Current Adopted APhA Policy Statements

1963-2011
APhA House of Delegates

Policy Manual

1963-2011
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POLICY STATEMENTS

ADVERTISING

Advertising for Pharmacies

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

2007  
*Directory Listings for Pharmacies*
2002  
APhA encourages the listing of all pharmacies in telephone, Internet and other directories under "Pharmacies."

2002  
*Depiction of Pharmacists in Public Media*
1984  
APhA supports the development of guidelines or standards to enhance the depiction of the pharmacy profession in all public media.

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.

2000  
*Use of the Phrase "Community Pharmacy"*
APhA supports use of the phrase "community pharmacy" rather than "retail pharmacy."

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.

Drug Names

1996  
*Brand-Name Line Extensions*
APhA opposes the use of the same brand name (or minor modifications of the same name) for prescription and non-prescription drug products containing different active ingredients.

Prescription & Non-Prescription Drugs

2004  
*Prescription Drug Advertising*
1977  
APhA does not oppose the dissemination of price information to patients, by advertising or by any other means.

1999  
*Direct-to-Consumer Advertising of Medications*
1. APhA supports legislative and regulatory activities permitting direct-to-consumer advertising concerning medical or health conditions treatable by prescription or nonprescription drug products. These advertisements must conform to rules and regulations that assure complete, comprehensive, and
Understandable information that informs consumers of potential benefits and risks of the product.

2. APhA opposes false or misleading advertising for prescription or nonprescription drugs or any promotional efforts that encourage indiscriminate use of medication.

3. APhA supports the availability of accurate information to consumers about medication use, and recognizes the responsibility of pharmacists to provide appropriate responses to consumer inquiries stimulated by direct-to-consumer advertising as a compensated pharmaceutical service. In addition, APhA recommends that health care professionals, including but not limited to pharmacists, receive new product information on direct-to-consumer advertising campaigns prior to this information being made available to consumers.

1980

Non-prescription Drug Advertising

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

2. APhA supports disclosure of all therapeutically active ingredients of non-prescription drugs in advertising directed to the public.

2010

E-prescribing Standardization

1. APhA supports the standardization of user interfaces to improve quality and reduce errors unique to e-prescribing.

2. APhA supports reporting mechanisms and research efforts to evaluate the effectiveness, safety, and quality of e-prescribing systems, computerized prescriber order entry (CPOE) systems, and the e-prescriptions that they produce, in order to improve health information technology systems and, ultimately, patient care.

3. APhA supports the development of financial incentives for pharmacists and prescribers to provide high quality e-prescribing activities.

4. APhA supports the inclusion of pharmacists in quality improvement and meaningful use activities related to the use of e-prescribing and other health information technology that would positively impact patient health outcomes.

2010

Personal Health Records

1. APhA supports patient utilization of personal health records, defined as records of health-related information managed, shared, and controlled by the individual, to facilitate self-management and communication across the continuum of care.

2. APhA urges both public and private entities to identify and include pharmacists and other stakeholders in the development of personal health record systems and the adoption of standards, including but not limited to terminology, security, documentation, and coding of data contained within personal health records.

3. APhA supports the development, implementation, and maintenance of personal health record systems that are accessible and searchable by pharmacists and other health care providers, interoperable and portable across health information systems, customizable to the needs of the patient, and able to differentiate information provided by a health care provider and the patient.

4. APhA supports pharmacists taking the leadership role in educating the public about the importance of maintaining current and accurate medication-related information within personal health records.

2004

Automation and Technology in Pharmacy Practice

1. APhA supports the use of automation and technology in pharmacy practice, with pharmacists maintaining oversight of these systems.

2. APhA recommends that pharmacists and other pharmacy personnel implement policies and procedures addressing the use of technology and automation to ensure safety, accuracy, security, data integrity and
patient confidentiality.
3. APhA supports initial and on-going system-specific education and training of all affected personnel when automation and technology are utilized in the workplace.
4. APhA shall work with all relevant parties to facilitate the appropriate use of automation and technology in pharmacy practice.


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.


BIOTECHNOLOGY

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

(JAPhA NS50(4):471 July/August 2010)

2007 Biologic Drug Products
1. APhA encourages the development of safe, effective, and affordable therapeutically equivalent generic 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 versions of biologic drug products.
3 APhA should actively support legislation to hasten the development of an efficient regulatory process to approve therapeutically equivalent generic versions of biologic drug products.
4 APhA should initiate educational programs for pharmacists and other health care professionals concerning the determination of therapeutic equivalence of generic versions of biologic drugs products.

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

2005 Pharmaceutical Biotechnology Products
1988 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.


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

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 NS3(16);29 June 1991) (Reviewed 2004) (Reviewed 2007) (Reviewed 2010)

DISASTER PREPAREDNESS

2011 Health Mobilization
2002 APhA should continue to:
1996
1. Emphasize its support for programs on disaster preparedness which involve the services of pharmacists (e.g., Medical Reserve Corps) and emergency responder registration networks [e.g., Emergency System for Advance Registration of Volunteer Health Professions (ESAR-VHP)].
2. Improve and expand established channels of communication between pharmacists; local, state and national pharmacy associations; boards and colleges of pharmacy and allied health professions.
3. Maintain its present liaison with the Office of the Assistant Secretary for Preparedness and Response (ASPR) of the Department of Health and Human Services and continue to seek Office of Preparedness and Emergency Operations (OPEO) assistance through professional service contracts to further develop pharmacy's activities in all phases of preparation before disasters.
4. Encourage routine inspection of drug stockpiles and disaster kits by state boards of pharmacy.

(JAPhA NS5(14) 483; July/August 2011)

2011 Role of the Pharmacist in National Defense
2002 APhA endorses the position that the pharmacist, as a member of the health care team, has the ethical responsibility to assume a role in disaster preparedness and emergency care operations. These responsibilities include:
1. Pharmacists, by their education and training as medication experts, should be involved intimately in all elements of the procurement, storage, handling, compounding, and dispensing of drugs and supplies in planning for as well as during any national emergency.
2. Pharmacists, by their education in anatomy, physiology, and pharmacology, are readily adaptable to assist in the emergency medical treatment of patients and for training the public in medical self-help.
3. Pharmacists, by their constant contact with the members of the health team, as well as a significant portion of their communities, provide the potential for coordinating preparedness measures, and establishing meaningful standby emergency operational plans.

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


2007 Pharmacy Personnel Immunization Rates
1. APhA supports efforts to increase immunization rates of healthcare professionals, for the purposes of protecting patients, and urges all pharmacy personnel to receive all immunizations recommended by the Centers for Disease Control (CDC) for healthcare workers.
2. APhA encourages employers to provide necessary immunizations to all pharmacy personnel.
3. APhA encourages federal, state, and local public health officials to recognize pharmacists as first responders (like physicians, nurses, police, etc) and prioritize pharmacists to receive medications and immunizations.

(APHa NS45(5): 580 September/October 2007) (Reviewed 2009)

2006 Model Disaster Plan for Pharmacists

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


2005 Emergency Preparedness

APhA supports the continuing efforts of the Joint Commission of Pharmacy Practitioners working group on emergency preparedness and response to network with the Office of Homeland Security and with any other relevant governmental and/or military agency.


2001 Biological Terrorism, Infectious Diseases, and Pharmacy

APhA supports pharmacist involvement in bioterrorism preparedness planning.


DISPENSING AUTHORITY

2006 Dispensing Criteria

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


2005 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.


2004 Issuing of Drugs by Non-pharmacists

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


2003 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.

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.

1979 Out of State Prescription Orders
APhA supports the repeal of state laws, which prohibits the dispensing of an otherwise legal prescription order, issued by a prescriber licensed in another state.

1979 DRUG ABUSE, CONTROL AND EDUCATION

2011 Funding for Pharmacist Recovery Programs
2005 APhA supports and encourages a cooperative effort among state and national pharmacy associations, state boards of pharmacy, and state legislative bodies to authorize, develop, implement and maintain mechanisms for the comprehensive funding of state recovery programs for pharmacists, student pharmacists and pharmacy technicians.

2005 Pharmacists with Impairments that Affect Practice
2003 1. APhA advocates that pharmacists should not practice while subject to physical or mental impairment due to the influence of drugs -- including alcohol -- or other causes that might adversely affect their abilities to function properly in their professional capacities.
1982 2. APhA supports establishment of counseling, treatment, prevention, and rehabilitation programs for pharmacists and student pharmacists who are subject to physical or mental impairment due to the influence of drugs -- including alcohol -- or other causes, when such impairment has potential for adversely affecting their abilities to function in their professional capacities.

2003 Drug Addiction/Chemical Dependency Education
APhA urges pharmacists and pharmacy students to become educated in the recognition and treatment of drug addiction and chemical dependency.

2003 Drug Abuse Education
1987 APhA supports comprehensive drug abuse prevention programs consisting of education and rehabilitation.
2003  **The Use of Controlled Substances in the Treatment of Intractable Pain**

1983  1. APhA supports the continued classification of heroin as a Schedule I controlled substance.
2. APhA supports research by qualified investigators under the Investigational New Drug (IND) process to explore the potential medicinal uses of Schedule I controlled substances and their analogues.
3. APhA supports comprehensive education to maximize the proper use of approved analgesic drugs for treating patients with chronic pain.
4. APhA recognizes pharmacists receiving controlled substance prescription orders used for analgesia have a responsibility to ensure that the medication has been prescribed for a legitimate medical use and that patients achieve the intended therapeutic outcomes.
5. APhA advocates that pharmacists play an important role on the patient care team providing pain control and management.


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2003  **Security - Pharmacists’ Responsibility**

1971  APhA encourages pharmacists to voluntarily remove all proprietary drug products with potential for abuse or adverse drug interactions from general sales areas and to make their dispensing the personal responsibility of the pharmacist.


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1997  **DEA Employment Waiver**

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


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1990  **Drug Testing in the Workplace**

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


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1982  **Innovative Approaches to Combatting Pharmacy Crime**

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


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**Hallucinogens**

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

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


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**Marijuana**

1980  **Medicinal Use of Marijuana**

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

Methadone

2003 *Methadone Used as Analgesic and Antitussive*

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


Performance-Enhancing Drugs

1986 *Use of Performance-enhancing Drugs by Athletes*

1. APhA is opposed to the use of performance-enhancing drugs by athletes.
2. APhA should educate the public on the dangers of the use of performance-enhancing drugs by athletes.
3. APhA encourages enforcement of laws related to the use of performance-enhancing drugs by athletes.


State Drug Laws and Legalization Issues

2010 *Discontinuation of the Sale of Tobacco Products in Pharmacies and Facilities that Include Pharmacies*

1. APhA urges pharmacies and facilities that include pharmacies to discontinue the sale of tobacco products.
2. APhA urges the federal government and state governments to limit participation in government-funded prescription programs to pharmacies that do not sell tobacco products.
3. APhA urges state boards of pharmacy to discontinue issuing and renewing licenses to pharmacies that sell tobacco products and to pharmacies that are in facilities that sell tobacco products.
4. APhA urges colleges of pharmacy to only use pharmacies that do not sell tobacco products as experience sites for their students.
5. APhA urges the Accreditation Council for Pharmacy Education (ACPE) to adopt the position that college-administered pharmacy experience programs should only use pharmacies that do not sell tobacco products.
6. APhA urges pharmacists and student pharmacists who are seeking employment opportunities to first consider positions in pharmacies that do not sell tobacco products.

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

2006 *Conversion of Nonprescription Products Into Drugs of Abuse*

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

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

2005 *Efforts to Limit Methamphetamine Access*

APhA supports legislation that balances the need for patient/consumer access to medications for legitimate medical purposes with the need to prevent diversion and abuse.

APhA supports stringent enforcement of criminal laws against individuals who engage in the illegal trafficking of methamphetamine and methamphetamine precursors.

APhA supports retail sales limits of non-prescription products that contain methamphetamine precursors to prevent diversion.

APhA supports education of employees involved in the distribution chain of methamphetamine precursors about diversion, methamphetamine abuse and prevention of abuse. APhA supports patient/consumer education of consequences of methamphetamine abuse.
APhA supports public and private initiatives that result in increased funding to address the escalating needs for drug abuse treatment and prevention.


1999 **Sale of Sterile Syringes**
APhA encourages state legislatures and boards of pharmacy to revise laws and regulations to permit the unrestricted sale or distribution of sterile syringes and needles by or with the knowledge of a pharmacist in an effort to decrease the transmission of blood-borne diseases.


1990 **Legalization or Decriminalization of Illicit Drugs**
APhA opposes legalization or decriminalization of the possession, sale, distribution, or use of drug substances for non-medicinal uses.


**DRUG CLASSIFICATION**

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 assure 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 non-prescription medications and dietary supplements to facilitate patient/caregiver interaction with their pharmacist

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

2005 **Non-Prescription Availability of Nonsedating Antihistamines**
2001 APhA, as an issue of public safety, encourages manufacturers and the Food and Drug Administration (FDA) to transition nonsedating antihistamines from prescription to nonprescription status.


**DRUG PRICING AND DISTRIBUTION**

2010 **Transfer Incentives**
APhA advocates the elimination of coupons, rebates, discounts, and other incentives provided to patients that promote the transfer of prescriptions between competitors.

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

2004 **Protecting the Integrity of the Medication Supply**
1. APhA encourages pharmacists to enhance their role in protecting the integrity of the medication supply, including careful consideration of the source and distribution pathways of the medications they dispense.
2. APhA recommends that all individuals and entities of the pharmaceutical supply system, including manufacturers, wholesalers, pharmacies, pharmacists, and other, adopt appropriate technology, tracking mechanisms, business practices, and other initiatives to protect the integrity of the drug supply.
3. APhA supports public education about the risk of using medications whose production, distribution, or sale does not comply with US federal and state laws and regulations.
4. APhA urges pharmacists and other health care professionals to report suspected counterfeit products to the Food and Drug Administration.


2004 **Manufacturers’ Pricing Policies**
1968 APhA supports pharmaceutical industry adoption of a "transparent pricing" system which would eliminate hidden discounts, free goods, and other subtle economic devices.

**Distribution Programs: Circumvention of the Pharmacist**

1966 APhA opposes distribution programs and policies by manufacturers, governmental agencies, and voluntary health groups which circumvent the pharmacist and promote the dispensing of prescription, legend drugs by non-pharmacists. These programs and policies should, in the public interest, be eliminated.


**Product Licensing Agreements and Restricted Distribution**

1994 APhA opposes any manufacturer-provider relationship which involves product licensing agreements and/or restricted distribution arrangements which infringe on pharmacists' rights to provide pharmaceuticals and pharmaceutical care to their patients.


**Patient Education on Medication Storage**

1989 APhA supports the continued development and use of educational resources for patients regarding the proper storage of drug products.


**Impact of Drug Distribution Systems on Integrity and Stability of Drug Products**

1989 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.


**Pharmaceutical Pricing**

1985 APhA supports a system of equal opportunity with the same terms, conditions, and prices available for all pharmacies.


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

1978 APhA opposes any legislation that would grant FDA authority to restrict the channels of drug distribution for any prescription drug as a condition for approval for marketing the drug under approved labeling.


**DRUG PRODUCT PACKAGING**

**Unit-of-Use Packaging**

2003 APhA encourages the continued development, distribution and use of unit-of-use packaging as the industry standard to enhance patient safety, patient compliance, and efficiencies in drug distribution.

APhA shall collaborate with the pharmaceutical industry, third party payors, and appropriate federal agencies to affect the changes necessary for the adoption of unit-of-use packaging as the industry standard.

APhA encourages the enactment of legislation and regulations to permit pharmacists to modify prescribed quantities to correspond with commercially available unit-of-use packages.


1992 APhA supports the role of the pharmacist to select appropriate drug product packaging.

2. APhA supports the pharmaceutical industry’s performance of compatibility and stability testing of drug products in officially defined containers to assist pharmacist selection of appropriate drug product packaging.

3. APhA supports the value of unit-of-use packaging to enhance pharmaceutical care, but recognizes that product and patient needs may preclude its use.

4. APhA encourages the pharmaceutical industry to ensure that all unit-of-use packaging will accommodate a standard pharmacy label.

2004  **Single Dose Containers for Parenteral Use**
1971  APhA supports packaging all drugs intended for parenteral use in humans in single-dose containers, except where clearly not feasible.

**DRUG PRODUCT SELECTION**

2011  **Potential Conflicts of Interest in Pharmacy Practice**
1. APhA reaffirms that as health care professionals, pharmacists are expected to act in the best interest of patients when making clinical recommendations.
2. APhA supports pharmacists using evidence-based practices to guide decisions that lead to the delivery of optimal patient care.
3. APhA supports pharmacist development, adoption, and use of policies and procedures to manage potential conflicts of interest in practice.
4. APhA should develop core principles that guide pharmacists in developing and using policies and procedures for identifying and managing potential conflicts of interest.
(JAPhA NS51(4) 482; July/August 2011)

2009  **Non-FDA-Approved Drugs and Patient Safety**
1. The American Pharmacists Association calls for education and collaboration among health professional organizations, federal agencies, and other stakeholders to ensure that all manufacturer, distributor, and repackager marketed prescription drugs used in patient care have been FDA-approved as safe and effective.
2. APhA supports initiatives aimed at closing regulatory and distribution-system loopholes that facilitate market entry of new prescription drugs products without FDA approval.
3. APhA encourages health professionals to consider FDA approval status of prescription drug products when making decisions about prescribing, dispensing, substitution, purchasing, formulary development, and in the development of pharmacy/medical education programs and drug information compendia.
(JAPhA NS49(4):492 July/August 2009)

2005  **Complementary and Alternative Medications**
1997  1. APhA shall support informed decision-making based upon the professional judgment of pharmacists regarding the appropriateness of use or the sale of complementary and alternative medicines.
2. APhA shall assist pharmacists and student pharmacists in becoming knowledgeable about complementary and alternative medications to facilitate the counseling of patients regarding effectiveness, proper use, indications, safety and possible interactions.

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

2001  **Uniform Designation for Drug Product Selection Authority**
1989  APhA supports a uniform procedure nationwide for designating on a prescription order that drug product selection by the pharmacist is precluded by the prescriber.

