary team
2. Measurement and tracking of the health outcomes and the actual cost of care for each patient
3. Reimbursement for the entire care cycle (bundled payments) for medical conditions
4. Integration of care across a network of facilities
5. Geographical expansion of excellent and innovative providers within their areas of expertise and integration of their care across community providers
6. Creation of a reliable information technology platform to support each of these processes

Pharmacists' integration into multidisciplinary teams should add value for patients, providers, and the system. Measuring health outcomes and tracking the cost of care for each patient are relevant to defining roles for a health care provider. Measurement and tracking will help determine exactly where the intervention is needed and also reduce the overlapping of roles and responsibilities of each member of the multidisciplinary team. Bundled payments, or payments for episodes of care, could serve in stimulating each provider to optimize health care outcomes because the provider is responsible for the patient across the continuum of care. In some aspects, bundled payments may also decrease patients' unwillingness or inability to seek care for a health care episode. Integrating a system of communication through shared access of a patient's care enables optimization of care and should decrease medical and medication errors. This integration also should eliminate duplicate work, thereby improving efficiency. Additionally, acknowledging and expanding the use of each provider's expertise should further facilitate a multidisciplinary approach to health care.

Furthermore, a recent study indicated that individual physicians might benefit from understanding the actual costs of care and the specific outcomes achieved by certain patients with certain conditions. Researchers from the University of Utah measured quality and outcomes from 2012 to 2016. In particular, they outlined a strategy based on three essential concepts. First, their business model became value improvement instead of FFS. Second, their work was organized around specific patient conditions. Third, their value improvement effort was driven by the creation of multidisciplinary teams.

In a one-year span from July 1, 2014, to June 30, 2015, researchers measured 1.7 million patient visits and 34,000 inpatient discharges. In their study, they determined that professional costs accounted for 24.3%of total costs for inpatient episodes and 41.9% of total costs for outpatient visits. They also broke down these costs into total direct costs for each specific disease state or health care event (e.g., sepsis, organ transplant, total joint replacement, hospital laboratory testing). Their results are important to consider. For example, for total joint replacement, clinical outcomes were improved while costs declined by 11%. Another example of improvement in quality and efficiency was modification of physical therapists' schedules so that most patients were out of bed or mobile on the day of surgery. This change was associated with a 9.5% decrease in average length of stay. These observations resulted in changes that can help improve the success of a value-based care model. Notably, these outcomes occur when health care teams place emphasis on specific conditions in which patients have similar needs and align a multidisciplinary team to serve the specific

patient or condition.[16] In an editorial, Porter and Lee stated that these "findings offer proof of concept that improving value by patient condition can lead to lower costs and better quality—at the same time."[17] If prescribers and health care systems alike can better understand and align the costs and outcomes involved, they may aid in the integration of a pharmacist on a multidisciplinary team to improve outcomes.

Acknowledgment of a Pharmacist as Part of the Health Care Team

Pharmacists are already providing services within their current roles that should fit the model of a value-based health care delivery model. A key component to creating value and improving outcomes is acknowledgment of a pharmacist as part of the multidisciplinary health care team. Pharmacists serve an essential role in the medication-use process. In this role, they are part of each patient's care in his or her journey throughout a health care event, no matter how small or large. Therefore, a pharmacist has an essential role in a successful value-based care model. As described by The Joint Commission, the medication-use process includes prescribing, dispensing, administering, monitoring, and systems and management control. See Table 1 for details on pharmacists' roles in the medication-use process.[18]

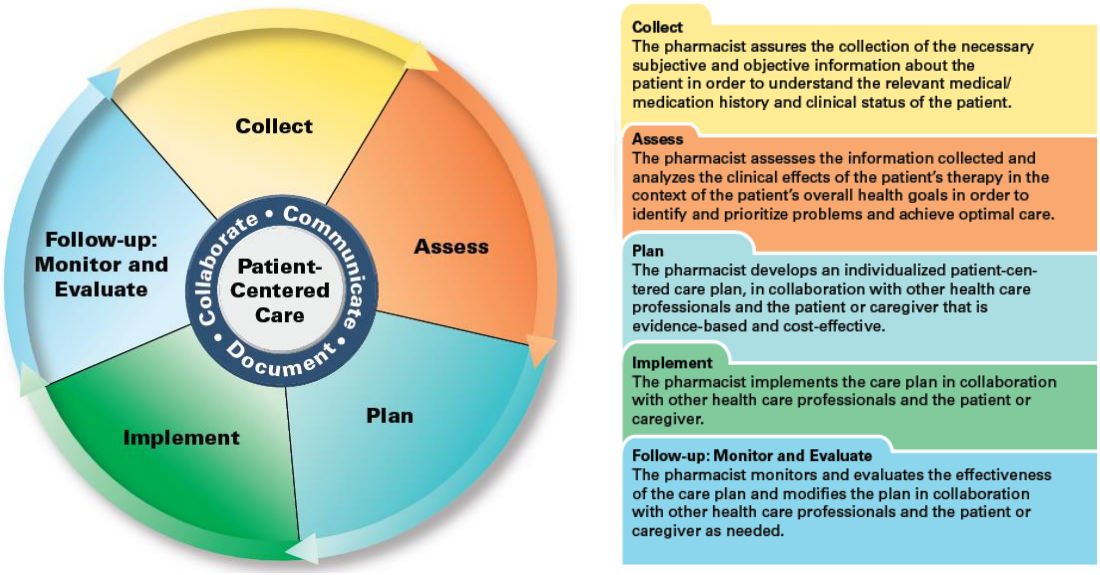
Table 1. Description of the Medication-Use Process

Role	Action
Prescribing	Assessing the need for and selecting the correct drug Individualizing the therapeutic regimen Designing the desired therapeutic response
Dispensing	Reviewing the order for correct dose and indication for use Processing the order Compounding or preparing the drug Dispensing the drug in a timely manner
Administering	Administering the correct medication to the correct patient Administering the medication when indicated Informing the patient about the medication Including the patient in administration
Monitoring	Monitoring and documenting the patient's response Identifying and reporting adverse drug reactions Reevaluating the drug selection, drug regimen, frequency, and duration
Systems and management control	Collaborating and communicating among caregivers Reviewing and managing the patient's complete therapeutic drug regimen

Source: Reference 7.

Additionally, pharmacists are trained to use a patient-centered approach in collaboration with other health care providers to optimize patient health and medication outcomes. See Figure 4 for the Pharmacists' Patient Care Process that provides a framework for delivering patient care in any practice setting.[19]

Figure 4. Pharmacists' Patient Care Process



Source: Reference 19.

In addition to medication-related services through the medication-use process, pharmacists can serve roles in prevention and wellness and chronic condition management. If one considers pharmacists' abilities, training, and expertise, acknowledging a pharmacist as part of a team should serve to add value, decrease cost, and increase efficiency. Overall, outcomes based on metrics will typically be necessary, and pharmacists are already providing services within their current scope of practice that should fit within a value-based health care delivery model.

Pharmacists' Scope of Practice and Educational Training

A pharmacist's scope of practice refers to the boundaries in which one may practice. It is established by state legislatures and typically regulated by the State Boards of Pharmacy. In general, the goals of the Doctor of Pharmacy (PharmD) curriculum are to produce pharmacists who have the abilities and skills necessary to achieve certain outcomes related to health care and to improve patient safety. To afford student pharmacists the opportunity to develop a strong foundation to build on these skills, the curriculum emphasizes several areas of instruction. The American Association of Colleges of Pharmacy (AACP) publishes the Center for the Advancement of Pharmacy Education (CAPE) outcomes, which help define curricular priorities. These educational outcomes include the following:[20]

1. Foundational Knowledge
    a. Life-long learning (Learner)
2. Essentials for Practice and Care
    a. Patient-centered care (Caregiver)
    b. Medication use systems management (Manager)
    c. Health and wellness (Promoter)
    d. Population-based care (Provider)

3. Approach to Practice and Care
    a. Problem solving (Problem Solver)
    b. Educator (Educator)
    c. Patient and health care advocacy (Advocate)
    d. Interprofessional collaboration (Collaborator)
    e. Cultural sensitivity (Includer)
    f. Communication (Communicator)
4. Personal and Professional Development
    a. Self-awareness (Self-aware)
    b. Leadership (Leader)
    c. Innovation and Entrepreneurship (Innovator)
    d. Professionalism (Professional)

Student pharmacists are expected to achieve these outcomes by the end of their professional program.

In order for pharmacists to define and expand their roles in a value-based care model, legal and regulatory aspects also need to be considered. First and foremost, governing agencies and boards (pharmacy and medical) will need to support pharmacists in actively serving a role in a multidisciplinary health care team through scopes of practice that fully reflect their training. Furthermore, a pharmacist's scope of practice can be expanded through collaborative practice authority. Currently, 48 states and the District of Columbia authorize pharmacists to enter into collaborative practice agreements (CPAs) with a prescriber. CPAs expand the services a pharmacist may provide through prescriber delegation of certain functions in accordance with the terms of the agreement.[21]

Pharmacists are already the most accessible health care professionals. They are widespread throughout the nation in both urban and rural settings.[22] Pharmacists' centralized placement in the community and their clinical expertise place them in the ideal position to both educate patients and advocate for the overall systems' health needs.

Pharmacists' Effect on the Value of Services Provided

A pharmacist serves a key role between a prescriber and patients. Typically, to receive medication or medication education, it is necessary for a patient to interact with a pharmacist. Pharmacists can have a significant effect on patient care through medication therapy management, medication reconciliation, monitoring of contraindications and medication overuse, monitoring of patient safety, development of personalized medication care plans, chronic disease state management, establishment of self-management goals, and communication and counseling on the care plan with a patient and others. Typical roles of a pharmacist include screening and early detection for disorders and disease states (e.g., dyslipidemia, hypertension, diabetes), health promotion and disease prevention (e.g., immunization, smoking cessation), medication history and assessment, review and application of evidence-based medication, pharmacotherapeutic interventions (e.g., drug-related problems, initiation, modification, discontinuation, monitoring), documentation, and communication and follow-up. There is clear evidence of value-added pharmacist services in various practice settings dating back several years. This evidence includes increased physician availability, decreased hospitalization rates,[23] medication cost savings,[24] improved quality of care through a more thorough work-up of patients, management of adherence issues,[25] improved treatment outcomes,[26–28] and fewer adverse drug reactions.[29] More recently, a report released by Avalere Health

highlights numerous value-added services by pharmacists, including chronic disease state management, medication reconciliation, preventive care services, educational and behavioral counseling, and collaborative care team-based models.[30] As evidenced by a systematic review of 298 studies in the United States, direct patient care provided by pharmacists demonstrated favorable effects across various patient outcomes, health care settings, and disease states.[31] To advance in a value-based care model, all pharmacists need to promote their services in order to spread awareness to other health care providers and patients.

Pharmacists' Role in the Outpatient and Inpatient Health Care Settings

Pharmaceutical care can be described as the "direct, responsible provision of medication-related care for the purpose of achieving definite outcomes that improve a patient's quality of life."[32] Pharmaceutical care is taught in pharmacy schools and used throughout pharmacists' careers in a variety of ways. Pharmaceutical care should include high-quality, coordinated, and continuous medication management.

The American Society of Health-System Pharmacists has set forth minimum standards for pharmaceutical care services in ambulatory care. These minimum standards include the following:[33]

- Leadership and practice management
- Management of the medication-use process
- Drug product procurement and inventory management
- Patient care
- Preparation, packaging, and labeling of medications
- Medication delivery
- Evaluation of the effectiveness of the medication-use system
- Research

Value-based health care models affect the outpatient setting as well as the inpatient setting. Research suggests that the demand for primary care physicians will increase by 14% from 2010 to 2020. At the same time, the supply of primary care physicians will increase only marginally by 8%.[34] This research clearly acknowledges that a greater demand exists for multidisciplinary, team-based approaches to deliver primary care services.[35] Primary care has been described as the health care setting accountable for addressing the majority of a patient's health care needs. Primary care is often the beginning and the end of the health care cycle. Pharmacists are capable of delivering expanded services through pharmaceutical care in collaboration with other health care providers. In these roles, pharmacists can provide benefits to patients including, but not limited to, valuable access to medication information, prevention and resolution of medication-related problems, improved outcomes, and increased patient satisfaction. Pharmacists' primary responsibility should be to optimize patients' medication regimen in order to improve patient safety and health care outcomes. In doing so, pharmacists should serve a role in each component of the medication-use process. The statement of the American Society of Health-System Pharmacists on a pharmacist's role in primary care demonstrates that in collaboration with a prescriber, pharmacists' roles could include the following:[36]

- Performing patient assessment for medication-related factors
- Ordering laboratory tests necessary for monitoring outcomes of medication therapy
- Interpreting data related to medication safety and effectiveness
- Initiating or modifying medication therapy care plans on the basis of patient responses

- Providing information, education, and counseling to patients about medication-related care
- Documenting the care provided in patients' records
- Identifying any barriers to patient compliance
- Participating in multidisciplinary reviews of patients' progress
- Communicating with payers to resolve issues that may impede access to medication therapies
- Communicating relevant issues to physicians and other team members
- Providing individualized health promotion and disease prevention, including administration of immunizations where authorized
- Performing limited physical assessment and supervising medication therapy with appropriate authority for collaborative drug therapy management

In each role listed above, a pharmacist can provide a wide range of services, from consulting to direct patient involvement. To be a part of value-based care, the service must be proven to be cost-effective with improved outcomes. In the primary care setting, history has demonstrated well-documented cases of value-added services for chronic disease state management services (e.g., asthma, hypertension, dyslipidemia, anticoagulation, dermatology, diabetes, and psychotherapeutics).[37–44]

