House of Delegates

Policy and Procedures Manual

1963–2024

APhA
American Pharmacists Association

APhA Policy and Procedures Manual
1963-2024
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American Pharmacists Association
House of Delegates
Rules of Procedure

Approved March 24, 2023

The following information reflects the final language adopted by the APhA House of Delegates during its House sessions March 24-27, 2023

Rule 1 Delegate Appointment

All delegates, except APhA Membership Organization delegates, shall be appointed no later than June 1 of each year and will continue to function in that role until May 31 of the following year. APhA Membership Organizations have the flexibility to appoint their delegates based upon their existing processes with a delegate appointment deadline of no later than August 1, or these seats will also be subject to Speaker appointment as described in Rule 3 of the APhA House Rules of Procedure. APhA's student Academy delegates must be appointed no later than November 30.

Rule 2 Unfilled Delegate Seats

Unfilled delegate seats of any delegation, as defined by APhA Bylaws Article VI, Section 2, Subsection G, shall become inactive if unfilled during in-person Annual Meeting and virtual House sessions for three consecutive House cycles (March–March). This historical information shall be reported annually to the House Rules Review Committee and the APhA Board of Trustees, in addition to being made available to the representative of any delegation being impacted. The Speaker may issue exceptions to this rule in response to extenuating circumstances, in consultation with the House Rules Review Committee. Delegation Coordinators shall be notified 60 days prior to the inactivation of delegate seats and may petition the Secretary of the House for reappointment of any inactive seats.

Rule 3 Speaker Appointment of Unfilled Delegate Seats

Per APhA Bylaws Article VI, Section 2, subsection A.i, the Speaker may appoint delegates to unfilled delegate seats of Affiliated State Organizations (ASO). The Speaker will give preference to appointing delegates who served the delegation in previous House sessions. The Speaker must select an individual who resides or works within the state represented by the ASO and for which they will represent in the House. This process also applies to delegations who have an inactive delegate seat per APhA Bylaws Article VI, Section 2, Subsection G. The Speaker will make a reasonable attempt to notify the ASO executive staff of the Speaker appointment. In the event the ASO has a preferred individual to serve in the House after the Speaker has made the appointment, then the ASO's choice will take precedence if it is received not less than 30 days prior to any House session. All individuals appointed under this rule will be seated with their ASO's delegation, irrespective of whether the ASO or the Speaker appointed them into the seat.

Rule 4 Delegates and Voting

At each session of the House of Delegates, the Secretary shall report the number of authorized delegates who shall then compose the House of Delegates. Each delegate shall be entitled to one (1) vote. No delegate shall act as proxy of another delegate nor as delegate for more than one (1) association or organization. During in-person House sessions, a member registered as an alternate may, upon proper clearance by the Secretary of the House, be transferred from alternate to delegate at any time during the continuance of business. During virtual House sessions, a member registered as an alternate may, upon proper clearance by the Secretary of the House, be transferred from alternate to delegate if the request is provided at least 24 hours prior to the scheduled virtual session meeting time. Only authorized delegates shall have access to voting technology during House sessions.

Rule 5 Delegate Identification

Each delegate is required to wear a delegate ribbon attached to the convention name badge while seated in an in-person session of the House of Delegates. Only authorized delegates will receive access to the virtual platform to vote during virtual House sessions and must display their first and last name within the virtual platform. Any APhA member will be allowed access to observe any House session whether in person or virtual.

Rule 6 Consideration of Committee Reports

The order for consideration of Committee Reports and recommendations in any House of Delegates session agenda shall be determined by the Speaker in consultation with the Secretary of the House. The House shall receive any Committee Reports prior to Committee open forums or webinars and any session where debate on a Committee Report would occur. The Policy Reference Committee, Policy Review Committee, and New Business Review Committee shall consider delegate input received through open forums, webinars, and other communication means and will develop recommendations for consideration by the House on each whole-numbered statement or recommendation. During House sessions, the Committee chair will recommend adoption of policy statements and recommendations and preside over the debate. Action on the report will be governed by Robert's Rules of Order (current edition).

Rule 7 Privilege of the Floor

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

Rule 8 Nomination and Election of Speaker-elect

The House of Delegates Committee on Nominations shall consist of five delegates, including the Chair, and shall be appointed by the Immediate Past (nonincumbent) Speaker of the House of Delegates, and that Committee shall meet preceding the House session at which election-related activities shall occur to select candidates for the office of Speaker-elect of the House of Delegates.

Elections for Speaker-elect will occur every even-numbered year. Only two candidates for the office of Speaker-elect of the House of Delegates shall be nominated by the Committee on Nominations, and this report shall be presented prior to the House session at which election-related activities shall occur. No member of the Committee on Nominations shall be nominated by that Committee. All candidates examined by the Committee shall be notified of the results as soon as possible after the nominees have been selected by the Committee on Nominations. Nominations may then be made from the floor by any delegate immediately following the presentation of the Report of the Committee on Nominations. Candidates must have been interviewed by the House of Delegates Committee on Nominations to be eligible to be nominated from the floor after the announcements of the slate.

All candidates must be an APhA member as defined in Article III, Section 2, of the APhA Bylaws, and a seated delegate in the House of Delegates. During in-person House sessions, candidates will be introduced and permitted to speak to the House for no more than two (2) minutes following announcements of the slate of candidates. Candidates will then be permitted to address the House for a maximum of three (3) minutes at the House session at which election-related activities shall occur. Candidates shall be listed in alphabetical order on the ballot, regardless of whether they were slated by the Committee on Nominations or nominated from the floor of the House. A majority vote of delegates present and voting is required for election. If no majority is obtained on the first ballot, a second ballot shall be cast for the two candidates who received the largest vote on the first ballot. If electronic voting mechanisms are available, then the election shall be conducted utilizing the technology, with the results not publicly displayed. During extenuating circumstances where a vote for Speaker-elect cannot occur during an in-person House session, the Speaker and Secretary of the House, in consultation with the House Rules Review Committee, may recommend alternative methods to collect vote tallies.

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

Rule 9 Amendments to Resolutions

All amendments to Committee recommendations or New Business Item Statements shall be submitted in writing, handwritten or provided electronically, to the Secretary through a designated process confirmed by the Speaker for each House session. There are no secondary amendments or "friendly" amendments. The Speaker will rule any delegates out of order who express a desire to make a secondary amendment or "friendly" amendment.

Rule 10 Rules of Order

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

Rule 11 Amendments to House of Delegates Rules of Procedure

Every proposed amendment of these rules shall be submitted in writing and will require a two-thirds vote for passage. A motion to suspend the rules shall require an affirmative vote of two-thirds of the total number of delegates present and voting.

Rule 12 Grammar/Punctuation Corrections

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

Rule 13 New Business

The New Business Review Committee shall consist of 7–10 delegates, including the Chair, and are appointed by the Speaker. The Committee members should be present for open forum sessions held in person or virtually. After reviewing feedback provided from APhA members, the Committee will meet in executive session to develop recommendations on assigned New Business Items. New Business Items are due to the Speaker of the House no later than 60 days before the start of any House session where regular action on New Business Items (not urgent items) are scheduled to take place. An urgent item can be considered, without a suspension of the House rules, if presented to the Speaker, with necessary background information, at least 24 hours prior to the beginning of any House session. Urgent items are defined as matters that, due to the nature of their content, must be considered by the House outside of the normal policy processes. The House leadership (Speaker, Speaker-elect [when present], and Secretary) will evaluate submitted urgent items based on the timely and impactful nature of the presented item and determine if the urgent item is to be approved as New Business. The House shall then be informed of any approved urgent items to be considered by the House as soon as is possible by the Speaker. Approved urgent items shall be considered with other New Business Items and discussed during the New Business Open Hearing, if one is scheduled to take place. No immediate action shall be taken on urgent new business items without prior review of proposed statements and background information by all delegates. Appropriate action will be recommended by the New Business Review Committee in the same manner as other New Business Items. Urgent items denied consideration by House Officers may still be addressed by the House, with a suspension of House rules at the House session where New Business will be acted upon.

Delegates wishing to amend existing APhA policy on topics not covered within the Policy Committee or Policy Review Committee agenda may submit proposed policy statements through the New Business Review Process. Restatements of existing policy are discouraged and should be included only as background information.

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

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

The New Business Review Committee's recommendations will be addressed by the House of Delegates in the following order:

1. New Items submitted by the Policy Review Committee
2. General New Business Items
3. Urgent New Business Items

If the New Business Review Committee recommends no action on a New Business Item, the Speaker of the House shall place the New Business Item before the House of Delegates for consideration and action. Each whole-numbered statement within the New Business Item should be considered separately. A consent agenda process may be used to consider multiple recommendations within a single New Business Item, in accordance with Robert's Rules of Order. New Business Items can be considered at a virtual session of the House of Delegates at the discretion of the Speaker, in accordance with these rules of procedure. Debate on new business items in a virtual session will be time limited. At the Speaker's discretion, proposed New Business items may be referred to the next session of the House for further deliberation.

Rule 14 Policy Review Committee

The Policy Review Committee shall consist of 7–10 delegates, including the Chair, and are appointed by the Speaker. The Committee members should be present for open forum sessions held in person or virtually. The Policy Review Committee shall meet annually and review any policy that has (1) not been reviewed or revised in the past 10 years; (2) policy related to statements adopted in the most recent House session; and (3) if applicable, contemporary issues identified by the Speaker.

The House shall receive and consider the recommendations of the House Policy Review Committee to archive, rescind, retain, or amend existing policy. A singular motion to archive, rescind, or retain all such existing policy, with limited debate, shall be in order. Items identified by the Policy Review Committee as needing any amendments will be introduced as separate motions for consideration.

If the Policy Review Committee Report is considered in a virtual House of Delegates session, the debate will be time limited. At the Speaker's discretion, recommendations of the Policy Review Committee may be referred to the next House session for further deliberation.

