

**CURRENT APhA POLICIES
RELATED TO THE
PRACTICE ENVIRONMENT & QUALITY OF WORKLIFE ISSUES**

As adopted by the APhA House of Delegates Through March 2002

EMPLOYER/EMPLOYEE RELATIONS

Employment Issues

2001 Pharmacist Workforce Census

- 1969** 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 to establish funding mechanisms to conduct an ongoing census of pharmacists to establish and track changes in workforce demographics and practice characteristics. (*JAPhA NS41(5) Suppl.1:S8. September/October, 2001*); (*JAPhA NS9:361. July, 1969*)

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 NS41(5) Suppl.1:S8. September/October 2001*)

1977 Employers' Use of Lie Detection Tests

1. Polygraph tests should not be used as a means of pre-employment screening in pharmacies.
2. Polygraph tests should not be used in pharmacies for routine "security" checking of employees.
3. Polygraph tests should not be used in pharmacies in the course of investigations for cause. (*JAPhA NS17:450. July, 1977*)

Productivity Requirements

2001 Employer Requirement: Number of Prescriptions Pharmacist Dispenses

- 1969** APhA opposes workload requirements that stifle professional motivation and prerogatives. (*Reviewed 2001*) (*JAPhA NS9:361. July, 1969*)

Unionization

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 pharmaceutical 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 pharmaceutical care as established by the profession. (*JAPhA 39(4): 447. July/ August 1999; (Reviewed 2001)*)

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

1971 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 39(4):447. July/August, 1999); (JAPhA NS11:273. May, 1971)

1999 *Unionization of Pharmacists*

1970 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 39(4):447. July/August 1999);(JAPhA NS10:353. June, 1970);(Reviewed 2001)*

Working Conditions

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)

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 pharmaceutical care is essential.

2. APhA reaffirms its policy, adopted in 1969, which 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 pharmaceutical care. *(Am Pharm. NS35(6):36. June 1995)*

1994 *Sexual Harassment in the Workplace*

1. APhA is committed to the principle that all work environments and educational settings be free of sexual harassment.

2. APhA recommends all pharmacy practice environments and educational settings have a

written policy on sexual harassment prevention and grievance procedures.

3. APhA recommends that every owner/employer in facilities where pharmacists work institute a sexual harassment awareness education and training program for all employees.

4. APhA adopts the model guidelines on "Sexual Harassment Prevention and Grievance Procedures" as published in the Report of the 1993-94 Policy Committee on Educational Affairs and promotes wide distribution of these.

(AmPharm NS34(6): 55, June 1994)(Reviewed 2001)

1977 *Pharmacy Practice: Professional Judgment*

1. Each pharmacist, regardless of place or style of practice, must be free to exercise individual professional judgment and must have complete authority for those individual professional responsibilities assumed.

2. In cases where group decisions by pharmacists regarding professional matters are indicated, the decision-making process should ensure the opportunity for input by all pharmacists affected by the decisions. *(JAPhA NS17:463, July, 1977); (Reviewed 2001)*

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 pharmaceutical 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 unhesitatingly 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 to the individual sick person includes not depriving the public of their pharmaceutical 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 pharmaceutical 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 pharmaceutical associations and national specialty associations to use their good offices, whenever invited, to resolve specific issues which may arise.
3. Assisting state pharmaceutical associations and national specialty associations to use their good offices, whenever invited, to resolve specific issues which may arise.
4. Assisting state pharmaceutical 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.
10. 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*)

ETHICAL ISSUES

1998 *Pharmacist Conscience Clause*

1. APhA recognizes the individual pharmacist's right to exercise conscientious refusal and supports the establishment of systems to ensure patient's access to legally prescribed therapy without compromising the pharmacist's right of conscientious refusal.
2. APhA shall appoint a council to serve as a resource for the profession in addressing and understanding ethical issues. (*JAPhA 38(4): 417. July/August 1998*)

1997 *Physician Assisted Suicide*

1. Recognizing the diversity of opinions among its members and the public at large on the issue of physician-assisted suicide, the APhA shall support informed decision-making based upon the professional judgment of pharmacists, rather than endorsing a particular moral stance.
2. APhA reaffirms its 1977 policy that states:
Each pharmacist, regardless of place or style of practice, must be free to exercise individual professional judgment and must have complete authority for those individual professional responsibilities assumed.
3. APhA reaffirms its 1977 policy that states:
In cases where group decisions by pharmacists regarding professional matters are indicated, the decision-making process should ensure the opportunity for input by all pharmacists affected by the decisions.

4. APhA opposes laws and regulations that mandate or prohibit the participation of pharmacists in physician-assisted suicide. (*JAPhA NS37(4):459, July/August, 1997*)

1995 *Physician Assisted Suicide*

The American Pharmaceutical Association shall appoint a special committee for the purpose of identifying and outlining the questions and concerns facing the profession of pharmacy within the issue. (*Am Pharm. NS35(6):38, June, 1995*)

1994 *Code of Ethics for Pharmacists*

Preamble

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

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

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

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

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

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

A pharmacist promotes the right of self-determination and recognizes individual self-worth by encouraging patients to participate in decisions about their health. A pharmacist communicates with patients in terms that are understandable. In all cases, a pharmacist respects personal and cultural differences among patients.

IV. A pharmacist acts with honesty and integrity in professional relationships.

A pharmacist has a duty to tell the truth and to act with conviction of conscience. A pharmacist avoids discriminatory practices, behavior or work conditions that impair professional judgment, and actions that compromise dedication to the best interests of patients.

V. A pharmacist maintains professional competence.

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

VI. A pharmacist respects the values and abilities of colleagues and other health professionals.

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

VII. A pharmacist serves individual, community, and societal needs.

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

VIII. A pharmacist seeks justice in the distribution of health resources.

When health resources are allocated, a pharmacist is fair and equitable, balancing the needs of patients and society. (*Adopted by the membership, October 27, 1994*)

1989 *Ethics and Technology*

APhA, in recognition of pharmacists' professional and ethical responsibility to society, endorses the consideration of ethical principles in the design, conduct, and application of scientific research. (*Am Pharm. NS29(1):76. January, 1989*)

1985 *Pharmacist Involvement in Execution by Lethal Injection*

1. APhA opposes the use of the term "drug" for chemicals when used in lethal injections.
2. APhA opposes laws and regulations which mandate the participation of pharmacists in the process of execution by lethal injection. (*Am Pharm. NS25(5):51. May, 1985*)

1963 *Membership Misconduct*

APhA should establish a clear and proper procedure for the handling of any charges of misconduct among pharmacists and that such procedure be recommended as a guideline to the various states for the implementation of similar procedures where they may not now be in existence. (*JAPhA NS3:298. June, 1963*)

LICENSURE, REGISTRATION AND REGULATION

Composition of State Boards of Pharmacy

1972 *Boards of Pharmacy: Consumer Representation*

APhA encourages state pharmaceutical associations to actively seek appointment of lay representation of the public to their respective boards of pharmacy and other health profession licensing and regulatory agencies. (*JAPhA NS12:281. June, 1972*)