Additionally, 91%of Americans live within 5 miles of a community pharmacy.[45] Community pharmacists are the most accessible health care practitioners. Their roles in value-based care models include not only traditional medication dispensing but also direct patient care services. Some of these roles are outlined as follows:[46]

- Medication dispensing
- Immunizations
- Wellness and prevention screening
- Medication management
- Chronic condition management
- Patient education and counseling

An overarching role for pharmacists could include helping define a high-risk patient as well as aiding in the management of the high-risk patient population. The role of inpatient–hospital pharmacists in value-based care models includes expanding their roles into a multidisciplinary approach and transitions of care. Inpatient–hospital pharmacists are in an ideal position to help manage a high-risk patient population because this population typically comprises patients with multiple chronic disease states taking multiple medications. The inpatient–hospital pharmacist could play a role in coordination of care by providing thorough education; notifying a patient's primary care clinical pharmacist, community pharmacist, or provider of his or her discharge; and performing thorough medication reconciliation at admission and discharge. Additionally, according to the Centers for Disease Control and Prevention, direct pharmacist involvement is one of the seven core elements of hospital antibiotic stewardship programs. The Centers for Disease Control and Prevention reports the necessity of appointing at minimum a single pharmacist leader as a drug expert responsible for working to improve antibiotic use.[47] Pharmacists' direct involvement in antibiotic stewardship in inpatient and outpatient settings can help decrease costs and improve patient outcomes, thereby increasing value.[48]

Finally, medication reconciliation is extremely important in value-based care models. Pharmacists play an essential role in medication reconciliation in the inpatient and outpatient setting. As stated previously,

value-based care models include a comprehensive team-based approach to care. Medication errors can be better circumvented with pharmacist involvement. Around 60% of medication errors in patient charts occur at transitions of care.[49] Additionally, between 54% and 74% of patients admitted to a hospital may have at least one discrepancy in their admission medication history.[50–54] Pharmacists' roles in medication reconciliation should include, but are not limited to, the following:[55]

- Providing leadership in designing and managing medication reconciliation systems
- Educating patients and health care professionals about the benefits and limitations of the medication reconciliation process
- Providing medication reconcilation and medication management during care transitions
- Serving as patient advocates throughout transitions of care

Value-Based Payment Models: Accountable Care Organizations, Patient-Centered Medical Homes, and Bundled Models

The National Commission on Physician Payment Reform requested a restructuring of physician payment, including eventually rejecting the current FFS payment model in favor of a payment model that rewards value rather than volume. Several care and payment models have evolved from this ideal including, but not limited to, pay-for-performance (PFP), care coordination payments, bundled payments, patient-centered medical homes (PCMHs), and accountable care organizations (ACOs).[56]

Pay-for-Performance

PFP is one of the most rudimentary models of payment reform. Essentially, it is a health care payment model that rewards providers for meeting benchmarks of quality service. This model generates a system that incentivizes health care providers to improve the quality of their services. PFP differs from FFS for all health care providers. For pharmacists specifically, a FFS model rewards production of more units of service such as the number of prescriptions filled. In contrast, the PFP model rewards the quality of those units, such as patient adherence to prescriptions dispensed. In relation to the value equation, cost needs to be considered as well. According to a systematic review on health policy, the "evidence is not convincing" from a cost-effectiveness perspective of PFP.[57] Unfortunately, additional costs are associated with managing and funding rewards. Cost-effectiveness also depends on a variety of factors, including the actual measures used to assess performance, the extent of the performance payments, and the recipients of the rewards.[58]

Care Coordination Payments

CMS and certain private insurers use care coordination payments with some primary care practices. This model combines the FFS payment model with the addition of a small capitation payment. This additional payment is thought to enable resources and incentives for enhanced management of patients with chronic conditions. For example, a primary care office caring for 100 patients with diabetes may render a bill of $40 per patient with diabetes per month. The theory is that the primary care office will use those additional funds to hire a health coach, nurse case manager, or ancillary staff member to aid in coordinating patients' control of their diabetes.[56] In this model, pharmacists placed in primary care practices can use their knowledge and skills in chronic disease state management to increase the value of care for the patient by assisting with care coordination and helping manage patients' diabetes, including their medications. Although pharmacists may not be able to render a bill for their services, this model could enhance the role of a pharmacist by increasing his or her visibility to the health care team and patient, improve the value of

services, and improve the number of services allotted to each patient. It also could create efficiencies in the primary care practice, and incentive payments for meeting quality metrics could contribute to supporting a pharmacist in the practice.

Bundled Payments

The bundled payment model differs considerably from the FFS model. Payments for a health care episode essentially are bundled together into a single payment. As described by CMS's Bundled Payments for Care Improvement Initiative, health care organizations enter into payment arrangements that include financial and performance accountability for episodes of care. For Medicare, these models have the potential to lead to higher quality and more coordinated care at a lower cost.[59] One example would be a bundled payment for a heart failure episode. Substantial evidence shows that patients who experience heart failure are prone to increased hospitalizations as a result of inpatient and outpatient complications and lack of understanding of how to manage the disorder through medications, diet, and lifestyle.[60] Heart failure is one of the most expensive conditions billed to Medicare.[61] All coordinated care of a patient from the time of the event, including admission, to discharge to post-discharge care is bundled together. In this model, all health care stakeholders are equally involved in the care of a patient. A bundled payment model is an opportunity for pharmacists to be involved in and to improve care. Here, pharmacists' roles could be focused on medication reconciliation, medication management, education, and transitions of care.

Patient-Centered Medical Homes

PCMHs are a team-based approach to comprehensive primary care coordinated by a personal physician or other primary care provider. The term *PCMH* encompasses five functions and attributes, including comprehensive care, patient-centered care, coordinated care, accessible services, and quality and safety.[62] Comprehensive care requires a team of health care providers that could include, but is not limited to, prescribers, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators. In the PCMH, pharmacists generally serve a pertinent role in chronic condition management and medication management. Pharmacists also can be instrumental in helping implement evidence-based prescribing guidelines, providing Annual Wellness Visits (AWV) and other preventive services, and helping meet required quality metrics for the practice. Being patient centered means that care is focused on the whole patient and providers work to equip patients with the necessary tools to self-manage and self-organize their care while considering patients' culture and values. Patient-centered care increases relative value by enhancing perceived value. Coordinated, patient-centered care is pertinent to decrease costs, errors, and confusion. Throughout a health care event, patients can experience many transitions of care. Aligning patients with providers helps build a network of communication and trust between the patient and the health care stakeholders. Providing patients with accessible services can decrease wait times and improve patient satisfaction and access to health care. Therefore, improving access should, in theory, improve value. Finally, quality and safety are of utmost importance. Using evidence-based medicine and clinical decision-support tools within a system helps improve performance, health outcomes, and safety and aids in the guidance of shared decision making. Therefore, improving quality and safety should, in theory, improve value.[63] Pharmacists can help improve access to health care and quality and safety by providing their expertise in these areas.

Accountable Care Organizations

As stated previously, comprehensive care aids in value. Regardless of the role of the health care provider, the goal of each care model should be outlined so that the method improves quality and reduces spending, enables the provision of comprehensive care, and maximizes the efficiency of the system within a bundle of care. ACOs are groups of physicians, hospitals, and other health care providers who voluntarily come together to provide coordinated, high-quality care to patients, demonstrating a value-based health care model. ACOs provide the pharmacy profession with the opportunity to optimize the use of medications and to help medication management services evolve into current and future health care models. ACOs focus significantly on population health by addressing gaps in care, developing and managing best practices and quality metrics, and using data analytics to identify high-risk patients in need of care. Pharmacists delivering direct patient care within ACOs focus on transition-of-care services and readmission reduction programs, medication adherence services, and medication management and chronic disease state management services.[64] Pharmacists' roles in ACOs could include quantifying and preventing medication discrepancies and errors, notifying health care providers when prescriptions are filled, minimizing polypharmacy by implementing protocols to eliminate duplicate medications, and participating in direct patient care. Additionally, a pharmacist could aid in formulary management by exploring coverage of providers' services and optimizing the use of the highest-value medications, medication reconciliation, and therapy optimization.

Others

The Part D Enhanced Medication Therapy Management (MTM) model launching through the Center for Medicare and Medicaid Innovation (CMMI) in January 2017 may offer enhanced opportunities for pharmacists as well. Rolling out the model in five regions over a five-year period, CMS will relax current regulatory requirements for Part D MTM, allowing participating plans in those regions to deliver innovative MTM services. The objectives of this program are for stand-alone Part D Prescription Drug Plan sponsors to identify and implement innovative strategies to optimize medication use, improve care coordination, and strengthen system linkages. These strategies should permit individualized health care interventions through a multidisciplinary approach, and pharmacists' roles can align with each incentive.[65]

Medicare also has outlined a value-based insurance design model that is ready to begin operation in January 2017. This model is focused on chronic conditions and should reduce costs for medications and health care services that are considered most effective for chronic conditions. In each of these models, pharmacists' roles could include development and use of clinical pathways based on the most effective treatment through evidence-based medicine. Promotion of ongoing research to monitor outcomes that can involve pharmacists will be needed.[66]

Current Examples of Pharmacists Involved in Value-Based Care Models

At Kannapolis Internal Medicine in Kannapolis, North Carolina, pharmacists have integrated into a PCMH model. Essentially, the pharmacists are involved in a multidisciplinary approach to care in a variety of chronic disease state management models. Their model has been shown to improve value, and some pharmacists are clinical pharmacist practitioners as well. In this model, pharmacists' roles include a collaborative practice approach to care whereby the pharmacists optimize a patient's medication regimen based on the patient's medical conditions. A manuscript by Sheehan et al. illustrates some of the pharmacists' services performed as the main care provider for each chronic disease state, and resulting

effects, with regard to medications for anticoagulation, diabetes, dyslipidemia, metabolic syndrome, hypertension, and chronic obstructive pulmonary disease (COPD). Over a one-year review in 2012, Sheehan et al. noted the following under the pharmacists' services:[67]

- Anticoagulation:
    - Share of INRs (international normalized ratios) in range on warfarin was 74.62% (higher than national average).
    - Time in therapeutic range was 82.95% (higher than national average).
- Diabetes:
    - Share of patients with A1Cs > 9% was 5.25% (lowest percentage in the local physician network).
- Dyslipidemia:
    - Of the 1,391 patients with dyslipidemia and diabetes, 54.43% achieved a low-density lipoprotein (LDL) < 100 mg/dL in 2012.
    - Of the patients with dyslipidemia with coronary artery disease (CAD), 82% achieved an LDL < 100 mg/dL and 43% achieved an LDL < 70 mg/dL in 2012.
- COPD:
    - Of the patients evaluated by the pharmacist, 82% said they experienced overall improvement in their COPD symptoms.
- Metabolic syndrome:
    - Only 6% of patients developed type 2 diabetes.
    - Only 11% of patients were diagnosed with CAD.
    - All patients improved in at least one of the following components: blood pressure, cholesterol, and fasting blood glucose.

Use of this model continues to spread across a variety of chronic disease states. It helps prove that pharmacists serve an integral role in the PCMH model. Also, the team-based approach helps achieve high-quality outcomes.

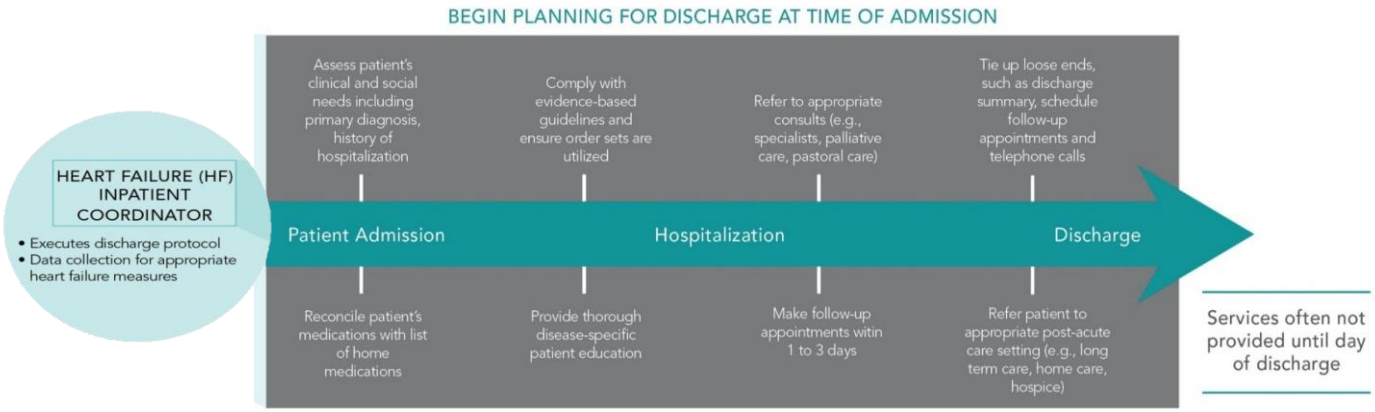
Another type of multidisciplinary approach to care has been demonstrated by the Advanced Heart Failure and Cardiac Transplant Service of the Sanger Heart and Vascular Institute in Charlotte, North Carolina, part of the Carolinas HealthCare System. This team manages several different cardiovascular disorders through a variety of clinic models. These clinic or disease state models all emphasize the same essential aspect of care—a multidisciplinary approach centered on a patient. The staff that assesses the patient includes a physician or advanced clinical practitioner (ACP) (i.e., PA-C or NP), clinical pharmacist, nurse, social worker, dietician, health advocate, and medical office assistant. One clinic is the Heart Success Transition Clinic (HSTC). This is a multidisciplinary team approach model and represents patient care from the beginning of a patient's hospital stay until a minimum of four weeks or visits after their discharge. The nurse navigator identifies patients and enrolls them in the HSTC, follows their progress throughout the clinic, and ensures that the patients have proper follow-up for their condition. The multidisciplinary team assesses a patient at each visit. A pharmacist's roles in this model include, but are not limited to, the following:

- Preparation and work-up of the patient:
    - Pharmacist aids the nurse navigator in his or her roles of inpatient and outpatient evaluation.