**Anti-Substitution Laws**

2004  **Anti-substitution Laws: Pharmacists' Responsibility**
1971  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.
**Therapeutic Equivalence**

**2007 Biologic Drug Products**
1. APhA encourages the development of safe, effective, and affordable therapeutically equivalent generic 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 versions of biologic drug products.
3. APhA should actively support legislation to hasten the development of an efficient regulatory process to approve therapeutically equivalent generic versions of biologic drug products.
4. APhA should initiate educational programs for pharmacists and other health care professionals concerning the determination of therapeutic equivalence of generic versions of biologic drugs products.

*(JAPhA NS45(5):580 September-October 2007)*

**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.


**1983 Pharmaceutical Alternates**
APhA supports recognition of the pharmacist's role in the selection of pharmaceutical alternates (i.e., drug products containing the same therapeutic moiety, but differing in salt, ester, or comparable physical/chemical form or differing in dosage form.)


**1982 Legislative Restrictions on Therapeutic Judgment**
APhA opposes the enactment of legislation which would act to restrict the therapeutic judgments of medical practitioners and other health professionals.


**DRUG RECALLS**

**2011 Product Recall Policy**

**2004** APhA supports:

**1995** (a) the use of contemporary communications technologies to enhance communication of recall information to all relevant parties,
(b) developing and promoting strategies to identify and communicate with patients who may have received recalled products, when appropriate,
(c) identifying compensation mechanisms for resources expended in responding to recalls, and
(d) maintaining the FDA recall program, which ensures that appropriate promptness of action can be taken based on the depth and severity of the recall.


**EDUCATION, CURRICULUM AND COMPETENCE FOR PHARMACISTS**

**Competency and Training in Specific Areas**

**2009 Non-FDA-Approved Drugs and Patient Safety**
1. The American Pharmacists Association calls for education and collaboration among health professional organizations, federal agencies, and other stakeholders to ensure that all manufacturer, distributor, and repackager marketed prescription drugs used in patient care have been FDA-approved as safe and effective.
2. APhA supports initiatives aimed at closing regulatory and distribution-system loopholes that facilitate market entry of new prescription drugs products without FDA approval.
3. APhA encourages health professionals to consider FDA approval status of prescription drug products when making decisions about prescribing, dispensing, substitution, purchasing, formulary development, and in the development of pharmacy/medical education programs and drug information compendia.

(\textit{JAPhA NS49}(4):492 July/August 2009)

\textbf{2005 Complementary and Alternative Medications}
\textbf{1997} 1. APhA shall support informed decision-making based upon the professional judgment of pharmacists regarding the appropriateness of use or the sale of complementary and alternative medicines.
5. APhA shall assist pharmacists and student pharmacists in becoming knowledgeable about complementary and alternative medications to facilitate the counseling of patients regarding effectiveness, proper use, indications, safety and possible interactions.


\textbf{2005 Pharmaceutical Biotechnology Products}
\textbf{1988} 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.


\textbf{2003 Drug Addiction/Chemical Dependency Education}
APhA urges pharmacists and pharmacy students to become educated in the recognition and treatment of drug addiction and chemical dependency.


\textbf{2001 Credentialing and Pharmaceutical Care}
1. APhA should continue to assist in the unification of the profession and the development of a national strategy by its continued support of the Council on Credentialing in Pharmacy as the body responsible for the leadership, standards, public information and coordination of the profession’s voluntary credentialing programs.
2. APhA, in conjunction and cooperation with the Council on Credentialing and other national associations, should provide competence-based material and testing via technology, such as the APhA Web site and state association Web sites, to further the profession’s self-assessment.
3. APhA, in conjunction and cooperation with the Council on Credentialing and other national associations, should develop the necessary products and programs to educate the public, insurers, and health professionals on credentialing and make them available to state associations at cost.
4. APhA supports the development, on a continuing basis, of programs such as Project ImPACT, which provide the opportunity to promote the profession and its impact on clinical, economic, and humanistic patient outcomes.


\textbf{1987 Drug Product Equivalence}
APhA shall continue to support educational programs for pharmacists on issues regarding generic drugs.


\textbf{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.

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 pharmaceutical education to offer education and training on the subject of nutrition.


1981  **Pharmacist Training in Physical Assessments**
APhA supports education and training by schools and colleges of pharmacy, as well as providers of continuing pharmaceutical education, to prepare pharmacists to perform physical assessments of patients.


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**Continuing Education**

2009  **Pharmacist’s Role in Patient Safety**
1. It is APhA’s position that patient safety initiatives must include pharmacists in leadership roles.
2. APhA encourages dissemination of best practices derived from nationally aggregated reporting data systems to pharmacists for the purpose of improving the medication use process and making informed decisions that directly impact patient safety and quality.
3. APhA encourages the profession of pharmacy to continually review and evaluate ways to enhance training, curricula, continuing education and accountability of pharmacists to improve patient safety.
4. APhA encourages risk management and post-marketing surveillance programs to be standardized and include infrastructures and compensation necessary to allow pharmacists to support these patient safety programs.
5. APhA supports the creation of voluntary, standardized and interoperable reporting systems for patient safety events to minimize barriers to pharmacist participation and to enable aggregation of data and improve quality of medication use systems. The system should be free, voluntary, non-punitive, easily accessible, and user friendly for all providers within the healthcare system.
6. APhA supports the elimination of hand-written prescriptions or medication orders.

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

2009  **Health Information Technology**
1. APhA supports the delivery of informatics education within pharmacy schools and continuing education programs to improve patient care, to understand interoperability among systems, to understand where to find information, to increase productivity, and to improve the ability to measure and report the value of pharmacists in the health care system.
2. APhA urges that pharmacists have read/write access to electronic health record data for the purposes of improving patient care and medication use outcomes.
3. APhA encourages inclusion of pharmacists in the defining, development and implementation of health information technologies for the purpose of improving the quality of patient-centric health care.
4. APhA urges public and private entities to include pharmacist representatives in the creation of standards, certification of systems, and integration of medication use systems with health information technology.

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

2005  **Continuing Professional Development**
1. APhA supports continuing professional development, a self-directed, individualized, systematic approach to life-long learning, to support pharmacists’ efforts to maintain professional competence in their practice.
2. APhA should work with appropriate organizations to provide self-assessment and plan development tools. APhA shall help identify and facilitate access to quality educational programs
3. Employers should foster and support pharmacist participation in continuing professional development.
4. Continuing professional development is a learning process that requires full participation to achieve desired individual outcomes. To facilitate that participation, each pharmacist controls disclosure of their individual assessments and outcomes.

2005  Cross-Discipline Accreditation of Continuing Education

1992  1. APhA supports the acceptance, for pharmacy continuing education credit of relevant, quality programs offered by other health-related continuing education providers.
2. APhA supports the acceptance of relevant programs offered by the Accreditation Council for Pharmacy Education (ACPE)-accredited providers to meet continuing education requirements in other health disciplines.


2003  Continued Competence Assessment Examination

1997  1. APhA should develop, in cooperation with other state and national associations, a voluntary process for self assessing pharmaceutical care competence.
2. APhA opposes regulatory bodies utilizing continuing competence examinations as a requirement for renewal of a pharmacist’s license.
3. APhA supports programs that measure and evaluate pharmacist competence based on established valid standards.


2003  Continuing Education

1974  APhA strongly endorses continuing education for pharmacists.


1982  Use of Academic and Continuing Education Credit

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


1975  Pharmacists’ Responsibility for Continuing Competence

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


Degree/Designation

2011  Distance Education in First Professional Pharmacy Degree Programs

2003  1. Distance education components of first professional pharmacy degree programs must be constructed in a way to assure socialization into the profession and understanding the ethos and essence of the profession, as such development is primarily derived through practical experience and interaction with faculty, colleagues and patients.
2. APhA expects the Accreditation Council for Pharmacy Education to develop, maintain, and enforce applicable standards to ensure students trained in distance education programs achieve the same educational and professional competencies as students in on-site programs.

Doctor of Pharmacy Attainment Through Non-traditional Mechanisms

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

Internships/Externships and Residencies

Discontinuation of the Sale of Tobacco Products in Pharmacies and Facilities that Include Pharmacies

1. APhA urges pharmacies and facilities that include pharmacies to discontinue the sale of tobacco products.
2. APhA urges the federal government and state governments to limit participation in government-funded
   prescription programs to pharmacies that do not sell tobacco products.
3. APhA urges state boards of pharmacy to discontinue issuing and renewing licenses to pharmacies that sell
   tobacco products and to pharmacies that are in facilities that sell tobacco products.
4. APhA urges colleges of pharmacy to only use pharmacies that do not sell tobacco products as experience
   sites for their students.
5. APhA urges the Accreditation Council for Pharmacy Education (ACPE) to adopt the position that college-
   administered pharmacy experience programs should only use pharmacies that do not sell tobacco
   products.
6. APhA urges pharmacists and student pharmacists who are seeking employment opportunities to first
   consider positions in pharmacies that do not sell tobacco products.

Introductory Pharmacy Practice Experience

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

Experiential Education

1. APhA urges state boards of pharmacy, the Accreditation Council for Pharmacy Education (ACPE), the
   American Association of Colleges of Pharmacy (AACP) and other professional associations; employers,
   and other stakeholders to collaborate in the development of a blueprint that evaluates, streamlines, and
   consolidates all student pharmacists’ experiential education requirements.
2. APhA encourages the American Association of Colleges of Pharmacy (AACP), in collaboration with state
   boards of pharmacy, practitioner organizations and other stakeholders, to develop national standardization
   among schools and colleges of pharmacy to improve the quality of student pharmacists’ experiential
   education. This standardization should be adopted by all schools and colleges of pharmacy and should
   include:
   (a) A preceptor training program
   (b) A model instrument for preceptors to evaluate student pharmacist performance in required pharmacy
       practice experiences
   (c) A set of quality indicators for each required pharmacy practice experience
   (d) A report of quality indicator outcomes made available to all schools and colleges of pharmacy,
       faculty, and current and prospective students.
3. APhA urges schools and colleges of pharmacy to dedicate adequate and equitable financial and human
   resources to experiential education.
**2008 Pharmacy Practice-based Research Networks**

1. APhA supports establishment of pharmacy practice-based research networks (PBRNs) to strengthen the evidence base in support of MTM and pharmacy primary care services.
2. APhA encourages collaborations among stakeholders to determine the minimal infrastructure and resources needed to develop and implement local, regional and nationwide networks for performing pharmacy practice-based research.
3. APhA encourages pharmacy residency programs to actively participate in pharmacy practice-based research network.

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

**2008 Residency Training for Pharmacists**

1. APhA urges continued growth in the number of accredited pharmacy residency positions in all practice settings to better meet the future health care needs of our nation.
2. APhA advocates for the allocation of adequate funding for accredited pharmacy residencies in all practice settings by governmental and other entities.
3. APhA supports post-graduate training for new PharmD graduates.

*(JAPhA NS48(4):470 July/August 2008)*

**2006 Residency Programs**

APhA supports accreditation of all pharmacy residency programs by federally recognized accrediting bodies to ensure quality training experiences.

*(JAPhA NS45(5):562 September/October 2006) (Reviewed 2008)*

**2006 Residency Programs**

APhA encourages active involvement of schools and colleges of pharmacy in the development and advancement of accredited pharmacy practice residency programs.

*(JAPhA NS45(5):562 September/October 2006) (Reviewed 2008)*

**2005 Regulation of Student Pharmacists’ Practice Experience**

1. APhA encourages state boards of pharmacy to use the title “student pharmacist” to identify all students enrolled in their professional years of pharmacy education in an Accreditation Council for Pharmacy Education (ACPE) accredited program.
2. APhA encourages state boards of pharmacy to permit a student pharmacist to perform the duties of a pharmacist within the applicable state’s scope of practice under a pharmacist’s supervision. Preceptors shall consider the experience and education of student pharmacists when providing pharmacy practice opportunities.


**2005 Expansion and Recognition of Internship, Externship, and Clerkships**

1990

1. APhA encourages schools and colleges of pharmacy to establish and maintain experiential education programs in non-traditional areas of practice.
2. APhA encourages state boards of pharmacy to accept, at least on an hour-for-hour basis, hours of experiential education obtained in non-traditional areas of pharmacy practice as fulfilling internship hour requirements.


**1984 Residencies in Community Pharmacy**

APhA supports the development and implementation of residency programs in community pharmacy which would enable pharmacists to acquire or enhance their practice skills necessary to meet the changing needs of their patients.

2010 Discontinuation of the Sale of Tobacco Products in Pharmacies and Facilities that Include Pharmacies
1. APhA urges pharmacies and facilities that include pharmacies to discontinue the sale of tobacco products.
2. APhA urges the federal government and state governments to limit participation in government-funded prescription programs to pharmacies that do not sell tobacco products.
3. APhA urges state boards of pharmacy to discontinue issuing and renewing licenses to pharmacies that sell tobacco products and to pharmacies that are in facilities that sell tobacco products.
4. APhA urges colleges of pharmacy to only use pharmacies that do not sell tobacco products as experience sites for their students.
5. APhA urges the Accreditation Council for Pharmacy Education (ACPE) to adopt the position that college-administered pharmacy experience programs should only use pharmacies that do not sell tobacco products.
6. APhA urges pharmacists and student pharmacists who are seeking employment opportunities to first consider positions in pharmacies that do not sell tobacco products. (JAPhA NS40(4):471 July/August 2010)

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

2009 Pharmacist’s Role in Patient Safety
1. It is APhA’s position that patient safety initiatives must include pharmacists in leadership roles.
2. APhA encourages dissemination of best practices derived from nationally aggregated reporting data systems to pharmacists for the purpose of improving the medication use process and making informed decisions that directly impact patient safety and quality.
3. APhA encourages the profession of pharmacy to continually review and evaluate ways to enhance training, curricula, continuing education and accountability of pharmacists to improve patient safety.
4. APhA encourages risk management and post-marketing surveillance programs to be standardized and include infrastructures and compensation necessary to allow pharmacists to support these patient safety programs.
5. APhA supports the creation of voluntary, standardized and interoperable reporting systems for patient safety events to minimize barriers to pharmacist participation and to enable aggregation of data and improve quality of medication use systems. The system should be free, voluntary, non-punitive, easily accessible, and user friendly for all providers within the healthcare system.
6. APhA supports the elimination of hand-written prescriptions or medication orders. (JAPhA NS49(4):492 July/August 2009)  (Reviewed 2010)

2009 Health Information Technology
APhA supports the delivery of informatics education within pharmacy schools and continuing education
1. programs to improve patient care, to understand interoperability among systems, to understand where to find information, to increase productivity, and to improve the ability to measure and report the value of pharmacists in the health care system.
2. APhA urges that pharmacists have read/write access to electronic health record data for the purposes of improving patient care and medication use outcomes.
3. APhA encourages inclusion of pharmacists in the defining, development and implementation of health information technologies for the purpose of improving the quality of patient-centric health care.
4. APhA urges public and private entities to include pharmacist representatives in the creation of standards, certification of systems, and integration of medication use systems with health information technology. (JAPhA NS49(4):492 July/August 2009) (Reviewed 2010)
2005 Pharmacy Schools' Curriculum and Contemporary Pharmacy Needs
1990
1. APhA will work with schools and colleges of pharmacy and pharmacy organizations to address differences between contemporary pharmacy practice and curriculum offerings.
2. APhA encourages pharmacists to cooperate with schools and colleges of pharmacy by participating as preceptors and permitting their practices to be used as experiential sites.


2005 Professional Development of Student Pharmacists
1995
1. APhA believes that it is essential to integrate professionalism throughout a student pharmacist's educational experience.
2. APhA will assist schools and colleges of pharmacy to develop and utilize recruitment materials that emphasize the professional role and responsibilities associated with the provision of pharmaceutical care.
3. APhA encourages schools and colleges of pharmacy to interview candidates during the admissions process to assess their characteristics for the potential for development of professional attitudes and behaviors.
4. APhA recommends that schools and colleges of pharmacy administer the model pledge of professionalism, as developed by the APhA-ASP/American Association of Colleges of Pharmacy Council of Deans Task Force on Professionalism, to all student pharmacists.
5. APhA encourages schools and colleges of pharmacy and the American Association of Colleges of Pharmacy to develop and implement ongoing programs for faculty, staff, preceptors, and other mentors to enhance their ability to serve as role models and teach professionalism.
6. APhA will develop and institute a forum for faculty, students, preceptors, and others to establish and foster mentor relationships.


2005 Regulation of Student Pharmacists’ Practice Experience
1. APhA encourages state boards of pharmacy to use the title “student pharmacist” to identify all students enrolled in their professional years of pharmacy education in an Accreditation Council for Pharmacy Education (ACPE) accredited program.
2. APhA encourages state boards of pharmacy to permit a student pharmacist to perform the duties of a pharmacist within the applicable state’s scope of practice under a pharmacist’s supervision. Preceptors shall consider the experience and education of student pharmacists when providing pharmacy practice opportunities.


1993 Payment System Reform Curriculum
APhA encourages the colleges and schools of pharmacy to incorporate the concept of payment system reform throughout the curricula for all professional programs, and should work with pharmacy organizations to ensure the integration of these concepts into practitioners' continuing development.


1992 Balanced Education for Pharmacists
1. APhA encourages schools and colleges of pharmacy to continue to develop educational requirements to ensure the provision of a balanced, general education in order to graduate educated citizens and competent, health care professionals.
2. APhA supports development of admission processes by schools and colleges of pharmacy that assure that students possess qualities necessary to become educated citizens and competent, health care professionals.


1991 Emerging Technologies
APhA encourages schools of pharmacy to include information regarding emerging technologies in their curricula.

1988  **Professional Ethics in Educational Curricula and Practice**  
APhA supports the incorporation of professional ethics instruction in pharmacy curricula and post-graduate continuing education and training.  

1984  **Primary and Secondary Education in Science, Mathematics, and English**  
APhA supports efforts to improve education at the primary and secondary school levels, particularly in the areas of science, mathematics, and English.  