Licensure and Registration of Personnel

1997 *Continued Competence Assessment Examination*

1. APhA should develop, in cooperation with other state and national associations, a voluntary process for self-assessing pharmaceutical care competence.
2. APhA opposes regulatory bodies utilizing continuing competence examinations as a requirement for renewal of a pharmacist's license. (*JAPhA NS37(4): 160. July/August 1997*)

1996 *Technician Licensure and Registration*

1. APhA recognizes, for the purpose of these policies, the following definitions;

(a) Licensure: The process by which an agency of government grants permission to 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 (Ref: Credentialing health manpower. U.S. Department of Health, Education and Welfare, July 1977; DHEW publication no. (OS)77-50057). 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. (Ref: Black's Law Dictionary, 5th edition. St.Paul, MN: West Publishing)

2. APhA supports the role of the State Boards of Pharmacy in protecting the public in its interaction with the profession, including the Boards' oversight of pharmacy technicians, through their control of pharmacists and pharmacy licenses.

3. In States where the Board of Pharmacy chooses to exercise some direct oversight of technicians, APhA recommends a registration system.

4. APhA reaffirms its opposition to licensure of pharmacy technicians by statute or regulation. (*JAPhA. NS36(6):396. June 1996*)

1993 *Universal Unique Identifier Numbering System*

APhA supports the development and use of a universal unique identifier numbering system that identifies all health care professionals involved with medication use. (*Am Pharm. NS33(7):56. July, 1993*)

1991 *Development of Internship/Preceptor Guidelines*

1. APhA encourages state boards of pharmacy to review existing internship program objectives and to update or develop quality assurance procedures regarding internship.

2. APhA supports efforts by NABP and national pharmacy associations to identify, review, update, and publish pharmacy internship guidelines as they pertain to all practice environments. (*Am Pharm. NS31(6):28. June, 1991*)

1980 *Reciprocity*

APhA supports systems of reciprocity which recognize a current license issued by any state and eliminate the requirement for pharmacists to maintain active practice licenses in the states of initial licensure. (*Am Pharm. NS20(7):76. July, 1980*)

Licensure, Registration, and Inspection of Facilities

2001 *Regulatory Compliance/Regulatory Burden*

APhA, in conjunction with the Occupational Safety and Health Administration and other appropriate regulators, shall educate employers and employee groups and the public about applicable regulations. APhA supports measures that protect the patient, public and employees from pharmacy conditions that pose a threat to health. (*JAPhA NS41 (5) Suppl. 1:S9. September/October, 2001*)

1985 *Registration of Facilities Involved in the Storage and Issuing of Legend Drugs to Patients*

APhA supports enactment of state and federal laws and regulations which would require registration with the state boards of pharmacy of all facilities involved in the storage and issuing of legend drugs to patients, provided that such registration does not restrict the pharmacist from providing professional services independent of a facility. (*Am Pharm. NS25(5):51. May, 1985*)

1985 *Regulation of Mobile Facilities*

APhA supports enactment of state and federal laws and regulations which would govern the dispensing and issuing of legend drugs from mobile facilities. (*Am Pharm. NS25(5):51. May, 1985*)

1978 *State Boards of Pharmacy/Inspections*

1. APhA supports inspections of pharmacies and peer review of pharmacists that promote high quality pharmaceutical service and thereby serve to improve public health.

2. Routine non-criminal pharmacy inspections should not utilize criminal investigative techniques.

3. All facilities within a state where drugs are dispensed, stored, or offered for sale should be subject to regulation by the board of pharmacy and inspected in the same manner as pharmacies. (*Am Pharm. NS18(8):36. July, 1978*)

1977 *Licensing Boards: Inspection of Pharmacies*

1. Necessary steps, which may include legislation, should be taken at the state level to ensure that all non-criminal inspections of pharmacies are under the direct control of each state board of pharmacy.

2. APhA recommends that the various state boards of pharmacy should require at least a BS degree in pharmacy and licensure as a minimum qualification for employment of pharmacy inspectors and require individuals employed as pharmacy inspectors to regularly update their knowledge of pharmacy practice.

3. NABP should be responsible for development of uniform guidelines and standards for non-criminal inspections of pharmacies. (*JAPhA NS17:456. July, 1977*)

Pharmacy Law and Practice Acts

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 believes that standards of pharmacy practice should reflect the APhA Mission Statement for the Pharmacy Profession. (*Am Pharm. NS31(6):28. June, 1991*)

PHARMACY CRIME AND SECURITY

1982 *Innovative Approaches to Combating Pharmacy Crime*

APhA encourages pharmaceutical associations to work with state legislators in an effort to provide mandatory imprisonment for the theft of controlled substances and the restriction of bail for such crimes. (*Am Pharm. NS22(7):32. July, 1982*)

1980 *Pharmacy Robberies*

APhA supports legislation to provide for a specific federal income tax credit for the purchase and installation of security devices to meet each pharmacy's unique, individual needs for security against robberies and burglaries. (*Am Pharm. NS20(7):62. July, 1980*)

1971 *Security--Pharmacists' Responsibility*

The committee recommends that APhA encourage pharmacists to voluntarily remove all proprietary drug products with potential for abuse or adverse drug interactions from general sales areas and to make their dispensing the personal responsibility of the pharmacist. (*JAPhA NS11: 267. May, 1971*)

PHARMACY PRACTICE

2002 *National Framework for Practice Regulation*

1. APhA supports state-based systems to regulate pharmacy and pharmacist practice.
2. APhA encourages States to provide pharmacy boards:
 - a) adequate resources,
 - b) independent authority, including autonomy from other agencies, and
 - c) assistance in meeting their mission to protect the public health and safety of consumers. (*JAPhA NS42(5) Suppl.1:S60. September/October 2002*)

2002 Professional Practice Regulation

1. APhA encourages the revision of pharmacy laws to assign the responsibility and accountability to the pharmacy license holder for the operations of the pharmacy, including but not limited to quality improvement, staffing, inventory, and financial activities. Further, APhA supports the responsibility and accountability of the pharmacist for dispensing of the pharmaceutical product and for the provision of pharmaceutical care services.
2. APhA encourages the pharmacy license holder to provide adequate resources and support for pharmacists to meet their professional responsibilities, and for pharmacists to utilize the resources and support appropriately and efficiently. APhA encourages state boards of pharmacy to hold pharmacy license holders accountable for failure to provide such adequate resources and support. *(JAPhA NS42(5) Suppl. 1:S60. September/October 2002)*