- Before the office visit:
    - Pharmacist meets with the ACP to discuss the patient, provide recommendations, and discuss a potential plan.
- During the office visit with the ACP, pharmacist, and nurse, and patient:
    - Pharmacist examines medications and aids in medication reconciliation.
    - ACP and pharmacist collaboratively evaluate a plan based on examination, medication reconciliation findings, and the patient's abilities and wishes.
- After ACP and nurse leave the office visit:
    - Pharmacist discusses and educates the patient on each medication (indication, dosing, monitoring, potential side effects, etc.).
    - Pharmacist aids in insurance and cost-containment management.
    - Pharmacist educates the patient on the medication plan and potential future plan with regard to medications.
    - Pharmacist provides tools necessary for adherence and education (e.g., pill planner, medication bag, pill splitter) and fills a pill planner if necessary.
    - Pharmacist discusses medications to avoid.
- Pharmacist aids in laboratory recommendations before and after each visit, follow-ups, refills, prior authorizations, and in providing any additional information dealing with medications.

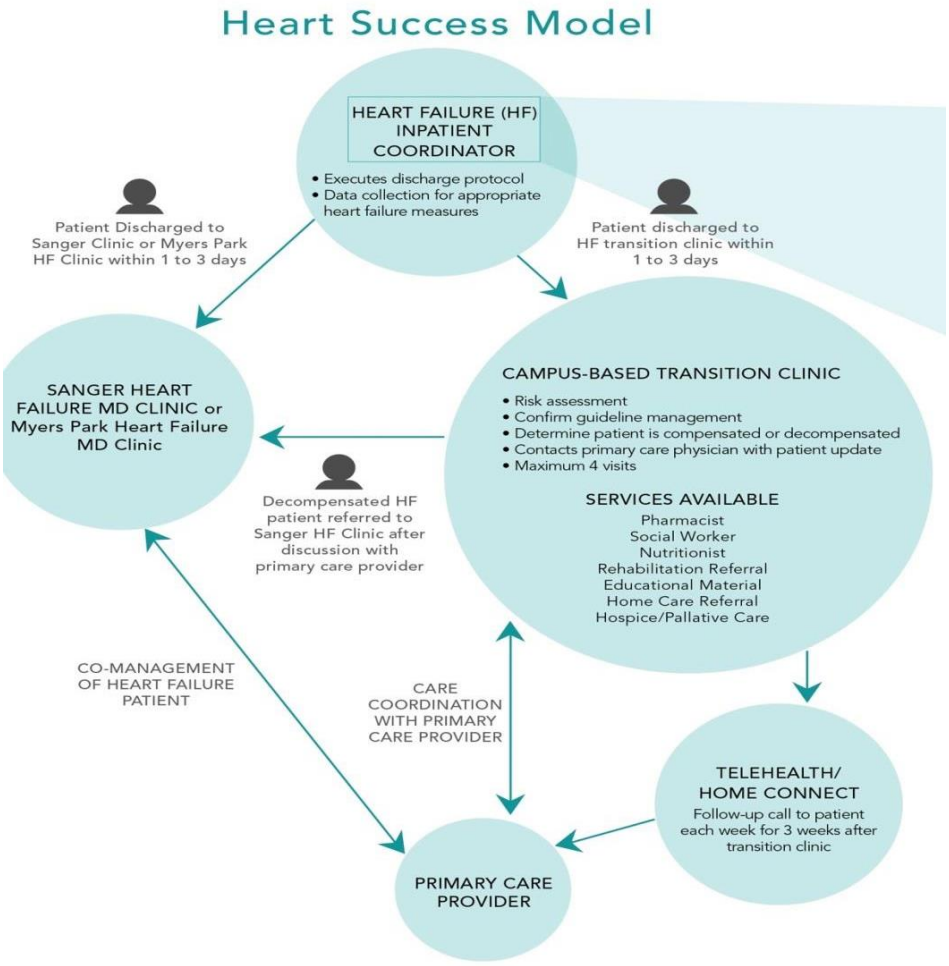
See Figures 5 and 6 for a pictorial description and timeline of the HSTC model by the Sanger Heart and Vascular Institute.[68]

Figure 5. Planning Timeline of Heart Success Transition Clinic



Source: Reference 68.

Figure 6. Description of Heart Success Transition Clinic Model



Source: Reference 68.

The multidisciplinary team of the HSTC model continues to improve patient outcomes as compared to the national average. According to CMS (reporting period of July 2011 through June 2014), the median national average for heart failure readmissions was 21.9%.[69] Table 2 lists the readmission outcome measures for this team's multidisciplinary approach, including its HSTC, Longitudinal Heart Failure and Cardiac Transplant Clinic (HFC/Txplnt), Myers Park Heart Failure Clinic (MPHFC), and noncaptured patients.

Table 2. Readmission Statistics for the Advanced Heart Failure and Cardiac Transplant Services

Statistic	HSTC	HFC/Txplnt	MPHFC	Noncaptured patients	Total
Index admissions	258	271	81	254	864
Readmissions	17	40	13	48	118
Readmission rate (%)	6.6	14.7	16.0	18.9	13.6
Share of index Admissions (%)	29.9	31.3	9.4	29.4	100.0

Source: Reference 69

Furthermore, this clinic also uses a virtual heart success clinic that models the multidisciplinary team clinic approach with the addition of video software, virtual stethoscope hardware and software, and a home health or clinic nurse on the phone line helping assess the patient. The multidisciplinary team virtual clinic has proven value, including the following:

- Time, efficiency, and convenience: savings of > 34,500 miles (travel distance avoided) and > 950 hours for patients and families
- Noncapture rate: < 5% versus 30% at Carolinas Medical Center
- No-show rate: < 2% (Sanger Heart and Vascular Institute–Lincolnton) versus 8–9% at Carolinas Medical Center and Carolinas HealthCare System–Northeast
- All patient satisfaction surveys: top-notch rating
- Clinical facetime: improved to 100% in home
- Ratio of observed-to-expected readmissions: 0.78 (mortality rate 22% lower than expected)

In this multidisciplinary team approach, value-based care is used. In the clinic and virtual settings, pharmacists are not billing specifically for their services. However, readmissions are significantly reduced, and patient outcomes have improved. The clinic uses provider-based billing based on the level of service provided by the physician or the ACP. Although patients are not charged for use of the multidisciplinary team, the contribution margin is increased for the system. Specifically, patients are being monitored more appropriately, the number of diagnostic tests is decreasing and tests are ordered more appropriately, and overall patient outcomes are improved. In general, final revenue can be related to patient outcomes. Clearly, a pharmacist serves many roles from medication reconciliation to education and follow-up in this setting. The pharmacist is able to provide patient care through the scope of practice and cognitive services to help achieve optimal outcomes efficiently. This clinic distinctly shows that value is created with a multidisciplinary team that includes pharmacists' involvement by reducing readmissions and costs, improving patient satisfaction, and improving outcomes.

Moreover, another model that brings together inpatient and outpatient settings is the Carilion Clinic in Virginia. It developed a project (involving one urban and six rural hospitals and 20 primary care practices) that unites hospital pharmacists, community pharmacists, primary care clinical pharmacists, and physicians to improve medication therapy and chronic disease state management for at-risk patients. The care delivery model trains pharmacists in transitions of care and chronic disease state management protocols. The

pharmacists have shared access to electronic medical records and participate in care coordination. This approach enables pharmacists to participate in improving medication adherence and management, ultimately resulting in better health, reduced hospitalizations and emergency room visits, and fewer adverse drug events for patients with multiple chronic diseases. This project is ongoing and helps prove that acute care pharmacists, ambulatory care pharmacists, and community pharmacists can serve major roles within value-based care models.[70]

Challenges and Aspects That May Have Contributed to Lack of Pharmacist Involvement

Pharmacists face several challenges as their roles progress throughout health care evolution. Some of these challenges include building team dynamics, gaining nonintegrated access to medical records, changing the public's perception of the pharmacist, marketing pharmacists' services, delivering patient education, and being reimbursed for services. Building team dynamics is especially important and challenging because an overlapping scope of practice within a multidisciplinary team is likely to occur. However, clarifying roles and responsibilities of each team member will be necessary to enhance the dynamics and improve patient outcomes. Currently, a lack of communication exists between community providers.

Most pharmacists do not have access to patients' medical records or do not share similar electronic medical records. Creating a system of shared access should improve communication and decrease errors. This approach also would aid in developing pharmacists' role in better serving patients.

Additionally, changing the public's perception of pharmacists is particularly important. Pharmacists are already a trusted profession, but likely they are not yet viewed as members of a multidisciplinary team for the public. Marketing pharmacists' services always has been challenging. Pharmacists will need to educate patients and health care providers alike on the vast scope of practice that pharmacists can provide. Pharmacists' extensive expertise providing medication management will improve the prescriber's confidence in pharmacists' providing medication management services outside of the prescriber's office. Patient education is difficult for all providers. For pharmacists, effectiveness of patient education will need to be emphasized, and they will need training throughout school and via professional development. Pharmacists will need to explore different education methods for subjects such as group disease state, medication education visits, and interactive versus didactic education while also considering the varying levels of education and multicultural aspects among patients. Creating a demand for the cognitive services that pharmacists can provide will bring together team dynamics, marketing of pharmacists' services, and patient education alike. The development of demand and the creation of awareness will generate an improved recognition for reimbursement of pharmacists' services.

Future

As the U.S. health care delivery model moves toward value-based care delivery models, pharmacists will need to examine how to enhance their roles. Future directions for pharmacists in value-based care models include identifying representative metrics to measure the quality of care, measuring and documenting pharmacists' effect on longer-term health outcomes, and becoming collaborative providers or prescribers. Gaining trust from other health care colleagues and patients is extremely important for enhancing pharmacists' roles in an ever-expanding health care system. Furthermore, one would expect that expanding the regulatory boundaries of a pharmacist to permit prescriptive authority in collaboration with a physician would add value to a health care system. Finally, as stated by Desselle and Zgarrick, "One of the goals of

value-added services is to receive compensation for services. This means that the patient, insurance company, or some other entity has paid for the direct cost of the service plus the perceived value of that service."[71] Pharmacists and their regulatory counterparts are needed to aid in the development of reimbursement mechanisms for pharmacists' patient care services. Even in a value-based care model, pharmacists' services can be measured and reimbursed through outcomes from the team rather than the individual.

Conclusion

Health care delivery is changing in a way that one hopes will provide pharmacists increased opportunity to add value to the system. Currently, the pharmacy profession is not fully integrated into a health care team so that it could better service the roles outlined in a value-based health care delivery model. A value-based health care delivery model is patient centered, includes a multidisciplinary team, and pays for the value versus volume of care. Typically, metrics will be necessary to measure outcomes, which will include integrating some degree of incentives similar to other health care delivery models. Pharmacists are accessible and trustworthy health care professionals. They have the training, knowledge, and tools to become a direct player in a value-based health care delivery model. Pharmacists are already serving roles that fit into a value-based health care model, and these include more direct patient care opportunities:

- Medication reconciliation
- Medication-use process
- Transitions of care
- Pharmacotherapeutic interventions
- Medication therapy management
- Chronic disease state medication management
- Immunizations
- General health and wellness prevention and screenings
- Patient education and counseling

Acknowledgment of a pharmacist as part of the multidisciplinary team is pertinent to achieving these roles. Support from legal and regulatory bodies is necessary. Pharmacists in each health care setting can serve in roles in a value-based health care model. Michael Porter, professor at Harvard Business School, described a solid foundation of structural components for a successful value-based health care delivery model, and a pharmacist should fit the mold in each of these components. Pharmacists' are responsible for integrating themselves into a value-based health care delivery model and further defining their roles to fit this model. Challenges will need to be overcome, and metrics will need to be measured to improve outcomes. However, pharmacists are already adding value in the roles they serve. Pharmacists are in the ideal place to be directly involved in a value-based health care delivery model.

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Relevant APhA Policies

2011 Pharmacist's Role in Health Care 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)

2013 Ensuring Access to Pharmacists' Services

1. Pharmacists are health care providers who must be recognized and compensated by payers for their professional services.
2. APhA actively supports the adoption of standardized processes for the provision, documentation, and claims submission of pharmacists' services.
3. APhA supports pharmacists' ability to bill payers and be compensated for their services consistent with the processes of other health care providers.
4. APhA supports recognition by payers that compensable pharmacist services range from generalized to focused activities intended to improve health outcomes based on individual patient needs.
5. APhA advocates for the development and implementation of a standardized process for verification of pharmacists' credentials as a means to foster compensation for pharmacist services and reduce administrative redundancy.
6. APhA advocates for pharmacists' access and contribution to clinical and claims data to support treatment, payment, and health care operations.
7. APhA actively supports the integration of pharmacists' service level and outcome data with other health care provider and claims data.

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

2013, 2009 Independent Practice of Pharmacists

1. APhA recommends that health plans and payers contract with and appropriately compensate individual pharmacist providers for the level of care rendered without requiring the pharmacist to be associated with a pharmacy.
2. APhA supports adoption of state laws and rules pertaining to the independent practice of pharmacists when those laws and rules are consistent with APhA policy.
3. APhA, recognizing the positive impact that pharmacists can have in meeting unmet needs and managing medical conditions, supports the adoption of laws and regulations and the creation of payment mechanisms for appropriately trained pharmacists to autonomously provide patient care services, including prescribing, as part of the health care team.