Rule 15 Policy Reference Committee

The House of Delegates Policy Reference Committee shall consist of the chair of the Policy Committee, two or three members of the Policy Committee, and three or four new members appointed by the Speaker of the House. Members of the Committee must be delegates and should be present for open forum sessions held in person or virtually. The Policy Reference Committee shall consider delegate comments received through open forums, webinars, and other communication means and meet in executive session to issue their report and recommendations prior to the House session where those recommendations would be considered by the House.

Rule 16 Virtual House of Delegates

As defined by APhA Bylaws Article VI, Section 7, the House of Delegates, at the discretion of the Speaker, may conduct electronic meetings prior to the regular meeting of the House, in accordance with these House Rules of Procedure. The Secretary of the House must notify delegates at least 30 days prior to any virtual session.

Rule 17 Unfinished and Referred Business Items

Debate in any session of the House may be time limited, as designated by the Speaker. If the Speaker, the Committee chair, or any Delegates feel additional debate on the policy statement is warranted, the item may be carried over to an open hearing or a future session of the House. The remaining items requiring action will be brought back for final consideration at the next House session as "Unfinished Business."

Upon confirmation of an "Unfinished Business Item," the Speaker must clearly identify within the "Actions of the House Report" how Unfinished Business Items will receive further action. Unless defined within a motion from a Delegate, the Speaker, in consultation with the Secretary of the House, has the authority to assign "Unfinished Business Items" to an appropriate House Committee, the Board of Trustees, or a future session of House business for further action. An update on "Unfinished Business Items" or any "Referred Business Items" from any prior House session should be provided by the Speaker at future House sessions until action has been taken by the House or no further action is recommended on the item.

The following recommendations were submitted by the APhA House Rules Review Committee and adopted by the 1995 APhA House of Delegates.

Administrative Recommendations for Improvements in House Operations

In 1995, the Rules Review Committee made the following recommendations for managing administrative aspects of the House of Delegates operations. The status of each recommendation is noted after the item:

A. *Create a single governance document for adoption by the House of Delegates named "House of Delegates Rules" incorporating the actions of the House in 1994 and 1995; this will amend the current House of Delegates Rules and Bylaws.*

Status: Single House of Delegates Rules were adopted by delegates at the conclusion on 1995 House of Delegates.

B. *Policy Committees should consist of 11 - 13 members each in order to reflect the diversity of membership (e.g., practice site, geography, gender) and provide expertise relevant to the assigned topic.*

Status: This recommendation guides staff and Trustees in developing budget and the Speaker in selecting committee participants.

C. *The Policy Committee reports shall be printed in the Pharmacy Today rather than the Journal to permit their timely distribution.*

Status: All proposed policy recommendations (including those of STATs) will be published in a timely manner. Reports are posted on the APhA website.

D. *The title of the summary information supporting the policy statements in the final report should be entitled "Summary of the Committee Discussions" rather than "Background".*

Status: Accomplished.

E. *Recommendations on the floor of the House to change the title of a Policy Committee report or the Summary of Discussion will be ruled out of order by the Speaker as these are not retained as part of the official policy.*

Status: This has been incorporated into House operations.

F. *If a Policy Committee is assigned a topic but determines that no policy recommendations are needed, the topic will appear in an "information only" section of the Policy Committee report. The Speaker will rule any discussion on the topic out of order.*

Status: This has been incorporated into House operations.

G. *Any amendments offered during all House sessions shall be presented in writing on a standard form available to all delegates.*

Status: House Rule #7.

H. Association leadership reports should be scheduled during a general session, not a session of the House of Delegates.

Status: These oral reports were deleted from House of Delegates sessions beginning in 1996. Delegates received a written report and are encouraged to ask officers questions.

I. The Rules Review Committee affirms that the New Business Review Committee should continue to hold an open hearing on all new business items that will be open to any person. The Committee shall then meet in Executive Session to discuss the testimony and formulate the Committee's recommendations, if any, to the House of Delegates.

Status: Standard procedure since 1993.

J. The rule which specifies that only delegates may introduce business on the floor of the House of Delegates shall be retained.

Status: House Rule #5.

K. Any individual that is duly recognized by the Speaker and/or House may have the privilege of the floor in order to address the delegates.

Status: House Rule #5.

Parlimentary Procedures At A Glance

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

APhA Committee Handbook

I. APhA Policy Committees and Strategic & Tactical Analysis Teams

Importance of Committees in Developing APhA Policy

APhA's Policy Committees play a key role in the development of Association policy. Its recommendations are considered at open hearings held at the APhA Annual Meeting & Exposition and by the APhA House of Delegates. APhA's Strategic & Tactical Analysis Teams focus more time and resources on implementing APhA policy and less time on establishing policy positions. STATs will focus their energy on implementation of programs, legislation and regulations, but may also propose policy when existing policy statements fail to address key issues.

A. Appointment

APhA Policy Committee members are appointed by the Speaker of the APhA House. Members of the STATs are jointly appointed by the APhA President and Speaker of the APhA House. Nominations for APhA Policy & STAT members are solicited from the membership and organizations represented in the APhA House of Delegates.

B. Terms

APhA Policy Committee appointments are for a one year term, terminating at the Annual Meeting. A STAT, unlike a Policy Committee, may remain active for a longer period of time, depending on its topic.

C. Topics and Issues for Consideration

1. Official Policy

Topics on which the APhA Policy Committee may recommend that the APhA House of Delegates adopt official policy. Such recommendations to the House of Delegates deal only with initiating new policy or changing existing policy. STATs may also propose policy when there is no existing policy for their implementation recommendations.

2. General Guidance

Topics on which the APhA Board of Trustees seeks the general thinking and opinion of the committees. The APhA Policy Committee and STATs are not expected to develop a specific policy recommendation on these topics; rather they are asked to initiate preliminary consideration of a major issue. It is anticipated that, as a result of such preliminary discussion, the Board of Trustees can determine what action to take on the topic.

D. Duties

Each APhA Policy Committee and STAT with an assigned agenda meets at least once annually prior to the next Annual meeting and submits a written report of its recommendations to the members of the House of Delegates prior to the next Annual meeting.

E. Quorum

A majority of the members of the APhA Policy Committee or STAT constitutes a quorum for the transaction of business.

F. Basic Responsibilities of APhA Policy Committee or STAT Members

1. *Acknowledge immediately all communications requiring a response.*
2. *Review thoroughly the agenda and pertinent background information before meeting.*
3. *Do related research, if necessary.*
4. *Approach all policy issues objectively.*
5. *Participate actively in discussion of policy issues related to the subject under discussion.*
6. *Prepare to advocate policy recommendations at Annual Meeting.*
7. *Work with the Chair to speak on behalf of recommendations at the Annual Meeting.*

G. Functions of the Chair

The key to a successful APhA Policy Committee or STAT – even with able members and solid objectives – is the Chair. The smooth management and creative achievements of an APhA Policy Committee or STAT are largely dependent on the Chair's ability to lead and direct the group's activities.

1. Basic Functions

The basic function of the Chair is to preside and to assure that the Policy Committee or STAT completes its business.

2. General Responsibilities and Duties

The Policy Committee Chair is responsible to the Speaker of the House of Delegates. The STAT Chair is responsible to the Speaker of the House of Delegates and the President of the Association. His or her primary duties are:

a. Planning

The Chairman consults with the staff in preparing for the meeting of the committee.

b. Conducting Meetings

The Chair directs the Policy Committee or STAT in reviewing and achieving its objectives. The Chair should stimulate group thinking, encourage and channel discussion, weigh the value of expressed ideas and suggestions, summarize constructive suggestions, and seek out decisions.

H. Voting

APhA Policy Committee or STAT meetings are conducted in an informal manner according to the directions of the Chair. Votes are taken to determine a position regarding final recommendation. A majority of the votes cast by a quorum is sufficient to decide a question. The yeas, nays and abstentions of such votes are recorded. In the event that a vote is not unanimous, any member wishing to do so may submit written "minority views" explaining his or her disagreement with the Policy Committee or STAT action.

In all questions arising between meetings which can be settled by vote, the Chair may order the vote to be taken by mail, fax, email, or telephone ballot. This vote has the same force and effect as if the members had been personally present.

I. Association Staff Services

APhA staff resources are available to all Policy Committee and STAT Members. Staff assists in developing a final report, which includes the groups' recommendations for that specific policy topic.

Progress reports from each STAT group will be presented during the Association's Annual Meeting.

J. Consideration of STAT Reports

The APhA Policy Committee and STAT reports, which are mailed to delegates in the House of Delegates, are considered at open hearings conducted during the Annual Meeting.

Action is taken on policy recommendations at both the first and second sessions of the APhA House of Delegates.

II. APhA New Business Review Committee

The APhA House of Delegates has a New Business Review Committee.

A. Appointment

The Speaker of the APhA House of Delegates appoints a chairman and four other members to the APhA New Business Review Committee from among the delegates attending the Annual Meeting.

B. Term

The APhA New Business Review Committee members serve until the end of the Annual Meeting of their appointment.

C. Duties
The APhA New Business Review Committee receives testimony at an open hearing during the Annual Meeting on items of new business submitted by the delegates. The hearing of the APhA New Business Review Committee is open to any person.

D. Quorum
A majority of the members of the APhA New Business Review Committee constitutes a quorum of that Committee for the transaction of business.

E. New Business Review Committee Executive Session
Following the open hearing, the Committee shall meet in Executive Session to discuss the testimony and formulate the Committee's recommendations, if any, to the House of Delegates.

F. APhA Staff Services to New Business Review Committee
APhA staff is available for consultation throughout the open hearing and Executive Session of the New Business Review Committee. Staff will also assist the Committee in preparing its report and will arrange for its reproduction and distribution to delegates.

G. Consideration of APhA New Business Review Committee Report by the House of Delegates
After each motion for a new business item is introduced by the originator to the APhA House of Delegates for action, the chairman of the New Business Review Committee shall be recognized by the Speaker to present the Committee's recommendations, if any, for adoption, referral, amendment, or rejection of the item of new business. The House will vote on the policy resolution if the New Business Review Committee recommends adoption or rejection. If the committee recommends referral or amendment, then the House will vote on the committee recommendation. Originators of New Business items that are referred to the Board or committee for further consideration shall be notified when the item is on the agenda and may attend the meeting at their expense.