2001 Administrative Contributions to Medication Error

1. APhA encourages implementation of a standard prescription drug card to improve the dispensing process and encourages the use of technology in this implementation.
2. APhA supports the use of technology to facilitate record-keeping of patient prescription information for third-party audit purposes and regulatory compliance.
3. APhA supports education of the public regarding the responsibility to be informed consumers of their pharmacy benefits provided through third-party plans.
4. APhA encourages third-party plans to provide pharmacies all information necessary for benefits administration in a timely organized manner or to provide access to the information through the Internet or similar technologies at no cost to the pharmacy.
5. APhA supports the distinction of plan management messages (e.g., days' supply limitations or formulary management) from drug utilization review messages (e.g., drug-drug interactions). APhA supports the communication of all plan management options available (e.g., approved formulary alternatives) from the claims processor to the pharmacist.
6. APhA supports the development and use of systems to communicate in-pharmacy drug utilization review messages with on-line claims processing systems to eliminate redundant and/or repetitive messages.
7. APhA encourages the transmission of pre-adjudication drug utilization review messages (i.e., drug utilization review communication between the prescriber and claims processor) to the pharmacist.
8. APhA supports efforts to:
 - (a) improve on-line drug utilization review messages by the establishment of evidence-based criteria to prevent drug related conflicts that have the potential for causing serious harm, and
 - (b) eliminate drug utilization review messages that have questionable or inconsequential impact on patient outcomes. *(JAPhA NS41(5)Suppl. 1:S7. September/October, 2001)*

2001 Automation and Technical Assistance

APhA supports the use of automation for prescription preparation and supports technical and personnel assistance for performing administrative duties and facilitating pharmacist's provision of pharmaceutical care. *(JAPhA NS41(5)Suppl. 1:S8. September/October, 2001)(Reviewed 2001)*

2001 Medication Error Reporting

1. APhA strongly encourages pharmacists' voluntary, non-punitive, and anonymous participation in error reporting at the organizational (pharmacy/institution) level and in other established state and national reporting programs.
2. APhA encourages direct error reporting by the individual(s) involved in the incident to ensure that the most relevant and detailed information is available for evaluation of the

incident and for systems improvement.

3. Error reporting programs should regularly analyze and report information about the leading types and causes of errors reported to their system so that practitioners can utilize this information for systems enhancements and quality improvement.

4. APhA encourages state boards of pharmacy and other responsible entities to consider pharmacists' participation in reporting of errors as a mitigating factor in determining any legal or disciplinary action related to the incident. (*JAPhA NS41(5)Suppl. 1:S8. September/October, 2001*)

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*)

2001 Regulatory Infringements on Professional Practice 1990

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. (*JAPhA NS41(5)Suppl. 1:S9. September/October, 2001*); (*Am Pharm. NS30(6):45. June, 1990*)(Reviewed 2001)

2000 Emergency Contraception

The American Pharmaceutical Association 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*)

2000 Medication Errors

1. APhA, as the national professional society of pharmacists, will work to ensure that pharmacy is the profession responsible for providing leadership in developing a safe, error-free medication use process.

2. APhA supports continuation and expansion of medication error reporting programs.

3. Medication error reporting programs should be non-punitive in nature and allow appropriate anonymity to facilitate error reporting and development of solutions to eliminate error.

4. APhA supports identifying the system-based causes of errors and building systems to support safe medication practice. (*JAPhA NS40(5)Suppl. 1:S8. September/October, 2000*)

2000 Pharmacogenomics

1. Recognizing the benefits and risks of pharmacogenomics and applications of this technology, APhA supports further research and assessment of the clinical, economic and humanistic impact of pharmacogenomics on the health care system. This includes collaboration with other health care system. This includes collaboration with other health care and consumer organizations for information sharing and development of pharmaceutical care processes involving these therapies. Pharmacogenomics is defined as the application of genomic technology in drug development and therapy.

2. APhA supports ongoing vigilance by all individuals and organizations with access to genetic information to maintain the confidentiality of the information.

3. APhA supports the development of educational materials to train and educate pharmacists, pharmacy students, pharmacy technicians, and consumers regarding pharmacogenomics. (JAPhA NS40(5)Suppl.1:S8. September/October, 2000)

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)

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)

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

APhA supports the establishment and enforcement of regulations through Boards of Pharmacy that restrict the use of the words "pharmacy", "drug store", "apothecary" or any other words or symbols of similar meaning or type in signage or the name of a business, in which the practice of pharmacy is conducted. (JAPhA NS37: 460. July/ August 1997) (Reviewed 2002)

1996 Tech-Check-Tech

The American Pharmaceutical Association supports the pharmacists' authority to control the distribution process and the responsibility for all completed medication orders regardless of practice setting. (JAPhA. NS36(6):396. June 1996)

1996 Quality Assurance and Improvement in Pharmacy Practice

1. APhA recommends that all pharmacists incorporate principles and tools available to continually improve the quality of patient care and management activities in their practices.

2. APhA recommends that content on principles and tools available to continually improve the quality of patient care and management practices be incorporated into pharmacy school curricula and into post-graduate education for pharmacists.

3. APhA supports appropriate evaluation and recognition of providers of pharmaceutical care. (JAPhA. NS 36(6):395. June 1996)

1996 Empowerment of Pharmacists as Drug Therapy Managers

1. APhA encourages pharmacists to take an active role in achieving the goals of Healthy People 2000 concerning immunizations, which includes increasing the rate of basic immunization series among children under the age of two to at least 90 percent and increasing the rate of other pediatric and adult immunizations through:

- (a) advocacy,
- (b) contracting with other health care professionals, or
- (c) pharmacists administering vaccines to vulnerable patients.

2. APhA encourages the availability of all vaccines to all pharmacies in order to meet public health needs.

3. APhA supports the compensation of pharmacists for the administration of immunizations and the reimbursement for vaccine distribution.

4. APhA should facilitate the development of programs that educate pharmacists about their role in immunizations in public health. (JAPhA. NS36(6):395. June 1996)

1995 Pharmacists' Role in the Development and Implementation of Disease-Based Clinical Guidelines

1. APhA advocates direct involvement of pharmacists in the development, evaluation, and

implementation of disease-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 disease-based clinical guidelines should promote optimal patient care built upon the best available scientific data. These guidelines should be developed using an interdisciplinary approach and should be evaluated regularly to ensure 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 disease-based practice guidelines in all practice settings.

4. APhA advocates the use by pharmacists, in all practice settings, of disease-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 they reflect current practice standards. (*Am Pharm. NS35(6):37. June, 1995*)

1993 Commitment to Pharmaceutical Care

APhA believes that in order to reform the payment system, individual pharmacists must commit themselves to the provision of pharmaceutical care. (*Am Pharm. NS33(7):54. July, 1993*)

1993 Patient Compliance: Pharmacists' Responsibilities

1. APhA affirms that pharmacists are responsible for assisting patients to become active, informed, decision makers regarding compliance with their prescribed therapeutic plans.