**EMPLOYER/EMPLOYEE RELATIONS**

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)*

2009  **Independent Practice of Pharmacists**  
1. APhA recommends that plans and payers contract with and appropriately compensate individual pharmacist providers for medication therapy management and other clinical services rendered without requiring the pharmacist to be associated with a pharmacy.
2. APhA supports adoption of state laws and rules pertaining to independent practice of pharmacists that 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 creation of payment mechanisms for appropriately trained pharmacists to autonomously provide patient care services that include prescribing as part of the health care team.  
*(JAPhA NS49(4):492; July/August 2009)*

2008  **Internet Access by Pharmacists**  
APhA supports ready access to Internet resources by pharmacists at their practice site, to facilitate delivery of patient care and support professional development.  
*(JAPhA NS 48(4):471; July/August 2008)*

2007  **Pharmacy Personnel Immunization Rates**  
1. APhA supports efforts to increase immunization rates of healthcare professionals, for the purposes of protecting patients, and urges all pharmacy personnel to receive all immunizations recommended by the Centers for Disease Control (CDC) for healthcare workers.
2. APhA encourages employers to provide necessary immunizations to all pharmacy personnel.
3. APhA encourages federal, state, and local public health officials to recognize pharmacists as first responders (like physicians, nurses, police, etc) and prioritize pharmacists to receive medications and immunizations.  
*(JAPhA NS 45(5):580 September-October 2007) (Reviewed 2009)*

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.  
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.

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.

Productivity Requirements

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

1999 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.

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.
Working Conditions

2007 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 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 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.
4. Increasing its activities directed towards educating the profession about the mutual employment responsibilities of employers and employed pharmacists.
5. Developing benefits programs wherever possible to assist employers in providing employed pharmacists with economic security.
6. 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.


2007 Impact of the Pharmacists' Working Conditions on Public Safety

2001

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 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
3. APeA opposes employment practices that limit a pharmacist's ability to provide effective pharmaceutical care.

2004 Sexual Harassment in the Workplace

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

2004 Pharmacy Practice: Professional Judgment

1977 1. APeA 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. APeA supports decision-making processes that ensure the opportunity for input by all pharmacists affected by the decisions.

2004 Stress and Conflict in the Workplace

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

ENVIRONMENTAL CONCERNS

2009 Medication Disposal

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

2007 Recycling of Pharmaceutical Packaging

1992 APeA 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.

2007 Re-Distribution of Previously Dispensed Medications

1. As a matter of patient safety, APeA opposes the re-dispensing of a previously dispensed medication once it has been out of the control of a health care professional.
2. APeA 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.
2004  Medication Disposal
1. APhA encourages the Environmental Protection Agency and other appropriate entities to continue research exploring any connection between the disposal of discarded prescription and OTC medications and contamination of the water supply.
2. APhA encourages the development of programs for safe medication disposal.
3. APhA encourages appropriate government entities to accept responsibility for implementation and associated costs of safe medication disposal programs for consumers.

2004  Fluorinated Hydrocarbons: Utilization in Aerosol Products
1977  APhA supports legislative or regulatory actions banning the non-essential use of fluorinated hydrocarbons; however, APhA recognizes the essential role played by fluorinated hydrocarbons in some medicinal aerosols and supports the selective exemption of medicinal aerosols.

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.

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.

ETHICAL ISSUES

2011  Potential Conflicts of Interest in Pharmacy Practice
1. APhA reaffirms that as health care professionals, pharmacists are expected to act in the best interest of patients when making clinical recommendations.
2. APhA supports pharmacists using evidence-based practices to guide decisions that lead to the delivery of optimal patient care.
3. APhA supports pharmacist development, adoption, and use of policies and procedures to manage potential conflicts of interest in practice.
4. APhA should develop core principles that guide pharmacists in developing and using policies and procedures for identifying and managing potential conflicts of interest

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

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


**Pharmacist Involvement in Execution by Lethal Injection**

**1985**  
1. APHA opposes the use of the term "drug" for chemicals when used in lethal injections.  
2. APHA opposes laws and regulations which mandate or prohibit the participation of pharmacists in the process of execution by lethal injection.  

*Am Pharm  NS25(5):51  May 1985*  
*JAPhA NS44(5):551  September/October 2004* (Reviewed 2010)

**Code of Ethics for Pharmacists**

*The Code of Ethics for Pharmacists was adopted by the membership of the American Pharmacist Association (then the American Pharmaceutical Association) October 27, 1994.*

**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.


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.


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.


FEDERAL PROGRAMS AND POLICIES

2011 Pharmacists as Providers Under the Social Security Act
APhA supports changes to the Social Security Act to allow pharmacists to be recognized and paid as providers of patient care services, including but not limited to medication therapy management.

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

2010 Discontinuation of the Sale of Tobacco Products in Pharmacies and Facilities that Include Pharmacies
1. APhA urges pharmacies and facilities that include pharmacies to discontinue the sale of tobacco products.
2. APhA urges the federal government and state governments to limit participation in government-funded prescription programs to pharmacies that do not sell tobacco products.
3. APhA urges state boards of pharmacy to discontinue issuing and renewing licenses to pharmacies that sell tobacco products and to pharmacies that are in facilities that sell tobacco products.
4. APhA urges colleges of pharmacy to only use pharmacies that do not sell tobacco products as experience sites for their students.
5. APhA urges the Accreditation Council for Pharmacy Education (ACPE) to adopt the position that college-administered pharmacy experience programs should only use pharmacies that do not sell tobacco products.
6. APhA urges pharmacists and student pharmacists who are seeking employment opportunities to first consider positions in pharmacies that do not sell tobacco products.

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

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


2004 IRS Drug Deduction
1980 APhA supports amendment of the federal and state personal income tax laws to permit all personal expenditures for medicines and drugs to be totally deductible and exempt from any exclusionary limits.


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

FREEDOM OF ACCESS (FREEDOM OF CHOICE)

1990  Freedom to Choose
APHa supports the patient's freedom to choose a provider of health care services and a provider's right to be offered participation in governmental or other third-party programs under equal terms and conditions.
APHa opposes government or other third-party programs that impose financial disincentives or penalties that inhibit the patient's freedom to choose a provider or health care services.
APHa supports that patients who must rely upon governmentally-financed or administered programs are entitled to the same high quality of pharmaceutical services as are provided to the population as a whole.


HEALTHCARE REFORM

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)

1994  Pharmacy Services Benefits in Health Care Reform
APHa supports reform of the U.S. health care system and believes that any reform at the state or national level must provide for the following:
1. universal coverage for pharmacy service benefits that include both medications and pharmacists' services;
2. specific provisions for the access to and payment for pharmaceutical care services, including, but not limited to, patient compliance and preventive care, medication therapy management (MTM) of complex and high-risk patients, health education, drug regimen review, and drug utilization review;
3. a single set of pricing rules, eliminating class-of-trade distinctions, for medications, medication delivery systems, and other equipment so that no payer, patient, or provider is disadvantaged by cost shifting.
4. the right for every American to choose his/her own provider of medications and pharmacists' services and for all pharmacists to participate in the health plans of their choice under equally applied terms and conditions;
5. quality assurance mechanisms to improve and substantiate the effectiveness of medications and health services;
6. information and administrative systems designed to enhance patient care, eliminate needless bureaucracy, and provide patients and providers price and quality information needed to make informed patient-care decisions;
7. relief from antitrust laws and regulations to enable pharmacists to establish systems that balance provider needs relative to corporate and governmental interests;
8. reform in the professional liability system, including caps on non-economic damages, attorneys' fees, and other measures;
9. representation on the controlling board of each plan by an active health care practitioner from each
discipline within the scope of the plan; and
10. recognition of the pharmacist's role in delivering primary health care services.


1994 The Scientific Implications of Health Care Reform
1. APhA advocates that the public and private sectors maintain or increase their level of commitment to assure
adequate resources for both basic and applied research within a reformed health care system.
2. APhA encourages the public and private research communities to preferentially expend resources for the
discovery and development of new drugs and technologies that provide substantive, innovative therapeutic
advances.
3. APhA advocates an increased emphasis on outcomes research in all areas of health services, including drug
and disease-specific research encompassing clinical, economic, and humanistic dimensions (e.g., quality of
life, patient satisfaction, ethics.) and advocates for action related to conclusions for such research.
4. APhA encourages interdisciplinary collaboration in research efforts within and between the public and
private research communities.


INTERNET PHARMACY

2005 Telemedicine/Telehealth/Telepharmacy
2004 1. APhA supports the pharmacist as the only appropriate provider of telepharmacy services, a component of
telehealth, for which compensation should be provided. Telepharmacy is defined as the provision of
pharmaceutical care to patients through the use of telecommunications and information technologies.
1999 2. APhA shall assist pharmacists and student pharmacists in becoming knowledgeable about telepharmacy and
telehealth.
3. APhA shall participate in the ongoing development of the telehealth infrastructure, including but not limited
to regulations, standards development, security guidelines, information systems, and compensation.
4. APhA acknowledges that state boards of pharmacy are primarily responsible for the regulation of the
practice of telepharmacy, encourages appropriate regulatory action that facilitates the practice of
telepharmacy and maintains appropriate guidelines to protect the public health and patient confidentiality.


INTERPROFESSIONAL RELATIONS

Consumer

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


General Health Care Organizations

2004 Other Health Care Professional Organizations
1975 APhA supports continuing joint action with other health care and professional organizations.


1989 The Joint Commission
1. APhA supports increased interaction with The Joint Commission regarding accreditation standards and
procedures pertaining to pharmacy and therapeutics.
2. APhA supports pharmacy representation on appropriate The Joint Commission professional and technical
advisory committees.

Mental Health

2004  Mental Health Programs
1965  APhA supports pharmacists' participation in the development and implementation of all aspects of mental health programs so that the special needs and problems of the mentally ill can be effectively met.

Physicians

2011  Health Practitioners and Pharmacists: Relationships and Compensation
2004  APhA opposes any method which provides an inappropriate sharing of compensation between the prescriber and dispenser.

2004  Guidelines for Physician Ownership
1965  APhA supports efforts to develop guidelines on physician ownership of pharmacies due to the inherent conflict of interest.

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 agreement.

Public Health

2011  The Role and Contributions of the Pharmacist in Public Health
In concert with the American Public Health Association’s (APHA) 2006 policy statement, “The Role of the Pharmacist in Public Health,” APhA encourages collaboration with APHA and other public health organizations to increase pharmacists’ participation in initiatives designed to meet global, national, regional, state, local, and community health goals
   *(JAPhA NS51(4):482; July/August 2011)*

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

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.

Veterinary Medicine

2004  Pharmacists’ Relationship to Veterinarians
1988  APhA encourages pharmacists and student pharmacists to become more knowledgeable about veterinary drugs and their usage.
**Expiration Dating and Drug Storage Instructions**

2004 "Beyond-use Dating" by Pharmacists

1989 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.  

2004 Expiration Dating

1971 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.  

**Identification of Drug and Manufacturer:**

2004 Identification of Prescription Drug Products

1980 APhA supports a federal legislative or regulatory requirement that a name, trademark, number, or code be included on the drug dosage form.  

2004 National Drug Code: Uniform Identification Numbers

1975 APhA supports modification of the National Drug Code system to provide uniform identification numbers for the same drug entity, dosage form, strength, and quantity in addition to a manufacturer's identification number.  

2004 Manufacturer's Name Included on Labels

1969 APhA supports legislation that would require the name of the actual manufacturer of the dosage forms on all drug products.  

2004 Standardized Manufacturers' Control Numbers

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

**Ingredients**

2004 Disclosure of Ingredients in Drug Products

1970 APhA supports legislation or regulation to require a full disclosure of therapeutically inactive, as well as active ingredients of all drug products.  

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 2007)

LICENSURE, REGISTRATION, AND REGULATION

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)

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.


Licensure and Registration of Personnel

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
   b. Certification by the Pharmacy Technician Certification Board (PTCB).
5. APhA supports state board of pharmacy regulation that requires 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.

(JAPhA NS48(4):470 July/August 2008)

2004  Technician Licensure and Registration
1996  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.

Continued Competence Assessment Examination
1997
1. APhA should develop, in cooperation with other state and national associations, a voluntary process for self-assessing pharmaceutical care competence.
2. APhA opposes regulatory bodies utilizing continuing competence examinations as a requirement for renewal of a pharmacist’s license.
3. APhA supports programs that measure and evaluate pharmacist competence based on established valid standards.

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

Reciprocity
1980
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.

Licensure, Registration and Inspection of Facilities

2011 Pharmacy Practice Accreditation
1. APhA should lead the creation of consensus-based, pharmacy profession–developed accreditation standards and methods of evaluation to optimize the quality and safety of patient care and promote best practices.
2. APhA urges that accrediting bodies use profession-developed standards for pharmacy.
3. APhA supports only those pharmacy accreditation processes that are voluntary, transparent, consensus-based, reasonably executable, and affordable, while avoiding duplication and barriers to patient care.
4. APhA opposes mandatory pharmacy accreditation.
5. APhA shall assume the leadership role among stakeholders on the design and implementation of an appropriate process for any new pharmacy accrediting program.
6. APhA supports the appropriate use of data gathered from pharmacy practice monitoring processes to facilitate the advancement of pharmacy practice and quality of patient care.
(JAPhA NS51(4):482 July/August 2011)

2010 Discontinuation of the Sale of Tobacco Products in Pharmacies and Facilities that Include Pharmacies
1. APhA urges pharmacies and facilities that include pharmacies to discontinue the sale of tobacco products.
2. APhA urges the federal government and state governments to limit participation in government-funded prescription programs to pharmacies that do not sell tobacco products.
3. APhA urges state boards of pharmacy to discontinue issuing and renewing licenses to pharmacies that sell tobacco products and to pharmacies that are in facilities that sell tobacco products.
4. APhA urges colleges of pharmacy to only use pharmacies that do not sell tobacco products as experience sites for their students.
5. APhA urges the Accreditation Council for Pharmacy Education (ACPE) to adopt the position that college-administered pharmacy experience programs should only use pharmacies that do not sell tobacco products.
6. APhA urges pharmacists and student pharmacists who are seeking employment opportunities to first consider positions in pharmacies that do not sell tobacco products.
(JAPhA NS40(4):471 July/August 2010)

2008 Pharmacy Compounding Accreditation
1. APhA reaffirms the 1992 Compounding Activities of Pharmacists policy, which states that APhA affirms that compounding pursuant to or in anticipation of a prescription or diagnostic preparation order is an essential part of health care that is the prerogative of the pharmacist.
2. APhA supports compounding as defined by the Pharmacy Compounding Accreditation Board (PCAB) as a means to meet patient drug therapy needs.
3. APhA opposes compounding when identical medications are commercially and readily available in strength and dosage form to meet patient drug therapy needs.

4. APhA asserts that compounding is subject to regulations and oversight from state boards of pharmacy. APhA urges state boards of pharmacy to identify and take appropriate action against entities who are illegally manufacturing medications under the guise of compounding.

5. APhA supports accreditation of compounding sites by PCAB to ensure patient safety. APhA encourages state boards of pharmacy to recommend accreditation for those sites that engage in more than basic non sterile compounding as defined by PCAB.

6. APhA supports the development of education, training and recognition programs that enhance pharmacist and student pharmacist knowledge and skills to engage in compounding beyond basic, non sterile preparations as defined by PCAB.

7. APhA encourages the exploration of a specialty certification in the area of compounding through the Board of Pharmaceutical Specialties (BPS).

2008 Regulatory Compliance/Regulatory Burden

2001 APhA supports measures that protect the patient, public and employees from pharmacy conditions that pose a threat to health.

2004 State Boards of Pharmacy/Inspections

1978
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. APhA opposes the use of criminal investigative techniques during routine non-criminal pharmacy inspections.
3. APhA supports regulation and inspection by boards of pharmacy of all facilities within a state where drugs are dispensed, stored, or offered for sale in the same manner as pharmacies.

2004 Licensing Boards: Inspection of Pharmacies

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

2004 Licensure/Registration of Drug Manufacturers

1970 APhA supports the requirements that all drug manufacturers must obtain a federal license or registration, conditioned upon an inspection of the manufacturer's facilities, before manufacturing is begun.

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.

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.
1991  **Updating of State Pharmacy Practice Acts**

2004  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.


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.
3. APhA supports efforts of state Boards of Pharmacy to adopt uniform standards and definitions of pharmacy and pharmacist practice.
4. APhA encourages state Boards of Pharmacy to recognize and facilitate innovations in pharmacy and pharmacist practice.


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.


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**MAIL SERVICE PRESCRIPTIONS**

1992  **Pharmaceutical Care and Medication Distribution Systems**

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.


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**MEDICAL AND PHARMACEUTICAL EQUIPMENT AND PRODUCTS**

2008  **Re-use of devices intended for “Single-Use”**

APhA opposes the reuse of devices intended for “single use” in the diagnosis and treatment of patients consistent with the Centers for Disease Control and Prevention (CDC) and Occupational Safety and Health Administration (OSHA) guidelines

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

2008  **Sale of Home-use Diagnostic and Monitoring Products**

1987  1. APhA recognizes 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 recognizes that the pharmacist is a widely available and qualified health professional to advise patients in the use of the more complex home-use diagnostic and monitoring products.


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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)

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)

1999 **Sale of Sterile Syringes**
APhA encourages state legislatures and boards of pharmacy to revise laws and regulations to permit the unrestricted sale or distribution of sterile syringes and needles by or with the knowledge of a pharmacist in an effort to decrease the transmission of blood-borne diseases.

**MINORITIES IN PHARMACY**

1991 **Recruitment of Minorities into Pharmacy**
1. APhA supports a vigorous long term program for the recruitment of minority students into the pharmacy profession.
2. APhA encourages the development and regular updating of comprehensive recruitment materials, directed toward minorities, that address such issues as pharmacy career opportunities, financial aid, and educational prerequisites, and that highlight professional minority 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 minority students.
4. APhA supports the development of guidelines that assist schools of pharmacy in implementing minority student recruitment programs.

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 sex, age, race, or creed.

**MISCELLANEOUS POLICIES**

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

2004 **Center for Human Organ Acquisition**
1. APhA supports activities that would increase voluntary human organ donations.
2. APhA encourages all pharmacists to consider becoming organ donors themselves, and to inform and encourage their patients to participate in organ donor programs.
3. APhA strongly urges all pharmacists, especially those in emergency room and intensive/critical care settings, to sensitize the other health care team members to the basic need for asking if a patient is an organ donor as part of the admission.
**1979**  
**Child Abuse Reporting**  
APhA urges pharmacists to report all suspected cases of child abuse to proper authorities.  