III. APhA House of Delegates Nominations Committee

The Committee shall meet preceding the first session of the House of Delegates at Association Annual Meetings held in even-numbered years to select candidates for the office of Speaker-elect of the APhA House of Delegates.

A. Appointment
The APhA House of Delegates Committee on Nominations shall consist of five delegates including the Chairman, and shall be appointed by the Immediate Past (non-incumbent) Speaker of the APhA House of Delegates.

B. Term
The APhA Nominations Committee members serve until the end of the Annual Meeting of their appointment.

C. Duties
The Committee shall meet preceding the first session of the House of Delegates at Association Annual Meetings held in even-numbered years to select candidates for the office of Speaker-elect of the APhA House of Delegates.

D. Quorum
A majority of the members of the APhA Nominations Committee constitutes a quorum of that Committee for the transaction of business.

E. Basic Responsibilities

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

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

All candidates must be a Member as defined in Article III, Section 2, of the APhA Bylaws, and a seated delegate in the APhA House of Delegates. Candidates will be introduced at the first session of the APhA House of Delegates. The candidates will be permitted to address the House for a maximum of three minutes at the second session prior to voting on the candidates by the House. Candidates shall be listed in alphabetical order on the ballot regardless of whether they were slated by the APhA Committee on Nominations or nominated from the floor of the House. A majority vote of delegates present and voting is required for election. If no majority is obtained on the first ballot, a second ballot shall be cast for the two candidates who received the largest vote on the first ballot.

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

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POLICY STATEMENTS

ADVERTISING

Advertising for Pharmacies

2024, 2016, 1997

Use of the Word "Pharmacy" in Unlicensed Environments

APhA supports the establishment and enforcement of laws, regulations, and policies 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 signage and business names to entities in which the practice of pharmacy is conducted.

(JAPhA. NS37:460; July/August 1997) (Reviewed 2002) (Reviewed 2006) (Reviewed 2011) (JAPhA. 56(4): 380; July/August 2016) (JAPhA 64(4);102117, July/August 2024)

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) (Reviewed 2015)

2007, 2002, 1968

Directory Listings for Pharmacies

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

(JAPhA. NS8:380; July 1968) (JAPhA. NS42(5) (suppl 1):S62; September/October 2002) (Reviewed 2006) (JAPhA. NS45(5):580; September/October 2007) (Reviewed 2012) Reviewed 2017)

2002, 1984

Depiction of Pharmacists in Public Media

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

(Am Pharm. NS24(7):60; July 1984) (JAPhA. NS42(5)(suppl 1:S62; September/October 2002) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016) (Reviewed 2018)

2002

Investigation of Discount Card Issuer Practices

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

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

2000

Use of the Phrase "Community Pharmacy"

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

(JAPhA. NS40(5)(suppl 1):S8; September/October 2000) (Reviewed 2002) (Reviewed 2007) (Reviewed 2012)(Reviewed 2017)

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 nonprescription drug products containing different active ingredients.

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

Prescription & NonPrescription Drugs

2024, 1999

Direct-to-Consumer Advertising of Medications

1. APhA supports laws, regulations, and policies permitting direct-to-consumer advertising concerning medical or health conditions treatable by prescription or nonprescription drug products. These advertisements must conform to existing laws, regulations, and policies that ensure 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.

(JAPhA. 39(4):447; July/August 1999) (Reviewed 2004) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016) (JAPhA 64(4);102117, July/August 2024)

2004, 1977

Prescription Drug Advertising

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

(JAPhA. NS17:448; July 1977) (JAPhA. NS44(5):552; September/October 2004) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016)

ASSOCIATION-RELATED

2021

Increasing Awareness and Accountability to End Harassment, Intimidation, Abuse of Power, Position or Authority in Pharmacy Practice

1. APhA calls on all national and state pharmacy organizations, colleges/schools of pharmacy, and other stakeholders to support the development of a profession-wide effort to address harassment, intimidation, and abuse of power or position.
2. APhA supports the development of a profession-wide guideline on reporting harassment, intimidation, or abuse of power or position in their pharmacy education and training, professional practice, or volunteer service to pharmacy organizations.
3. APhA recommends all pharmacy organizations incorporate harassment, intimidation, and abuse training in their member professional development and education activities.

(JAPhA. 61(4):e15-e16; July/August 2021) (Reviewed 2024)

2021

Unity and Strength of the National Pharmacy Practitioner Organizations

APhA supports the initiation of a collaborative/federated organizational structure that brings pharmacy organizations together. This model will unify pharmacy's voice in healthcare and regulatory settings, improve operational efficiencies, conserve limited resources, and will preserve individual organizational identities and traditions all for the benefit of the profession of pharmacy.

(JAPhA. 61(4):e16; July/August 2021)

AUTOMATION AND TECHNOLOGY IN PHARMACY PRACTICE

2024

Artificial Intelligence Use in Pharmacy Practice

1. APhA opposes the replacement of a pharmacist's professional judgment or patient's access to their pharmacist with artificial intelligence.
2. APhA calls on the profession of pharmacy and all related organizations to proactively assess and respond to the evolving role of artificial intelligence in pharmacy practice and workforce dynamics.
3. APhA encourages judicious use of artificial intelligence by pharmacists and pharmacy personnel as a tool to elevate pharmacy practice and enhance patient care.
4. APhA advocates for the integration of pharmacists into the development, design, validation, implementation, and maintenance of artificial intelligence solutions.
5. APhA calls on regulatory bodies, employers, and other relevant parties to develop laws, regulations, and policies as applicable for artificial intelligence to ensure patient safety, privacy, public awareness, and public protection.
6. APhA calls on those providing artificial intelligence solutions to implement processes that identify and mitigate bias and misinformation in artificial intelligence.
7. APhA advocates for education providers to facilitate, and pharmacy personnel to seek out, education and training on the lawful, ethical, and clinical use of artificial intelligence.

(JAPhA 64(4);102117, July/August 2024)

2024, 2021

Continuity of Care and the Role of Pharmacists During Public Health and Other Emergencies

1. APhA asserts that pharmacists, student pharmacists, pharmacy technicians, and pharmacy support staff are essential members of the healthcare team and should be actively engaged and supported in surveillance, mitigation, preparedness, planning, response, recovery, and countermeasure activities related to public health and other emergencies.
2. APhA reaffirms the 2016 policy on the Role of the Pharmacist in National Defense, and calls for the active and coordinated engagement of all pharmacists in public health and other emergency planning and response activities.
3. APhA advocates for the timely removal of legal, regulatory, and policy restrictions; practice limitations; and financial barriers during public health and other emergencies to meet immediate patient care needs.
4. APhA urges regulatory bodies and government agencies to recognize pharmacists' training and ability to evaluate patient needs, provide care, and appropriately refer patients during public health and other emergencies.
5. APhA advocates for pharmacists' authority to ensure patient access to care through the prescribing, dispensing, and administering of medications, as well as provision of other patient care services during times of public health and other emergencies.
6. APhA calls for processes to ensure that any willing and able pharmacy and pharmacy practitioner is not excluded from providing pharmacist patient care services during public health and other emergencies.
7. APhA calls on public and private payers to establish and implement payment policies that compensate pharmacists providing patient care services, including during public health and other emergencies, within their recognized authority.
8. APhA advocates for the inclusion of pharmacists as essential members in the planning, development, and implementation of alternate care sites or delivery models during public health and other emergencies.
9. APhA reaffirms the 2015 Interoperability of Communications Among Health Care Providers to Improve Quality of Care and encourages pharmacists, as members of the healthcare team, to communicate care decisions made during public health and other emergencies with other members of the healthcare team to ensure continuity of care.

(JAPhA. 61(4):e15; July/August 2021) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024

Cybersecurity in Pharmacy

1. APhA advocates for implementation and maintenance of cybersecurity systems, safeguards, and response mechanisms to mitigate risk and minimize harm or disruption for all pharmacies and related parties who manage or access electronic health and business information.
2. APhA advocates for all pharmacies and related business entities responsible for electronic health and business information to have cyber liability insurance or an equivalent self-funded plan to protect all relevant parties in the event of a cyberattack and data breach.
3. APhA advocates for education providers to facilitate, and pharmacy personnel to seek out, education and training on cybersecurity laws, regulations, and best practices.

(JAPhA 64(4);102117, July/August 2024)

2024, 2020, 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.
5. APhA supports laws, regulations, and policies that require e-prescribing of controlled substances to reduce fraudulent prescriptions.

(JAPhA. NS40(4):471; July/August 2010) (Reviewed 2012) (Reviewed 2014) (Reviewed 2015) (JAPhA. 60:(5):e10); September/October 2020) (JAPhA 64(4);102117, July/August 2024)

2024, 2020, 2015

Integrated Nationwide Prescription Drug Monitoring Program

1. APhA advocates for nationwide integration and uniformity of prescription drug monitoring programs (PDMP) that incorporate federal, state, and territory databases for the purpose of providing health care professionals with accurate and real-time information to assist in clinical decision making when providing patient care services related to controlled substances.

2. APhA supports pharmacist involvement in the development of uniform standards for an integrated nationwide prescription drug monitoring program (PDMP) that includes the definition of authorized registered users, documentation, reporting requirements, system response time, security of information, minimum reporting data sets, and standard transaction format.
3. APhA supports mandatory prescription drug monitoring program (PDMP) enrollment by all health care providers, mandatory reporting by all those who dispense controlled substances, and appropriate system query by registrants during the patient care process related to controlled substances.
4. APhA advocates for the development of seamless workflow integration systems that would enable consistent use of a nationwide prescription drug monitoring program (PDMP) by registrants to facilitate prospective drug review as part of the patient care process related to controlled substances.
5. APhA advocates for continuous, sustainable federal funding sources for practitioners and system operators to utilize and maintain a standardized integrated and real-time nationwide prescription drug monitoring program (PDMP).
6. APhA supports the use of interprofessional advisory boards that include pharmacists to coordinate collaborative efforts for

(a) compiling, analyzing, and using prescription drug monitoring program (PDMP) data trends to identify misuse of controlled substances and/or fraud;
(b) providing focused provider education and patient referral to treatment programs; and
(c) supporting research activities on the impact of PDMPs.