2. APhA will convey to the public, employee benefit managers, third-party payers, and other health care decision makers, the value and cost-effectiveness of the role of the pharmacist in comprehensive medication-use management. (*Am Pharm. NS33(7):55. July, 1993*)

1993 Patient Compliance: Industry Programs

1. APhA supports the development of patient compliance programs that adhere to the principles of pharmaceutical care and are intended to improve the patient's health.

2. APhA should exert a leadership position in a collaborative effort with industry, the medical profession, and other organizations to develop guidelines for patient compliance programs.

3. APhA opposes patient compliance programs that compromise a pharmacist's ability to provide pharmaceutical care to a patient. (*Am Pharm. NS33(7):56. July, 1993*)

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 2001*)

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

APhA believes that it is a responsibility of the pharmacists to take an active role in the selection and use of diagnostic drugs as an integral component in the development and implementation of a patient's therapeutic plan. (*Am Pharm. NS33(7):56. July, 1993*)

1992 Compounding Activities of Pharmacists

APhA affirms that compounding pursuant to or in anticipation of a prescription or diagnostic preparation order is an essential part of health care that is the prerogative of the pharmacist. (*Am Pharm. NS32(6):515. June, 1992*)

1992 Pharmaceutical Care and Medication Distribution Systems

1. APhA endorses the concept of "pharmaceutical care."

2. APhA supports practice environments, technologies, and distribution systems that enhance the pharmacists-patient relationship.
3. APhA encourages those responsible for practice environments without direct patient/pharmacist contact to use methods to enhance communication, face-to-face interaction, and pharmaceutical care.
4. APhA recognizes the value of pharmacists' cognitive services and supports the dissemination of information regarding the value of these services. (*Am Pharm. NS32(6):515. June, 1992*) (*Reviewed 2001*)

1991 *Biotechnology*

APhA reaffirms the pharmacist's traditional authority and responsibility for achieving optimal therapeutic outcomes by assuring appropriate use of all medications, devices, and associated services, including the unique biotechnology-based products. (*Am Pharm. NS31(6):29. June, 1991*)

1991 *Emerging Technologies*

1. APhA supports programs to monitor the development of emerging technologies and their impact on the delivery of pharmaceutical care.
2. APhA supports education of pharmacists regarding emerging technology including their development and impact on the delivery of pharmaceutical care.
3. APhA supports the inclusion of pharmacists in the development and application of the emerging technologies in the delivery of pharmaceutical care. (*Am Pharm. NS31(6):28. June, 1991*)

1991 *Mission of Pharmacy Practice*

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*)

1991 *Pharmaceutical Care and the Provision of Cognitive Services with Technologies*

1. APhA supports the utilization of technologies to enhance the pharmacist's ability to provide pharmaceutical care.
2. APhA believes that the use of technologies should not replace the pharmacist/patient relationship.
3. APhA emphasizes that maximizing patient benefit from technologies depends upon the pharmacist/patient relationship.
4. APhA affirms that the utilization of technologies by pharmacists shall not compromise the patient's right to confidentiality. (*Am Pharm. NS32(6):515. June, 1992*) (*Reviewed 2001*)

1989 *Drug Use Control by Pharmacists for All Prescription Drugs*

1. APhA reaffirms the authority and responsibility of pharmacists in the management and control of all legend drug products, including, but not limited to, radiopharmaceuticals, contrast media, pharmaceutical biotechnology products, and investigational drug products.
2. APhA strongly urges that corporate, government, and health-care organizations recognize and utilize the unique expertise of the pharmacist in the management and control of all legend drug products. (*Am Pharm. NS29(1):66. January 1989*)

1988 *Computerized and/or Automated Pharmacy Systems*

1. APhA endorses the development and application of computer and/or automation technology by pharmacists to enhance pharmacy services.

2. APhA recommends that pharmacists maintain authority and responsibility for drug use control in the utilization of computerized and/or automated pharmacy systems. (*Am Pharm NS28(6):395. June, 1988*)(Reviewed 2001)

1988 Drug Usage Evaluation (DUE)

1. APhA supports drug usage evaluation (DUE) as one element of a quality assurance program for medication use.

2. APhA advocates that DUE must address enhancement of the quality of care as well as the control of costs.

3. APhA advocates pharmacists' participation along with other health care providers and consumers in the development, implementation, and administration of DUE programs.

4. APhA encourages further development of data collection systems to improve the extent and accuracy of DUE programs.

5. APhA maintains that the primary emphasis of DUE intervention should be educational with the goal of positive behavior modification.

1987 Drug Regimen Review (DRR)

1. APhA recognizes that the pharmacist is uniquely qualified to perform drug regimen review in all settings where drug therapy is used.

2. APhA recognizes the pharmacist as the health professional ultimately responsible for drug regimen. (*Am Pharm. NS27(6):422. June, 1987*)

1983 Stocking a Complete Inventory of Pharmaceutical Products

APhA supports the rights and responsibilities of individual pharmacists to determine their inventory and dispensing practices based on patient need, practice economics, practice security, and professional. (*Am Pharm. NS23(6):52. June, 1983*)

1980 Development of the Cost Effectiveness of Clinical Pharmacy Services

APhA should develop programs, tools, and data useful in assessing the cost effective nature and benefits of patient oriented services within all areas of pharmacy practice. (*Am Pharm. NS20(7):77. July, 1980*)

1979 Endorsement of Standards of Practice

APhA endorses the recommended standards of practice resulting from the 1978 APhA/AACP A National Study of the Practice of Pharmacy and recommends that pharmacists voluntarily implement these standards in their professional practices. (*Am Pharm. NS19(7):67. June, 1979*)

1979 Proposal on Drug Regimen Review (DRR) by Pharmacists

1. APhA endorses drug regimen review as an appropriate role for pharmacists in all settings where drug therapy is used.

2. 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*)

1978 Drug Information

The profession of pharmacy has the primary responsibility to foster the development of an organized system for the accumulation and dissemination of drug information and knowledge. (*Am Pharm. NS18(8):42. July, 1978*)

1978 Pharmacists and Ambulatory Patients

APhA should study and develop new methods and procedures whereby pharmacists can

increase their ability and expand their opportunities to provide health care services to ambulatory patients. (*Am Pharm. NS18(8):47. July, 1978*)

1978 *Roles in Health Care for Pharmacists*

APhA supports legislative and judicial actions that confirm pharmacists' professional rights to perform those functions consistent with APhA's definition of pharmacy practice and that are necessary to fulfill pharmacists' professional responsibilities to the patients they serve. (*Am Pharm. NS18(8):42. July, 1978*)

1971 *Drug Storage and Return Goods Policy*

1. The committee recommends that all practitioners and wholesalers provide controlled, room temperature, storage conditions as defined in the official compendia to adequately store drug products.

2. The committee recommends that manufacturers adopt return goods policies that allow the return of drug products even if the expiration date has not yet occurred.