**NEW DRUG APPLICATIONS AND INVESTIGATIONAL NEW DRUGS**

**Investigational New Drugs**

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

**2004**  
**Therapeutic Orphans**  
**1980**  
APhA supports the adoption of policies in the new drug application (NDA) process that, beyond the pre-market, clinical testing, would result in post-marketing, clinical testing of the drug for important new clinical uses or population groups. Post-marketing studies may also be preferable for other indications where circumstances may require a lengthy gathering of data due to limitations in numbers of clinical cases, and for which initial marketing approval for the major indication(s) or population groups should not be delayed.  
*Am Pharm NS20(7):73 July 1980*  

**1990**  
**Reimbursement of Pharmacy Services Associated with Drugs Undergoing Assessment**  
1. APhA recognizes that investigational new drugs (IND) play a significant role in the delivery of innovative drug therapy approaches and as adjunctive aids in various diagnostics testing modalities.  
2. APhA supports coverage by government and other third-party payers for pharmacy services associated with the use of drugs undergoing assessment.  
*Am Pharm NS30(6):46 June 1990*  
*Reviewed 2004*  
*Reviewed 2009*  
*Reviewed 2010*

**1981**  
**Investigational New Drug (IND) Studies**  
APhA encourages investigators and sponsors who are conducting IND studies to utilize the professional services of pharmacists in carrying out such studies.  
*Am Pharm NS2(5):40 July 1981*  
*Reviewed 2004*  
*Reviewed 2009*  
*Reviewed 2010*

**OFF-LABEL INDICATIONS**

**1994**  
**Off-label Use of FDA-approved Products**  
1. APhA advocates the collaboration of pharmacists, other health care professionals, industry, and the FDA in developing procedures to evaluate off-label use of FDA-approved products.  
2. APhA encourages industry and government cooperation to streamline approval of beneficial off-label therapeutic or diagnostic use of FDA-approved products.  
3. APhA advocates removal of restrictions on reimbursement of pharmaceutical services and FDA-approved products when, in the judgment of the pharmacist, those products are for medically acceptable, off-label uses.  
*Am Pharm NS34(6):56 June 1994*  
*Reviewed 2004*  
*Reviewed 2010*
ORPHAN DRUGS

2004  *Needed Drugs of Limited Commercial Value (Orphan Drugs)*

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


PATIENT/PHARMACIST RELATIONSHIPS

2010  *Transfer Incentives*

APhA advocates the elimination of coupons, rebates, discounts, and other incentives provided to patients that promote the transfer of prescriptions between competitors.

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

2009  *Disparities in Healthcare*

APhA supports elimination of disparities in health care delivery.

*(JAPhA NS49(4):493 July/August 2009)*

2006  *Cultural Health Beliefs and Medication Use*

1. APhA supports culturally sensitive outreach efforts to increase mutual understanding of the risks and other issues of using prescription medications without a prescription order or using unapproved products.
2. APhA supports expanding culturally competent health care services in all communities.

*(JAPhA NS46(5):561 September/October 2006) (Reviewed 2009)*

2005  *Cultural Competence*

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


2005  *Health Literacy*

2002  1. APhA encourages pharmacists and student pharmacists to increase their awareness of health literacy. Health literacy is "the degree to which people can obtain, process, and understand basic health information and services they need to make appropriate health decisions."
2. APhA encourages pharmacists and student pharmacists to assess patients' health literacy and then implement appropriate communications and education.
3. APhA encourages the review of all patient information for health literacy appropriateness.


2005  *Patient Safety*

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

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

2002  Pharmacist/Patient Communication
1991  1. (a) Patients have the right to be informed participants in decisions related to their personal health care.
1991  2. (b) Pharmacists have a professional obligation to contribute to the education of patients to help achieve optimal drug therapy.
1991  3. (c) Pharmacists should provide drug related information to their patients (or patients' agent) by face-to-face oral consultation, supplemented by written or printed material, or any other means or combination of means that is best suited to an individual patient's needs for specific information.
1977  2. APhA acknowledges that the pharmacist is responsible for initiating pharmacist/patient dialogue and assessing the patient's ability to comprehend and communicate so as to optimize the patient's understanding of and compliance with drug therapy.
1977  3. APhA encourages the research and development of ancillary communication aids and techniques to maximize patient understanding of medication and its proper use.

2001  Administrative Contributions to Medication Errors
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.
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.


1995 Continuum of Patient Care
1. APhA advocates and will facilitate pharmacists' participation in the continuum of patient care. The continuum of patient care is characterized by the interdisciplinary care provided a patient through a series of organized, connected events or activities independent of time and practice site, in order to optimize desired therapeutic outcomes.
2. APhA will facilitate pharmacists' participation in the continuum of patient care by:
   - Achieving recognition for the pharmacist as a primary care provider;
   - Securing access for pharmacists to patient information systems, including creation of the necessary software for the purpose of record maintenance of cognitive services provided by pharmacists;
   - Developing means and methods to establish and enable pharmacists' direct participation in the continuum of patient care.


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


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


1987 Cost-effectiveness of Drug Products and Pharmacy Services
APhA supports the development of programs which educate pharmacy's several publics about the cost-effectiveness of drug products and related comprehensive pharmacists services.


1971 Communications with Patients: Drug Delivery Practice
The committee recommends that the APhA adopt as policy the Academy of General Practice of Pharmacy statement on drug delivery practice:

"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."


PHARMACEUTICAL CARE

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.

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

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

2008 Pharmacy Practice-based Research Networks
1. APhA supports establishment of pharmacy practice-based research networks (PBRNs) to strengthen the evidence base in support of MTM and pharmacy primary care services.
2. APhA encourages collaborations among stakeholders to determine the minimal infrastructure and resources needed to develop and implement local, regional and nationwide networks for performing pharmacy practice-based research.
3. APhA encourages pharmacy residency programs to actively participate in pharmacy practice-based research networks.

2003 The Pharmacist’s Role in Laboratory Monitoring and Health Screening
1. APhA supports pharmacist involvement in appropriate laboratory testing and health screening to include pharmacists directly conducting the activity, supervision of such activity, and ordering and interpreting such tests and communicating such test results.
2. APhA supports revision of relevant laws and regulations to facilitate pharmacist involvement in appropriate laboratory testing and health screening as essential components of patient care.

3. APhA encourages research to further demonstrate the value of pharmacist involvement in laboratory testing and health screening services.

4. APhA supports public and private sector compensation for pharmacist involvement in laboratory testing and health screening services.

5. APhA supports training and education of pharmacists and pharmacy students to direct, perform, and interpret appropriate laboratory testing and health screening services. Such education and training should include proficiency testing, quality control, and quality assurances.

6. APhA encourages collaboration and research with other health care providers to ensure appropriate interpretation and use of laboratory monitoring and health screening results.

2003  *The Pharmacist's Role in Therapeutic Outcomes*

1992  1. APhA affirms that achieving optimal therapeutic outcomes for each patient is a shared responsibility of the health care team.

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

1989  *Pharmacy-based Screening and Monitoring Services*

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

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.

1971  *Prescription Department Security*

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

(JPhA NS51(4) 482; July/August 2011)

2011  Pharmacy Practice Accreditation
1. APhA should lead the creation of consensus-based, pharmacy profession–developed accreditation standards and methods of evaluation to optimize the quality and safety of patient care and promote best practices.
2. APhA urges that accrediting bodies use profession-developed standards for pharmacy.
3. APhA supports only those pharmacy accreditation processes that are voluntary, transparent, consensus-based, reasonably executable, and affordable, while avoiding duplication and barriers to patient care.
4. APhA opposes mandatory pharmacy accreditation.
5. APhA shall assume the leadership role among stakeholders on the design and implementation of an appropriate process for any new pharmacy accrediting program.
6. APhA supports the appropriate use of data gathered from pharmacy practice monitoring processes to facilitate the advancement of pharmacy practice and quality of patient care.

(JPhA NS51(4) 482; July/August 2011)

2011  Pharmacists as Providers Under the Social Security Act
APhA supports changes to the Social Security Act to allow pharmacists to be recognized and paid as providers of patient care services, including but not limited to medication therapy management.

(JPhA NS51(4) 482; July/August 2011)

2011  Potential Conflicts of Interest in Pharmacy Practice
1. APhA reaffirms that as health care professionals, pharmacists are expected to act in the best interest of patients when making clinical recommendations.
2. APhA supports pharmacists using evidence-based practices to guide decisions that lead to the delivery of optimal patient care.
3. APhA supports pharmacist development, adoption, and use of policies and procedures to manage potential conflicts of interest in practice.
4. APhA should develop core principles that guide pharmacists in developing and using policies and procedures for identifying and managing potential conflicts of interest.

(JPhA NS51(4) 482; July/August 2011)

2011  The Role and Contributions of the Pharmacist in Public Health
In concert with the American Public Health Association’s (APHA) 2006 policy statement, “The Role of the Pharmacist in Public Health,” APhA encourages collaboration with APHA and other public health
organizations to increase pharmacists’ participation in initiatives designed to meet global, national, regional, state, local, and community health goals

(JAPhA NS51(4): 482; July/August 2011)

2010 E-prescribing Standardization
1. APhA supports the standardization of user interfaces to improve quality and reduce errors unique to e-prescribing.
2. APhA supports reporting mechanisms and research efforts to evaluate the effectiveness, safety, and quality of e-prescribing systems, computerized prescriber order entry (CPOE) systems, and the e-prescriptions that they produce, in order to improve health information technology systems and, ultimately, patient care.
3. APhA supports the development of financial incentives for pharmacists and prescribers to provide high quality e-prescribing activities.
4. APhA supports the inclusion of pharmacists in quality improvement and meaningful use activities related to the use of e-prescribing and other health information technology that would positively impact patient health outcomes.

(JAPhA NS49(4): 471 July/August 2010)

2010 Personal Health Records
1. APhA supports patient utilization of personal health records, defined as records of health-related information managed, shared, and controlled by the individual, to facilitate self-management and communication across the continuum of care.
2. APhA urges both public and private entities to identify and include pharmacists and other stakeholders in the development of personal health record systems and the adoption of standards, including but not limited to terminology, security, documentation, and coding of data contained within personal health records.
3. APhA supports the development, implementation, and maintenance of personal health record systems that are accessible and searchable by pharmacists and other health care providers, interoperable and portable across health information systems, customizable to the needs of the patient, and able to differentiate information provided by a health care provider and the patient.
4. APhA supports pharmacists taking the leadership role in educating the public about the importance of maintaining current and accurate medication-related information within personal health records.

(JAPhA NS49(4): 471 July/August 2010)

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

(JAPhA NS50(4): 471 July/August 2010)

2009 Non-FDA-Approved Drugs and Patient Safety
1. The American Pharmacists Association calls for education and collaboration among health professional organizations, federal agencies, and other stakeholders to ensure that all manufacturer, distributor, and repackager marketed prescription drugs used in patient care have been FDA-approved as safe and effective.
2. APhA supports initiatives aimed at closing regulatory and distribution-system loopholes that facilitate market entry of new prescription drugs products without FDA approval.
3. APhA encourages health professionals to consider FDA approval status of prescription drug products when making decisions about prescribing, dispensing, substitution, purchasing, formulary development, and in the development of pharmacy/medical education programs and drug information compendia.

(JAPhA NS49(4): 492 July/August 2009)
**2009 Pharmacist’s Role in Patient Safety**
1. It is APhA’s position that patient safety initiatives must include pharmacists in leadership roles.
2. APhA encourages dissemination of best practices derived from nationally aggregated reporting data systems to pharmacists for the purpose of improving the medication use process and making informed decisions that directly impact patient safety and quality.
3. APhA encourages the profession of pharmacy to continually review and evaluate ways to enhance training, curricula, continuing education and accountability of pharmacists to improve patient safety.
4. APhA encourages risk management and post-marketing surveillance programs to be standardized and include infrastructures and compensation necessary to allow pharmacists to support these patient safety programs.
5. APhA supports the creation of voluntary, standardized and interoperable reporting systems for patient safety events to minimize barriers to pharmacist participation and to enable aggregation of data and improve quality of medication use systems. The system should be free, voluntary, non-punitive, easily accessible, and user friendly for all providers within the healthcare system.
6. APhA supports the elimination of hand-written prescriptions or medication orders.

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

**2009 Independent Practice of Pharmacists**
1. APhA recommends that plans and payers contract with and appropriately compensate individual pharmacist providers for medication therapy management and other clinical services rendered without requiring the pharmacist to be associated with a pharmacy.
2. APhA supports adoption of state laws and rules pertaining to independent practice of pharmacists that 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 creation of payment mechanisms for appropriately trained pharmacists to autonomously provide patient care services that include prescribing as part of the health care team.

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

**2009 Health Information Technology**
1. APhA supports the delivery of informatics education within pharmacy schools and continuing education programs to improve patient care, to understand interoperability among systems, to understand where to find information, to increase productivity, and to improve the ability to measure and report the value of pharmacists in the health care system.
2. APhA urges that pharmacists have read/write access to electronic health record data for the purposes of improving patient care and medication use outcomes.
3. APhA encourages inclusion of pharmacists in the defining, development and implementation of health information technologies for the purpose of improving the quality of patient-centric health care.
4. APhA urges public and private entities to include pharmacist representatives in the creation of standards, certification of systems, and integration of medication use systems with health information technology.

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

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

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

56
2008 *Pharmacy Compounding Accreditation*

1. APhA reaffirms the 1992 Compounding Activities of Pharmacists policy, which states that APhA affirms that compounding pursuant to or in anticipation of a prescription or diagnostic preparation order is an essential part of health care that is the prerogative of the pharmacist.

2. APhA supports compounding as defined by the Pharmacy Compounding Accreditation Board (PCAB) as a means to meet patient drug therapy needs.

3. APhA opposes compounding when identical medications are commercially and readily available in strength and dosage form to meet patient drug therapy needs.

4. APhA asserts that compounding is subject to regulations and oversight from state boards of pharmacy. APhA urges state boards of pharmacy to identify and take appropriate action against entities who are illegally manufacturing medications under the guise of compounding.

5. APhA supports accreditation of compounding sites by PCAB to ensure patient safety. APhA encourages state boards of pharmacy to recommend accreditation for those sites that engage in more than basic non sterile compounding as defined by PCAB.

6. APhA supports the development of education, training and recognition programs that enhance pharmacist and student pharmacist knowledge and skills to engage in compounding beyond basic, non sterile preparations as defined by PCAB.

7. APhA encourages the exploration of a specialty certification in the area of compounding through the Board of Pharmaceutical Specialties (BPS).


2008 *Pharmacy Practice-based Research Networks*

1. APhA supports establishment of pharmacy practice-based research networks (PBRNs) to strengthen the evidence base in support of MTM and pharmacy primary care services.

2. APhA encourages collaborations among stakeholders to determine the minimal infrastructure and resources needed to develop and implement local, regional and nationwide networks for performing pharmacy practice-based research.

3. APhA encourages pharmacy residency programs to actively participate in pharmacy practice-based research networks.

(APhA NS48(4):470 July/August 2008)

2001 *Regulatory Compliance/Regulatory Burden*

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)(Reviewed 2008)

2008 *Re-use of devices intended for “Single-Use”*

APhA opposes the reuse of devices intended for “single use” in the diagnosis and treatment of patients consistent with the Centers for Disease Control and Prevention (CDC) and Occupational Safety and Health Administration (OSHA) guidelines.

(JAPhA NS48(4):471 July/August 2008)

2007 *Pharmacist Primary Care*

1. APhA recommends the use of pharmacists as primary care providers, alone or in collaboration with other providers, in community pharmacy based health clinics.


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)
2006  **Continuity of Care**
1. APhA supports the pharmacist as the most appropriate member of the health care team responsible for reconciling medication use when patients move between practice settings within the continuum of care.
2. APhA supports the development and use, in practice, of a standardized, portable, accessible, HIPAA compliant, and secure Electronic Health Record (EHR) to facilitate continuity of care across all practice settings. The EHR shall include the clinical data elements necessary to support the performance of medication reconciliation.
3. APhA supports patient access to pharmacists with specialized skills and expertise. The patient’s pharmacist should make patient referrals where appropriate.


2005  **Compounding with Multicomponent Vehicles**
1. APhA encourages companies that offer multi-component vehicles for compounding to list all ingredients and to restrict claims about the vehicles to the structure and function of the ingredients in those vehicles unless clinical evidence exists to support more specific claims.
2. When claims are made by companies for systemic delivery of active ingredients in multi-component vehicles, APhA encourages pharmacists to secure bioavailability data in support of such claims.

(JAPhA NS45(5):555 September/October 2005) (Reviewed 2009)

2005  **Pharmacogenomics**

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


2005  **Empowerment of Pharmacists as Drug Therapy Managers**

2003 1. APhA encourages pharmacists to take an active role in achieving the goals of the Healthy People program regarding 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.


2004  **Drug Use Control by Pharmacists for All Prescription Drugs**

1989 1. APhA supports the authority and responsibility of pharmacists in the management and control of all approved and investigational drug products.
2. APhA encourages corporate, government, and health-care organizations to recognize and utilize the unique expertise of the pharmacist in the management and control of all approved and investigational drug products.

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


2004 Drug Regimen Review (DRR) by Pharmacists
1979 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.


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


2004 Roles in Health Care for Pharmacists
1978 1. APhA shall develop and maintain new methods and procedures whereby pharmacists can increase their ability and expand their opportunities to provide health care services.
2. APhA supports legislative and judicial action that confirms 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 patients they serve.


2004 Drug Storage and Return Goods Policy
1971 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.


2003 The Pharmacist's Role with Diagnostic Drugs in Therapeutic Outcomes
1993 APhA recognizes that it is a responsibility of the pharmacists to take an active role in the selection and use of diagnostic drugs as an integral component in the development and implementation of a patient's therapeutic plan.


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.


2001 Administrative Contributions to Medication Errors
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
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.

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.

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.