7. APhA supports education and training for registrants about a nationwide prescription drug monitoring program (PDMP) to ensure proper data integrity, use, and confidentiality.

(JAPhA. N55(4):364-365; July/August 2015) (JAPhA. 60(5):e10; September/October 2020) (JAPhA 64(4);102117, July/August 2024)

2024, 2020

Transfer of Schedule III–V Prescriptions for Purposes of Initial Fill as Well as Refill

APhA supports laws, regulations, and policies that would allow pharmacies to transfer prescriptions for controlled substances for the purposes of an initial fill.

(JAPhA. 60(5):e10); September/October 2020) (JAPhA 64(4);102117, July/August 2024)

2022, 2018

Proactive Immunization Assessment and Immunization Information Systems

1. APhA supports mandatory requirements for ALL immunization providers to report pertinent immunization data into Immunization Information Systems (IIS).
2. APhA calls for government entities to fund enrollment and engagement of all immunization providers in Immunization Information Systems (IIS). This engagement should support lifetime tracking of immunizations for patients.
3. APhA calls for a National Immunization Information System (IIS) to receive and report vaccination data from all registries for the purpose of providing health care professionals, patients, and their caregivers with accurate and timely information to assist in clinical decision-making.
4. APhA advocates that all appropriate health care personnel involved in the patient care process have timely access to Immunization Information Systems (IIS) and other pertinent data sources to support proactive patient assessment and delivery of immunization services while maintaining confidentiality.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the bidirectional exchange of data with Immunization Information Systems (IIS).

(JAPhA. 58(4):355-365 July/August 2018) (JAPhA. 62 (4):941; July 2022)

2020

Digital Health Integration in Pharmacy

1. APhA supports education about digital health technologies and integration in pharmacy practice, in pharmacy school curricula, and for the pharmacy workforce.
2. APhA supports inclusion of pharmacists in the design and development of digital health technologies.
3. APhA supports that digital health technologies be interoperable with and integrated into pharmacy management systems and electronic health records.
4. APhA supports pharmacists applying digital health technologies to optimize patient care outcomes.

(JAPhA. 60(5):e11; September/October 2020)

2018

Pharmacists Electronic Referral Tracking

1. APhA supports the development of electronic systems that enhance and simplify the ability of pharmacists in all practice settings to receive, send, and track referrals among all members of the health care team, including other pharmacists, irrespective of the health care system, model, or network in which the patient participates.
2. APhA supports the interoperability and integration of referral tracking systems with electronic health records so patients can receive the benefit of optimally coordinated care from all members of the health care team.

(JAPhA. 58(4):356; July/August 2018) (Reviewed 2020)

2018

Use of Genomic Data Within Pharmacy Practice

1. APhA emphasizes genomics as an essential aspect of pharmacy practice.
2. APhA recognizes pharmacists as the health care professional best suited to provide medication-related consults and services based on a patient's genomic information. All pharmacists involved in the care of the patient should have access to relevant genomic information.
3. APhA supports processes to protect patient data confidentiality and opposes unethical utilization of genomic data.
4. APhA demands payers include pharmacists as eligible providers for covered genomic interpretation and related services to support sustainable models that optimize patient care and outcomes.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the exchange, storage, utilization, and documentation of clinically actionable genetic variations and actions taken by the pharmacist in the provision of patient care.
6. APhA recommends pharmacists and pharmaceutical scientists lead the collaborative development of evidence-based practice guidelines for pharmacogenomics and related services.
7. APhA recommends the inclusion of pharmacists and pharmaceutical scientists in the collaborative development of pharmacogenomics clinical support tools and resources.
8. APhA encourages pharmacists to use their professional judgment and published guidelines and resources when providing access to testing or utilizing direct-to-consumer genomic test results in their patient care services.
9. APhA urges schools and colleges of pharmacy to include clinical application of genomics as a required element of the Doctor of Pharmacy curriculum.
10. APhA encourages the creation of continuing professional development and post-graduate education and training programs for pharmacists in genomics and its clinical application to meet varying practice needs.
11. APhA encourages the funding of pharmacist-led research examining the cost effectiveness of care models that utilize pharmacists providing genomic services.

(JAPhA. 58(4):355; July/August 2018) (Reviewed 2023)

2015

Interoperability of Communications Among Health Care Providers to Improve Quality of Patient Care

1. APhA supports the establishment of secure, portable, and interoperable electronic patient health care records.
2. APhA supports the engagement of pharmacists with other stakeholders in the development and implementation of multidirectional electronic communication systems to improve patient safety, enhance quality care, facilitate care transitions, increase efficiency, and reduce waste.
3. APhA advocates for the inclusion of pharmacists in the establishment and enhancement of electronic health care information technologies and systems that must be interoperable, HIPAA compliant, integrated with claims processing, updated in a timely fashion, allow for data analysis, and do not place disproportionate financial burden on any one health care provider or stakeholder.
4. APhA advocates for pharmacists and other health care providers to have access to view, download and transmit electronic health records. Information shared among providers using a health information exchange should utilize a standardized secure interface based on recognized international health record standards for the transmission of health information.
5. APhA supports the integration of federal, state, and territory health information exchanges into an accessible, standardized, nationwide system.
6. APhA opposes business practices and policies that obstruct the electronic access and exchange of patient health information because these practices compromise patient safety and the provision of optimal patient care.
7. APhA advocates for the development of systems that facilitate and support electronic communication between pharmacists and prescribers concerning patient adherence, medication discontinuation, and other clinical factors that support quality care transitions.

8. APhA supports the development of education and training programs for pharmacists, student pharmacists, and other health care professionals on the appropriate use of electronic health records to reduce errors and improve the quality and safety of patient care.
9. APhA supports the creation and non-punitive application of a standardized, interoperable system for voluntary reporting of errors associated with the use of electronic health care information technologies and systems to enable aggregation of protected data and develop recommendations for improved quality.

(JAPhA. N55(4):364; July/August 2015) (Reviewed 2019) (Reviewed 2023) (Reviewed 2024)

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) (Reviewed 2013) (Reviewed 2014) (Reviewed 2015) (Reviewed 2019) (Reviewed 2023)

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 ongoing 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.

(JAPhA: NS44(5):551; September/October 2004) (Reviewed 2006) (Reviewed 2008) (Reviewed 2013) (Reviewed 2014) (Reviewed 2015) (Reviewed 2019) (Reviewed 2023)

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 pharmacists' provision of pharmaceutical care.

(JAPhA. NS41(5)(suppl 1):S8; September/October 2001) (Reviewed 2004) (Reviewed 2007) (Reviewed 2008)(Reviewed 2013) (Reviewed 2015)

BIOTECHNOLOGY

2024, 2016

Biologic, Biosimilar, and Interchangeable Biologic Drug Products

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

(JAPhA. 56(4):369; July/August 2016) (JAPhA 64(4);102117, July/August 2024)

2019, 2010

Pharmacogenomics/Personalized Medicine

4. APhA supports the inclusion of pharmacogenomic analysis in the drug development/approval and postmarketing surveillance processes.

(JAPhA. NS50(4):471; July/August 2010) (Reviewed 2015) (JAPhA. 59(4):e17; July/August 2019) (Reviewed 2023)

2018

Use of Genomic Data Within Pharmacy Practice

1. APhA emphasizes genomics as an essential aspect of pharmacy practice.
2. APhA recognizes pharmacists as the health care professional best suited to provide medication-related consults and services based on a patient's genomic information. All pharmacists involved in the care of the patient should have access to relevant genomic information.
3. APhA supports processes to protect patient data confidentiality and opposes unethical utilization of genomic data.
4. APhA demands payers include pharmacists as eligible providers for covered genomic interpretation and related services to support sustainable models that optimize patient care and outcomes.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the exchange, storage, utilization, and documentation of clinically actionable genetic variations and actions taken by the pharmacist in the provision of patient care.
6. APhA recommends pharmacists and pharmaceutical scientists lead the collaborative development of evidence-based practice guidelines for pharmacogenomics and related services.
7. APhA recommends the inclusion of pharmacists and pharmaceutical scientists in the collaborative development of pharmacogenomics clinical support tools and resources.
8. APhA encourages pharmacists to use their professional judgment and published guidelines and resources when providing access to testing or utilizing direct-to-consumer genomic test results in their patient care services.
9. APhA urges schools and colleges of pharmacy to include clinical application of genomics as a required element of the Doctor of Pharmacy curriculum.
10. APhA encourages the creation of continuing professional development and post-graduate education and training programs for pharmacists in genomics and its clinical application to meet varying practice needs.
11. APhA encourages the funding of pharmacist-led research examining the cost effectiveness of care models that utilize pharmacists providing genomic services.

(JAPhA. 58(4):355; July/August 2018) (Reviewed 2023)

2005, 1988

Pharmaceutical Biotechnology Products

APhA recognizes the urgent need for education and training of pharmacists and student pharmacists relative to the therapeutic and diagnostic use of pharmaceutical biotechnology products. APhA, therefore, supports the continuing development and implementation of such education and training.