3. The committee recommends that APhA 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*)

PHARMACY TECHNICIANS

1997 *Pharmacy Technician Membership*

APhA should establish a membership category and services for pharmacy technicians. (*JAPhA NS37(4): 460. July/August 1997*)

1996 *Tech-Check-Tech*

The American Pharmaceutical Association supports the pharmacists' authority to control the distribution process and the responsibility for all completed medication orders regardless of practice. (*JAPhA. NS36(6):395. June 1996*)

1996 *Technician Licensure and Registration*

1. APhA recognizes, for the purpose of these policies, the following definitions:
(a) Licensure: The process by which an agency of government grants permission to 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 (Ref: Credentialing health manpower. U.S. Department of Health, Education and Welfare, July 1977; DHEW publication no. (OS)77-50057). 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. (Ref: Black's Law Dictionary, 5th edition. St.Paul, MN: West Publishing)

2. APhA supports the role of the State Boards of Pharmacy in protecting the public in its interaction with the profession, including the Boards' oversight of pharmacy technicians, through their control of pharmacists and pharmacy licenses.

3. In States where the Board of Pharmacy chooses to exercise some direct oversight of technicians, APhA recommends a registration system.

4. APhA reaffirms its opposition to licensure of pharmacy technicians by statute or regulation. (*JAPhA. NS36(6):395. June 1996*) (*Reviewed 2001*)

1971 *Subprofessionals: Functions, Standards and Supervision*

The committee recommends that APhA endorse the use of properly supervised supportive personnel in pharmacy practice as a positive step toward improving the quality and quantity of pharmaceutical services provided by the profession. (*JAPhA NS11:277. May, 1971*)

1966 *Subprofessionals*

The committee would be opposed to any assumption of the pharmacist's professional functions by subprofessionals or technicians. There is a need to determine exactly what these functions are and the relative position of the pharmacy intern. Under no circumstance should a subprofessional program in pharmacy create an individual such as the former "qualified assistant" still practicing in some states. (*JAPhA NS6:332. June, 1966*)

PRESCRIPTIONS AND PRESCRIPTION ORDERS

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. APhA encourages all prescribers to use such technology or to legibly hand print prescriptions.

2. APhA supports the use of technology where appropriate standards for patient confidentiality and prescriber and pharmacist verifications are established.

3. APhA supports the transmission of complete prescriber information on or with the prescription order that enables the pharmacists 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*)

1997 *Red "C" Stamp Regulations*

APhA supports the repeal of laws and rules requiring the red "C" stamp on all hard copy schedule prescriptions. (*JAPhA NS37(4): 460. July/August 1997*)

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 written and verbal 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*)

1993 *Access to Patient Information*

1. APhA supports the right of pharmacists, in all practice environments, to have access to patient-specific information necessary to achieve optimal therapeutic outcomes.

2. APhA encourages the prescriber's assessment of the patient's disease state and desired or intended therapeutic outcome to accompany the prescription order. (*Am Pharm. NS33(7):54. July, 1993*)(Reviewed 2001)

1990 *Facsimile (Fax) Transmission of Prescription Orders*

APhA encourages state boards of pharmacy and DEA to develop regulations governing the use of facsimile devices in pharmacy practice settings, with regard to such issues as verification of source of order, quality of facsimile transmission, and appropriate use with prescription orders for controlled substances. (*Am Pharm. NS30(6):46. June, 1990*) (Reviewed 2001)

1989 *Multiple Copy, Prescription Order Programs*

1. APhA opposes federally mandated, multiple copy, prescription order programs.
2. APhA supports the right of individual states to develop programs to prevent drug abuse and drug diversion. (*Am Pharm. NS29(7):464. July, 1989*)(Reviewed 2001)

1979 *Prescription Transfer Authorization*

- 1978**
1. APhA endorses the FDA view that "the only safe and proper course for a pharmacist who receives a copy of a prescription order (from a patient) is to call the prescribing physician for authorization to renew (dispense) the prescription.
 2. APhA does not endorse the use of written copies of prescription orders as a means of transferring renewal authorizations among pharmacists and holds that copies should serve only as informational documents.
 3. APhA recommends that, where legally permissible, pharmacists utilize a "verbal transfer order" procedure for prescription renewals in necessary situations. A verbal transfer order is a telephone or other verbal communication between two pharmacists by which one pharmacist transfers to another pharmacist a prescriber's prescription order to dispense a prescription drug. This procedure requires that:
 - (a) The receiving pharmacist prepare a transfer document that indicates the location and file number of the original prescription order, the dates of original dispensing and of the most recent dispensing, and the number of valid renewals remaining;
 - (b) The transferring pharmacist mark the original prescription order to indicate to whom a verbal transfer order had been issued, the date of issuance, and the extent of authorization; and
 - (c) The transferring pharmacist apprise the pharmacist receiving the verbal transfer order of pertinent patient medication information.

(*Am Pharm. NS19(7):56. June, 1979; (Am Pharm. NS18(30). July, 1978)*)

RECORD SYSTEMS

1998 *Access and Contribution to Health Records*

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

(*JAPhA 38(4): 417. July/August 1998*)

1996 *Confidentiality of Patient Data*

APhA supports the establishment of uniform national privacy protection standards for personally identifiable health information. These standards should:

- a) include provisions for patients to access and request modification of their health

information, and disclosure of who will have access to the information;
b) establish broad privacy protections for the individual patient without compromising patient care or creating an excessive administrative burden for health care providers; and
c) make a distinction between the clinical information required for communication among health care professionals, and the administrative or financial information required by others (e.g., claims processors and payers).

(JAPhA NS36(6):396. June, 1996)

1994 Confidentiality of Computer-generated Patient Records

APhA, in cooperation with the National Council of Prescription Drug Programs, Inc. (NCPDP), shall encourage the development and implementation of uniform, prescription, computer software standards to prevent unauthorized access to confidential patient records.

(Am Pharm. NS34(6):60. June 1994)

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

1. APhA recognizes that effective drug utilization review (prospective, concurrent, retrospective), as component of pharmaceutical care, depends upon complete and accurate patient information.

2. APhA advocates eliminating the economic and operational obstacles pharmacists encounter when conducting drug utilization review for optimal patient care.

3. APhA supports utilization of universal and comprehensive standards for On-line Realtime Drug Utilization Review (ORDUR).

4. APhA encourages the development of a standardized method of electronic transfer of patient medical data between all health professionals involved in the care of a patient.

(Am Pharm. NS34(6):58. June, 1994)

1993 Documentation

1. APhA encourages development of systems that document problems in patient therapy, the type and intensity of services provided, and the result or outcome of the services.

2. APhA believes that systems of payment and documentation must be compatible with contemporary computer systems used by providers and payers and should emphasize administrative efficiency.

(Am Pharm. NS33(7):54. July, 1993)

1993 Patient Information

1. APhA shall facilitate the development, dissemination, and use of an information system that documents the components of comprehensive medication-use-management services.

2. APhA encourages development of quality assurance standards that guarantee the integrity and accuracy of information included in proprietary information systems.