2001 Pharmacist Counseling on Administration Devices
APhA encourages patient and caregiver education by a pharmacist on the appropriate use of drug administration devices.

2000 Use of the phrase "Community Pharmacy"
APhA supports use of the phrase "community pharmacy" rather than "retail pharmacy."

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.


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 postgraduate education for pharmacists.
3. APhA supports appropriate evaluation and recognition of providers of pharmaceutical care.


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.

(Reviewed 2008)

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.

(Reviewed 2010)

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.

(Reviewed 2007)

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.

(Reviewed 2007)

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.

(Reviewed 2004) (Reviewed 2010)
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.


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.


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.


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


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.


Facility Design and Face-to-Face Communication

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.


1992 Pharmaceutical Care and Medication Distribution Systems
APhA encourages those responsible for practice environments without direct patient/pharmacist contact to use methods to enhance communications, face-to-face interaction, and pharmaceutical care.

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
   b. Certification by the Pharmacy Technician Certification Board (PTCB).
5. APhA supports state board of pharmacy regulation that requires 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.

(JAPhA NS48(4):470 July/August 2008)

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)

1996  Technician Licensure and Registration
2004  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.


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.


POISON PREVENTION

2004  Poison Control, Information, and Treatment: Pharmacists' Responsibility
1968  1. APhA encourages pharmacists to familiarize themselves with the available resources on poisons and toxicology.
2. APhA encourages pharmacists to become familiar with the position control, information and treatment center in their localities.


2004  Poison Control, Information, and Treatment: Pharmacists' Responsibilities
1967  APhA recommends that pharmacists take a more active role in poison prevention and establishing poison information, poison treatment, and poison control centers where none exists.

**POST-MARKET SURVEILLANCE**

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

*(JPhA NS50(4):471 July/August 2010)*

**2009 Pharmacist’s Role in Patient Safety**
1. It is APhA’s position that patient safety initiatives must include pharmacists in leadership roles.
2. APhA encourages dissemination of best practices derived from nationally aggregated reporting data systems to pharmacists for the purpose of improving the medication use process and making informed decisions that directly impact patient safety and quality.
3. APhA encourages the profession of pharmacy to continually review and evaluate ways to enhance training, curricula, continuing education and accountability of pharmacists to improve patient safety.
4. APhA encourages risk management and post-marketing surveillance programs to be standardized and include infrastructures and compensation necessary to allow pharmacists to support these patient safety programs.
5. APhA supports the creation of voluntary, standardized and interoperable reporting systems for patient safety events to minimize barriers to pharmacist participation and to enable aggregation of data and improve quality of medication use systems. The system should be free, voluntary, non-punitive, easily accessible, and user friendly for all providers within the healthcare system.
6. APhA supports the elimination of hand-written prescriptions or medication orders.

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

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


**PREScribing Authority**

**2009 Independent Practice of Pharmacists**
1. APhA recommends that plans and payers contract with and appropriately compensate individual pharmacist providers for medication therapy management and other clinical services rendered without requiring the pharmacist to be associated with a pharmacy.
2. APhA supports adoption of state laws and rules pertaining to independent practice of pharmacists that 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 creation of payment mechanisms for appropriately trained pharmacists to autonomously provide patient care services that include prescribing as part of the health care team.

(JAPhA NS49(4):492 July/August 2009)

2003 Emergency Contraception
2000 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.


2003 The Pharmacist's Role in Therapeutic Outcomes
1992 1. APhA affirms that achieving optimal therapeutic outcomes for each patient is a shared responsibility of the health care team.
2. APhA recognizes that a primary responsibility of the pharmacist in achieving optimal therapeutic outcomes is to take an active role in the development and implementation of a therapeutic plan and in the appropriate monitoring of each patient.


1987 Pharmacist Prescribing
APhA supports authority for pharmacists to select non-prescription and certain prescription medications as part of pharmacists’ responsibilities to design, implement, and monitor drug regimens for patients, in consultation with practitioners when appropriate.


1980 Prescribing by Pharmacists
APhA supports the concept of a team approach to health care in which health professionals perform those functions for which they are distinctively educated. APhA recognizes that the pharmacist is the expert on drugs and drug therapy on the health care team and supports a prescribing role for the pharmacist, based on the specific diagnosis of a qualified health practitioner.


PRESCRIPTIONS AND PRESCRIPTION ORDERS

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


2010 Prescription Order Requirements
2001 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.


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

1. It is APhA’s position that patient safety initiatives must include pharmacists in leadership roles.

2. APhA encourages dissemination of best practices derived from nationally aggregated reporting data systems to pharmacists for the purpose of improving the medication use process and making informed decisions that directly impact patient safety and quality.

3. APhA encourages the profession of pharmacy to continually review and evaluate ways to enhance training, curricula, continuing education and accountability of pharmacists to improve patient safety.

4. APhA encourages risk management and post-marketing surveillance programs to be standardized and include infrastructures and compensation necessary to allow pharmacists to support these patient safety programs.

5. APhA supports the creation of voluntary, standardized and interoperable reporting systems for patient safety events to minimize barriers to pharmacist participation and to enable aggregation of data and improve quality of medication use systems. The system should be free, voluntary, non-punitive, easily accessible, and user friendly for all providers within the healthcare system.

6. APhA supports the elimination of hand-written prescriptions or medication orders.

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

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.


**PUBLIC HEALTH**

**Alcohol and Tobacco**

2010  **Discontinuation of the Sale of Tobacco Products in Pharmacies and Facilities that Include Pharmacies**

1. APhA urges pharmacies and facilities that include pharmacies to discontinue the sale of tobacco products.

2. APhA urges the federal government and state governments to limit participation in government-funded prescription programs to pharmacies that do not sell tobacco products.

3. APhA urges state boards of pharmacy to discontinue issuing and renewing licenses to pharmacies that sell tobacco products and to pharmacies that are in facilities that sell tobacco products.

4. APhA urges colleges of pharmacy to only use pharmacies that do not sell tobacco products as experience sites for their students.

5. APhA urges the Accreditation Council for Pharmacy Education (ACPE) to adopt the position that college-administered pharmacy experience programs should only use pharmacies that do not sell tobacco products.

6. APhA urges pharmacists and student pharmacists who are seeking employment opportunities to first consider positions in pharmacies that do not sell tobacco products.

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

2006  **Tobacco Use Data Entry Field in Pharmacy Patient Records**

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

(JAPhA NS46(5):561 September/October 2006)(Reviewed 2011)
2005  **Cigarette Sales in Pharmacies**

1971  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.


2005  **Cigarette Sales in Pharmacies**

1968  APhA recommends that pharmacists not allow smoking in their prescription departments.


1996  **Exclusion of Alcohol and Tobacco Sales in Pharmacy Practice Settings**

APhA opposes the sale of tobacco products and non-medicinal alcoholic beverages in pharmacies.


### Community Awareness and Education

2005  **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 pharmacists students.
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 organization to include pharmacists and student pharmacists in the development of public health programs.


2005  **Pharmacists' Responsibilities in Community Medication Awareness Programs**

1986  1. APhA supports the development of a comprehensive educational program on the proper use of prescription and non-prescription medication.
2. Pharmacists should take a major educational responsibility in proactive programs which optimize therapeutic outcomes and minimize risks from inappropriate medication use.


2000  **Medication Use in Schools**

APhA recognizes the role of pharmacists in improving the use of medications in schools and supports pharmacist activities to work with teachers, school nurses, parents, school administrators and other personnel to improve medication use in this environment. APhA recommends that pharmacists be involved in the development of guidelines for medication use in schools.

(JAPhA NS19(9):40 September/October 2000) (Reviewed 2005 (Reviewed 2009)

### HIV/AIDS

2005  **HIV/AIDS Education**

1993  1. APhA encourages pharmacists and student pharmacists to become more knowledgeable about HIV/AIDS.
2. APhA supports the development of cooperative efforts among health care organizations and agencies to facilitate the collection, evaluation, and distribution of information on HIV/AIDS.
3. APhA supports the development of educational programs for pharmacists and student pharmacists that would enable them to assume a service role in the prevention and treatment of HIV/AIDS.


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2005  **HIV Testing**
1993  1. APhA opposes mandatory HIV testing of pharmacists, student pharmacists, and pharmacy personnel.
2. APhA supports voluntary and confidential HIV testing of pharmacists, student pharmacists, and pharmacy personnel, to facilitate early detection and disease intervention.
3. APhA supports training designed to foster compliance with infection control procedures outlined in current Centers for Disease Control and Prevention (CDC) guidelines for universal precautions and OSHA standards for blood-borne pathogens.
4. APhA encourages the development of support networks to assist HIV-positive health care professionals and students.


2005  **Needle/Syringe Exchange Programs in the Prevention of the Spread of Human Immunodeficiency Virus (HIV) and Other Infections**
1990
1. APhA supports distribution of educational materials on the risks of sharing needles/syringes with respect to the spread of human immunodeficiency virus (HIV) and other blood-borne infectious diseases.
2. APhA supports the objective gathering and analysis of data and information about the effectiveness of pilot needle/syringe exchange programs in preventing the spread of HIV and other blood-borne infectious diseases.
3. APhA supports needle/syringe exchange programs when part of a comprehensive approach in the prevention of the spread of HIV and other blood-borne infections.


1999  **Sale of Sterile Syringes**
APhA encourages state legislatures and boards of pharmacy to revise laws and regulations to permit the unrestricted sale or distribution of sterile syringes and needles by or with the knowledge of a pharmacist in an effort to decrease the transmission of blood-borne diseases.


1996  **HIV Testing in Pregnant Women**
APhA encourages pharmacists to provide pharmaceutical care to women, including education about the availability and benefits of HIV testing in pregnancy to decrease the risk of HIV transmission to unborn children, APhA encourages pharmacists to provide education about the availability and benefits of HIV testing in pregnancy.


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**Immunizations**

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)

2007  **Pharmacy Personnel Immunization Rates**
1. APhA supports efforts to increase immunization rates of healthcare professionals, for the purposes of protecting patients, and urges all pharmacy personnel to receive all immunizations recommended by the Centers for Disease Control (CDC) for healthcare workers.
2. APhA encourages employers to provide necessary immunizations to all pharmacy personnel.
3. APhA encourages federal, state, and local public health officials to recognize pharmacists as first responders (like physicians, nurses, police, etc) and prioritize pharmacists to receive medications and immunizations.

(JAPhA NS45(5):580  September-October 2007) (Reviewed 2009)

2005  **Empowerment of Pharmacists as Drug Therapy Managers**
2003  1. APhA encourages pharmacists to take an active role in achieving the goals of the Healthy People program regarding 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.

Other Public Health Issues

2011 The Role and Contributions of the Pharmacist in Public Health
In concert with the American Public Health Association’s (APHA) 2006 policy statement, “The Role of the Pharmacist in Public Health,” APhA encourages collaboration with APHA and other public health organizations to increase pharmacists’ participation in initiatives designed to meet global, national, regional, state, local, and community health goals.

2011 Fluoridation of Water Supplies
1996 APhA reaffirms its 1954 position in support of appropriate fluoridation of water supplies and encourage pharmacists to assist in implementing such programs in their local communities.

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. Further, 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.

2008 Re-use of devices intended for “Single-Use”
APhA opposes the reuse of devices intended for “single use” in the diagnosis and treatment of patients consistent with the Centers for Disease Control and Prevention (CDC) and Occupational Safety and Health Administration (OSHA) guidelines.

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.

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.

2006 Conversion of Nonprescription Products Into Drugs of Abuse
1. APhA supports legislative, regulatory, and private sector efforts that include input from pharmacists to balance the need for patient/consumer access to medications for legitimate medical purposes with the need to prevent diversion and abuse.
2. APhA supports consumer sales limits of nonprescription drug products that may be illegally converted into drugs for illicit use.

3. APhA encourages education of all personnel involved in the distribution chain of nonprescription products concerning the potential for certain products to be illegally converted into drugs for illicit use.

4. APhA supports public and private initiatives that result in increased funding to address the escalating needs for drug abuse treatment and prevention.

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

2005  **Efforts to Limit Methamphetamine Access**

APhA supports legislation that balances the need for patient/consumer access to medications for legitimate medical purposes with the need to prevent diversion and abuse.

APhA supports stringent enforcement of criminal laws against individuals who engage in the illegal trafficking of methamphetamine and methamphetamine precursors.

APhA supports retail sales limits of non-prescription products that contain methamphetamine precursors to prevent diversion.

APhA supports education of employees involved in the distribution chain of methamphetamine precursors about diversion, methamphetamine abuse and prevention of abuse. APhA supports patient/consumer education of consequences of methamphetamine abuse.

APhA supports public and private initiatives that result in increased funding to address the escalating needs for drug abuse treatment and prevention.


2005  **Health Literacy**

2002  1. APhA encourages pharmacists and student pharmacists to increase their awareness of health literacy.

   Health literacy is "the degree to which people can obtain, process, and understand basic health information and services they need to make appropriate health decisions."

2. APhA encourages pharmacists and student pharmacists to assess patients' health literacy and then implement appropriate communications and education.

3. APhA encourages the review of all patient information for health literacy appropriateness.


2005  **Emergency Preparedness**

2002  APhA supports the continuing efforts of the Joint Commission of Pharmacy Practitioners working group on emergency preparedness and response to network with the Office of Homeland Security and with any other relevant governmental and/or military agency.


2005  **Complementary and Alternative Medications**

1997  1. APhA shall support informed decision-making based upon the professional judgment of pharmacists regarding the appropriateness of use or the sale of complementary and alternative medicines.

2. APhA shall assist pharmacists and student pharmacists in becoming knowledgeable about complementary and alternative medications to facilitate the counseling of patients regarding effectiveness, proper use, indications, safety and possible interactions.


2005  **Prevention and Control of Sexual Transmitted Diseases**

1972  1. APhA calls upon all producers of prophylactic devices to include in or on their packaging adequate instructions for use so as to better ensure the effectiveness of the devices in the prevention of sexually transmitted diseases.

2. APhA urges pharmacists to make more readily available to the public educational materials, prophylactic devices, and adequate instructions for use in combating sexually transmitted diseases.

2002  **Homeopathy**
1. APhA supports the demonstration of safety and efficacy of homeopathic products from adequate, well-designed scientific studies before pharmacists advocate or sell homeopathic products.
2. APhA recognizes patient autonomy regarding the use of homeopathic products. Pharmacists should educate patients who choose to use homeopathic products.
3. APhA shall work with Congress to modify the Food, Drug and Cosmetic Act or enact other legislation to require that homeopathic manufacturers provide evidence of efficacy and safety for all products, including products currently in the marketplace.


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.


1986  **Reye Syndrome**
1. APhA supports all initiatives which enhance public education about the potential relationship between Reye Syndrome and oral and rectal salicylate-containing products, including settings where pharmacists are not available for consultation.


**PUBLIC RELATIONS**

2002  **Promotion of Pharmacists' Value**
1971  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.


2002  **Health Education: Selection of Pharmacist**
1964  APhA supports education of consumers about the importance of selecting their personal pharmacist to assist them in the proper use of all medications and therapeutic devices.


1999  **Promotion of Pharmaceutical Care**
(See Appendix for APhA Principles of Practice for Pharmaceutical Care)
APhA should continue to promote to the public the concepts and benefits of pharmaceutical care, differentiating pharmaceutical care practice from other pharmacy services.
APhA opposes the use of the term "pharmaceutical care" by any individual or entity unless the pharmaceutical care service provided by the individual or entity incorporates the concepts specified in the APhA Principles of Practice for Pharmaceutical Care.

1987  **Future of Pharmacy**
1. APhA supports programs which plan for the future of pharmacy.
2. APhA supports programs which encourage innovations in the practice of pharmacy in a changing health care environment.
3. APhA supports programs which reflect a positive image of pharmacists.


1986  **Use of the Title "Pharmacist"**
APhA encourages the use of the title "Pharmacist" in communications and all public media.


**QUALITY ASSURANCE**

2011  **Pharmacy Practice Accreditation**
1. APhA should lead the creation of consensus-based, pharmacy profession–developed accreditation standards and methods of evaluation to optimize the quality and safety of patient care and promote best practices.
2. APhA urges that accrediting bodies use profession-developed standards for pharmacy.
3. APhA supports only those pharmacy accreditation processes that are voluntary, transparent, consensus-based, reasonably executable, and affordable, while avoiding duplication and barriers to patient care.
4. APhA opposes mandatory pharmacy accreditation.
5. APhA shall assume the leadership role among stakeholders on the design and implementation of an appropriate process for any new pharmacy accrediting program.
6. APhA supports the appropriate use of data gathered from pharmacy practice monitoring processes to facilitate the advancement of pharmacy practice and quality of patient care.

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

2011  **Measuring the Quality of Patient Care**
1995  **1.** APhA believes that quality assessment measures must evaluate the accessibility, acceptability, and technical quality of pharmacy services, as well as the patient-centered and economic outcomes of patient care. These measures must consider the perspectives of patients, pharmacists, and other health care providers.
2. APhA believes quality assessment measures of patient care should be tested for validity and reliability in various pharmacy practice settings prior to widespread application.
3. APhA should develop tools and/or programs that enable pharmacists to apply quality assessment measures to their delivery of patient care.
4. APhA should promote efforts to educate patients, pharmacists, other health care providers, payers, policy makers, and other interested parties on the appropriate use of quality assessment measures to evaluate and improve the delivery of patient care.


2009  **Pharmacist’s Role in Patient Safety**
1. It is APhA’s position that patient safety initiatives must include pharmacists in leadership roles.
2. APhA encourages dissemination of best practices derived from nationally aggregated reporting data systems to pharmacists for the purpose of improving the medication use process and making informed decisions that directly impact patient safety and quality.
3. APhA encourages the profession of pharmacy to continually review and evaluate ways to enhance training, curricula, continuing education and accountability of pharmacists to improve patient safety.
4. APhA encourages risk management and post-marketing surveillance programs to be standardized and include infrastructures and compensation necessary to allow pharmacists to support these patient safety programs.
5. APhA supports the creation of voluntary, standardized and interoperable reporting systems for patient safety events to minimize barriers to pharmacist participation and to enable aggregation of data and improve quality of medication use systems. The system should be free, voluntary, non-punitive, easily accessible, and user friendly for all providers within the healthcare system.
6. APhA supports the elimination of hand-written prescriptions or medication orders.