(Am Pharm. NS28(6):394; June 1988) (JAPhA. NS45(5):559; September/October 2005) (Reviewed 2006) (Reviewed 2007) (Reviewed 2010) (Reviewed 2015) (Reviewed 2016) (Reviewed 2017)

1991

Biotechnology

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

(Am Pharm. NS31(6):29; June 1991) (Reviewed 2004) (Reviewed 2007) (Reviewed 2010) (Reviewed 2015)(Reviewed 2016) (Reviewed 2017)

DISASTER PREPAREDNESS

2024, 2021

Continuity of Care and the Role of Pharmacists During Public Health and Other Emergencies

1. APhA asserts that pharmacists, student pharmacists, pharmacy technicians, and pharmacy support staff are essential members of the healthcare team and should be actively engaged and supported in surveillance, mitigation, preparedness, planning, response, recovery, and countermeasure activities related to public health and other emergencies.
2. APhA reaffirms the 2016 policy on the Role of the Pharmacist in National Defense, and calls for the active and coordinated engagement of all pharmacists in public health and other emergency planning and response activities.
3. APhA advocates for the timely removal of legal, regulatory, and policy restrictions; practice limitations; and financial barriers during public health and other emergencies to meet immediate patient care needs.
4. APhA urges regulatory bodies and government agencies to recognize pharmacists' training and ability to evaluate patient needs, provide care, and appropriately refer patients during public health and other emergencies.
5. APhA advocates for pharmacists' authority to ensure patient access to care through the prescribing, dispensing, and administering of medications, as well as provision of other patient care services during times of public health and other emergencies.
6. APhA calls for processes to ensure that any willing and able pharmacy and pharmacy practitioner is not excluded from providing pharmacist patient care services during public health and other emergencies.
7. APhA calls on public and private payers to establish and implement payment policies that compensate pharmacists providing patient care services, including during public health and other emergencies, within their recognized authority.
8. APhA advocates for the inclusion of pharmacists as essential members in the planning, development, and implementation of alternate care sites or delivery models during public health and other emergencies.
9. APhA reaffirms the 2015 Interoperability of Communications Among Health Care Providers to Improve Quality of Care and encourages pharmacists, as members of the healthcare team, to communicate care decisions made during public health and other emergencies with other members of the healthcare team to ensure continuity of care.

(JAPhA. 61(4):e15; July/August 2021) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2015

Disaster Preparedness

APhA encourages pharmacist involvement in surveillance, mitigation, preparedness, planning, response, and recovery related to natural, technological, or human-caused incidents.

(JAPhA. N55(4):365; July/August 2015) (Reviewed 2021)(JAPhA 64(4);102117, July/August 2024)

2024, 2021

Multi-State Practice of Pharmacy

1. APhA affirms that pharmacists are trained to provide patient care, and have the ability to address patient needs, regardless of geographic location.
2. APhA advocates for the continued development of uniform laws, regulations and policies that facilitate pharmacists', student pharmacists', and pharmacy technicians' timely ability to practice in multiple states to meet practice and patient care needs.
3. APhA supports individual pharmacists' and student pharmacists' authority to provide patient care services across state lines whether in person or remotely.
4. APhA supports consistent and efficient centralized processes across all states for obtaining and maintaining pharmacist, pharmacy intern, and pharmacy technician licensure and/or registration.
5. APhA urges state boards of pharmacy to reduce administratively and financially burdensome requirements for licensure while continuing to uphold patient safety.
6. APhA encourages the evaluation of current law exam requirements for obtaining and maintaining initial state licensure, as well as licensure in additional states, to enhance uniformity and reduce duplicative requirements.
7. APhA urges state boards of pharmacy and the National Association of Boards of Pharmacy (NABP) to involve a member of the board of pharmacy and a practicing pharmacist in the review and updating of state jurisprudence licensing exam questions.
8. APhA calls for development of profession-wide consensus on licensing requirements for pharmacists and pharmacy personnel to support contemporary pharmacy practice.

(JAPhA. 61(4):e14-e15;July/August 2021) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2020

Pharmaceutical Safety and Access During Emergencies

1. APhA urges government authorities to hold pharmaceutical manufacturers, wholesalers, pharmacies, and other pharmaceutical supply distributors and providers accountable to state and federal price gouging laws, regulations and policies in selling those items to patients, pharmacies, hospitals, and other health care providers during times of local, state, or national emergency.
2. APhA urges government authorities to aggressively enforce laws and regulations against adulterated products and false and misleading claims by entities offering to sell pharmaceutical and medical products to health care providers and consumers.

(JAPhA. 60(5):e11; September/October 2020) (JAPhA 64(4);102117, July/August 2024)

2024, 2020

Protecting Pharmaceuticals as a Strategic Asset

1. APhA asserts that the quality and safety of pharmaceutical and other medical products and the global pharmaceutical and medical product supply chain are essential to the United States national security and public health.
2. APhA advocates for pharmacist engagement in the development and implementation of national and global strategies to ensure the availability, quality, and safety of pharmaceutical and other medical products.
3. APhA calls for the development, implementation, and oversight of enhanced and transparent processes, standards, and information that ensure quality and safety of all pharmaceutical ingredients and manufacturing processes.
4. APhA calls on the federal government to penalize entities who create barriers that threaten the availability, quality, and safety of United States pharmaceutical and other medical product supplies.
5. APhA calls for the development of redundancy and risk mitigation strategies in the manufacturing process to ensure reliable and consistent availability of safe and high-quality pharmaceutical and other medical products.
6. APhA advocates for legal regulatory, policy and market incentives that bolster the availability, quality, and safety of pharmaceutical and other medical products.
7. APhA calls for greater transparency, accuracy, and timeliness of information and notification to health care professionals regarding drug shortages, product quality and manufacturing issues, supply disruption, and recalls.
8. APhA encourages pharmacy providers, health systems, and payers to develop coordinated response plans, including the use of therapeutic alternatives, to mitigate the impact of drug shortages and supply disruptions.
9. APhA supports federal legislation and regulations that engages pharmacists, other health professionals, and manufacturers in developing a United States-specific essential medicines list and provides funding mechanisms to ensure consistent availability of these products.
10. APhA recommends the use of pharmacists in the delivery of public messages, through media and other communication channels, regarding pharmaceutical supply and quality issues.

(JAPhA. 60(5):e9; September/October 2020) (JAPhA 64(4);102117, July/August 2024)

2023

Uncompensated Care Mandates in Pharmacy

APhA calls for commensurate compensation for the provision of compulsory or mandated pharmacy services that include all products, supplies, labor, expertise, and administrative fees based on transparent economic analyses of existing and future services.

(JAPhA. 63(4):1265; July/August 2023)

2022 2007

Pharmacy Personnel Immunization Rates

1. APhA supports efforts to increase immunization rates of health care 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 officials and agencies to recognize pharmacists, student pharmacists, pharmacy technicians, and pharmacy support staff as among the highest priority groups to receive medications, vaccinations, and other protective measures as essential healthcare workers.

(JAPhA. NS45(5):580; September/October 2007) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019) (JAPhA. 62(4):942; July 2022) (Reviewed 2023)

2022, 2014

Use of Social Media

1. APhA encourages the use of social media in ways that advance patient care and uphold pharmacists as trusted and accessible health care providers.
2. APhA supports the use of social media as a mechanism for the delivery of patient-specific care in a platform that allows for appropriate patient and provider protections and access to necessary health care information.
3. APhA supports the inclusion of social media education, including but not limited to appropriate use and professionalism, as a component of pharmacy education and continuing professional development.
4. APhA affirms that the patient's right to privacy and confidentiality shall not be compromised through the use of social media.
5. APhA urges pharmacists, pharmacy technicians and student pharmacists to self-monitor their social media presence for professionalism and that posted clinical information is accurate and appropriate.
6. APhA advocates for continued development and utilization of social media by pharmacists and other health care professionals during public health emergencies.

(JAPhA. 54(4):357; July/August 2014) (Reviewed 2019)(Amended 2022)

2020

Protecting Pharmacy Personnel During Public Health Crisis

1. APhA strongly urges all employers of pharmacists and pharmacy personnel, and the settings in which they practice, to implement protection and control measures and procedures, per consensus recommendations when available, and access to protective gear and cleaning supplies that ensure the safety of pharmacy personnel and that of their family members and the public.
2. APhA urges federal and state government officials, manufacturers, distributors, and health system administrators to recognize pharmacists and pharmacy personnel as "front-line providers" who should receive appropriate personal protective equipment and other resources to protect their personal safety and support their ability to continue to provide patient care.

(JAPhA. 60(5):e11; September/October 2020)

2016, 2011, 2002, 1963

Role of the Pharmacist in National Defense

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. In view of these responsibilities, it shall be the policy of APhA,

1. Cooperate with all responsible agencies and departments of the federal government;
2. Provide leadership and guidance for the profession of pharmacy by properly assuming its role with other health profession organizations at the national level (e.g., American Medical Association, American Hospital Association, American Dental Association, American Nurses Association, and American Veterinary Medical Association);
3. 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. 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 their proper place in civil defense operations; and
5. 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 their position as a member of the health team.

(JAPhA. NS3:330; June 1963) (JAPhA. NS42(5)(suppl 1):S62; September/October 2002) (Reviewed 2006) (Reviewed 2010) (JAPhA. NS51(4): 483; July/August 2011) (JAPhA. 56(4):379; July/August 2016) (Reviewed 2021) (Reviewed 2023)

2011, 2002, 1996

Health Mobilization

APhA should continue to:

1. Emphasize its support for programs on disaster preparedness that 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 Emergency Management (OEM) assistance through professional service contracts to further develop pharmacy's activities in all phases of preparation before disasters; and

4. Encourage routine inspection of drug stockpiles and disaster kits by state boards of pharmacy.

(JAPhA. N)S6:328; June 1996) (JAPhA. NS42(5)(suppl 1):S62; September/October 2002) (Reviewed 2006) (JAPhA NS51(4):483; July/August 2011) (Reviewed 2016) (Reviewed 2022) (Reviewed 2023)

2006, 2002, 1971

Model Disaster Plan for Pharmacists

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

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

DISPENSING AUTHORITY

2024, 2005, 1998

Administration of Medications

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

(JAPhA. 38(4):417; July/August 1998) (JAPhA. NS45(5):559; September/October 2005) (Reviewed 2006)(Reviewed 2011) (Reviewed 2012) (Reviewed 2017) (Reviewed 2020) (JAPhA 64(4);102117, July/August 2024)

2024, 2006, 2004, 1978

Dispensing Criteria

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

(Am Pharm. NS18(8):42; July 1978) (JAPhA. NS44(5):551; September/October 2004) JAPhA. NS46(5):562; September/October 2006) (Reviewed 2015) (JAPhA 64(4);102117, July/August 2024)

2024, 1979

Out-of-State Prescription Orders

APhA supports the repeal of state laws, regulations, and policies that prohibit the dispensing of an otherwise legal prescription order, issued by a prescriber licensed in another state.