(Am Pharm. NS33(7):53. July, 1993)

1993 Professional Association-driven Unique Identification System

APhA supports the development of a universal unique identifier numbering system for prescribers that relies on voluntary adoption of identifiers that are created by associations of health care professionals; enhances current activities and commitments of professional associations to manage and maintain data on their professions' constituencies; is centralized into a non-governmental national directory by an organization that is mutually agreeable to the affected associations; and assures open access to legitimate users and accuracy, security, and confidentiality of the information.

(Am Pharm. NS33(7):56. July, 1993)

1993 Universal Unique Identifier Numbering System

APhA supports the development and use of a universal unique identifier numbering system

that identifies all health care professionals involved with medication use.
(Am Pharm. NS33(7):56. July, 1993)

1983 *American Medical Association: Patient Medication Program*

1. APhA shall strongly and actively encourage pharmacists to be available for and provide patient consultation, including written drug information, when requested or professionally appropriate.

2. APhA supports patient information programs that include reference to seeking medication information from pharmacists and does not endorse programs which, by ignoring the professional capabilities of pharmacists, may limit the patient's ability to receive needed drug information and consultation.

(Am Pharm. NS23(6):53. June, 1983)

1981 *Access to Medical Records*

APhA supports pharmacists' access to patient medical record information, when such access is required by the pharmacist for the purpose of providing professional service to a patient.

(Am Pharm. NS21(5):40. May, 1981)

1979 *Proposal on Application of Privacy Concepts to Health Care Records*

1965

1. APhA opposes any survey or audit of confidential patient information which results in disclosure of the name of the patient and/or the prescribing physician, without the express authorization of the patient or physician, or both, if both are to be identified.

2. APhA does not oppose pharmacists providing information on the prescribing of a particular drug product if the patient and/or the prescriber is not identified.

3. APhA believes that providing patient or prescriber identity and prescription order details to third-party payers for the purpose of submitting a third-party payment program service claim is in the patient's best interest.

(Am Pharm. NS19(7):68. June, 1979)

4. APhA opposes allowing unauthorized personnel to extract information from confidential patient

(Am Pharm. NS19(7):68. June, 1979)

REIMBURSEMENT AND COMPENSATION

2002 *Investigation of Discount Card Issuer Practices*

APhA encourages the Federal Trade Commission, the US attorney general or other appropriate agency to investigate misleading and deceptive marketing practices of issuers of discount cards. *(JAPhA NS42(5) Suppl.1:S61. September/October 2002)*

1996 *Empowerment of Pharmacists as Drug Therapy Managers*

1. APhA encourages pharmacists to take an active role in achieving the goals of Healthy People 2000 concerning immunizations, which includes increasing the rate of basic immunization series among children under the age of two to at least 90 percent and increasing the rate of other pediatric and adult immunizations through:

- (a) advocacy,
- (b) contracting with other health care professionals, or
- (c) pharmacists administering vaccines to vulnerable patients.

2. APhA encourages the availability of all vaccines to all pharmacies in order to meet public health needs.

3. APhA supports the compensation of pharmacists for the administration of immunizations and the reimbursement for vaccine distribution.

4. APhA should facilitate the development of programs that educate pharmacists about their role in immunizations in public health. (*JAPhA. NS36(6):395. June 1996*)

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-related cognitive 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*)

1990 *Reimbursement for Unapproved (Off-label) Uses of FDA-Approved Drug Products*

APhA supports coverage of FDA-approved drugs and pharmaceutical services connected with the delivery of such drugs by government and other third-party payers when used rationally for indications other than those specified in the product labeling. (*Am Pharm. NS30(6):45. June, 1990*)

1987 *Catastrophic Illness: Coverage for Pharmacy Services Included*

1. APhA supports comprehensive, catastrophic illness, insurance coverage that recognizes the essential need for pharmaceutical products and services in all patient care environments, including the home.

2. APhA encourages inclusion of pharmaceutical services, the most efficient and readily accessible system of drug delivery, in any insurance coverage for catastrophic illness that may be enacted. (*Am Pharm. NS27(6):422. June, 1987*)

1987 *Drug Regimen Review (DRR)*

APhA endorses adequate compensation to pharmacists for performing drug regimen review. (*Am Pharm. NS27(6):422. June, 1987*)

1985 *Pharmacists and Home Health Care*

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

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

3. Medicaid and other third-party programs also should reimburse pharmacists for innovative packaging and services that will minimize drug defaulting, increase the opportunity for audit and drug use review, and better meet the informational needs of the elderly and the care giver. (*Am Pharm. NS25(5):51. May, 1985*)

1980 *Inclusion of Clinical Pharmacy Services in Health Programs*

APhA supports the policy that clinical pharmacy services should be recognized as a reimbursable service. (*Am Pharm. NS20(7):69. July, 1980*)

1979 *Proposal on 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):65. June, 1979*)

1964 *Insurance to Cover Catastrophic Illness*

APhA recognizes and is most concerned with the problems that can occur with the unfortunate

advent of catastrophic illness and, therefore, encourages the health insurance industry to provide coverage which would specifically meet the costs associated with such catastrophic illnesses. (*JAPhA NS4:429. August, 1964*)

Federal Programs

1980 Inclusion of Clinical Pharmacy Services in Health Programs

APhA supports the inclusion of clinical pharmacy functions in health care programs that are developed and/or funded by governments and private agencies and organizations. (*Am Pharm.NS20(7):69. July, 1980*)

1978 Drug Benefits for the Aged

1. APhA endorses extension of Medicare coverage to include an out-of-hospital, pharmaceutical service benefit for the elderly.
2. A Medicare, out-of-hospital, pharmaceutical service benefit for the elderly should:
 - (a) Place drug product cost reimbursement on an Actual Acquisition Cost (AAC) basis;
 - (b) Ensure a dispensing fee comparable to that charged the self-paying public;
 - (c) Allow for professional discretion in identification of drug products in the labeling of dispensed prescriptions;
 - (d) Guarantee pharmacy representation on the Drug Benefits Council that will administer the program;
 - (e) Prevent dispensing by physicians under this program; and
 - (f) Remove the price-posting requirement as a condition of participation in the program.