(JAPhANS 49(4):492 July/August 2009)(Reviewed 2012)(JAPhA 53(4):366 July/August 2013)

2013, 2001, 1994 Pharmacist-Patient-Prescriber-Payer Responsibilities in Appropriate Drug Use

1. APhA advocates the following guidelines for pharmacist-patient-prescriber-payer responsibilities in appropriate drug use:

(a) Pharmacists' Responsibilities

- Serve as a drug information resource;
- Provide primary care;
- Collaborate with the prescriber and patient in the design of cost-effective treatment regimens that produce beneficial outcomes;
- Identify formulary or generic products as a means to reduce costs;
- Intervene on behalf of the patient to identify alternate therapies;
- Educate the patient about the treatment regimen and expectations, and verify the patient's understanding;
- Identify, prevent, resolve, and report drug-related problems;
- Document and communicate pharmaceutical care activities;
- Monitor drug therapy in collaboration with the patient and prescriber to ensure compliance and assess therapeutic outcomes;
- Maintain an accurate and efficient drug distribution system; and
- Maintain proficiency through continuing education.

(b) Patients' Responsibilities

- Assume a responsibility for wellness;
- Understand the coverage policies of their benefit plan;
- Share complete information with providers, including demographics and payment mechanism(s);
- Share complete information regarding medical history, lifestyle, diet, use of prescription and over-the-counter medications, and other substances;
- Participate in the design of the treatment regimen;
- Understand the treatment regimen and expected outcomes;
- Adhere to the treatment regimen; and
- Alert prescribers and pharmacists to possible drug-related problems or changes in health status.

(c) Prescribers' Responsibilities

- Assess and diagnose the patient;

- Share pertinent information in collaboration with the pharmacist and patient in the design of cost-effective treatment regimens that produce beneficial outcomes;
- Clearly communicate the treatment plan and its intended outcomes to the patient directly or in collaboration with the pharmacist;
- Remain alert to the possible occurrence of drug-related problems and initiate needed changes in therapy;
- Collaborate with the patient and the pharmacist in drug therapy monitoring; and
- Maintain proficiency through continuing medical education.

(d) Payers' Responsibilities

- Determine the objectives and desired benefits of pharmacy service;
- Design the coverage with patient and provider input using products and services to produce beneficial outcomes;
- Contract with providers on the basis of outcomes and efficient use of resources;
- Adopt efficient, clear, and uniform administrative processes;
- Communicate requirements of compensation for levels of care;
- Educate patients and providers about current eligibility and benefit information;
- Expeditiously process payments; and
- Be responsive to advances in contemporary practice.

(Am Pharm NS34(6):57 June 1994)(JAPhA NS41(5):Suppl.1:S9 September/October 2001)(Reviewed 2008)(Reviewed 2010)(Reviewed 2011)(Reviewed 2012)(JAPhA 53(4):367 July/August 2013)

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)

1994 Product and Payment Systems

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

(Am Pharm NS34(6):56 June 1994) (Reviewed 2005) (Reviewed 2009) (Reviewed 2010)

2016–2017 APhA Policy Committee Report

Pharmacy Performance Networks

The committee recommends that the association adopt the following statements:

1. APhA supports performance networks that improve patient care and health outcomes, reduce costs, use pharmacists as an integral part of the health care team, and include evidence-based quality measures.
   [Refer to Summary of Discussion Items 2, 3, 4, 5, 6.]

2. APhA urges public and private payers to develop transparent and fair reimbursement strategies for medication products separate and apart from performance measurements associated with the provision of pharmacists' patient care services.
   [Refer to Summary of Discussion Items 7, 8, 9, 10, 11, 12.]

3. APhA advocates for prospective notification of evidence-based quality measures that will be used by a performance network to assess provider and practice performance. Further, updates on provider and practice performance against these measures should be provided in a timely and regular manner.
   [Refer to Summary of Discussion Items 12, 13, 14.]

4. APhA supports pharmacists' professional autonomy to appropriately identify and select the interventions that improve evidence-based quality measures within performance networks.
   [Refer to Summary of Discussion Items 15, 16, 17.]

Summary of Discussion

1. The committee first acknowledged APhA's antitrust policies before discussing this topic and developing associated policy statements. The committee inherently did not want to oppose parts of contract negotiations.

2. The committee reviewed the APhA **2011 Pharmacy Practice Accreditation** policy statement on pharmacy practice accreditation and acknowledged that accreditation can be a mechanism for the credentialing process for pharmacy performance networks.

3. The committee discussed that the pharmacy performance network topic should focus on the value of pharmacists and pharmacies in affecting performance in a given network. The committee was not tied to a single definition for *performance network* and determined that coordination of the provider working with the payer to improve outcome measures that affect the Triple Aim (improve outcomes, increase access, decrease cost) was the best focus for these statements.

4. The committee discussed how networks are driven and defined primarily by health plans and/or pharmacy benefit managers, but noted that nothing precludes pharmacies or pharmacists from creating their own performance networks. Pharmacy performance networks could be created by payers, individual practices, or anyone who has a common goal in meeting certain standards.

5. The committee discussed the potential existence of a performance network as part of a larger offering of additional networks for pharmacies as a means to avoid reducing access to patients.

6. The committee discussed that the goal for performance networks related to pharmacy services is to provide adequate patient access to high-quality pharmacists or pharmacies. The committee recognized that performance networks should not be used by a health plan or pharmacy benefit manager to recuperate fees imposed on it by another source.

7. The committee discussed the importance of each practice setting developing and implementing strategies related to performance measures. A pharmacist is the individual who determines what is best for the patient at the setting where services and medications are delivered.

8. The committee discussed the use of compensation versus reimbursement and determined that reimbursement was the most correct choice for this topic.

9. The committee discussed how the quality and performance of a pharmacist or pharmacy is not always related to a medication, and therefore a fee should not be imposed on product reimbursement because of variance in quality and performance. The committee acknowledged that a separate service reimbursement and product reimbursement should exist and that associated fees would be imposed on the respective reimbursement.

10. The committee discussed the current issue surrounding direct and indirect remuneration fees and other fees being imposed on pharmacies. The committee intended to keep the statement broad in order to avoid limiting it to a single type of fee or deduction to a pharmacy when future fees may arise.

11. The committee reviewed the APhA **2004, 1968 Manufacturers Pricing Policies** policy statement as it pertains to the issue of transparency related to pricing.

12. The committee acknowledged that transparency means prospective and retrospective disclosure of information as it applies to the inclusion of specific measures and to the calculation of payment related to performance.

13. The committee discussed that all measures included in performance networks should be evidence based and show improvement in patient outcomes. Although all measures may not always be tied specifically to medication, they should show a pharmacist's effect on total quality and costs of health care.

14. The committee discussed how a standard list of measures should be available for all pharmacy settings and that there would be flexibility in which of these standard measures pharmacies would then be measured and graded upon. The committee reviewed the existing quality measures, including CMS's Accountable Care Organization quality program measures, Pharmacy Quality Alliance–developed measures, measures used within the Comprehensive Primary Care Initiative, and measures to be included in the Medicare Access and CHIP Reauthorization Act of 2015.

15. The committee discussed the inclusion of both services and tools and determined that both are important to call out in the policy statement. Some aspects of patient care are more administrative by nature and are included in the term *tool,* whereas *services* includes activities related to cognitive services provided by a pharmacist.

16. The committee acknowledged that *processes* and *clinical interventions* include the Pharmacists' Patient Care Process by the Joint Commission of Pharmacy Practitioners, clinical interventions, documentation tools, and other tools and resources used by pharmacists.

17. The committee specifically used the term *appropriate* to ensure a measure would be used in the same manner that it was developed. The committee discussed the process of measure development and identified that use of a measure outside of the scope in which it was scientifically developed is inappropriate. The committee also acknowledged that measures should come with some form of guidance in order to ensure adherence to their scope of effective measurement.

18. The committee discussed the need for the use of quality measures to incentivize continuous quality improvement in the practice setting. The committee reviewed the nature of risk-based payment models and determined that if pharmacists participate in one of these models, then pharmacists need to be willing to risk losing dollars owing to a lack of performance.

19. The committee reviewed the need for pharmacist education, development, and training regarding performance networks, but believed that the important part of this policy topic is transparency. Therefore, a transparent process would result in pharmacists understanding how they are being measured and how any reimbursement would be affected by quality.

Pharmacy Performance Networks

Background Paper Prepared for the 2016–2017 APhA Policy Committee

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2016–2017 APhA Federal Fellow

Issue

The American Pharmacists Association (APhA) Board of Trustees has directed the 2016–2017 Policy Committee to recommend policy issues to the APhA House of Delegates. As described herein, the policy is related to pharmacists' involvement in performance-based networks. The Board's guidance on this topic included, but was not limited to, issues related to (1) direct and indirect remuneration (DIR) fees and the negative implications for the profession and the delivery of care to patients; (2) performance measurement as it relates to pharmacies and pharmacists; (3) contract transparency between pharmacies and other organizations; and (4) potential harm to patients who are unable to choose which pharmacy to use to obtain their medications and patient care services.

Summary of Key Concepts

- The health care payment model is moving from a fee-for-service model to a quality-based payment model providing opportunities for pharmacists to affect quality measures.
- Numerous rating systems, such as the Part D Star Ratings program, have been developed to measure and assess the quality of health care provided to patients.
- Significant gaps still exist in the standardization and implementation of performance metrics in health care.
- A need exists for pharmacist education on current performance measurement, the way to access performance data, and the way such data ultimately affect payment.
- The definition and implementation of DIR fees have changed over time and affect the profitability and viability of community pharmacy operations.
- New legislation and payment models have created opportunities for pharmacists to partner with providers and access alternate funding streams.
- Concern exists about the lack of transparency in pharmaceutical benefit manager (PBM) contracts related to performance and other quality measures and compensation policy.

Background

The Centers for Medicare and Medicaid Services (CMS) defines quality measures as "tools that help measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care."[1] These measures may be referred to as performance measures, star measures, quality metrics, or any other number of names. Regardless of the name used, the goal is the same—to recognize, reward, and improve the quality of the care delivered to patients. Payers across the United States currently use quality measures in performance-based networks to identify and reward high performers and best practices.

The ability to document appropriately the patient care delivered, as it relates to the quality measure, is an essential task in implementing and being compensated for the care provided. Additionally, a clear understanding of what is being measured by the person(s) delivering care and the way it is being evaluated by those paying for the care is needed. Given the multitude of different health care plans that a pharmacy may service, the disparity in the quality metrics being evaluated, and the lack of transparency in some plans as to how the metrics are calculated, tremendous potential exists for a negative effect on pharmacy operations and patient care, which is opposite of the intended purpose articulated by CMS for quality measures.

Pharmacy Profession's Role in Quality Measures

For well over half a century, agencies such as The Joint Commission have been involved in assessing the quality of health care organizations. This assessment affected prestige and accreditation but was not tied directly to funding. Change began in 2003 when The Joint Commission and CMS aligned their quality measures and published a document titled *Specifications Manual for National Hospital Inpatient Quality Measures.*[2] The goal of this process was to minimize data collection efforts for common measures so that these common data could be used to improve the health care delivery processes and provide a mechanism for benchmarking practices. Shortly before this period of time, the National Quality Forum (NQF) had been established and began creation of the quality measurement framework we see today.

NQF was created in 1999 after a presidential commission concluded that an organization was needed to promote and ensure health care quality and patient protection by assessing and measuring health care quality and reporting its findings publicly. NQF is the only consensus-based organization recognized by the Office of Management and Budget. Thus, its endorsed measures are used by federal, state, and private sector organizations to evaluate performance and share information.[3]

The pharmacy profession was not a primary stakeholder in the early discussions on quality. Because of the importance of and need for the pharmacy profession to have a voice in this discussion, the Pharmacy Quality Alliance (PQA) was established in 2006. Its initial focus was "improving health care quality and patient safety through a collaborative, consensus-based process aimed at defining performance measures that focused on appropriate use of medications and pharmacy services."[4] PQA's focus broadened in 2009 as it moved to collaborate more with key stakeholders to improve all processes related to medications. PQA continues to evolve in its staffing, processes, and initiatives. It has a number of notable accomplishments over the past several years: receipt of NQF endorsement of several quality measures; use by CMS of a number of measures for evaluation of Medicare Part D plans; and inclusion as a member organization of the National Priorities Partnership convened by NQF.

The role of PQA continues to grow in effect and importance as quality becomes more and more linked to reimbursement and compensation. The traditional fee-for-service (FFS) payment structure is nearing its end as quality and value move to the forefront. This shift is reflected in PQA's current mission statement: "improve the quality of medication management and use across healthcare settings *with the goal of improving patients' health* through a collaborative process to develop and implement performance measures and recognize examples of exceptional pharmacy quality [emphasis in original]."[5] On a broader

scale, this change is evidenced by the aggressive push of the Department of Health and Human Services (HHS) to move to value-based health care that measures both the quality and the cost of care delivered. HHS outlined its plan in early 2015:

> HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs. This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments.[6]

Star Ratings

With the paradigm shift from using FFS to paying for quality, payers like CMS had to determine how to measure and assess this quality. This assessment is based on a set of predefined performance measures, and, in the case of CMS, measures form the foundation for many different programs, including the Part D Star Ratings Program. Part D prescription drug plans are rated between one and five stars depending on how a plan meets a variety of quality metrics, with five stars being the best.[7] Plans with higher ratings might receive incentives such as better marketing or bonus payments, while poorly performing plans risk being dropped from the CMS contract. One should note that star ratings apply to health plans, not pharmacies, but pharmacies can affect the overall star rating through their services provided to improve patient health and outcomes. Pharmacies that positively affect quality metrics can see benefits such as preferred pharmacy network status, which would allow them to charge lower copays and have access to more patients.[8] Although each plan determines its own metrics for quality, noting that PQA measures account for almost 50% of Part D summary ratings for stand-alone prescription drug programs is important.[7]

Though the star ratings system applies to Medicare only, HHS is soliciting participation from state and commercial plans as well. It hopes to align efforts across government and private sector plans to meet its goals for shifting the payment structure from FFS to performance based. As such, the Health Care Payment Learning and Action Network was established. It is a collaboration between CMS, private payers, employers, consumers, and state programs to support and expand alternative pay models for their programs:[9]

> The Health Care Payment Learning and Action Network will:
>
> - Serve as a convening body to facilitate joint implementation of new models of payment and care delivery,
> - Identify areas of agreement around movement toward alternative payment models and how best to analyze data and report on these new payment models,
> - Collaborate to generate evidence, share approaches, and remove barriers,

- Develop common approaches to core issues such as beneficiary attribution, financial models, benchmarking, quality and performance measurement, risk adjustment, and other topics raised for discussion, and
- Create implementation guides for payers, purchasers, providers, and consumers.[9]

Because this network will be building practice models, shaping collaboration efforts, and developing payment structures, pharmacists and pharmacy organizations absolutely must play a role.