(Am Pharm. NS19(7):67; June 1979) (Reviewed 2004) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016) (JAPhA 64(4);102117, July/August 2024)

2024, 2018, 2013

Revisions to the Medication Classification System

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

5. APhA urges manufacturers, FDA, and other stakeholders to include pharmacists' input in the development and adoption of technology and standardized processes for services related to medications and medical devices under FDA's defined conditions of safe use.
6. APhA supports the utilization of best practices, treatment algorithms, and clinical judgment of pharmacists and other health care providers to guide the evaluation and management of care delivery related to medications and medical devices under FDA's approved conditions of safe use.
7. APhA encourages the inclusion of medications, medical devices, and their associated services provided under FDA's defined conditions of safe use within health benefit coverage.
8. APhA supports compensation of pharmacists and other health care professionals for the provision of services related to FDA's defined conditions of safe use programs.

(JAPhA. 53(4):365; July/August 2013) (JAPhA. 58(4):356; July/August 2018) (Reviewed 2022) (JAPhA 64(4);102117, July/August 2024)

2024, 2015

Role of the Pharmacist in the Care of Patients Using Cannabis

1. APhA supports legal, regulatory, and policy changes to further facilitate clinical research related to the clinical efficacy and safety associated with the use of cannabis and its various components.
2. APhA encourages health care provider education related to the clinical efficacy, safety, and management of patients using cannabis and its various components.
3. APhA advocates that the pharmacist collect and document information in the pharmacy patient profile about patient use of cannabis and its various components and provide appropriate patient counseling.
4. APhA supports pharmacist participation in independently prescribing cannabis and its various components when scientific data support the legitimate medical use of the products and delivery mechanisms, and federal, state, or territory laws or regulations permit pharmacists to independently prescribe them.
5. APhA opposes pharmacist involvement in independently prescribing cannabis and its various components for recreational use.

(JAPhA. N55(4):365; July/August 2015) (JAPhA 64(4);102117, July/August 2024)

2017

Patient Access to Pharmacist-Prescribed Medications

1. APhA asserts that pharmacists' patient care services and related prescribing by pharmacists help improve patient access to care, patient outcomes, and community health, and they align with coordinated, team-based care.
2. APhA supports increased patient access to care through pharmacist prescriptive authority models.
3. APhA opposes requirements and restrictions that impede patient access to pharmacist-prescribed medications and related services.
4. APhA urges prescribing pharmacists to coordinate care with patients' other health care providers through appropriate documentation, communication, and referral.
5. APhA advocates that medications and services associated with prescribing by pharmacists must be covered and compensated in the same manner as for other prescribers.
6. APhA supports the right of patients to receive pharmacist-prescribed medications at the pharmacy of their choice.

(JAPhA. 57(4):442; July/August 2017) (Reviewed 2019) (Reviewed 2020) (Reviewed 2021) (Reviewed 2023) (Reviewed 2024)

2004, 1984

Issuing of Drugs by Non-Pharmacists

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

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

2003, 2000

Emergency Contraception

APhA supports the voluntary involvement of pharmacists, in collaboration with other health care providers, in emergency contraceptive programs that include patient evaluation, patient education, and direct provision of emergency contraceptive medications.

(JAPhA. NS40(5)(suppl 1):S8; September/October 2000) (JAPhA. NS43(5)(suppl 1):S58; September/October 2003) (Reviewed 2006) (Reviewed 2008) (Reviewed 2009) (Reviewed 2014) (Reviewed 2018)

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;
   (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, that can be dispensed in an emergency situation, is enough so that the emergency situation can subside, and the patient can be sustained for the immediate emergency, as determined by the pharmacist's professional judgment.
3. APhA supports expansion of state Good Samaritan Acts to provide pharmacists immunity from professional liability for dispensing in emergency situations without order from a licensed prescriber.
4. APhA supports permitting pharmacists to lawfully dispense and/or administer legend drugs without an order from a licensed prescriber during disaster situations.

(Am Pharm. NS19(7):68; June 1979) (Reviewed 2002) (Reviewed 2006) (Revised 2007) (Reviewed 2012) (Reviewed 2012) (Reviewed 2017) (Reviewed 2021) (Reviewed 2022) (Reviewed 2023)

DRUG ABUSE, CONTROL AND EDUCATION

2024, 2014

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

1. APhA supports education for pharmacists and student pharmacists to address issues of pain management, palliative care, appropriate use of opioid reversal agents in opioid-associated emergencies, drug diversion, and substance use disorders.
2. APhA supports recognition of pharmacists as the health care providers who must exercise professional judgment in the assessment of a patient's conditions to fulfill corresponding responsibility for the use of controlled substances and other medications with the potential for misuse and/or diversion.
3. APhA supports pharmacists' access to and use of prescription monitoring programs to identify and prevent drug misuse and/or diversion.
4. APhA supports the development and implementation of state and federal laws, regulations, and policies that permit pharmacists to independently prescribe opioid reversal agents to prevent deaths due to opioid-associated emetgencies.
5. APhA supports the pharmacist's role in selecting appropriate therapy and dosing and initiating and providing education about the proper use of opioid reversal agents to prevent deaths due to opioid-associated emergencies.

(JAPhA. 54(4):358; July/August 2014) (Reviewed 2015)(Reviewed 2018) (Reviewed 2021) (Reviewed 2022) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2017

Drug Disposal Program Involvement

APhA urges pharmacists to expand patient access to secure, convenient, and environmentally responsible drug disposal options, in accordance with the Secure and Responsible Drug Disposal Act of 2010, by implementing disposal programs they deem appropriate for their individual practice sites, patient care settings, and business models in an effort to reduce the amount of dispensed but unused prescription drug product available for diversion and misuse.

(JAPhA. 57(4):441; July/August 2017) (JAPhA 64(4);102117, July/August 2024)

2024, 2020

Increasing Access to and Advocacy for Medications for Opioid Use Disorder– (MOUD)

1. APhA supports the use of evidence-based medicine as first-line treatment for patients with opioid-use disorder, including healthcare professionals in and out of the workplace, for as long as needed to treat their disease.
2. APhA encourages pharmacies to maintain an inventory of medications used in treatment of opioid-use disorder (MOUD), to ensure access for patients.
3. APhA encourages pharmacists and payers to ensure patients have equitable access to, and coverage for, at least one medication from each class of medications used in the treatment of opioid-use disorder.

(JAPhA. 60(5):e11; September/October 2020) (JAPhA 64(4);102117, July/August 2024)

2024, 2021

Increasing Access to and Affordability of Naloxone

1. APhA supports laws, regulations, policies and practices that increase the availability of naloxone.
2. APhA supports the availability of naloxone as both a prescription and non-prescription medication.

3. APhA encourages pharmacists and payers to ensure equitable access to and affordability of at least one naloxone formulation regardless of prescription status.
4. APhA encourages payers to provide fair reimbursement to dispensers of naloxone.

(JAPhA. 61(4):e16; July/August) (JAPhA 64(4);102117, July/August 2024)

2024, 2020, 2015

Integrated Nationwide Prescribing Drug Monitoring Program

1. APhA advocates for nationwide integration and uniformity of prescription drug monitoring programs (PDMP) that incorporate federal, state, and territory databases for the purpose of providing health care professionals with accurate and real-time information to assist in clinical decision making when providing patient care services related to controlled substances.
2. APhA supports pharmacist involvement in the development of uniform standards for an integrated nationwide prescription drug monitoring program (PDMP) that includes the definition of authorized registered users, documentation, reporting requirements, system response time, security of information, minimum reporting data sets, and standard transaction format.
3. APhA supports mandatory prescription drug monitoring program (PDMP) enrollment by all health care providers, mandatory reporting by all those who dispense controlled substances, and appropriate system query by registrants during the patient care process related to controlled substances.
4. APhA advocates for the development of seamless workflow integration systems that would enable consistent use of a nationwide prescription drug monitoring program (PDMP) by registrants to facilitate prospective drug review as part of the patient care process related to controlled substances.
5. APhA advocates for continuous, sustainable federal funding sources for practitioners and system operators to utilize and maintain a standardized integrated and real-time nationwide prescription drug monitoring program (PDMP).
6. APhA supports the use of interprofessional advisory boards that include pharmacists to coordinate collaborative efforts for

(a) compiling, analyzing, and using prescription drug monitoring program (PDMP) data trends to identify misuse of controlled substances and/or fraud;
(b) providing focused provider education and patient referral to treatment programs; and
(c) supporting research activities on the impact of PDMPs.

7. APhA supports education and training for registrants about a nationwide prescription drug monitoring program (PDMP) to ensure proper data integrity, use, and confidentiality.

(JAPhA. N55(4):364-365; July/August 2015) (JAPhA. 60(5):e10; September/October 2020) (JAPhA 64(4);102117, July/August 2024)

2024, 2016

Opioid Overdose Prevention

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

(JAPhA. 56(4):370; July/August 2016) (Reviewed 2020) (Reviewed 2022) (JAPhA 64(4);102117, July/August 2024)

2024, 2019, 2016

Substance Use Disorder

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

(JAPhA. 56(4):369; July/August 2016) (JAPhA. 59(4): e28; July/August 2019) (Reviewed 2022) (JAPhA 64(4);102117, July/August 2024)

2024, 2020

Transfer of Schedule III–V Prescriptions for Purposes of Initial Fill as Well as Refill

APhA supports laws, regulations, and policies that would allow pharmacies to transfer prescriptions for controlled substances for the purposes of an initial fill.