(*Am Pharm. NS18(8):30. July, 1978*)

1977 Third-party Reimbursement: Maximum Allowable Cost (MAC)

1. APhA supports only those government operated or financed, third-party, prescription programs which ensure 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*)

1970 Medicare, Medicaid, and Other Third-party Payment Programs

1. The committee recommends that no changes be made in APhA policy favoring out-of-hospital, prescription benefits under Medicare.
2. The committee recommends that APhA vigorously advocate a professional fee system of reimbursement in Medicare and Medicaid and other third-party payment programs which would recognize variations in services provided and costs incurred by individual pharmacies.
3. The committee recommends that APhA maintain close liaison with proponents of national health insurance programs to ensure that pharmacy will have an opportunity to make its views known in the development of such proposals. (*JAPhA NS10:346. June, 1970*)

1969 Medicare and Pharmaceutical Service

1. The committee reiterates that it is APhA policy that health care, including the essential component of pharmaceutical 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. The committee believes that the current Medicare (a federal program of hospital and medical insurance for nearly all people 65 and over) is grossly deficient in that it fails to provide a drug benefit to non-institutionalized patients. The committee, therefore, strongly recommends that APhA continue to support federal legislation to eliminate this deficiency.
3. The committee recommends that APhA support the Part B mechanism which is the voluntary supplementary medical insurance program financed equally by beneficiaries and the government.
4. The committee recommends that APhA oppose legislation which would restrict the drug benefit to specific, chronic diseases.
5. The committee recommends that the basic policy of APhA be interpreted to support the inclusion of pharmaceutical 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*)

1969 Medicare Task Force: Policy Guidelines

The following guidelines supplement those adopted by APhA in 1967:

1. Provide for beneficiary contribution toward program financing.
2. Provide for government reimbursement of claims directly to the pharmacist.
3. Compensate pharmacists by means of a professional fee commensurate with the level of professional service performed in addition to making reimbursement for the cost of the drugs.
4. Establish a per-prescription, fixed amount (co-payment) which must be paid by the beneficiary when obtaining drugs.
5. To assure patients of receiving safe and effective drugs, establish a list of reimbursable amounts for each drug based on a nationally available product of acceptable quality and cost.
6. Include all drugs having therapeutic use, whether for chronic or acute conditions.
7. Include all persons eligible for Part B Medicare coverage. (*JAPhA NS9: 343. July, 1969*)

1969 Veterans Administration Hometown Prescription Program

The committee recommends that VA adopt the professional fee method for its Hometown Prescription Program. (*JAPhA NS9:352. July, 1969*)

1968 Medicare: Reimbursement Procedures

The committee recommends that APhA more fully acquaint pharmacists with aspects of reimbursement procedures and concepts associated with Medicare. (*JAPhA NS8:368. July, 1968*)

1968 Medicare Pharmaceutical Services

1. S.2936 authorizes the formulary committee to publish and disseminate (at least annually) an alphabetical list of qualified drugs by established names and other representative names by which the drugs are commonly known, along with the benefits allowable, therefore, to pharmacists, physicians, and other interested persons, including the Social Security beneficiaries. The committee recommends that APhA seek revision of this provision to delete "beneficiaries" from the distribution.

2. In its 1967 report, the committee recommended guidelines for use by the APhA Board of Trustees in considering and acting upon proposals in the area of drug costs. The committee believes that S.2936 meets these established criteria. We recommend that the House of Delegates continue its support of these guidelines and endorse S.2936 with the change recommended. (*JAPhA NS8:369. July, 1968*)

1968 Medicare Pharmaceutical Services

1. The committee does not think it reasonable to deny those receiving Social Security benefits the essential item of pharmaceutical services so necessary to complete therapy and health care benefits in this modern day society. In this regard, the committee reaffirms its support of the criteria set forth in the 1967 report of the committee on legislation and recommends that APhA continue its support of S.2936.

2. Where a formulary is established, we recommend that APhA insist that the selection of drugs in the formulary be governed by appropriate and qualified health care practitioners guided by the medical needs of the recipients. We further urge that any such formulary provide appropriate procedures to accommodate the need for a non-formulary drug when medical necessity so requires. (*JAPhA NS8:361. July, 1968*)

1968 Medicare/Medicaid: Standards of Pharmaceutical Service

1. The committee reaffirms its admonition that the profession must insist that high standards of pharmaceutical service be available under any government-funded, pharmaceutical service program.

2. The committee reiterates the standards established in 1967 as the proper guide for APhA in future legislative activity for Title XIX. (*JAPhA NS8:361. July, 1968*)

1967 Drugs Provided Under Social Security Act: Guidelines for Pharmaceutical Service

Since it is probable or likely that APhA may have to consider and act upon some proposals in the area of drug costs before the next annual meeting, we recommend that APhA Board of Trustees be guided by whether the proposals:

1. Permit pharmacists to select and dispense a quality drug product;
2. Establish some mechanism to assist pharmacists in selecting quality, drug products under the cost and other criteria established;
3. Permit the use of any available drug product when unique medical circumstances so require;
4. Establish a reasonable remuneration base for pharmacists rendering services under the program;
5. Guarantee recipients free choice of pharmacy; and
6. Limit the reimbursement for pharmaceutical services to those provided by duly licensed pharmacists.

(*JAPhA NS7:315. June, 1967*)

1967 Medicaid: Objectives for State Legislation

A number of states have enacted enabling legislation for Title XIX programs during this past year. APhA has been working with state pharmaceutical societies to:

1. Establish freedom of choice provisions in state laws;
2. Have the law incorporate a pharmaceutical advisory committee (or a committee of the medical advisory committee) to review programs and policies dealing with pharmaceutical services in the public assistance program;
3. Attempt to have prescribed drugs included within the authorized services; and
4. Limit payment for prescribed drugs to licensed pharmacist in accordance with HEW guidelines. (*JAPhA NS7:313. June, 1967*)

1967 Medicare Formulary Committee

S.17 would authorize the Formulary Committee to publish and disseminate (at least annually) an alphabetical list of the qualified drugs along with the allowable expenses established, therefore, to pharmacists, physicians, and other interested persons, including the Social Security beneficiaries. We recommend that APhA seek to have this provision changed to delete "beneficiaries" from the distribution. (*JAPhA NS7:313. June, 1967*)

1967 Medicare Reimbursement Procedures

We recommend that the House of Delegates endorse S.17 in principle and instruct APhA staff to seek to have some of the details changed to conform to the objectives of the profession. Under S.17, the pharmacist would look to the patient for remuneration in the traditional manner. The allowable cost would be the amount the government would reimburse the patient for prescribed drugs for which the patient had paid the pharmacist. This will provide some pressure for lower cost drugs, of course, but the committee also recognizes that this mechanism will provide some pressure upon the government from patients to establish realistic reimbursement amounts as well. In this context, S.17 does not differ from the financial arrangement provided in major medical insurance contracts under which pharmacists have participated for some years now. (*JAPhA NS7:313. June, 1967*)

1967 *State Association Relations with Welfare and Health*

The committee recommends that APhA continue to help state associations improve their working relationships with their respective welfare or health departments so that adequate pharmaceutical service will be provided to eligible recipients and so that pharmacists will receive a reasonable reimbursement for their services. (*JAPhA NS7:311. June, 1967*)

1966 *Medicaid: State Legislation, Pharmacists' Participation, and Reimbursement*

1. The committee recommends that APhA assist state associations in establishing, preferably in the authorizing state legislation, pharmaceutical consultant and pharmaceutical advisory committee provision in state plans under title XIX to assist the state in complying with the federal law in the area of pharmaceutical services.