Standardization of Metrics

As stated by PQA's executive director, Laura Cranston, last year, "It is critically important for pharmacists to understand not only what is being measured but also which payers are using the measures. Then, pharmacists can determine what role they can play in delivering point-of-care interventions and services that will help drive safer and more appropriate medication use in a measurable way."[7]

A significant number of quality metrics, with noteworthy variability between them, exist. These differences can be overwhelming to providers and pharmacies alike. This lack of consistency speaks to the need for standardized metrics, and efforts are being made to improve the current environment. An initial step occurred in February 2016, when an agreement was announced between CMS and America's Health Insurance Plans. This agreement outlines seven sets of standardized quality measures across both public and private payers.[10] The focus areas surrounded specialty practice areas of cardiology, gastroenterology, HIV (human immunodeficiency virus) and hepatitis C, medical oncology, obstetrics and gynecology, and orthopedics. However, one of the sets has a much broader scope; it covers accountable care organizations, patient-centered medical homes, and primary care.[11] The overall goal of the agreement is to avoid the costs and confusion inherent in separate systems developed between public and private plans. This collaboration also should help provide more clarity to patients who will now have more information available for comparison shopping in the health care marketplace.

From a pharmacy standpoint, having standard core measures for different services would be helpful. Finding meaningful medication-related measures that matter is the ultimate goal. PQA is performing measure development work in this area and participating in national efforts to create core measure sets. By having a set of standardized metrics, pharmacies and pharmacists can gain insight to identify areas that they might affect, benchmark their performance against high-performing organizations, and seek to improve revenue streams on the basis of actions taken on the data.

Access to Data

Accompanying the movement to more standardized quality metrics is a need to identify the way to gather the data regarding how a particular provider, plan, or pharmacy is meeting the metric. Even just a few years ago, this endeavor was very difficult. Metrics were designed for health plans, not for pharmacies. Additionally, most pharmacists lacked the ability to access data on the metrics being measured by the health plans. This circumstance affected the average community pharmacist's ability to identify areas in which to affect practice and to improve the quality of care provided to patients.

In an effort to address this deficiency, PQA partnered with CECity in 2013 and created Pharmacy Quality Solutions (PQS). Their goal was to create a measurement tool for health plans and pharmacies that is timely, reliable, actionable, and simply understood.[12] PQS's most widely used resource, EQuIPP (Electronic Quality Improvement Platform for Plans and Pharmacies), is a national platform for quality measurement and benchmarking. By serving as a neutral intermediary and aggregating data from multiple health plans and pharmacies, PQS hopes to foster collaboration among health plans, PBMs, and pharmacies. As of October 2015, EQuIPP encompassed prescription claims data for more than 55% of Medicare beneficiaries nationwide and was used in almost 90% of community pharmacies.[13]

One of PQA's early demonstration projects showing the value of such a tool was dubbed "The Pennsylvania Project." The study involved more than 29,000 patients across more than 200 community pharmacies. The pharmacists involved initially received training on quality and the way to interpret quality report cards. The second phase of the project included pharmacists taking action on adherence data reflected in quality reports received in the pharmacies. Pharmacists involved also received training on how to assess adherence using established survey tools as well as access to monthly benchmarking reports from PQS. Adherence was assessed using proportion of days covered (PDC). A PDC of 80% (PDC80), meaning a patient had medication on hand for at least 80% of the expected period, is considered to be the minimal amount of medication needed to achieve the desired clinical outcome.[14] At the end of the one-year pilot, PDC80 increased in the study group, as compared to the control group, ranging from a 3.1% increase in PDC80 for beta-blockers and a 4.8% increase for diabetes medications. As adherence increased, costs decreased. The study results showed an annual decrease of $341 per patient in health care costs for patients on diabetes medication and $241 per patient for those on a statin medication.[14] This pilot study emphasizes the value of the community pharmacist in decreasing overall health care costs, as well as the value of using and tracking quality metrics to improve the overall care of the patient.

Reimbursement Structure

Complicating the pay-for-quality discussion is the current landscape of compensation for pharmacy services in general. Navigating the reimbursement landscape for community pharmacies can be difficult. Medicare, Medicaid, and private plans all use different processes to calculate the reimbursement paid on prescription medications. Average manufacturer price (AMP) is the principle component for drug pricing under Medicaid. CMS then uses this number, along with several weighted factors, to calculate the federal upper limit (FUL), which is the actual number used for Medicaid payment.[15] With the advent of the Affordable Care Act, FUL reimbursement rates for brand name drugs and generic drugs available from multiple manufacturers were reduced. This calculation of lower FUL reimbursement became known as the maximum allowable cost (MAC). An additional variable is the ingredient cost calculation, which is determined by each state's Medicaid program and differs from state to state.[16]

These processes cover (or may not fully cover) only the ingredient cost of the medication being dispensed. A community pharmacy still must address rent, utilities, insurance, payroll, equipment, and patient care services related to the medication product. A dispensing fee comes into play at this point. The dispensing fee should be high enough to cover these expenses while allowing a little room for profit. However, in recent years, this area has seen drastic cuts from state Medicaid programs in their effort to

save dollars. Additionally, the Medicaid dispensing fee varies from state to state and consists of a sizable range of values, further emphasizing the need for consistency in pricing calculations and methodology.[16]

In an effort to increase pricing transparency, CMS issued its final rule for Part D prescription drug benefit programs in May 2015. This rule contained two main provisions that help create transparency. First, Part D drug plans and PBMs are now required to make available to contracted pharmacies their reimbursement rates under MAC pricing standards. Second, these reimbursement rates must be updated every 7 days.[17] These changes went into effect for the 2016 plan year.

At the same time, CMS had planned to publish the final Medicaid AMP-based FULs in July 2015. However, because of concerns from the field regarding the rapid implementation timeline, this publication was delayed. The final AMP-based FULs became effective April 1, 2016, with a 30-day window for states to implement the FULs. CMS provided states 1 year to move to cost-based product reimbursement and make any necessary adjustments to dispensing fees.[18] This approach would provide better updated pricing at the time of dispensing, thereby protecting pharmacists when the AMP-based FUL is actually less than the acquisition cost of the medication.

DIR Fee Issues

CMS established DIR fees to track rebates and other price adjustments affecting the cost paid by the consumer for a given prescription drug. The savings were then passed back to CMS.[19] Apparently, the original intent of this measure was to develop a means to pass PBM savings back to Medicare. However, the definition and application of DIR fees have changed over time. DIR fees now encompass a wide range of definitions and costs that include the pay-to-play cost for a pharmacy to participate in a PBM's network, the adjustment of the MAC and the rate a pharmacy can expect to be reimbursed for a medication, and any adjustments to pharmacy fees (positive or negative) based on quality metrics.[19]

Problems arise with this system because pharmacies have no way to determine what profit, if any, is made at the point of sale. As a general rule, the PBM industry does not publish MAC rates, and it retains the right to change these rates for any reason and at any time.[20] Moreover, most DIR fees are assessed as part of the reconciliation and claims adjudication process, so the additional charges do not appear until several months later. Because of this delay, a pharmacy has extreme difficulty assessing its actual reimbursement rate at the start of a contract, at the dispensing of the prescription, and at the end of the contract term.[21]

On September 29, 2014, CMS published *Proposed Guidance on Direct and Indirect Remuneration (DIR) and Pharmacy Price Concessions* (the Proposed Guidance), revising the definition of the "negotiated price." This negotiated price would be the net of all price concessions and would eliminate possible sponsor manipulation of pharmacy network pricing when DIR fees are added to a year-end report rather than being applied as part of the negotiated price with the pharmacy.[22] These proposed changes were slated to go into effect January 1, 2016. The National Association of Chain Drug Stores and National Community Pharmacists Association have lobbied CMS to require that the calculation of pharmacy reimbursement be reflected in the drug cost reported to CMS. They asserted that this requirement would increase pricing transparency, decrease the complexity of tracking prices, and ensure that pharmacy reimbursement structures were not the cause of increased Medicare costs.[23] Additionally, APhA urged CMS to consider working with health care plans to set reasonable thresholds for DIR fees.[22] Unregulated

fee structures can limit pharmacy participation in Part D programs as pharmacies withdraw from networks with the result being limited patient access to pharmacy services.

The proposed guidance did not go into effect January 1, 2016, and has started gaining the attention of Congress. In June 2016, 30 members of the House of Representatives and 16 members of the Senate signed respective letters to HHS CMS Acting Administrator Andy Slavitt stating their support of the proposed guidance and requesting finalization and implementation of the proposed changes.[24,25] Congress also introduced legislation in early September (H.R. 5951,[26] S. 3308[27]) that would prohibit health care plans from retroactively being able to assess DIR fees on clean claims submitted by pharmacies. If passed, this legislation would allow community pharmacies to know the total cost of the claim at the time of processing.

Alternate Funding Streams

Just as pharmacists are trying to navigate star rating systems and DIR fees, physicians deal with similar challenges in navigating measures by the Physician Quality Reporting System and the Merit-based Incentive Payment System (MIPS). MIPS presents an emerging opportunity for pharmacists to collaborate with providers, increase future revenue streams, and improve overall patient outcomes.

On October 14, 2016, HHS issued its final rule to implement key provisions of the Medicare Access and CHIP Reauthorization Act of 2015. The overarching goal of the act was to align value-based health care delivery with payment models.[28] The final rule outlines a framework for a Quality Payment Program that includes two paths: MIPS and the Advanced Alternative Payment Models (APMs).[28] APMs provide opportunities for pharmacists working with physicians in accountable care organizations and patient-centered medical homes. For the 85% of providers forgoing the APM pathway, opportunities exist for pharmacist collaboration through the MIPS pathway.

MIPS is a pay-for-performance system in which base payments to physicians for services provided to Medicare beneficiaries will be increased or decreased by 4% to 9% annually on the basis of the physician's performance compared with other physicians.[29] Four performance categories will be used to make up the composite performance score to determine payment adjustments: (1) quality of care (replacing the physician quality reporting system); (2) resource use (replacing the cost component of the value-based modifier); (3) clinical practice improvement activities; and (4) advancing care information (meaningful use of certified electronic health record technology).[29] Pharmacists have the ability to affect both quality of care and clinical practice improvement activities, which encompass 65% of the MIPS weighting scale. This effect can be achieved through diabetic education, comprehensive medication reviews, reduction of hospital readmission, tobacco cessation counseling, and much more.[30] Additionally, opportunities exist to partner with physicians to provide chronic care management and transitional care management services. Many of the services pharmacists provide while assisting with MIPS can also meet the chronic care management standard. These activities justify additional discussions with providers on collaboration.

Contract Transparency and Patient Accessibility

If pharmacies or pharmacists are proactive, understand the metrics being measured, implement a means for data review and action, and establish provider collaborations, they still may find themselves at the mercy of an ambiguous or unclear contract. PBMs have a history of providing limited transparency in how much revenue they generate and whether this revenue is being shared according to terms of the contract.[31] PBMs contend that providing these data will increase administrative costs and prevent PBMs from negotiating the largest rebate possible. However, data from an analysis provided to CMS show just the opposite. From 2006 to 2016, rebates grew from 8.6% to 16.8% despite more stringent transparency requirements for Part D plans.[32]

PBMs continue to leverage their pull and force community pharmacies into some very rapid, difficult decisions. One recent example came at the end of May 2016. Humana sent a letter to pharmacies with a proposed amendment to its 2017 pharmacy provider agreement for the 2017 Part D plan year. In this letter, Humana outlined its plan to withhold a certain sum from every eligible claim that could be "earned back" on the basis of quality performance. From receipt of the letter, pharmacies would have 30 days to opt out or Humana would assume they agreed with the proposal. If a pharmacy decided to opt out, it would no longer be listed as an in-network pharmacy.[33]

On the surface, the offer looked reasonable. A pharmacy that performed well would receive its withheld money. Pharmacies had the opportunity to make an additional amount by hitting the 80th percentile in adherence measures for three classes of drugs. The National Community Pharmacists Association dug deeper and identified concerns with the transparency of the document. First, the money would be taken from every eligible claim, not just those for the classes of drugs affecting the quality measures. Second, Humana lists classes of excluded claims but fails to define or provide examples of any of them. Finally, the letter suggests that any pharmacy hitting the 80th percentile of PDC would receive the withheld money plus the additional money as payback. However, because Humana would assess all pharmacies against each other, pharmacies would need to be in the 80th percentile of all participating pharmacies.[34] This approach would lead to a scenario where all pharmacies in the network would be performing at the 80th percentile for PDC, yet only 20% of them would receive the full reimbursement and the rest potentially would lose money per claim.

These types of contracts place community pharmacies in very difficult positions. Pharmacies must determine whether to accept the terms of a less favorable contract or risk losing a portion of their potential patient base. For patients, these types of contracts cause further contraction of the network and limit their choices of where they can obtain their care.