(JAPhA. 60(5):e10); September/October 2020) (JAPhA 64(4);102117, July/August 2024)

2023, 2016

Medication for Substance Use Disorders Medication-Assisted Treatment

APhA supports expanding access to medications indicated for opioid use disorders (MOUDs) and other substance use disorders, including but not limited to pharmacist-administered injection services for treatment and maintenance of substance use disorders that are based on a valid prescription.

(JAPhA. 56(4):370; July/August 2016) (Reviewed 2021) (JAPhA. 63(4):1268; July/August 2023)

2022

Pharmacists Prescribing Authority and Increasing Access to Medications for Opioid Use Disorders

APhA advocates for pharmacists' independent prescriptive authority of medications indicated for opioid use disorders (MOUDs) and other substance use disorders to expand patient access to treatment.

(JAPhA. 62(4):942; July 2022)

2011, 2005, 2002

Funding for Pharmacist Recovery Programs

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

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

2005, 2003, 1982

Pharmacists With Impairments That Affect Practice

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

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

2003, 1971

Security: Pharmacists' Responsibility

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

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

2003, 1983

The Use of Controlled Substances in the Treatment of Intractable Pain

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 that 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.

(Am Pharm. NS23(6):52; June 1983) (JAPhA. NS43(5)(suppl 1):S58; September/October 2003) (Reviewed 2006) (Reviewed 2011) (Reviewed 2012) (Reviewed 2013) (Reviewed 2015)

1997

Drug Enforcement Agency Employment Waiver

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

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

1990

Drug Testing in the Workplace

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

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

1982

Innovative Approaches to Combating 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).
3. APhA encourages pharmaceutical associations to work with state legislators in an effort to provide mandatory imprisonment for the theft of controlled substances and the restriction of bail for such crimes.

(Am Pharm. NS22(7):32; July 1982) (Reviewed 2003) (Reviewed 2004) (Reviewed 2006) (Reviewed 2010) (Reviewed 2015)

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.

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

Marijuana

2024, 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, regulations, and policies pertaining to:
   (a) marketing approval of new drugs based on demonstrated safety and efficacy, or
   (b) controlling restrictions relating to those substances having a recognized hazard of abuse.

(Am Pharm. NS20(7):71; July 1980) (Reviewed 2003) (Reviewed 2006) (Reviewed 2011) (Reviewed 2015) (JAPhA 64(4);102117, July/August 2024)

2024, 2015

Role of the Pharmacist in the Care of Patients Using Cannabis

1. APhA supports legal, regulatory, and policy changes to further facilitate clinical research related to the clinical efficacy and safety associated with the use of cannabis and its various components.
2. APhA encourages health care provider education related to the clinical efficacy, safety, and management of patients using cannabis and its various components.
3. APhA advocates that the pharmacist collect and document information in the pharmacy patient profile about patient use of cannabis and its various components and provide appropriate patient counseling.
4. APhA supports pharmacist participation in independently prescribing cannabis and its various components when scientific data support the legitimate medical use of the products and delivery mechanisms, and federal, state, or territory laws or regulations permit pharmacists to independently prescribe them.
5. APhA opposes pharmacist involvement in independently prescribing cannabis and its various components for recreational use.

(JAPhA. N55(4):365; July/August 2015) (JAPhA 64(4);102117, July/August 2024)

Methadone

2024

Community Pharmacy Methadone Dispensing for Opioid Use Disorder

1. APhA supports changes in laws, regulations, and policies to permit DEA-registered and trained opioid treatment program clinicians and other providers the ability to prescribe methadone for opioid use disorder and refer patients for additional services as needed.
2. APhA supports changes in laws, regulations, and policies to permit community pharmacy dispensing of methadone for opioid use disorder and appropriate compensation for these services.
3. APhA supports partnerships and collaborations to increase patient access to opioid treatment programs (OTPs) and clinicians.
4. APhA advocates for interprofessional education on laws, regulations, and policies regarding office-based prescribing and community pharmacy dispensing of methadone in curricula, postgraduate training, and continuing professional development programs of all health professions.

(JAPhA 64(4);102117, July/August 2024)

2003, 1972

Methadone Used as Analgesic and Antitussive

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

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

Performance-Enhancing Drugs

2024, 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, regulations, and policies related to the use of performance-enhancing drugs by athletes.

(Am Pharm. NS26(6):420; June 1986) (Reviewed 2003) (Reviewed 2006) (Reviewed 2015) (JAPhA 64(4);102117, July/August 2024)

State Drug Laws and Legalization Issues

2024, 2019

Patient-Centered Care of People Who Uset Non-Medically Sanctioned Psychotropic or Psychoactive Substances

1. APhA encourages state legislatures and boards of pharmacy to revise laws, regulations, and policies to support the patient-centered care of people who use non-medically sanctioned psychotropic or psychoactive substances.
2. To reduce the consequences of stigma associated with drug use, APhA supports the expansion of interprofessional harm reduction education in the curriculum of schools and colleges of pharmacy, postgraduate training, and continuing professional development programs.
3. APhA encourages pharmacists to initiate, sustain, and integrate evidence-based harm reduction principles and programs into their practice to optimize the health of people who use non-medically sanctioned psychotropic or psychoactive substances.
4. APhA supports pharmacists' roles to provide and promote consistent, unrestricted, and immediate access to evidence-based, mortality- and morbidity-reducing interventions to enhance the health of people who inject nonmedically sanctioned psychotropic or psychoactive substances and their communities, including sterile syringes, needles, and other safe injection equipment, syringe disposal, fentanyl test strips, immunizations, condoms, wound care supplies, pre- and post-exposure prophylaxis medications for human immunodeficiency virus (HIV), point-of-care testing for HIV and hepatitis C virus (HCV), opioid reversal agents, and medications for opioid use disorder.
5. APhA urges pharmacists to refer people who use non-medically sanctioned psychotropic or psychoactive substances to specialists in mental health, infectious diseases, and substance use disorder treatment; to housing, vocational, harm reduction, and recovery support services; and to safe consumption facilities and syringe service programs.

(JAPhA. 59(4):e17; July/August 2019) (Reviewed 2021) (Reviewed 2022) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2023, 2016, 1990

Legalization or Decriminalization of Illicit Drugs

1. APhA opposes legalization of the possession, sale, distribution, or use of illicit drug substances for non-medical uses.
2. APhA supports decriminalization of the personal possession or personal use of illicit drug substances or paraphernalia.
3. APhA supports voluntary pathways for the treatment and rehabilitation of individuals who have been charged with the possession or use of illicit drug substances and who have substance use or other related medical disorders.
4 APhA supports criminal penalties for persons convicted of drug trafficking or illicit drug manufacturing, whenever alternate pathways are inappropriate as determined by the courts.

(Am Pharm. NS30(6):46; June 1990) (Reviewed 2003) (Reviewed 2006) (Reviewed 2011) (JAPhA 56(4):369; July/August 2016) (JAPhA. 63(4):1266; July/August 2023)

2012

Controlled Substances Regulation and Patient Care

1. APhA encourages the Drug Enforcement Administration (DEA) and other regulatory agencies to recognize pharmacists as partners that are committed to ensuring that patients in legitimate need of controlled substances are able to receive the medications.
2. APhA supports efforts to modernize and harmonize state and federal controlled substance laws.
3. APhA urges DEA and other regulatory agencies to balance patient care and regulatory issues when developing, interpreting, and enforcing laws and regulations.
4. APhA encourages DEA and other regulatory agencies to recognize the changes occurring in health care delivery and to establish a transparent and inclusive process for the timely updating of laws and regulations.
5. APhA encourages the U.S. Department of Justice to collaborate with professional organizations to identify and reduce
   (a) the burdens on health care providers,
   (b) the cost of health care delivery, and
   (c) the barriers to patient care in the establishment and enforcement of controlled substance laws.

(JAPhA. NS52(4):457; July/August 2012) (Reviewed 2015)

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) (Reviewed 2015)

DRUG CLASSIFICATION

2024, 2016

Biologic, Biosimilar, and Interchangeable Biologic Drug Products

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

(JAPhA. 56(4):369; July/August 2016) (JAPhA 64(4);102117, July/August 2024)

2024, 2020

Non-execution-Related Use of Pharmaceuticals in Correctional Facilities

1. APhA opposes drug manufacturers' refusal to supply certain drugs to correctional health services units necessary to provide medical treatment of those who are incarcerated.
2. APhA advocates for those who are incarcerated to have an opportunity, equal to that of nonmates, to access medications that correctional healthcare providers deem medically necessary for appropriate and humane health care treatment.
3. APhA advocates for correctional healthcare providers to have opportunity, equal to that of non-correctional healthcare providers, to access, prescribe, and procure pharmaceuticals deemed necessary for medical treatment of those incarcerated.

(JAPhA. 60(5):e11; September/October 2020) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2018, 2013

Revisions to the Medication Classification System

1. APhA supports the Food and Drug Administration's (FDA) efforts to revise the drug and medical device classification paradigms for prescription and nonprescription medications and medical devices to allow greater access to certain medications and medical devices under conditions of safe use while maintaining patients' relationships with their pharmacists and other health care providers.
2. APhA supports the implementation or modification of state laws, regulations, and policies to facilitate pharmacists' implementation and provision of services related to a revised drug and medical device classification system.
3. APhA supports a patient care delivery model built on coordination and communication between pharmacists and other health care team members in the evaluation and management of care delivery.
4. APhA affirms that pharmacists are qualified to provide clinical interventions on medications and medical devices under FDA's approved conditions of safe use.
5. APhA urges manufacturers, FDA, and other stakeholders to include pharmacists' input in the development and adoption of technology and standardized processes for services related to medications and medical devices under FDA's defined conditions of safe use.
6. APhA supports the utilization of best practices, treatment algorithms, and clinical judgment of pharmacists and other health care providers to guide the evaluation and management of care delivery related to medications and medical devices under FDA's approved conditions of safe use.
7. APhA encourages the inclusion of medications, medical devices, and their associated services provided under FDA's defined conditions of safe use within health benefit coverage.
8. APhA supports compensation of pharmacists and other health care professionals for the provision of services related to FDA's defined conditions of safe use programs.