(JAPhA NS49(4):492 July/August 2009) (Reviewed 2010)
**2005 Continuing Professional Development**

1. APhA supports continuing professional development, a self-directed, individualized, systematic approach to life-long learning, to support pharmacists’ efforts to maintain professional competence in their practice.
2. APhA should work with appropriate organizations to provide self-assessment and plan development tools. APhA shall help identify and facilitate access to quality educational programs.
3. Employers should foster and support pharmacist participation in continuing professional development.
4. Continuing professional development is a learning process that requires full participation to achieve desired individual outcomes. To facilitate that participation, each pharmacist controls disclosure of their individual assessments and outcomes.

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

**2001 Credentialing and Pharmaceutical Care**

1. APhA should continue to assist in the unification of the profession and the development of a national strategy by its continued support of the Council on Credentialing in Pharmacy as the body responsible for the leadership, standards, public information and coordination of the profession’s voluntary credentialing programs.
2. APhA, in conjunction and cooperation with the Council on Credentialing and other national associations, should provide competence-based material and testing via technology, such as the APhA Web site and state association Web sites, to further the profession’s self-assessment.
3. APhA, in conjunction and cooperation with the Council on Credentialing and other national associations, should develop the necessary products and programs to educate the public, insurers, and health professionals on credentialing and make them available to state associations at cost.
4. APhA supports the development, on a continuing basis, of programs such as Project ImPACT, which provide the opportunity to promote the profession and its impact on clinical, economic, and humanistic patient outcomes.


**2001 Pharmacist-Patient-Prescriber-Payer Responsibilities in Appropriate Drug Use**

**1994 APhA advocates the following guidelines for pharmacist-patient-prescriber-payer responsibilities in appropriate drug use:**

**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;
- Maintain proficiency through continuing education.

**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 treatment regimen;
• Alert prescribers and pharmacists to possible drug-related problems or changes in health status.

**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;
• Maintain proficiency through continuing medical education.

**Payers’ Responsibilities**

• Determine 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 for reimbursement;
• Educate patients and providers about current eligibility and benefit information;
• Expeditiously process payments;
• Be responsive to advances in contemporary practice.


**2000 Quality Assessment**

APhA reaffirms the 2000, 1980 and 1995 policy statements on quality assessment and improvement and supports the expanded implementation of those statements.


**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.


**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 pharmaceutical care and experience, in addition to education.
3. APhA will develop and implement curricular-based continuing education programs leading to certificates of competence in pharmaceutical 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.


**1994 Preventing Dispensing-related Problems**

1. APhA encourages the development of practice guidelines to identify, resolve, and prevent dispensing-related problems.
2. APhA supports the development of electronic systems that confidentially collect information to record dispensing-related problems.
3. APhA believes that pharmacists have a professional responsibility to document and report dispensing-related problems in an ongoing effort to improve the quality of the drug distribution system.
4. APhA will assume a leadership role in the gathering, analysis, and interpretation of the aggregate data regarding dispensing-related problems, and the dissemination of the results, which will enable pharmacists to further improve medication distribution.

(REviewed 2001) (Reviewed 2007) (Reviewed 2009)

RECORD SYSTEMS

2010  E-prescribing Standardization
1. APhA supports the standardization of user interfaces to improve quality and reduce errors unique to e-prescribing.
2. APhA supports reporting mechanisms and research efforts to evaluate the effectiveness, safety, and quality of e-prescribing systems, computerized prescriber order entry (CPOE) systems, and the e-prescriptions that they produce, in order to improve health information technology systems and, ultimately, patient care.
3. APhA supports the development of financial incentives for pharmacists and prescribers to provide high quality e-prescribing activities.
4. APhA supports the inclusion of pharmacists in quality improvement and meaningful use activities related to the use of e-prescribing and other health information technology that would positively impact patient health outcomes.

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

2010  Personal Health Records
1. APhA supports patient utilization of personal health records, defined as records of health-related information managed, shared, and controlled by the individual, to facilitate self-management and communication across the continuum of care.
2. APhA urges both public and private entities to identify and include pharmacists and other stakeholders in the development of personal health record systems and the adoption of standards, including but not limited to terminology, security, documentation, and coding of data contained within personal health records.
3. APhA supports the development, implementation, and maintenance of personal health record systems that are accessible and searchable by pharmacists and other health care providers, interoperable and portable across health information systems, customizable to the needs of the patient, and able to differentiate information provided by a health care provider and the patient.
4. APhA supports pharmacists taking the leadership role in educating the public about the importance of maintaining current and accurate medication-related information within personal health records.

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

2009  Health Information Technology
1. APhA supports the delivery of informatics education within pharmacy schools and continuing education programs to improve patient care, to understand interoperability among systems, to understand where to find information, to increase productivity, and to improve the ability to measure and report the value of pharmacists in the health care system.
2. APhA urges that pharmacists have read/write access to electronic health record data for the purposes of improving patient care and medication use outcomes.
3. APhA encourages inclusion of pharmacists in the defining, development and implementation of health information technologies for the purpose of improving the quality of patient-centric health care.
4. APhA urges public and private entities to include pharmacist representatives in the creation of standards, certification of systems, and integration of medication use systems with health information technology.

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

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

2005 Documentation

1993 1. APhA encourages development of systems that document review of 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.

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.

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).

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 a 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.
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.

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.
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.  

1983  **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.  

### REIMBURSEMENT AND COMPENSATION

2009  **Independent Practice of Pharmacists**  
1. APhA recommends that plans and payers contract with and appropriately compensate individual pharmacist providers for medication therapy management and other clinical services rendered without requiring the pharmacist to be associated with a pharmacy.  
2. APhA supports adoption of state laws and rules pertaining to independent practice of pharmacists that 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 creation of payment mechanisms for appropriately trained pharmacists to autonomously provide patient care services that include prescribing as part of the health care team.  
   *(JAPhANS 49(4):492 July/August 2009)*

2005  **Empowerment of Pharmacists as Drug Therapy Managers**  
2003  1. APhA encourages pharmacists to take an active role in achieving the goals of the Healthy People program regarding 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.  

2005  **Reimbursement for Unapproved (Off-label) Uses of FDA-Approved Drug Products**  
1990  APhA supports coverage of FDA-approved drugs and pharmacist 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.  

2005  **Catastrophic Illness: Coverage for Pharmacist Services Included**  
1987  1. APhA supports comprehensive, catastrophic illness insurance coverage that recognizes the essential need for pharmaceutical products and pharmacist services in all patient care environments, including the home.  
2. APhA encourages inclusion of pharmacist services and the most efficient and readily accessible system of drug delivery in any insurance coverage for catastrophic illness that may be enacted.  

77
2005 **Pharmacists and Home Health Care**

1985 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 maximize adherence, increase the opportunity for drug utilization review, and better meet the informational needs of the patient and the care giver.


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.


**Federal Programs**

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

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

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

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)

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

1980 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.

2005 Medicare Prescription Drug Benefits
1978 1. APhA endorses extension of Medicare coverage to include a Medicare prescription drug benefit.
2. A Medicare prescription drug benefit should:
   (a) Place drug product cost reimbursement on an actual acquisition cost 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) Prevent dispensing by physicians under this program; and
   (e) Remove the price-posting requirement as a condition of participation in the program.


2005 Government-Financed Reimbursement
1977 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.


2005 Medicare, Medicaid, and Other Third-party Payment Programs
1970 1. APhA advocates 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.
2. APhA supports maintaining 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.


2005 Medicare: Reimbursement Procedures
1969 APhA should educate pharmacists on aspects of reimbursement procedures and concepts associated with
Medicare.


2005 Medicare and Pharmaceutical Service
1969 1. 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. APhA 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. APhA should support the Part B mechanism which is the voluntary supplementary medical insurance
   program financed equally by beneficiaries and the government.
4. APhA should oppose legislation which would restrict the drug benefit to specific, chronic diseases.
5. APhA should 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.

2004 **Tablet Splitting**
APhA opposes mandatory tablet splitting.
*(JAPhA NS44(5):551  September/October 2004) (Reviewed 2010)*

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.

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.

**National Health Insurance**

2005 **National Health Insurance (NHI)**
1971 APhA endorses 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:
   (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 inadequacies in the delivery of health care.
   (c) A national health insurance plan must allow for maximum utilization of pharmacists 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.

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.


**New Payment Systems**

**2011 APhA’s Role in the Development and Support of New Payment Systems**

**1994**
1. APhA should continue its work with pharmacy benefits’ managers and other private and public payers to develop innovative pharmacy benefit designs and compensation strategies for pharmacists’ services.
2. APhA will endorse benefit design concepts that recognize and compensate pharmacists for their cognitive services to maximize therapeutic outcomes.


**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.


**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.


**2005 Payment System Reform**

**1993**
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.


**Professional Fees**

**2008 Billing and Documentation of Medication Therapy Management (MTM) Services**

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


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.


2005 Periodic Adjustments of Professional Fees in Federal Programs

1975 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.


Third Party and Prepaid Programs

2005 The Scientific Implications of Health Care Reform

1994 1. APhA advocates that the public and private sectors maintain or increase their level of commitment to assure adequate resources for both basic and applied research within a reformed health care system.
2. APhA encourages the public and private research communities to preferentially expend resources for the discovery and development of new drugs and technologies that provide substantive, innovative therapeutic advances.
3. APhA advocates an increased emphasis on outcomes research in all areas of health services, including drug and disease-specific research encompassing clinical, economic, and humanistic dimensions (e.g., quality of life, patient satisfaction, ethics) and advocates for action related to conclusions for such research.
4. APhA encourages interdisciplinary collaboration in research efforts within and between the public and private research communities.


2005 Third-party Reimbursement Legislation

1981 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.


2005 Exemption from the Employee Retirement Income Security Act (ERISA)

1984 APhA seeks introduction of legislation exempting state, third-party, and prescription program legislation from preemption by ERISA.


RESEARCH

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)*

**2008 Pharmacy Practice-based Research Networks**

1. APhA supports establishment of pharmacy practice-based research networks (PBRNs) to strengthen the evidence base in support of MTM and pharmacy primary care services.

2. APhA encourages collaborations among stakeholders to determine the minimal infrastructure and resources needed to develop and implement local, regional and nationwide networks for performing pharmacy practice-based research.

3. APhA encourages pharmacy residency programs to actively participate in pharmacy practice-based research networks.  

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

**2005 Public Access to Clinical Trials Data**

1. APhA supports access by healthcare professionals and the public to all clinical trial data derived from scientifically valid studies. APhA supports the establishment of a single, independent, publicly accessible clinical trials database that includes but is not limited to the following components:
   a. includes all studies, pre and post drug approval, throughout the research period (whether completed, in-progress or discontinued)
   b. clearly states the size, demographics, limitations and citations, if published, of each study listed
   c. includes an interpretative statement by an independent review body regarding the purpose of the study, methodology and outcomes to assist the public in understanding the posted information in a timely manner
   d. includes warnings to the public regarding inappropriate or incomplete use of the data in making clinical decisions in absence of an interpretive statement
   e. the sponsor and any supporting company, organization, or partnered institution of each clinical trial listed shall be clearly identified. (This includes Clinical Research Organizations, Academic Research Organizations, Site Management Organizations or any other group that is responsible – other than the investigator’s research site.)

*(JAPhA NS45(5):554-555 September/October 2005) (Reviewed 2009)*

**2005 Use of Representative Populations in Clinical Studies**

1. APhA supports the use of representative populations in clinical studies, including the use of women, minorities, the elderly, and children when appropriate.

2. APhA encourages the development of research techniques which would identify possible problems not readily detected in adult clinical investigations to aid in the safe and effective evaluation of drugs in children.  


**2005 Use of Animals in Drug Research**

1. APhA recognizes that animal experiments continue to be an essential, and indeed irreplaceable, component of biomedical research and testing.

2. When animals must be used for biomedical research and testing, APhA strongly supports humane treatment and adequate regulation, controls, and enforcement of appropriate measures relating to animal procurement, transportation, housing, care, and treatment.

3. APhA encourages the further development of methods of biomedical research and testing which do not require the use of animals.
4. APhA opposes legislative provisions that would penalize the properly controlled and conducted use of animals for biomedical research and testing.

1990 Federal Funding to Evaluate the Impact of Health Care Policies
1. APhA supports the study of economic, scientific, and social issues related to health care, particularly pharmaceutical services.
2. APhA urges the federal government to establish funding mechanisms for objective research to assess the impact of public policy on the health care system, particularly pharmaceutical services.
3. APhA urges that all federally-funded research addressing public policy pertaining to pharmaceutical services incorporate input from organized pharmacy.

1989 Pharmacists as Principal Investigators in Clinical Drug Research
1. APhA urges the sponsors of drug research to permit pharmacists to serve as principal investigators.
2. APhA encourages state and federal agencies to eliminate regulatory and policy obstacles that prohibit pharmacists from being investigators, including principal investigators, in drug research or sponsors of Investigational New Drug Applications, Investigational Device Evaluations, and Animal Investigational New Drug Applications.

1989 Scientist Manpower
APhA supports efforts to increase the number of pharmacists pursuing graduate education and research in the pharmaceutical sciences, including, but not limited to:
1. Dissemination of information to create awareness about graduate programs and career opportunities.
2. Pursuit of increased government, industry, and foundation funding.
3. Encouragement of innovative recruitment programs and curricula to facilitate career development.

1987 Impact of National Institutes of Health (NIH) Budget on Future Research
APhA recognizes the fundamental role of biomedical research in the profession of pharmacy and actively supports continued and predictable funding of NIH research.

1986 Positive Controls Versus Placebo Controls in Testing New Drugs
APhA recognizes the importance of and the need for placebo-controlled trials in testing new drugs. In addition, APhA supports the use of alternative study designs (such as positive controls), as well as innovative methodologies where they appear to be appropriate and useful.

1984 Freedom of Scientific Information
APhA supports the principle of the free dissemination and exchange of scientific information with only the following exceptions:
(a) prior mutual confidentiality agreement between sponsor and researcher;
(b) material that is essential to national security; and
(c) legitimate trade secrets and/or proprietary information.

1981 Modification of Patent Periods
APhA supports modifications of patent periods for prescription drugs and drug products that would create reasonable incentives for needed research on new drugs and drug products.

1966 APhA Study Proposal
APhA should expand its research programs and plans to help the profession find solutions to its problems, discover new opportunities for service, and improve its present practices.
**Investigational New Drugs**

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


**SAMPLING**

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

**1993**
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.


**SPECIALTIES IN PHARMACY**

**1989 Recognition of Pharmacy Practice Specialties**
1. APhA endorses the Board of Pharmaceutical Specialties' process for recognizing specialties and certifying pharmacists in pharmacy practice specialties.
2. APhA believes that because of the existence of the Board of Pharmaceutical Specialties' process, separate governmental recognition of pharmacy specialties and pharmacists in pharmacy practice specialties is not necessary.


**1980 Nuclear Pharmacy Regulations**
1. APhA supports the concept of state boards of pharmacy retaining their authority to regulate all aspects of professional pharmacy practice including nuclear pharmacy practice.
2. APhA urges state boards of pharmacy to promptly adopt appropriate rules and regulations for the practice of nuclear pharmacy, using the NABP Model Regulations for the Licensure of Nuclear Pharmacies as a model.


**TITLES/DESIGNATIONS**

**Community Pharmacy**

**2000 Use of the Phrase "Community Pharmacy"**
APhA supports use of the phrase "community pharmacy" rather than "retail pharmacy".


**Non-Pharmacists**

**1999 Use of Titles**
APhA opposes the use of titles such as "Pharmaceutical Specialist" and "Pharmaceutical Consultant" by sales representatives of pharmaceutical manufacturers.

1981  "P.D." (Pharmacy Doctor) Designation for Pharmacists
APhA opposes the term "P.D." (Pharmacy Doctor) as the uniform designation for pharmacists.

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.

Student Pharmacist

2008  Regulation of Student Pharmacists’ Practice Experience
2005 1. APhA encourages state boards of pharmacy to use the title “student pharmacist” to identify all students enrolled in their professional years of pharmacy education in an Accreditation Council for Pharmacy Education (ACPE) - accredited program.
2. APhA encourages state boards of pharmacy to permit a student pharmacist to perform the duties of a pharmacist within the applicable state’s scope of practice under a pharmacist’s supervision. Preceptors shall consider the experience and education of student pharmacists when providing pharmacy practice opportunities.

VACCINES

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)

2007  Pharmacy Personnel Immunization Rates
1. APhA supports efforts to increase immunization rates of healthcare professionals, for the purposes of protecting patients, and urges all pharmacy personnel to receive all immunizations recommended by the Centers for Disease Control (CDC) for healthcare workers.
2. APhA encourages employers to provide necessary immunizations to all pharmacy personnel.
3. APhA encourages federal, state, and local public health officials to recognize pharmacists as first responders (like physicians, nurses, police, etc) and prioritize pharmacists to receive medications and immunizations.
(JAPhA NS45(5):580 September-October 2007) (Reviewed 2009)

2005  Empowerment of Pharmacists as Drug Therapy Managers
2003 1. APhA encourages pharmacists to take an active role in achieving the goals of the Healthy People program regarding immunizations through:
1996  (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.

1997 Standards for Pharmacy-Based Immunization Advocacy
(Note: Guidelines approved by the APhA Board of Trustees in May, 1997; noted in Appendix.)
APhA should adopt and disseminate standards for immunization advocacy and delivery by pharmacists.

1987 Encouraging Availability and Use of Vaccines
1. APhA encourages the continued availability of vaccines to meet public health needs.
2. APhA supports the development of programs that educate the public about the role of immunizations in public health.
3. APhA supports the reimbursement by public and private third-party payers for immunizations.

1981 Vaccine Liability Programs
APhA supports legislative action to create a joint pharmaceutical industry/government program which would compensate victims and reduce the liability of vaccine manufacturers and health care professionals arising from adverse effects associated with the appropriate administration of properly manufactured vaccines.