Model Networks

Although some PBMs and health plans are manipulating performance-based networks in a negative way, others have used this platform to recognize and reward quality pharmacy performance. For instance, Sunflower Health Plan is a state Medicaid program in Kansas. Sunflower Health Plan recognizes that community pharmacies accredited by the Center for Pharmacy Practice Accreditation improve health outcomes and lower health care costs for their patients. Thus, beginning April 1, 2016, Sunflower Health Plan has been paying an enhanced professional fee on every claim paid to a center-accredited pharmacy

within its network.[35] A second example is the Inland Empire Health Plan Pharmacy Pay-for-Performance Plan. Under this plan, Inland Empire Health Plan has partnered with PQS to develop a way to validate the roles of community pharmacies in promoting health care quality and develop a pharmacy payment model for outcome-based medication therapy management services.[36] Under the provisions of this plan, participating pharmacies are assigned a star rating based upon their performance in several quality metrics. All pharmacies that receive a 3-star rating (average) or better receive full reimbursement on their claims. For all pharmacies that excel and meet certain thresholds, an additional bonus payment is made every 6 months on the basis of store volume.[36] This approach shows a process the industry could adopt regarding pay for performance: establish clear metrics up front, provide them to the participating pharmacies, and assess no penalty on pharmacies that meet the metric and reward those that exceed the metric. Ultimately, the higher the quality of care the pharmacies provide, the lower the overall health care costs for the plan.

Conclusion

The advent of value-based care is upon the health care industry. Demonstrating quality is more important now than ever before. With this paradigm shift comes a plethora of opportunities for pharmacists and pharmacies to demonstrate their value at improving patient outcomes and reducing overall health care costs. As a profession, pharmacists must continue to push for transparency in determining both how quality metrics are developed and how pharmacists are compensated for their effect on those metrics.

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Relevant APhA Policies

2011 Pharmacist's Role in Health Care 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)

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)

2013 Ensuring Access to Pharmacists' Services

1. Pharmacists are health care providers who must be recognized and compensated by payers for their professional services.
2. APhA actively supports the adoption of standardized processes for the provision, documentation, and claims submission of pharmacists' services.
3. APhA supports pharmacists' ability to bill payers and be compensated for their services consistent with the processes of other health care providers.
4. APhA supports recognition by payers that compensable pharmacist services range from generalized to focused activities intended to improve health outcomes based on individual patient needs.
5. APhA advocates for the development and implementation of a standardized process for verification of pharmacists' credentials as a means to foster compensation for pharmacist services and reduce administrative redundancy.

6. APhA advocates for pharmacists' access and contribution to clinical and claims data to support treatment, payment, and health care operations.
7. APhA actively supports the integration of pharmacists' service level and outcome data with other health care provider and claims data.
(JAPhA 53(4): 365 July/August 2013)

2012, 2005, 1969 Medicare and Patient Care Service
1. APhA believes that Health care, including the essential component of patient care services, should be made available to as many people as possible in our society through the most economical system compatible with an acceptable standard of quality.
2. APhA should support the Part B mechanism which is the voluntary supplementary medical insurance program financed equally by beneficiaries and the government.
3. APhA should oppose legislation which would restrict the Medicare drug benefit to specific, chronic diseases.
4. APhA should support the inclusion of patient care services under Medicare or any other federal financing mechanism, providing the program is designed to help persons who need it most and is administratively efficient and economical.
(JAPhA NS9:363 July 1969) (JAPhA NS45(5):558 September/October 2005) (Reviewed 2009) (JAPhA NS52(4) 460 July/August 2012)

2004, 1990 Freedom to Choose
1. APhA supports the patient's freedom to choose a provider of health care services and a provider's right to be offered participation in governmental or other third-party programs under equal terms and conditions.
2. APhA opposes government or other third-party programs that impose financial disincentives or penalties that inhibit the patient's freedom to choose a provider or health care services
3. APhA supports that patients who must rely upon governmentally-financed or administered programs are entitled to the same high quality of pharmaceutical services as are provided to the population as a whole.
(Am Pharm NS30(6):45 June 1990) (JAPhA NS44(5):551 September/October 2004) (Reviewed 2010) (Reviewed 2015)

2017 House of Delegates

Report of the New Business Review Committee

Committee Members

Pamela Piotrowski, Chair
Brandi Hamilton
Ronald Nosek
Kimberly Proffer
Garth Reynolds
L. Douglas Ried
Elizabeth Rodman

Ex Officio
Theresa Tolle, Speaker of the House
Michael D. Hogue, Speaker-elect of the House

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

Item No.: 1
Date received: 2/16/2017
Time received: 4:09 PM (EST)

American Pharmacists Association
House of Delegates – San Francisco, CA

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: **Phillip Lawrence**
(Name)

January 4, 2017 **APhA-Academy of Pharmacy Practice & Management**
(Date) **(Organization)**

Subject: Equal Employment Opportunity for Pharmacists

Motion: Move that the 2017 APhA House of Delegates amend the 2012, 1989 Equal Opportunities for Pharmacists policy as follows:

2012, 1989 Equal Rights and Opportunities for Pharmacists, Pharmacy Technicians, and Student Pharmacists

APhA reaffirms its unequivocal support of equal opportunities for professional employment and advancement, compensation, and organizational leadership positions for all pharmacists ~~regardless of~~ and pharmacy personnel. In addition, APhA opposes discrimination against pharmacists, pharmacy technicians, or student pharmacists based on an individual's gender, gender identity or expression, race, color, religion, national origin, age, disability, genetic information, sexual orientation, or any other category protected by federal or state law.

Background:

Currently, no national pharmacy organization includes anti-discrimination language pertaining to sexual orientation AND gender identity or expression in policy. The following organizations have official policies which include statements directed against discrimination or bias in the healthcare workforce and/or education: American Association of Medical Colleges,[1] American Medical Association,[2] the American College of Physicians,[3] the American Academy of Family Physicians,[4] the American Physical Therapy Association,[5] the American Psychological Association,[6] the American Public Health Association,[7] and the American Academy of Pediatrics.[8]

It is important that the revised policy wording include the broad but unique terms: sexual orientation, gender, gender identity and gender expression. Sexual orientation includes someone's emotional, sexual, or romantic attractions to others. While gender refers to attitudes, feelings and behaviors that a culture associates with biological sex, gender identity involves someone's "innermost concept of self as male, female, a blend of both, or neither." It describes how people may refer to themselves and how they perceive themselves whether different or the same as the gender they were assigned at birth. Gender expression is the "external appearance of one's gender identity, usually expressed through behavior, clothing, haircut, or voice," regardless whether one or more of these conforms to socially defined characteristics of male or female.[9]

Although only 30.8% of pharmacy schools have public written statements that include both sexual orientation and gender identity,[10] sex and gender minorities are represented in a wide variety of health professions and professional training programs.[11] Non-inclusive learning environments in the health professions are linked to higher rates of depression and discomfort.[12] Health professions students also cite "fear of discrimination" as one of the most common reasons to not disclose their sexual or gender minority status.[13] In the overall lesbian, gay, bisexual, or transgender (LGBT) populations, two thirds have experienced discrimination in some form due to their sexual orientation or gender identity.[14] Up to 28% of transgender people have experienced verbal harassment, a physical attack, or sexual assault at work, specifically.[15] Other forms of mistreatment at work related to transgender status including but not limited to forced resignation or sharing of private information have been reported by 23% of transgender individuals. Members of the LGBT community in our pharmacies, clinics, colleges, hospitals, and other healthcare settings deserve respect and equal treatment. Part of that process is reaffirming a commitment to fight discrimination in our professional community.

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Current APhA Policy & Bylaws:

2012, 1989 Equal Employment Opportunity for Pharmacists

APhA reaffirms its unequivocal support of equal opportunities for professional employment and advancement, compensation, and organizational leadership position for all pharmacists regardless of gender, race, color, religion, national origin, age, disability, genetic information, sexual orientation, or any other category protected by federal or state law.

(Am Pharm NS 29(7):464 July 1989) (Reviewed 2001) (Reviewed 2007)(JAPhA NS52(4) 459 July/August 2012)

1979 Consideration of the Equal Rights Amendment (Under "Women in Pharmacy" Section)

APhA Supports efforts to assure equal rights of all persons.

(AmPharm NS19(7):60 June 1979) (Reviewed 2009)(Reviewed 2014)

2012, 1991 Recruitment of a Diverse Population into Pharmacy

1. APhA supports a vigorous long term program for the recruitment of a diverse population of student pharmacists into the pharmacy profession.

2. APhA encourages the development and regular updating of comprehensive recruitment materials, directed toward diversity and inclusion, that address such issues as pharmacy career opportunities, financial aid, and educational prerequisites, and that highlight professional diverse role models.

3. APhA encourages national, state, and local association; schools; students; and industry to create a network of pharmacists who would serve as role models for a diverse population of student pharmacists.

4. APhA supports the development of guidelines that assist schools of pharmacy in implementing diversity and inclusion initiatives into student pharmacist recruitment programs.

(Am Pharm NS31(6):28 June 1991) (Reviewed 2001) (Reviewed 2007) (JAPhA NS52(4) 459 July/August 2012)

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

Item No.: 2
Date received: 2/21/2017
Time received: 4:19 PM (EST)

American Pharmacists Association
House of Delegates – San Francisco, CA

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: CDR Heather D. Hellwig, USN
(Name)

2/21/2017
(Date)

U.S. Navy
(Organization)

Subject: Drug Disposal

Motion: Move to adopt the following policy statement,

1. APhA urges pharmacists to expand patient access to secure, convenient, and ecologically responsible drug disposal options, in accordance with the Drug Disposal Act, by implementing disposal programs they deem appropriate for their individual practice sites, patient care settings, and business models in order to reduce the amount of dispensed but unused prescription drug product available for diversion and misuse.

Background:

The National Survey of Drug Use and Health 2010[1] concluded that friends and family are the primary sources of abused opioids. This study reported 55% of persons who reported non-medical use of pain relievers obtained their supply from a family member or friend. The Drug Enforcement Agency has hosted biannual Drug Take-Back events with spurious success. The Drug Disposal Act of 2010 amended the Controlled Substance Act to allow a subset of DEA pharmacy registrants to voluntarily register as authorized collection sites to increase access to secure and convenient disposal locations. Since then, numerous drug disposal options in addition to pharmacy-based receptacles have been made commercially available to end users including, but not limited to, reverse distribution mailing envelopes and drug deactivation and disposal pouches. APhA has endorsed the safe handling and disposal of medication, shared responsibility for the costs of implementing disposal programs, and pharmacists' role in planning and coordinating disposal programs via previous policy statements. However, the profession has never endorsed a statement of the specific role of pharmacists in offering access to disposal programs, nor the specific types of programs that could be offered. To fill this void, some state officials have asked pharmacies to assist in the prevention and treatment of the opioid addiction crisis specifically by registering as collection sites and installing drug take-back receptacles.[2] APhA is in a position to endorse the adoption of policy that advocates for pharmacies to develop and implement programs that best fit their specific environment from a variety of responsible disposal options aimed at increasing patient access to such services. The longer that APhA waits to endorse a variety of

intervention options supported by its own members, the more likely that additional requests and eventual mandates for the implementation of specific options will be submitted from outside the profession.

References:

1. United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality. National Survey on Drug Use and Health, 2010. ICPSR32722-v6. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2015-11-23.
2. December 28, 2016 letter from Secretary of Pennsylvania Department of Drug and Alcohol Programs Gary Tennis to Pennsylvania Pharmacists.

Current APhA Policy & Bylaws:

2013 Medication Take-Back/Disposal Programs

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

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

2009 Medication Disposal

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

(JAPhA NS49(4):493 July/August 2009)(Reviewed 2012)(Reviewed 2013)

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

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

(Am Pharm NS30(6):45 June 1990) (Reviewed 2004) (Reviewed 2007)(Reviewed 2012)

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

Item No.: 3
Date received: 2/21/2017
Time received: 4:19 PM (EST)

American Pharmacists Association
House of Delegates – San Francisco, CA

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: LCDR Patrick Harper
(Name)

02/21/2017
(Date)

U.S. Public Health Service
(Organization)

Subject: On-Label Indication and Medication Safety

Motion: Move to adopt the following policy statement,

1. APhA encourages pharmacists including the indication on prescription labels, using vocabulary appropriate for their unique practice sites and that addresses the needs of their specific patient populations, when such information is included by the prescriber on the prescription order or can be otherwise clearly and accurately discerned per the professional knowledge and judgement of the pharmacist.

2. APhA recognizes that the inclusion of on-label indications may not meet the wants and needs of every patient or may not be appropriate in all patient care situations and further encourages pharmacists' use of best judgement in executing self- or patient-initiated exclusion of on-label indication.

Background:

The Principles of Practice for Pharmaceutical Care, published by the American Pharmacists Association in 1995, supports the need to develop and implement a plan with the patient that "[assures] that the patient has a thorough understanding of the disease and the therapy/medications prescribed in the plan" and is in line with a "patient's level of comprehension[1]." Despite major statutory requirements such as the Omnibus Budget Reconciliation Act (OBRA) of 1990 – which imposes pharmacist counseling obligations, prospective drug utilization reviews, and record-keep rules first applied to Medicaid patients and now found in standard practice -- it is common to find many patients still unsure of the purpose of their medications[2]. "Right indication" has been proposed as the "sixth right" alongside the right patient, drug, dose, time, and route to improve patient safety and meet desired outcomes[3].