2. The committee repeats its recommendations made in 1964 and again in 1965 that state pharmaceutical societies encourage their state agencies to adopt the professional fee system. The committee further recommends that APhA prepare a detailed explanation of the professional fee system for distribution to state public assistance agencies. (*JAPhA NS6:312. June, 1966*)

1965 *Welfare Programs: Reimbursement for Pharmaceutical Service*

The committee recommends that continued emphasis be placed on the average professional fee as the method of choice for reimbursing pharmacists for professional services in state welfare programs and simplifying administration aspects of the programs. (*JAPhA NS5:278. May, 1965*)

National Health Insurance

1977 *National Health Insurance: Pharmaceutical Service Benefit*

1. A National Health Insurance pharmaceutical service benefit must include acceptable methods for ensuring equitable reimbursement to pharmacists for products and services which are to be provided under the program.

2. Reimbursement to pharmacists for dispensed medication and devices under a NHI plan should be based on professional fees for professional services, plus reimbursement for the actual cost of any drug product or device provided.

3. A NHI, pharmaceutical service benefit must optimize administrative efficiency and minimize administrative costs. (*JAPhA NS17:451. July, 1977*)

1971 *National Health Insurance (NHI)*

The committee recommends that APhA endorse the concept of national health insurance as one means by which the costs of health care may be controlled and rational order brought to the health care system.

The committee recommends the following as general policy guidelines for the Board of Trustees in its consideration and development of specific national health insurance proposals:

- (a) A national health insurance plan must recognize that high quality health care is a right

of every citizen regardless of his economic or social status.

(b) A national health insurance plan must, as a point of departure, provide a health care delivery system which will correct the present inadequacies in the delivery of health care.

(c) A national health insurance plan must allow for maximum utilization of pharmacist manpower in health care roles.

(d) Group practices established under national health insurance must permit pharmacists' participation on an equitable basis and not merely as employees of physician-controlled groups.

(e) A national health insurance plan should, to the extent feasible, utilize existing community pharmacies as health care facilities.

(f) Pharmacist compensation under national health insurance must be established in a manner which will provide high quality pharmaceutical services to the public at a reasonable cost and which will provide sufficient economic incentive to continue to attract required pharmacy manpower. (*JAPhA NS11:265. May, 1971*)

1963 *National Health Insurance (NHI): APhA Opposition*

1. The basic position of APhA opposing compulsory national health insurance was adopted by this House of Delegates in 1949. In keeping with this position, officers of APhA have testified on numerous occasions before Congressional committees. In the 87th Congress, APhA strongly opposed the King-Anderson legislation because of its compulsory characteristics and inadequacies.

2. It is the recommendation of this committee, however, that APhA now review its basic position. While considerable progress has been made since 1949 through voluntary programs, the profession must satisfy itself that all is being done that can be done to serve the public. In some instances, for example, remedial legislation could accelerate voluntary programs. (*JAPhA NS3:324. June, 1963*)

New Payment Systems

1995 *Integrated Risk/Capitation Payment Systems*

1. APhA should provide pharmacists with tools to evaluate compensation for their pharmaceutical care services through mechanisms based on concepts other than fee-for-service.

2. APhA must facilitate both economic and clinical research on cost-to-outcomes benefits of pharmaceutical care services under integrated risk/capitated health care systems.

3. APhA affirms the principle that any pharmacist or pharmacy that adheres to a program's quality standards and agrees to accept its compensation plan shall be able to participate in an integrated risk/capitated system or network. (*Am Pharm. NS35(6):37. June, 1995*)

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

1. APhA should continue its work with pharmacy benefits' managers and other private and public payers to develop innovative pharmacy benefit designs and compensation strategies for pharmacists' services.

2. APhA may endorse benefit design concepts that recognize and compensate pharmacists for their caregiving services to maximize therapeutic outcomes. (*Am Pharm. NS34(6):58. June 1994*)

1994 *Responsiveness to Emerging 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*)

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*)

Professional Fees

1987 Compensation for Cognitive Services

1. APhA recognizes that pharmacists provide to patients cognitive services (i.e., services requiring professional judgment) which may or may not be related to the dispensing or sale of a product.

2. APhA supports compensation of pharmacists for providing cognitive services (i.e., services requiring professional judgment) which may or may not be related to the dispensing or sale of a product. (*Am Pharm. NS27(6):422. June, 1987*)

1975 Periodic Adjustments of Professional Fees in Federal Programs

It is essential that federal regulations governing pharmacist professional fees in federally-supported, health care programs require review and equitable adjustments on a regularized, periodic basis. (*JAPhA NS15:330. June, 1975*)

1975 Professional Fees in Federal Programs: Maximum Allowable Cost (MAC)

Prompt and equitable adjustment of pharmacist professional fees in federally-supported health care programs must be undertaken concurrently with implementation of HEW's maximum allowable cost regulations, or any similar regulations. (*JAPhA NS15:330. June, 1975*)

1967 Fee for Service Guidelines

Obviously, this committee or APhA cannot recommend or set a fee, but we do recommend that APhA collect information on pharmacists serving as consultants to extended-care facilities and hospitals and make it available to the membership as a guide. (*JAPhA NS7:305. June, 1967*)

1967 Pharmaceutical Service Cost Information

The committee recommends that APhA, if invited to testify at these hearings, not presume that it has the facts and information to explain these wide pricing differences, this is data that the individual manufacturers will have to provide themselves. On the other hand, APhA should undertake to explain and document the charges pharmacists make to the public for their own professional services if called upon to do so. (*JAPhA NS7:316. June, 1967*)

1966 Professional Fee System

The methods used to determine prescription charges continue to be a subject of some controversy. The committee recommends that all pharmacists consider the value of the professional fee system as the most logical means of determining charges for pharmaceutical services. Whatever method is used, pharmacists should be prepared to discuss their fees with their patrons. To encourage this candid discussion, a plaque that announces the pharmacist's willingness to discuss his fees will be prepared and offered to those pharmacists who elect to display it. Some pharmacists who have adopted the professional fee method have used this as a competitive advertising advantage. This practice is to be discouraged. Methods of determining charges must be considered at the community level in light of local conditions and fixed costs. (*JAPhA NS6:332. June, 1966*)

Third Party and Prepaid Programs

2002 Investigation of Discount Card Issuer Practices

APhA encourages the Federal Trade Commission, the US attorney general or other appropriate agency to investigate misleading and deceptive marketing practices of issuers of discount cards. (*JAPhA NS42(5) Suppl.1:S61. September/October 2002*)

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

APhA seeks introduction of legislation exempting state, third-party, and prescription program legislation from preemption by ERISA. (*Am Pharm. NS24(7):61. July, 1984*)

1981 Third-party Reimbursement Legislation

APhA supports enactment of legislation requiring that third-party program reimbursement to pharmacists be at least equal to the 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 participating in the program. (*Am Pharm. NS21(5):40. May, 1981 (Reviewed 2001)*)