VITAMINS, MINERALS, NUTRITIONAL SUPPLEMENTS AND FOOD

2005 Complementary and Alternative Medications
1997 1. APhA shall support informed decision-making based upon the professional judgment of pharmacists regarding the appropriateness of use or the sale of complementary and alternative medicines.
2. APhA shall assist pharmacists and student pharmacists in becoming knowledgeable about complementary and alternative medications to facilitate the counseling of patients regarding effectiveness, proper use, indications, safety and possible interactions.

2002 Homeopathy
1. APhA supports the demonstration of safety and efficacy of homeopathic products from adequate, well-designed scientific studies before pharmacists advocate or sell homeopathic products.
2. APhA recognizes patient autonomy regarding the use of homeopathic products. Pharmacists should educate patients who choose to use homeopathic products.
3. APhA shall work with Congress to modify the Food, Drug and Cosmetic Act or enact other legislation to require that homeopathic manufacturers provide evidence of efficacy and safety for all products, including products currently in the marketplace.

2002 "Quack" Therapy
1986 APhA encourages efforts that would require the listing of all active ingredients of a food promoted as a drug or drug product in written promotional and advertising material.

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 cases.
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.


1988 Vitamins, Minerals, and Other Nutritional Supplement Usage
1. APhA advocates programs which address the public health implications of the misuse and/or abuse of vitamins, minerals, and other nutritional supplements.
2. APhA encourages pharmacists to provide health education regarding unsubstantiated and/or misleading health claims as they apply to vitamins, minerals, and other nutritional supplements.


1981 Federal Regulation of Salt in Processed Foods
APhA encourages manufacturers of processed foods voluntarily to reduce the salt (sodium chloride) added to their products and to use the minimum amount of salt necessary in the manufacturing process.


1980 Food Labeling
APhA supports requirements for disclosure in the labeling of processed food and the identity and, whenever appropriate, the quantity of ingredients, such as those preservatives, artificial colors and flavors, salts, sugars, and other substances, that represent a potential risk to the health or therapy of a portion of the general population.


WOMEN IN PHARMACY

1979 Consideration of the Equal Rights Amendment
APhA supports efforts to assure equal rights of all persons.

APPENDICES

APPENDIX A: APhA Bylaws
APPENDIX B: Seven Principles of Pharmaceutical Care Benefits
APPENDIX C: Guidelines for Pharmacy-based Immunization Advocacy
APPENDIX D: Sexual Harassment Guidelines
APPENDIX E: APhA Officers of the House of Delegates
American Pharmacists Association Bylaws
as amended through August 22, 2011.

ARTICLE I. NAME AND SEAL
Section 1. Name. This ASSOCIATION shall be called the “AMERICAN PHARMACISTS ASSOCIATION.”
Section 2. Seal. This ASSOCIATION shall have an official seal.

ARTICLE II. PURPOSE
Section 1. Purpose. This ASSOCIATION provides information, education, and advocacy to help all pharmacists improve medication use and advance patient care.
Section 2. Membership Benefits and Services. In furtherance of its lawful purposes and within its corporate powers, this ASSOCIATION shall conduct such programs and activities and provide such other membership benefits and services as may be established from time to time by its members or Board of Trustees.
Section 3. Code of Ethics. This ASSOCIATION shall provide and maintain a Code of Ethics for pharmacists.

ARTICLE III. MEMBERSHIP
Section 1. Classes of Membership. This ASSOCIATION shall have Member, Student Pharmacist Member, Pharmacy Technician Member, and Honorary Member classes of membership and such other classes of membership as may be established from time to time by the Board of Trustees.
Section 2. Member. Any pharmacist who is licensed in the United States or a graduate of an American Council on Pharmaceutical Education (ACPE) accredited school/college of pharmacy, any member of a pharmacy faculty, or any other individual who shares the ASSOCIATION’s mission and vision. Members of the former Life membership class shall be Members without payment of dues. A Member shall have full voting rights and may hold office in this ASSOCIATION as allowed by the individual office and in any of its membership organization groups in which membership is held as allowed by the individual office.
Section 3. Student Pharmacist Member. Any student enrolled in a school or college of pharmacy holding membership in the American Association of Colleges of Pharmacy or accredited by ACPE, or a student enrolled in a pre-pharmacy program, shall be eligible for membership as a Student Pharmacist Member. A Student Pharmacist Member shall also be a member of the ASSOCIATION’s student pharmacist membership organization group. A Student Pharmacist Member shall have full voting rights in the student pharmacist membership organization group and may hold office only in the ASSOCIATION’s student pharmacist membership organization group, provided, however, that a Student Pharmacist Member shall have full voting rights as a member of an ASSOCIATION committee or as a delegate in the ASSOCIATION House of Delegates. Student Pharmacist Members representing the student pharmacist membership organization group in the APhA House of Delegates shall have the right to vote in that year’s annual election for at-large APhA Board of Trustees members and APhA President-Elect, as well as any additional issues that may be placed on the ballot from time to time.
Section 5. Pharmacy Technician Member. Any individual who is a pharmacy technician shall be eligible for membership as a Pharmacy Technician Member. A Pharmacy Technician Member shall have full voting rights in a selected Association membership organization group and may hold office only in that selected membership organization group, provided, however, that a Pharmacy Technician Member shall have full voting rights as a member of an ASSOCIATION committee or as a delegate in the ASSOCIATION House of Delegates.
Section 6. Honorary Membership. Any individual may be granted Honorary membership by the Board of Trustees. An Honorary Member shall have no voting rights and may not hold office in this ASSOCIATION or any of its membership organization groups unless entitled to do so under another class of membership.
Section 7. Admission to Membership. Any individual shall be admitted to membership in the appropriate class of membership upon completion of administrative processing of any required application accompanied by required dues, provided, however, that the Board of Trustees may deny any individual membership for cause, meaning conduct tending to damage the public reputation of this ASSOCIATION.
Section 8. Membership Benefits and Services. Membership benefits and services for each class of membership shall be those established from time to time by the Board of Trustees. The Board of Trustees may add, delete, or adjust membership benefits and services as it deems necessary or desirable in furtherance of ASSOCIATION purposes. No addition, deletion, or adjustment of membership benefits or services shall require any adjustment of dues for the membership period during which the addition, deletion, or adjustment of membership benefits or services occurs.
Section 9. Termination of Membership. Any member may voluntarily terminate membership by notice to this ASSOCIATION. Termination of membership shall be effective upon completion of administrative processing of such notice. No such voluntary termination of membership shall be effective to avoid any debt to this ASSOCIATION. This ASSOCIATION may terminate the membership of any member for failure to pay required dues. Such termination of membership shall be effective at the convenience of this ASSOCIATION. Termination of membership shall terminate the right of any member to all membership benefits and services.
Section 10. Dues. Each member shall pay such dues as may be required from time to time by the Board of Trustees for each class of membership. The Board of Trustees may establish from time to time such administrative policies and procedures as it deems necessary or desirable to facilitate the payment and receipt of required dues. The Board of Trustees may also establish from time to time special dues within established classes of membership.
ARTICLE IV. OFFICERS

Section 1. Officers. The officers of the ASSOCIATION shall be the President, the President-elect, the Immediate Past President, the Treasurer, and the Executive Vice President.

Section 2. President, President-elect and Immediate Past President. The President shall be a pharmacist from the ASSOCIATION’s Member category and the principal elected officer of the ASSOCIATION and shall serve as a Trustee of this ASSOCIATION.

The President shall first be elected as President-elect, and the year thereafter shall serve as President with the third year of service as Immediate Past President. The President shall preside at meetings of this ASSOCIATION and shall appoint, with the approval of the Board of Trustees, all ASSOCIATION committees other than the ASSOCIATION House of Delegates Committees.

The President shall perform such other duties as may be assigned from time to time by the Board of Trustees, but shall have no individual duties or responsibility for administrative decisions or actions with regard to the continuing management of ASSOCIATION affairs.

No individual shall serve as President-elect immediately following a term as President or Immediate Past President. A vacancy in the office of President shall be filled by the President-elect. A vacancy in the office of President-elect or Immediate Past President may be filled by a pharmacist from the ASSOCIATION’s Member category appointed by the Board of Trustees, except that any appointment of a President-elect will be effective only until the next regular election at which time the membership shall elect both a President-elect and a President.

Section 3. Executive Vice President. The Executive Vice President shall be a pharmacist from the ASSOCIATION’s Member category appointed by the Board of Trustees and employed by the ASSOCIATION as chief executive officer on such terms and conditions as are approved by the Board of Trustees.

The Executive Vice President shall be responsible to the Board of Trustees in the exercise of assigned duties and authorities for executive and administrative decisions or actions with regard to the continuing management of the ASSOCIATION’s affairs. The Executive Vice President shall serve as Secretary of the ASSOCIATION and as Secretary of the House of Delegates. A vacancy in the office of Executive Vice President shall be filled by a pharmacist from the ASSOCIATION’s Member category appointed by the Board of Trustees.

Section 4. Treasurer. The Treasurer shall be a Member appointed by the Board of Trustees and shall serve for a term of three (3) years from the effective date of the appointment. No individual shall serve more than two (2) consecutive full three-year terms as Treasurer. A vacancy in the office of Treasurer shall be filled for the unexpired term by a Member appointed by the Board of Trustees.

Section 6. Removal. An Officer of the ASSOCIATION (except for the Executive Vice President) may be removed from office for any reason by a two-thirds (2/3) vote in favor of removal by the whole Board of Trustees, excluding the vote of the affected Officer. Trustees may only vote in person at an assembled meeting, face-to-face. No proxies, mail, telephone or other indirect means of voting shall be permitted. The vote shall be taken by secret written ballot. Counsel to the ASSOCIATION shall tally the ballots and shall announce only the result.

ARTICLE V. BOARD OF TRUSTEES

Section 1. Composition. Six (6) Elected Trustees, the Officers, the Speaker of the House of Delegates, and the Presidents of the membership organization groups of this ASSOCIATION shall constitute the Board of Trustees.

Section 2. Duties and Authority. The Board of Trustees shall be responsible for the general supervision and management of ASSOCIATION affairs, including, but not limited to, the specific duties and authority stated in these Bylaws. It shall have, in addition to the specific duties and authority stated in these Bylaws, such duties and authority which from time to time are imposed on or recognized by law as being applicable to nonprofit corporations. It shall adopt Bylaws and rules or procedures for the conduct of its business.

It shall act with regard to matters of ASSOCIATION policy for the House of Delegates in the interim between House of Delegates meetings and shall make an annual report to the membership regarding the programs and activities of this ASSOCIATION.

Section 3. Election of Trustees. Elected Trustees shall be elected as provided for in the Article on elections in these Bylaws.

Section 4. Term of Office. Elected Trustees shall be elected for a term of three (3) years and shall serve until their successors have been duly elected and installed. No individual shall serve more than two (2) successive full terms as an Elected Trustee. However, nothing in this Article shall prevent a Trustee who has served two full successive terms from being elected as President-elect or President.

Section 5. Vacancies. A vacancy among Elected Trustees shall be filled by a pharmacist from the ASSOCIATION’s Member category selected by the Board of Trustees to serve the remainder of the unexpired term. A vacancy among Officer Trustees shall be filled as provided for in the Article on Officers in these Bylaws. A vacancy in the Office of Speaker or the Office of Speaker-elect of the House of Delegates shall be filled as provided for in the Article on the House of Delegates in these Bylaws.

Section 6. Meetings. The Board of Trustees shall meet at the call of the President or on the call of a quorum of the Board of Trustees. The time and place of Board of Trustees meetings shall be established by the President.

Section 7. Quorum. A majority of Trustees plus one shall constitute a quorum for the transaction of business.

Section 8. Removal. A Trustee of the ASSOCIATION may be removed from office for any reason by a two-thirds (2/3) vote in favor of removal by the whole Board of Trustees, excluding the vote of the affected Trustee. Trustees may only vote in person at an assembled meeting, face-to-face. No proxies, mail, telephone or other indirect means of voting shall be permitted. The vote shall be taken by secret written ballot.

Counsel to the ASSOCIATION shall tally the ballots and shall announce only the result.

ARTICLE VI. HOUSE OF DELEGATES

Section 1. Composition. The House of Delegates shall consist of delegates from states, ASSOCIATION membership organization groups, Recognized National Organizations, and Delegates Ex Officio. Each delegate and Delegate Ex Officio must be a member of this ASSOCIATION.
Section 2. Apportionment of Delegates.

A. States: each shall have two (2) delegates plus one (1) delegate for each two hundred (200) Members of this ASSOCIATION, or major fraction thereof, who are members of this ASSOCIATION residing in the state. Delegates and alternate delegates from each state shall reflect the demographic diversity represented by the ASSOCIATION membership residing in that state.

B. ASSOCIATION membership organization groups: each shall have twenty-eight (28) delegates.

C. Recognized National Organizations: each shall have two (2) delegates, delegates who are members of the recognized organization.

D. Delegates Ex Officio: shall be each Trustee, ASSOCIATION Former Presidents, and Former Speakers of the House of Delegates.

E. Each appointing organization shall have the right to appoint one (1) alternate delegate for up to five (5) delegates that it appoints, plus one (1) alternate delegate for each additional five (5) delegates, or major fraction there-of, that it appoints.

Section 3. Duties and Authority. The House of Delegates shall serve as a legislative body in the development of ASSOCIATION policy. It shall act on such policy recommendations as shall come before it and shall adopt rules or procedures for the conduct of its business.

Section 4. Appointment of Delegates. Affiliated State Organizations, Recognized National Organizations, and ASSOCIATION membership organization groups will appoint the delegates and alternate delegates to which they are entitled. Appointing organizations shall notify the Secretary of the House of Delegates at least thirty (30) days before the regular meeting of the House of Delegates of the name and address of each of its delegates and alternate delegates. To the extent that an appointing organization does not so notify the Secretary of the House of Delegates, the Speaker of the House of Delegates will appoint any remaining delegates and alternate delegates to which the appointing organization is entitled. All delegates and alternate delegates other than Delegates Ex Officio shall serve until their successors have been appointed. Delegates Ex Officio shall serve for life or, in the case of Trustees serving as Delegates Ex Officio, until their successors have been duly appointed or elected and installed.

Section 5. Officers. The Officers of the House of Delegates shall be a Speaker, a Speaker-elect, and a Secretary. The Speaker shall appoint delegates and Committees as provided in these Bylaws, shall preside at meetings of the House of Delegates, and shall be responsible for a report of the actions of the House of Delegates to the members of this ASSOCIATION. The Speaker-elect shall assist the Speaker in the performance of the Speaker’s duties and/or perform such duties as specified by the House of Delegates. In the event of a vacancy in the Office of Speaker, or in the event the Speaker is unable to perform the duties of the office during a meeting of the House of Delegates, the Speaker-elect shall assume the duties of the Speaker. In the event of a vacancy in both the Office of Speaker and the Office of Speaker-elect, or in the event both the Speaker and the Speaker-elect are unable to perform the duties of the offices during a meeting of the House of Delegates, the House of Delegates shall elect a Speaker pro tem, at which time a Speaker and a Speaker-elect shall be elected. The Secretary of the House of Delegates shall be responsible for the administrative functions of the House of Delegates.

Section 6. Elections. The Speaker-elect shall be elected during the Annual Meeting of the ASSOCIATION by the House of Delegates from among a slate of delegates nominated by the House of Delegates Committee on Nominations and as otherwise may be provided for in rules or procedures adopted by the House of Delegates. Speaker-elect elections will be held every other year. The Speaker-elect shall serve until the end of the next Annual Meeting of the ASSOCIATION following election at which time the Speaker-elect shall be installed in the Office of Speaker. The Speaker shall serve for two years. The Speaker shall serve until a successor is duly elected and/or installed. The Executive Vice President of the ASSOCIATION shall serve as Secretary of the House of Delegates.

Section 7. Meetings. The House of Delegates shall hold a regular meeting during the Annual Meeting of this ASSOCIATION, this regular meeting to consist of such sessions and to have an order of business as specified in the official program of the Annual Meeting. The House of Delegates may hold special meetings at the call of the Speaker with the approval of the Board of Trustees, or upon written petition of a majority of authorized delegates. The time and place of special meetings of the House of Delegates shall be established by the Speaker with the approval of the Board of Trustees.

Section 8. Quorum. A majority of the delegates registered at any regular or special meeting of the House of Delegates shall constitute a quorum for the transaction of business.

Section 9. Committees. The House of Delegates shall have committees as established by the Speaker and the Board of Trustees. Such Committees shall be appointed by the Speaker of the House of Delegates. The House of Delegates shall have the following standing committees:

- Committee on Nominations
- Canvassers Committee
- Policy Committees.

Committees shall have such number of members as the Board of Trustees may establish and shall consider subjects only on agendas approved by the Board of Trustees. The House of Delegates Committee on Nominations shall nominate candidates for Speaker of the House of Delegates in accordance with such Bylaws, rules, or procedures as the House of Delegates deems necessary or desirable to facilitate its business. The House of Delegates Canvassers Committee shall certify the results of the House of Delegates elections.

Article VII. Recognized and Affiliated Organizations

Section 1. Recognized National Organizations. Any national organization representing pharmacy, the purposes of which are consistent with the purposes of this ASSOCIATION, may be designated a Recognized National Organization by the Board of Trustees. The status of such an organization as a Recognized National Organization may be terminated by the Board of Trustees.

Section 2. Affiliated State Organizations. A State Organization may be designated as an Affiliated State Organization by the Board of Trustees in its discretion.

Article VIII. Organization of Members

Section 1. Organization. The Association shall have a membership organization group representing at least the following segments of members: pharmacy practitioners, student phar-
Section 2. Additional membership organization groups. The Board may, from time to time, establish additional membership organization groups reflecting the diverse professional needs of the membership.

Section 3. Programming. Each membership organization group shall conduct such programs as may be established from time to time for the benefit of its members, the profession, or the public. Programs are subject to the approval of the Board of Trustees. The student pharmacist organization group may recognize an affiliated student pharmacist chapter at any ACPE-accredited or American Association of Colleges of Pharmacy recognized school or college of pharmacy.

Section 2. Special Meetings. The ASSOCIATION may hold special meetings at the call of the President with the approval of the Board of Trustees. The time and place of special meetings shall be established by the President. The order of business for a special meeting shall be as specified in the call, notice or agenda of the special meeting.