Patient knowledge impacts adherence to therapy[4]. Ignorance or misunderstanding of the reason a medication was prescribed has led to prescriber mistrust and refusal to take medication[3,5]. Not only do patients prefer a prescription

label with the indication, but as one of the patient's best source of information about their medication, prescription container bottles with on-label indications provide opportunity to enhance patient care[6-9]. In recognition of this, the United States Pharmacopoeia (USP) published, in November 2012, USP General Chapter <17> on prescription container labeling, stating the label should include a "purpose for use" based on patient preference[9]. As recently as November 2016, the Institute for Safe Medication Practices (ISMP) published agreement that "indications are the missing link connecting patients to their prescribed drugs, and that electronic prescribing systems must incorporate drug indications[10]." Thus, USP and ISMP join many providers, patients, and other key stakeholders in support of the inclusion of indication on prescription labels.

References

1. Principles of Practice for Pharmaceutical Care [Internet].: American Pharmacists Association; 1995 [cited 1/22/2017]. Available from: http://www.pharmacist.com/principles-practice-pharmaceutical-care#top.

2. Omnibus Budget Reconciliation Act of 1990, 1990).

3. Schiff GD, Seoane-Vazquez E, Wright A. Incorporating Indications into Medication Ordering--Time to Enter the Age of Reason. N Engl J Med. 2016 Jul 28;375(4):306-9.

4. Kuntz JL, Safford MM, Singh JA, Phansalkar S, Slight SP, Her QL, et al. Patient-centered interventions to improve medication management and adherence: a qualitative review of research findings. Patient Educ Couns. 2014 Dec;97(3):310-26.

5. Is An Indication-Based Prescribing System in Our Future? [Internet].: Institute for Safe Medication Practices; 2016 [updated November 7, 2016; cited 1/22/2017]. Available from: http://www.ismp.org/newsletters/acutecare/showarticle.aspx?id=1153.

6. Zargarzadeh AH, Law AV. Design and test of preference for a new prescription medication label. Int J Clin Pharm. 2011 Apr;33(2):252-9.

7. Sakharkar P, Zargarzadeh A, Law A. Examining preference of elderly for adding indication to the prescription label (Rx Label). European Journal for Person Centered Healthcare. 2014;2(4):523-32.

8. Burnside NL, Bardo JA, Bretz CJ, Busbee LA, Chrymko MM, Tuttle JA. Effects of including medication indications on prescription labels. J Am Pharm Assoc (2003). 2007 Nov-Dec;47(6):756-8.

9. Key Issue: USP–NF General Chapter Prescription Container Labeling [Internet].: United States Pharmacopoiea; 2012 [updated November 13, 2012; cited 1/22/2017]. Available from: http://www.usp.org/usp-nf/key-issues/usp-nf-general-chapter-prescription-container-labeling.

10. ISMP. Is an Indication-based Prescribing System in Our Future? *ISMP Medication Safety Alert!* 2016 NOV 17.

Current APhA Policy & Bylaws:

2010, 2001 Prescription Order Requirements

1. APhA supports the use of technology to facilitate the transmission of prescription order information from the prescriber to the pharmacist of the patient's choice at no additional cost to the pharmacy.
2. APhA supports the use of technology where appropriate standards for patient confidentiality and prescriber and pharmacist verification are established.
3. APhA supports the transmission of complete prescriber information on or with the prescription order that enables the pharmacist to readily identify and facilitate communication with the prescriber.
4. APhA supports the use of specific instructions with prescription orders. Use of potentially confusing terminology (such as "as directed", unclear use of Latin phrases, confusing abbreviations, etc.) should be avoided.

5. APhA supports the inclusion of the diagnosis or indication for use for which the medication is ordered on or with the transmission of the prescription order by use of standard diagnosis codes or within the directions for use. APhA further supports the inclusion of patient-specific information on or with the prescription order where appropriate.

6. APhA supports public education about the benefits and risks of technological advances in pharmacy practice.

(JAPhA NS41(5):Suppl.1:S8 September/October 2001) (Reviewed 2007)(Reviewed 2009)(Reviewed 2010)(Reviewed 2012)

2012 Medication Verification

APhA encourages including a description of a medication's appearance on the pharmacy label or receipt as a means of reducing medication errors and distribution of counterfeit medications.

(JAPhA NS52(4) 458 July/August 2012)

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APhA2017 MAKING AN IMPACT IN PATIENT CARE
San Francisco, CA | March 24–27
Annual Meeting & Exposition

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

Item No.: 4
Date received: 2/22/2017
Time received: 11:50 AM (EST)

American Pharmacists Association
House of Delegates – San Francisco, CA

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Heather Free, on behalf of the 2017 Policy Review Committee
(Name)

2/22/2017 **(Date)**

District of Columbia Delegation **(Organization)**

Subject: Work Schedules

Motion: We, the members of the Policy Review Committee, urge the 2017 House of Delegates to amend the following policy statement as follows:

2001 Work Schedules

1. APhA supports a work environment in which innovative work schedules are available to pharmacists and encourages employers to allow meal breaks and rest periods.

2. APhA encourages employers to offer benefit packages that provide dependent-care benefits, such as ~~including, but not limited to~~, flexible spending accounts, voucher systems, referral services, on-site dependent care, and negotiated discounts for use of day care facilities, to improve workforce conditions.

Background:

The purpose of this amendment is to provide a list of benefits as an example for employers to include within their dependent-care benefit packages. The original language stated that all of the items listed and others not listed, were to always be included. Smaller pharmacies may not have the capability to adhere to how the original statement was written specifically the on-site dependent care or use of day care facilities. The amendment suggests the items listed as examples of dependent-care benefits to include rather than require their inclusion altogether.

Current APhA Policy & Bylaws:

2012, 2007, 1970 Employment Standards Policy Statement

The employment relationship between pharmacists and their employers must start with the principle that pharmacists have a professional, inherent right to practice in a manner which will engender self-respect in pursuit of their professional and economic objectives.

It is the policy of APhA to further the following basic employment standards:

1. Employers are obligated to respect the professional status, privileges, and responsibilities of employed pharmacists.

2. Employers are obligated to provide working conditions that enhance the ability of employed pharmacists to utilize their full professional capacity in providing patient care service to the public.

3. Employers are obligated to provide employed pharmacists opportunities to increase their professional knowledge and experience.

4. Employers are obligated to fairly compensate employed pharmacists commensurate with their duties and performances. Such compensation should include benefits generally available to other professionals including, but not limited to, vacation, sick leave, insurance plans, and retirement programs.

5. Employed pharmacists are obligated to use their best efforts to further the services offered to the public by their employers.

6. Employed pharmacists are obligated to unhesitantly bring to the attention of their employers all matters which will assist the employers in maintaining professional standards and successful practices.

7. Employed pharmacists are obligated, when negotiating compensation, to consider not only prevailing economic conditions in their community, but also their economic position relative to other health care professionals.

8. Employed pharmacists are obligated to recognize that their responsibility includes not depriving the public of their patient care services by striking in support of their economic demands or those of others.

9. Both employers and employed pharmacists are obligated to reach and maintain definite understandings with regards to their respective economic rights and duties by resolving employment issues fairly, promptly, and in good faith.

It is the policy of APhA to support these basic employment standards by:

1. Encouraging and assisting state pharmacists associations and national specialty associations to establish broadly representative bodies to study the subject of professional and economic relations and to establish locally responsive guidelines to assist employers and employed pharmacists in developing satisfactory employment relationships.

2. Encouraging and assisting state pharmacists associations and national specialty associations to use their good offices, whenever invited, to resolve specific issues which may arise.

3. Assisting state pharmacists associations and national specialty associations to use their good offices, whenever invited, to resolve specific issues which may arise.

4. Assisting state pharmacists associations and national specialty associations to develop procedures for mediation or arbitration of disputes which may arise between employers and employed pharmacists so that pharmacists can call on their profession for such assistance when required.

5. Increasing its activities directed towards educating the profession about the mutual employment responsibilities of employers and employed pharmacists.

6. Developing benefits programs wherever possible to assist employers in providing employed pharmacists with economic security.

7. Continuously reminding pharmacists that the future development and status of pharmacy as a health profession rests in their willingness and ability to maintain control of their profession.

(JAPhA NS10:363 June 1970) (Reviewed 2001) (JAPhA NS45(5):580 September-October 2007)(JAPhA NS52(4) 458 July/August 2012)

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

Item No.: 5
Date received: 2/22/2017
Time received: 1:44 PM (EST)

American Pharmacists Association
House of Delegates – San Francisco, CA

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: LCDR Garrette Martin-Yeboah
(Name)

2/24/17 **U.S. Public Health Service**
(Date) **(Organization)**

Subject: Support for clinically-validated blood pressure measurement devices

Motion: Move that APhA adopt the following statements:

1. APhA supports the use of clinically validated blood pressure measurement devices.
2. APhA supports regulations and peer reviewed clinical validation testing for blood pressure measurement devices.
3. APhA promotes public awareness on accuracy of blood pressure measurement devices.
4. APhA promotes pharmacist involvement in blood pressure monitoring.

Background:

This background information is intended to provide a basis for APhA and other pharmacy organizations to consider joining with international hypertension organizations in calling on the private healthcare sector and governments worldwide to address the issue of inaccurate blood pressure (BP) devices and to advocate for accurate BP measurement to ensure proper patient diagnosis and treatment decisions.

Approximately 18-months ago, the APhA Foundation engaged with the American Medical Association (AMA), Association for the Advancement of Medical Instrumentation (AAMI), American Heart Association (AHA), American Society of Hypertension (ASH), and Canadian Hypertension Education Program (CHEP) to form the Coalition for Accurate Measurement of Blood Pressure (CAMBP) with the intent to develop a publicly available Validated Blood Pressure Device Listing (VDL). This VDL will provide consumers and healthcare professionals with a common point of reference for self-measured, clinical use, and ambulatory blood pressure measurement and is expected to be available through CAMBP efforts in November, 2017.

The APhA Foundation's collaboration with AMA has been based on the three following tenets:

1. Our collective intent is to improve care for the patients who we serve, to improve availability of accurate and objective information for clinical decision making, and to enhance meaningful patient-centered, team-based care.
2. We agree that it is important to communicate effectively about the importance of relying upon standards to assure the public that blood pressure measurements are precise, accurate, and trustworthy.
3. We believe that one of the best ways forward is having medicine and pharmacy work together on a clear, concise, collaborative initiative that presents a united front about the necessity of obtaining and utilizing valid blood pressure measurements in our healthcare delivery system.

The 2016 Centers for Disease Control and Prevention (CDC) publication, *Using the Pharmacists' Patient Care Process to Manage High Blood Pressure: A Resource Guide for Pharmacists*, supported by APhA and AMA also emphasizes the importance of measuring blood pressure accurately.

FDA 510(k) Clearance Issues

First, it's important to understand that the FDA classifies non-invasive BP devices as "low risk", and are therefore "class II", subject to the lesser standard of the FDA 510(k) pathway. This is different from the more rigorous FDA "PMA" pathway for "high risk" medical devices. The differences are described here: http://www.fda.gov/AboutFDA/Transparency/Basics/ucm194468.htm

The 510(k) pathway is fundamentally flawed due to poor US legislation, and there is very little staff within the FDA can do within the confines of US law to ensure the safety and efficacy of devices falling under the purview of the 510(k) program. Reference this 2011 congressional report by the Institutes of Medicine (IOM) that called for legislative action to correct the 510(k) issues in the interest of public health and safety: http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2011/Medical-Devices-and-the-Publics-Health-The-FDA-510k-Clearance-Process-at-35-Years/510k%20Clearance%20Process%202011%20Report%20Brief.pdf

The IOM report outlines the myriad issues concerning the 510(k) program. Please review their comments carefully, including their conclusion:
"The committee concludes that the FDA 510(k) process lacks the legal basis to be a reliable premarket screen of the safety and effectiveness of moderate-risk devices and, furthermore, that it cannot be transformed into one."

From direct experience working with blood pressure device manufacturers, and within standards organizations, and from multiple meetings with the FDA on the specific topic of BP Devices, the following concerns exist about the 510(k) program:

1. **No Transparency:** The public has no access to fundamental information about device performance. The manufacturer has 2 options with their submissions – submit a "Summary" or a "Statement" about the performance testing. The "summaries" posted on the FDA website contain little to no useful data in assessing the quality of the validation study. The "Statement" contains less, and the manufacturers that used the "statement" option are supposed to provide data to individuals asking for such data in a timely manner. As Dr. Alpert discovered in his published survey of kiosk manufacturers such inquiries are generally met with silence. The public can make a freedom of information request of the FDA but this process takes years, and the manufacturer in this case STILL has great flexibly to redact data as they see fit – clearly not a solution.

2. **No Assurance of Independent Testing:** It is common for manufacturers to perform "in-house" clinical testing of BP devices on their employees, by their employees, in the employer setting, with employees drafting the data analysis and submitting the reporting to file, or to the FDA. This raises obvious conflict of interest issues and calls into question the legitimacy of such data. Further, there is no way for the public to know whether a device has been cleared based on independent tests data, or "in-house" test data.

3. **Unclear Standards Applied:** FDA representatives have informed the AAMI Standards committee that the AAMI standard is used as a "guideline" for reviewing data, but that it is at the discretion of the reviewer to make exceptions when applying the standard. It is also possible that other, less rigorous worldwide standards (such as the ESH protocol, which is not recognized by ISO) may be deemed acceptable to certain FDA reviewers.

4. **No Peer Review:** Clinical data are not peer reviewed by experts outside the FDA prior to pre-market approval, and it is unclear the quality of the training nor knowledge of FDA peer reviewers in the highly specialized domain of BP device validation.

5. **Substantial Equivalence (SE):** The SE ruling is the most commonly applied ruling in 510(k) pre-market clearances. Despite the complexities of device algorithms, cuff design variations, module hardware changes, software changes, etc, devices can be cleared with "no testing required" based on a manufacturer claim of substantial equivalence to a predicate device.

6. **Letter to File:** Many manufacturers release re-engineered BP device models under existing 510(k) numbers without making any submission to the FDA under the "letter to file" option. In these instances, there is clearly no supervision and enforcement/inspection is severely lacking.

7. **No Intended Use Enforcement:** In the case of BP Kiosks, many devices have been cleared for which the intended use is "general public", yet the same clearance documents (and the required labelling) make it clear that the devices are not appropriate for large arms (approximately 45% of the US adult population). The 510(k) legislation mandates that if the labeling is accurate the device is legal, and essentially it is up to the public to ensure they are following the labeling instructions (with are generally not visible to the public). During one meeting between concerned citizens and the FDA, the FDA representative stated that they "can't regulate against ignorance". In this case the FDA is essentially clearing the way for off-label use of a BP device on a massive scale. The same is true with many other devices sold in the market that are intended for limited arm sizes.

8. **No Enforcement of False Claims:** Many device manufacturers tout their status as "FDA Approved", which is a false claim implying a much higher standard of validity than the 510(k) ever intended with its industry-friendly premarket approval approach. Devices are not "approved"; they are cleared to be legally marketed. There is apparently no proactive program within the FDA to monitor and enforce such false manufacturer claims.

The multi-layered issues with the 510(k) program indicate the issues are intractable and that small "adjustments" will not reestablish public confidence in the 510(k) ability to ensure the "safe and effective" use of BP devices across the US. Short of a legislative overhaul of the 510(k) program, the best solution will be the implementation of transparent and open device review programs driven through clinical organizations such as the AMA, APhA, AHA, and others. No opaque and secretive device validation and review process will be sufficient to establish the trust of the clinical community. The device validation process must be exposed to the light of public scrutiny. The healthcare stakes are extremely high, and unfortunately the required reform cannot happen with the confines of existing government regulatory framework.

Blood Pressure Kiosk Issues

APhA posted a Facebook page story in May of 2016 (see link below) about a local news reporter investigating the accuracy of in-store blood pressure kiosks. Two of the pharmacists interviewed admitted that they devices were not clinically sound. It seems counter intuitive that APhA does not have a position or policy statement on the appropriate use of clinically validated BP measurement devices by pharmacists.
http://www.ksby.com/story/31846334/ksby-news-investigates-how-accurate-are-in-store-or-at-home-blood-pressure-monitors

APhA should join with international hypertension organizations calling on the private healthcare sector and governments worldwide to address the issue of inaccurate blood pressure (BP) devices. Noting inadequate regulatory control and lack of published evidence for many devices, the authors of the "Position Statement" described below called for immediate action to ensure accurate patient diagnosis and treatment decisions.

Recent position statements on Public-Use Blood Pressure (BP) kiosks from both the American Society of Hypertension (ASH) (2015) and the World Hypertension League (WHL) (2016), warned healthcare providers against the use of clinically questionable, pharmacy-based blood pressure kiosks, many of which are not designed for patients with large arm sizes, and/or which have not been subject to peer-reviewed clinical validation testing. In addition, the FDA has issued a consumer alert, advising the public some BP Kiosk devices, while cleared by the FDA, fail to provide accurate results for many users. Both ASH and WHL indicated that accurate and reliable BP Kiosk options are commercially available, and stated that it is the responsibility of healthcare professionals to make informed and buying decisions in the best interests of their patients.

BP kiosks are located in over 25,000 US pharmacy locations, performing approximately one million BP tests every day. It is critical to the profession of pharmacy that the APhA provide strong leadership on this topic in the interest of patient safety and optimal patient care.

US hypertension leaders view insufficient regulatory oversight as a major impediment to improved blood pressure control rates. Because inaccurate measurement confounds the diagnosis and management of hypertension, it also undermines efforts to reduce incidences of stroke, heart attack, diabetes, and other cardiovascular conditions linked to hypertension.

According to the American Society for Hypertension:

"The Food and Drug Administration (FDA) published a consumer health information bulletin in 2014 referencing the shortcomings of many kiosks and the frequently inaccurate BP values obtained. The FDA recommended to the public that if a person had questions relating to BP kiosks that he/she should ask his/her doctor for advice.

Kiosks are free-standing units. The kiosk has a single-size cuff designed into the unit. The user does not have the opportunity to select a cuff of appropriate size for his/her arm. Blood pressure readings performed with a cuff that is too small for an arm may give erroneously high BP values.

Alpert et al summarized the current arm sizes of United States citizens and stated that the average United States male has an arm circumference of 34.1 cm. For most kiosks, the maximum arm circumference that can fit into the cuff is 33-34 cm. That means almost half of the United States population cannot expect to use those kiosks and obtain an accurate BP reading. In the United States alone, there are over a million kiosk readings done per day. The public health implications of this magnitude of incorrect BP readings being used for diagnosis and management of disease are of serious concern.

Clinicians are often faced with the decision as to whether the occasional in-office reading is an adequate basis for developing or modifying a treatment plan for hypertension or whether out-of-office readings can be reliably substituted to derive an optimized antihypertensive medication regimen. The kiosk approach to BP measurement presents a quandary to both patient and physician if it may not provide reliable information as when the kiosk has not undergone ANSI/AAMI/ISO validation and if an inappropriate size cuff is used, raising management questions.

Blood pressure measurement is not a recreational activity, it is a clinical service that has major implications on clinical decisions and health outcomes. Among other professional organizations recognizing the impact of accurate blood pressure management are the American Medical Association and the American Heart Association. They have joined together to

create Target:BP. This initiative is designed to raise awareness about the dangers of hypertension, and to provide resources to help patients effectively manage their blood pressure.

Dr. Mark Niebylski, CEO of the World Hypertension League (WHL) has stated, "There is a growing global consensus for improved BP device quality. New guidelines in the US call for self-measurement outside the office setting, but patients and providers are unsure what devices can be trusted. The WHL supports urgent regulatory action in the US, and internationally, to address this healthcare issue."

Asked about the role of community pharmacy, Dr. Niebylski added, "Pharmacies have an enormous opportunity to support improved BP control in the US, and to coordinate care with primary care physicians. But as the FDA and multiple clinical organizations have pointed out, recreational and 'gamification' blood pressure kiosks are providing inaccurate readings to millions of Americans. This is unacceptable to the WHL, and the clinical community in general. We urge pharmacies to upgrade into clinically valid BP Kiosk devices so that they can become an integral part of the hypertension care team. This issue goes to the core of professional trust between physicians and pharmacists."

Recreational kiosk companies (those with no clinical accuracy validation) have claimed that their devices generate 'meaningful health data'. How can their blood pressure data be 'meaningful' when the FDA and multiple physician groups have issued warnings about their technology in order to protect patient health? Additionally, millions of pharmacy customers use recreational blood pressure kiosks 'off-label', meaning the cuff is not designed to properly accommodate their large arm size. The situation is dangerous to patients, damages the reputation of the pharmacy profession, and is contrary to the hard-fought efforts of pharmacists nationwide to earn healthcare provider status.

Per the ASH and WHL recommendations, this policy should recommend that pharmacies use blood pressure kiosks that a) have been validated through peer-reviewed clinical trials to be clinically accurate (in accordance with the existing ISO standards), and b) employ a cuff size proven to accommodate at least 95% of the US adult population. In order to maintain their position as trusted health care professionals, pharmacists should not support use of unproven, or "recreational" medical devices in their professional environment or place of business.

Ensuring high standards for blood pressure measurement across the pharmacy profession will increase the trustworthiness of the profession, and will support efforts to contract with payers or providers for hypertension-related clinical services.

In conclusion, kiosk BP values can be of use in the diagnosis and treatment of patients, especially for the diagnosis of hypertension. The physician and patient need to be aware of the validation status, not just FDA clearance, and be knowledgeable about proper cuff size effects on BP measurement accuracy. It is our hope that all kiosk BP manufacturers will undergo independent validation of their devices using AAMI recommendations, or another acceptable standard, to foster confidence in the ability of kiosks to provide BP readings accurate enough to be useful in clinical care management."

References

1.http://onlinelibrary.wiley.com/doi/10.1111/jch.12782/abstract
2.https://www.ash-us.org/documents/files/2015/150422-DOCUMENT-Guide-Public-Use-BP-Kiosks-%283%29.pdf
3.http://onlinelibrary.wiley.com/doi/10.1111/jch.12671/epdf
4. http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm402287.htm

Current APhA Policy & Bylaws:

2016 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.

1991 Mission of Pharmacy

APhA affirms that the mission of pharmacy is to serve society as the profession responsible for the appropriate use of medications, devices, and services to achieve optimal therapeutic outcomes.

(Am Pharm NS31(6):29 June 1991) (Reviewed 2004) (Reviewed 2010) (Reviewed 2015)

2012, 2002, 1964 Health Education: Selection of Pharmacist

APhA supports education of consumers about the importance of selecting their personal pharmacist to assist them in the proper use of all medications and medical devices.

(JAPhA NS4:429 August 1964) (JAPhA NS42(5):Suppl. 1:S62 September/October 2002) (Reviewed 2007)(JAPhA NS52(4) 459 July/August 2012)

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)

2013, 1995 Pharmacists' Role in the Development and Implementation of Evidence-Based Clinical Guidelines

1. APhA advocates direct involvement of pharmacists in the development, evaluation, and implementation of evidence-based clinical guidelines. Well-designed guidelines promote an interdisciplinary team approach to patient care that utilizes pharmacists' expertise in optimizing patient outcomes.

2. APhA believes that evidence-based clinical guidelines should promote optimal patient care built on the best available scientific data. These guidelines should be developed using an interdisciplinary approach and should be evaluated regularly to ensure that they reflect current practice standards.

3. APhA should promote educational programs, products, and services that facilitate the participation of pharmacists in the development, evaluation, and implementation of evidence-based practice guidelines in all practice settings.

4. APhA advocates the use by pharmacists, in all practice settings, of evidence-based practice guidelines for pharmaceutical care built on the best scientific data to optimize patient outcomes. These guidelines should be developed using an interdisciplinary approach and should be evaluated regularly to ensure that they reflect current practice standards.

(Am Pharm NS35(6):37 June 1995) (Reviewed 2003) (Reviewed 2008)(JAPhA53(4):366 July/August2013)

****Phone numbers will only be used by the New Business Review Committee in case there are questions for the delegate who submitted the New Business Item Content.**

New Business Items are due to the Speaker of the House by **February 22, 2017** (30 days prior to the start of the first House session). Consideration of urgent items can be presented with a suspension of the House Rules at the session where New Business will be acted upon. Please submit New Business Items to the Speaker of the House via email at hod@aphanet.org.

APhA2017 MAKING AN IMPACT IN PATIENT CARE
San Francisco, CA | March 24–27
Annual Meeting & Exposition

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

Item No.: 6
Date received: 2/22/2017
Time received: 5:00PM (EST)

American Pharmacists Association
House of Delegates – San Francisco, CA

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: **Starlin Haydon-Greatting**
(Name)

02/12/2017 **Illinois Delegation**
(Date) **(Organization)**

Subject: Pharmacy Technician Education, Training, and Development

Motion: Move to adopt the following policy statements:

1. APhA supports the following minimum requirements for all new pharmacy technicians by the year 2027:
   (a) successful completion of a Pharmacy Technician Accreditation Commission (PTAC) accredited education and training program and
   (b) certification by the Pharmacy Technician Certification Board (PTCB).

2. APhA supports state board of pharmacy regulations that require pharmacy technicians to meet minimum standards of education, training, certification, and recertification. APhA also encourages state boards of pharmacy to develop a phase-in process for current pharmacy technicians.

3. APhA recognizes the important contribution and role of pharmacy technicians in assisting pharmacists and student pharmacists with the delivery of patient care.

4. APhA supports the development of resources and programs that promote the recruitment and retention of qualified pharmacy technicians.

5. APhA supports the development of continuing pharmacy education programs that enhance and support the continued professional development of pharmacy technicians.

6. APhA encourages the development of compensation models for pharmacy technicians that promote sustainable career opportunities.

Background:

The first two statements in this new policy are pulled from existing **2008 Pharmacy Technician Education and Training** and are meant to update the language with current dates, the appropriate accreditation group, and also to include recertification. If this item is adopted then the original statements from 2008 will be addressed by the 2017-18 Policy Review Committee. The new statements 3, 4, 5, and 6 all address the important role of pharmacy technicians and complement existing policy language.

Pharmacy Technicians are an essential to the advancement of pharmacy practice. The role of pharmacy technician is one that requires education, training, and development to best assist in the delivery of patient care. For many years, APhA has supported the advancement of pharmacy technicians and their education, training, and development. As the profession moves and the role of the pharmacist evolves, so will the needs and requirements placed on pharmacy technicians.

Current APhA Policy & Bylaws:

2008 Pharmacy Technician Education and Training

1. APhA reaffirms the 2005/2001/1996 Control of Distribution System policy, which states that APhA supports pharmacists' authority to control the distribution process and personnel involved and the responsibility for all completed medication orders, regardless of practice setting.
2. APhA supports nationally recognized standards and guidelines for the accreditation of pharmacy technician education and training programs.
3. APhA supports the continued growth of accredited education and training programs that develop qualified pharmacy technicians who will support pharmacists in ensuring patient safety and enhancing patient care.
4. APhA supports the following minimum requirements for all new pharmacy technicians by the year 2015:
    a. successful completion of an accredited education and training program and
    b. certification by the Pharmacy Technician Certification Board (PTCB).
5. APhA supports state board of pharmacy regulations that require pharmacy technicians to meet minimum standards of education, training, and certification. APhA also encourages state boards of pharmacy to develop a phase-in process for current pharmacy technicians.

2004, 1996 Technician Licensure and Registration

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

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

Item No. _____
Date received _____
Time received _____

American Pharmacists Association
House of Delegates – San Francisco, CA

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: _____
(Name)

_____ _____
(Date) **(Annual Meeting Contact Number)**

_____
(Organization)

Subject:

Motion:

Background:

Current APhA Policy & Bylaws:

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