Section 1. Annual Meeting. This ASSOCIATION shall hold an Annual Meeting each calendar year at a time and place established by the Board of Trustees. The Annual Meeting shall consist of such sessions and shall have an order of business as specified in the official program for the Annual Meeting.

Section 2. Nominating Committee. The Committee on Nominations shall nominate all candidates for President-elect and Elected Trustees as provided for in this Article. The Committee on Nominations shall consist of the most recent nonincumbent Former President, the immediate former Speaker of the House of Delegates, and three (3) other members appointed by the President. No individual shall serve on the Committee on Nominations in more than three (3) consecutive calendar years.

Section 3. Election Procedure. Except as may otherwise be provided in these Bylaws, the names of candidates for election and a mail ballot shall be provided all members entitled to vote. Executed ballots must be received by the date published on the ballot.

The Committee of Canvassers shall certify the results of all ASSOCIATION elections, except for elections in the House of Delegates. The Committee of Canvassers shall meet following a tally of timely, valid ballots and shall review the election procedure for compliance with these Bylaws. It shall certify to the Board of Trustees the results of the election for each position.

The Committee of Canvassers shall certify the results of all ASSOCIATION elections, except for elections in the House of Delegates. The Committee of Canvassers shall meet following a tally of timely, valid ballots and shall review the election procedure for compliance with these Bylaws. It shall certify to the Board of Trustees the results of the election for each position.
ARTICLE XII. BOARD OF PHARMACY SPECIALTIES

Section 1. Purposes. The Board of Pharmacy Specialties shall exist for the following purposes:

a. To grant recognition of appropriate pharmacy practice specialties based on criteria established by the Board of Pharmacy Specialties.
b. To establish standards for certification and recertification in recognized pharmacy practice specialties.
c. To grant qualified pharmacists certification and recertification in recognized pharmacy practice specialties.
d. To serve as a coordinating agency and informational clearinghouse for organizations and pharmacists in recognized pharmacy practice specialties.

Section 2. Bylaws and Composition. The Board of Pharmacy Specialties shall operate under Bylaws (and subsequent amendments) approved by the ASSOCIATION's Board of Trustees. The composition of the Board of Pharmacy Specialties shall be outlined in the approved Bylaws.

Section 3. Finances. The ASSOCIATION shall act as fiscal agent for the Board of Pharmacy Specialties in accordance with procedures established by the ASSOCIATION's Board of Trustees. The ASSOCIATION shall prepare an annual audited financial report of Board of Pharmacy Specialties activities.

ARTICLE XIII. PARLIAMENTARY AUTHORITY AND PRECEDENCE

Section 1. Parliamentary Authority. The rules contained in the current edition of Robert's Rules of Order shall govern this ASSOCIATION in all cases to which they are applicable. The Executive Vice President may retain the services of a qualified parliamentarian for any meeting when such services are deemed necessary or desirable and shall do so for all deliberative meetings of the House of Delegates.

Section 2. Precedence. In any case of conflict between these Bylaws and any other bylaws, parliamentary authority, or rules or procedures of any membership organization group, these Bylaws shall prevail. All such apparent conflicts shall be resolved by the Board of Trustees whose decision shall be binding on all interested parties.

ARTICLE XIV. AMENDMENTS

Section 1. Bylaws. Every proposed amendment of these Bylaws, following the approval of counsel and the Board of Trustees, shall be submitted with a mail ballot to all members entitled to vote. Executed ballots must be received by this ASSOCIATION by the date published on the ballot. A proposed amendment of these Bylaws shall become effective upon receiving a two-thirds (2/3) affirmative vote certified by the Committee of Canvassers to the Board of Trustees.

Section 2. Code of Ethics. Every proposed amendment of the Code of Ethics, with the approval of counsel and the Board of Trustees, shall be submitted with a mail ballot to all members entitled to vote. Executed ballots must be received by this ASSOCIATION by the date published on the ballot. A proposed amendment of the Code of Ethics shall become effective upon receiving a two-thirds (2/3) affirmative vote certified by the Committee of Canvassers to the Board of Trustees.

ARTICLE XV. NOTICE

Section 1. Previous Notice. Any previous notice required to be provided any member of this ASSOCIATION may be given by printing the notice in a publication regularly provided the member entitled to notice or by mailing the notice to each member entitled to notice at the member's mailing address then indicated in the membership records of this ASSOCIATION.
Appendix B

American Pharmacists Association
Seven Principles of Pharmaceutical Care Benefits

PRINCIPLE I: The Pharmaceutical Care Benefit recognizes the value of the patient-pharmacist relationship.

(a) The Pharmaceutical Care Benefit permits any pharmacist willing to meet specified service quality, delivery and financial requirements of a plan to participate in serving patients under that plan.

(b) Within the limits specified in I(a), the Pharmaceutical Care Benefit (1) ensures that patients have convenient access to prescription drug therapy and professional pharmacy services from the pharmacist of their choice and (2) avoids unreasonable administrative, distribution channel, or financial plan requirements that create unnecessary access barriers.

(c) The Pharmaceutical Care Benefit encourages the patient’s use of the most cost-effective drug therapy and professional pharmacy services through reasonable administrative rules and financial incentives that are equally applied to all participating pharmacists.

Principle II: The Pharmaceutical Care Benefit supports the provision of pharmaceutical care.

(a) The Pharmaceutical Care Benefit uses compensation systems that encourage pharmacists to provide cost-effective professional services and pharmaceutical products.

(b) The Pharmaceutical Care Benefit facilitates pharmacist-prescriber communication that assists prescribers in selecting optimal cost-effective therapy.

(c) The Pharmaceutical Care Benefit encourages pharmacist review, continuous oversight, and implementation of supportive care strategies that are based on recognized standards and are aimed at patient adherence to the prescriber’s therapy goals.

(d) The Pharmaceutical Care Benefit encourages patients, prescribers, and pharmacists to openly, actively, and regularly communicate about the anticipated effects, potential side effects, and actual experiences associated with drug use.

(e) The Pharmaceutical Care Benefit provides financial incentives for performance that promotes interactive pharmacist-patient drug therapy review and counseling that occurs, at a minimum, with the provision of all new medication prescriptions, first refills of new medicines, and at appropriate maintenance medication review periods.
Principle III: The Pharmaceutical Care Benefit provides support systems and materials to pharmacists and plan beneficiaries that facilitate their roles in achieving optimal therapy outcomes.

(a) The Pharmaceutical Care Benefit provides clear, well-articulated materials to pharmacists and plan beneficiaries. These materials include complete and accurate disclosure of plan design, financial incentives, and implementation procedures.

(b) The Pharmaceutical Care Benefit provides timely notification and educational materials relating to program enhancements to pharmacy providers and plan beneficiaries.

(c) The Pharmaceutical Care Benefit provides prompt notice of performance incentives to pharmacists, to help them identify appropriate processes and behaviors.

Principle IV: The Pharmaceutical Care Benefit renumeration to pharmacists should be based on sound, defensible methodology.

(a) The Pharmaceutical Care Benefit acknowledges quality, professional service delivery by pharmacists through compensation systems and reporting mechanisms that are identifiably separate and distinct from compensation for the drug product and its distribution.

(b) The Pharmaceutical Care Benefit provides product and service payment mechanisms to ensure that no provider or group of providers obtains financial arrangements that disadvantage any other provider or group of providers offering similar products and services.

Principle V: The Pharmaceutical Care Benefit administration uses technology that integrates health information and reflects current national standards.

(a) The Pharmaceutical Care Benefit uses an automated point-of-service processing system that complies with national standards.

(b) Pharmacists should be able to validate the patient’s participation in a Pharmaceutical Care Benefit and ensure appropriate coordination of benefits.

(c) The Pharmaceutical Care Benefit Program’s identification cards include all information needed to successfully provide service and adjudicate claims.

(d) Pharmaceutical Care Benefit Programs ensure prompt payment of claims, as adjudicated.

(e) The Pharmaceutical Care Benefit Program’s charges for participation as a provider, if any, should be fair, reasonable, and clearly disclosed.
Principle VI: The Pharmaceutical Care Benefit provides for ongoing program evaluation and documentation.

(a) The Pharmaceutical Care Benefit uses reporting systems that regularly disseminate relevant information to pharmacists to allow pharmacists to improve their performance and their management of patients. These reports should include drug therapy statistics; therapy guidelines; feedback on behaviors of individual prescribers and dispensing pharmacists with regard to prescribing and patient utilization efficiencies; and relative performance on DUR-related alerts, therapy interventions, and patient outcomes.

(b) The Pharmaceutical Care Benefit Program uses pharmacist/practitioner/patient involvement in program design, operations oversight, and ongoing evaluation.


(a) The Pharmaceutical Care Benefit Program provides access to patient information that assists pharmacists in providing comprehensive pharmaceutical care services.

(b) The Pharmaceutical Care Benefit Program uses procedures that ensure the security of patient-specific information and limits its use to health care providers.
Appendix C

Guidelines for Pharmacy-Based Immunization Advocacy and Administration

At the 1996 APhA Annual Meeting in Nashville, Tennessee, the House of Delegates adopted policy encouraging pharmacists to take an active role to increase the rate of immunizations among vulnerable patient populations. This role could be fulfilled by pharmacists' becoming educators, facilitators, or immunizers of the public.

Over the past year, APhA has invested many resources in the development of education, advocacy, and scientific programs related to the role of pharmacists in immunizations. These activities have assisted the profession to develop collaborative relationships with other health care professionals and to highlight the pharmacist's position within the health care system.

In response to a call by pharmacists and other entities for assistance in developing these expanded roles, a set of draft guidelines were developed. These proposed guidelines were presented to the 1997 APhA House of Delegates, in Los Angeles, California, as a New Business Item. The House referred the guidelines to the Board for the solicitation of further input and the adoption of a set of guidelines that would assist pharmacists in incorporating immunization activities into their practice. After receiving input from pharmacists, and other health care providers and organizations, the APhA Board of Trustees approved the attached document. The guidelines are a dynamic document and will be periodically reviewed as the health care arena changes.

For additional information, contact Mitch Rothholz, RPh, 202/429-7549 or mrothholz@aphanet.org.
Guidelines for Pharmacy-based Immunization Advocacy  
American Pharmacists Association

Guideline 1 – Prevention – Pharmacists should protect their patients’ health by being vaccine advocates.

(a) Pharmacists should adopt one of three levels of involvement in vaccine advocacy:

(1) Pharmacist as educator (motivating people to be immunized);
(2) Pharmacist as facilitator (hosting others who immunize);
(3) Pharmacist as immunizer (protecting vulnerable people, consistent with state law).

(b) Pharmacists should focus their immunization efforts on diseases that are the most significant sources of preventable mortality among the American people, such as influenza, pneumococcal, and hepatitis B infections.

(c) Pharmacists should routinely determine the immunization status of patients, then refer patients to an appropriate provider for immunization.

(d) Pharmacists should identify high-risk patients in need of targeted vaccines and develop an appropriate immunization schedule.

(e) Pharmacists should protect themselves and prevent infection of their patients by being appropriately immunized themselves.

Guideline 2 – Partnership – Pharmacists who administer immunizations do so in partnership with their community.

(a) Pharmacists should support the immunization advocacy goals and other educational programs of health departments in their city, county, and state.

(b) Pharmacists should collaborate with community prescribers and health departments.

(c) Pharmacists should assist their patients in maintaining a medical home, including care such as immunization delivery.

(d) Pharmacists should consult with and report immunization delivery, as appropriate, to primary-care providers, state immunization registries, and other relevant parties.

(e) Pharmacists should identify high-risk patients in hospitals and other institutions and assure that appropriate vaccination is considered either before discharge or in discharge planning.

(f) Pharmacists should identify high-risk patients in nursing homes and other facilities and assure that needed vaccinations are considered either upon admission or in drug regimen reviews.
Guideline 3 – Quality – Pharmacists must achieve and maintain competence to administer immunizations.

(a) Pharmacists should administer vaccines only after being properly trained and evaluated in disease epidemiology, vaccine characteristics, injection technique, and related topics.

(b) Pharmacists should administer vaccines only after being properly trained in emergency responses to adverse events and should provide this service only in settings equipped with epinephrine and related supplies.

(c) Before immunization, pharmacists should question patients and/or their families about contraindications and inform them in specific terms about the risks and benefits of immunization.

(d) Pharmacists should receive additional education and training on current immunization recommendations, schedules, and techniques at least annually.

Guideline 4 – Documentation – Pharmacists should document immunizations fully and report clinically significant events appropriately.

(a) Pharmacists should maintain perpetual immunization records and offer a personal immunization record to each patient and their primary care provider whenever possible.

(b) Pharmacists should report adverse events following immunization to appropriate primary-care providers and to the Vaccine Adverse Event Reporting System (VAERS).

Guideline 5 – Empowerment – Pharmacists should educate patients about immunizations and respect patients’ rights.

(a) Pharmacists should encourage appropriate vaccine use through information campaigns for health care practitioners, employers, and the public about the benefits of immunizations.

(b) Pharmacists should educate patients and their families about immunization in readily understood terms.

(c) Before immunizing, pharmacists should document any patient education provided and informed consent obtained, consistent with state law.

References:
Approved by the APhA Board of Trustees, August 1997.
APhA MODEL POLICY ON SEXUAL HARASSMENT PREVENTION AND GRIEVANCE PROCEDURES

INTRODUCTION

The (name of organization or company) is dedicated to providing its employees a work environment free from sexual harassment. Sexual harassment is a form of sexual discrimination as defined by Title VII of the Civil Rights Act of 1964, and therefore is prohibited.

Actions which are consistent with the definition of sexual harassment are in violation of this company’s policy. All employees have a responsibility to maintain the work place free of sexual harassment and to report such misconduct when it occurs. Any employee — regardless of position in the organization or gender — found in violation of this policy will be subject to disciplinary action by the organization.

DEFINITION

Unwelcome behavior or a sexual advance, a request for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment when:

1. Submission to such conduct is made either explicitly or implicitly a term or condition of an individual’s employment;
2. Submission to or rejection of such conduct by an individual is used as the basis of employment decisions affecting such individual; and/or
3. Such conduct has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile, or offensive working environment.

There are two categories of sexual harassment:

1. **Quid pro quo sexual harassment** occurs when decisions affecting a person’s employment are based on whether the person submits to or rejects sexual demands.
2. **Hostile environment sexual harassment** occurs when unwelcome sexual conduct unreasonably interferes with a person’s work performance or causes an intimidating, offensive, or hostile work environment even when the victim suffers no tangible or economic job consequences.

Examples of sexual harassment include but are not limited to:

- **Verbal:** sexual innuendo, suggestive comments, insults, threats, jokes about gender-specific traits, or sexual propositions;
- **Nonverbal:** making suggestive or insulting noises, leering, whistling, or making obscene gestures, or displaying pornographic material in the workplace; and
- **Physical:** touching, pinching, brushing the body, coercing sexual intercourse, or assault.
GRIEVANCE PROCEDURE

Any employee who believes that he or she has been the subject of sexual harassment should report the alleged misconduct immediately to (name(s) of person(s) at organization) in the (name of department).

An investigation of any complaint will be undertaken immediately by (name(s) listed above). The complaint will be held confidential to the extent possible so that a thorough investigation can take place. The employee making the complaint is asked not to talk with other employees about the complaint during the investigation.

The employee making the complaint must document, in writing, the alleged misconduct including the action, time, date, and location. This signed document must give (name(s) of organization) the employee’s consent to investigate the incident. This document must be submitted to (name(s) stated above) within (one) week of reporting the incident.

The employee making the complaint is assured that the matter will be investigated and a decision rendered with (30) days of receipt of the complaint.

No retaliation or discrimination against the employee making the complaint will be tolerated regardless of the outcome of the investigation.

INVESTIGATION PROCEDURE and DISCIPLINARY ACTION

A sexual harassment complaint will be investigated by (name(s) listed above) immediately and a decision rendered with (30) days of the receipt of the written document from the employee making the complaint.

The investigator will:

1) Establish whether the complaint of misconduct is true through interviews with both the complainant and the accused, research for corroborative evidence, and interviews with supervisors and/or colleagues.

2) Determine whether the alleged action constitutes sexual harassment. Is the action prohibited based on the definition of sexual harassment contained in this document? If the action is deemed to be sexual harassment, under which category of sexual harassment does it fall – “quid pro quo” or “hostile environment”?

3) Determine if remedial or more serious action is needed. If the action is deemed to fall under the category of “quid pro quo,” the investigator will recommend that the accused must be terminated. If the action is deemed to fall under the category of “hostile environment,” the investigator will recommend the type of disciplinary action. This action may range from a warning in the employee’s file up to termination. The disciplinary action will depend upon
the seriousness of the action and/or the accused’s previous record. (Whenever possible, the person making the final determination about the type of disciplinary action should not be the investigator).

4) File a full written report to (name of person making final decision on disciplinary action – even if no disciplinary action is recommended) within (20) days of receipt of the original written complaint. After (name in line above) has made a final decision, all parties will be informed in writing within (30) days of the date of original written complaint.

5) Keep on permanent record all materials to the complaint.

The (name of organization) recognizes that the issue of whether sexual harassment has occurred requires a factual determination based on all the evidence received. (Name of organization) also recognizes that false accusations of sexual harassment can have serious effects on innocent men and women.

This model policy is to be used as a guide only. Individuals and organizations considering adopting this policy should consult with their legal counsel. THERE CAN BE NO ASSURANCE THAT ADOPTION OF THIS POLICY WILL INSURE AGAINST CLAIMS OF SEXUAL HARASSMENT OR THAT THIS POLICY WILL SUCCESSFULLY WITHSTAND JUDICIAL CHALLENGE.
### Officers of the APhA House of Delegates 1912-2010

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<tr>
<th>Year</th>
<th>Chairman/Speaker</th>
<th>Vice Chairman/Vice Speaker-Elect</th>
<th>Secretary</th>
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<tr>
<td>1912-1913</td>
<td>William C. Anderson</td>
<td>C.M. Snow</td>
<td>C. Roehr</td>
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<td>1913-1914</td>
<td>C.M. Snow</td>
<td>W.S. Richardson</td>
<td>R.A. Kuever</td>
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