(JAPhA. 53(4):365; July/August 2013) (JAPhA. 58(4):356; July/August 2018) (Reviewed 2022) (JAPhA 64(4);102117, July/August 2024)

2006

Drug Classification System

1. APhA supports restructuring the current drug classification system and drug approval process. Evidence should drive the restructuring beyond the current prescription and nonprescription classes to ensure appropriate access to medications and pharmacist services and improve medication use and outcomes.
2. APhA encourages pharmacists to exercise their professional judgment to manage access to nonprescription medications and dietary supplements to facilitate patient/caregiver interaction with their pharmacist.

(JAPhA. NS46(5):561; September/October 2006) (Reviewed 2011) (Reviewed 2013) (Reviewed 2017)

DRUG PRICING AND DISTRIBUTION

2024, 2023

Access to Essential Medicines

APhA advocates for laws, regulations, and policies that recognize access to quality and affordable essential medicines as a fundamental human right.

(JAPhA. 63(4):1266; July/August 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2016

Biologic, Biosimilar, and Interchangeable Biologic Drug Products

1. APhA urges the development of laws, regulations, and policies that facilitate patient access to and affordability of biologic products.

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

(JAPhA. 56(4):369; July/August 2016) (JAPhA 64(4);102117, July/August 2024)

2024, 2021

Continuity of Care and the Role of Pharmacists During Public Health and Other Emergencies

1. APhA asserts that pharmacists, student pharmacists, pharmacy technicians, and pharmacy support staff are essential members of the healthcare team and should be actively engaged and supported in surveillance, mitigation, preparedness, planning, response, recovery, and countermeasure activities related to public health and other emergencies.
2. APhA reaffirms the 2016 policy on the Role of the Pharmacist in National Defense, and calls for the active and coordinated engagement of all pharmacists in public health and other emergency planning and response activities.
3. APhA advocates for the timely removal of legal, regulatory, and policy restrictions; practice limitations; and financial barriers during public health and other emergencies to meet immediate patient care needs.
4. APhA urges regulatory bodies and government agencies to recognize pharmacists' training and ability to evaluate patient needs, provide care, and appropriately refer patients during public health and other emergencies.
5. APhA advocates for pharmacists' authority to ensure patient access to care through the prescribing, dispensing, and administering of medications, as well as provision of other patient care services during times of public health and other emergencies.
6. APhA calls for processes to ensure that any willing and able pharmacy and pharmacy practitioner is not excluded from providing pharmacist patient care services during public health and other emergencies.
7. APhA calls on public and private payers to establish and implement payment policies that compensate pharmacists providing patient care services, including during public health and other emergencies, within their recognized authority.
8. APhA advocates for the inclusion of pharmacists as essential members in the planning, development, and implementation of alternate care sites or delivery models during public health and other emergencies.
9. APhA reaffirms the 2015 Interoperability of Communications Among Health Care Providers to Improve Quality of Care and encourages pharmacists, as members of the healthcare team, to communicate care decisions made during public health and other emergencies with other members of the healthcare team to ensure continuity of care.

(JAPhA. 61(4):e15; July/August 2021) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2004, 1966

Distribution Programs: Circumvention of the Pharmacist

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

(JAPhA. NS6:293; June 1966) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016) (Reviewed 2021) (JAPhA 64(4);102117, July/August 2024)

2024, 2012

Drug Supply Shortages and Patient Care

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

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

(JAPhA. NS52(4): 457; July/August 2012) (Reviewed 2017) (Reviewed 2021) (JAPhA 64(4);102117, July/August 2024)

2024, 2020

Non-execution-Related Use of Pharmaceuticals in Correctional Facilities

1. APhA opposes drug manufacturers' refusal to supply certain drugs to correctional health services units necessary to provide medical treatment of those who are incarcerated.
2. APhA advocates for those who are incarcerated to have an opportunity, equal to that of nonmates, to access medications that correctional healthcare providers deem medically necessary for appropriate and humane health care treatment.
3. APhA advocates for correctional healthcare providers to have opportunity, equal to that of non-correctional healthcare providers, to access, prescribe, and procure pharmaceuticals deemed necessary for medical treatment of those incarcerated.

(JAPhA. 60(5):e11; September/October 2020) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2016

Opioid Overdose Prevention

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

(JAPhA. 56(4):370; July/August 2016) (Reviewed 2020) (Reviewed 2022) (JAPhA 64(4);102117, July/August 2024)

2024, 2020

Pharmaceutical Safety and Access During Emergencies

1. APhA urges government authorities to hold pharmaceutical manufacturers, wholesalers, pharmacies, and other pharmaceutical supply distributors and providers accountable to state and federal price gouging laws, regulations and policies in selling those items to patients, pharmacies, hospitals, and other health care providers during times of local, state, or national emergency.
2. APhA urges government authorities to aggressively enforce laws and regulations against adulterated products and false and misleading claims by entities offering to sell pharmaceutical and medical products to health care providers and consumers.

(JAPhA. 60(5):e11; September/October 2020) (JAPhA 64(4);102117, July/August 2024)

2024, 1978

Post-Marketing Requirements (Restricted Distribution)

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

(Am Pharm. NS18(8):30; July 1978) (Reviewed 2004) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016) (Reviewed 2021) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2020

Protecting Pharmaceuticals as a Strategic Asset

1. APhA asserts that the quality and safety of pharmaceutical and other medical products and the global pharmaceutical and medical product supply chain are essential to the United States national security and public health.
2. APhA advocates for pharmacist engagement in the development and implementation of national and global strategies to ensure the availability, quality, and safety of pharmaceutical and other medical products.
3. APhA calls for the development, implementation, and oversight of enhanced and transparent processes, standards, and information that ensure quality and safety of all pharmaceutical ingredients and manufacturing processes.

4. APhA calls on the federal government to penalize entities who create barriers that threaten the availability, quality, and safety of United States pharmaceutical and other medical product supplies.
5. APhA calls for the development of redundancy and risk mitigation strategies in the manufacturing process to ensure reliable and consistent availability of safe and high-quality pharmaceutical and other medical products.
6. APhA advocates for legal regulatory, policy and market incentives that bolster the availability, quality, and safety of pharmaceutical and other medical products.
7. APhA calls for greater transparency, accuracy, and timeliness of information and notification to health care professionals regarding drug shortages, product quality and manufacturing issues, supply disruption, and recalls.
8. APhA encourages pharmacy providers, health systems, and payers to develop coordinated response plans, including the use of therapeutic alternatives, to mitigate the impact of drug shortages and supply disruptions.
9. APhA supports federal legislation and regulations that engages pharmacists, other health professionals, and manufacturers in developing a United States-specific essential medicines list and provides funding mechanisms to ensure consistent availability of these products.
10. APhA recommends the use of pharmacists in the delivery of public messages, through media and other communication channels, regarding pharmaceutical supply and quality issues.

(JAPhA. 60(5):e9; September/October 2020) (JAPhA 64(4);102117, July/August 2024)

2024, 2004

Protecting the Integrity of the Medication Supply

1. APhA supports public education about the risk of using medications whose production, distribution, or sale does not comply with U.S. federal and state laws, regulations, and policies.
4. APhA urges pharmacists and other health care professionals to report suspected counterfeit products to the Food and Drug Administration.

(JAPhA. NS44(5):551; September/October 2004) (Reviewed 2006) (Reviewed 2007) (Reviewed 2012) (Reviewed 2013) (Reviewed 2018) (Reviewed 2021) (JAPhA 64(4);102117, July/August 2024)

2023

Pharmacy Shortage Areas

1. APhA recognizes geographic proximity and transportation to pharmacies as key determinants in equitable access to medications, vaccines, and patient care services.
2. APhA calls for laws, regulations, and policies that reduce pharmacy shortage areas and ensure equitable access to essential services.
3. APhA supports the development of financial incentives to establish physical pharmacy locations in pharmacy shortage areas and to prevent the closure of pharmacies in underserved areas.

(JAPhA. 63(4):1266; July/August 2023)

2023

Uncompensated Care Mandates in Pharmacy

APhA calls for commensurate compensation for the provision of compulsory or mandated pharmacy services that include all products, supplies, labor, expertise, and administrative fees based on transparent economic analyses of existing and future services.

(JAPhA. 63(4):1265; July/August 2023)

2020

Coordination of the Pharmacy and Medical Benefit

APhA supports coordination of patients' comprehensive pharmacy and medical benefits that allows for provision of and compensation for pharmacists' patient care services; aligns incentives to optimize patient outcomes; streamlines administrative processes; reduces overall health care costs and preserves patients' right to choose providers under their pharmacy and medical benefits.

(JAPhA. 60(5):e10; September/October 2020)

2020

Specialty Pharmacy and Specialized Pharmacy Services

1. APhA recognizes that certain complex medications require more specialized care and resources. Further, APhA asserts that delineation of medications as specialty versus non-specialty, and associated payer and manufacturer practices, may introduce continuity of care disruption, patient access issues, and financial inequities.
2. APhA supports pharmacists and pharmacies choosing to specialize or incorporate specialty pharmacy services into their practice to optimize patient outcomes.

3. APhA opposes payer policies and practices that limit patient choice of pharmacy providers, disrupt continuity of care, or compromise patient safety through the creation of specialty drug lists, and restrictive specialty pharmacy networks
4. APhA opposes manufacturer distribution and related business practices that restrict patient or pharmacy access to medications, medical products, and patient care services.
5. APhA advocates for the adoption of pharmacy profession-developed, harmonized practice standards for specialized pharmacy practices, and specialty pharmacy services and products.
6. APhA encourages increased availability and use of data integration, patient financial assistance, and other resources to inform clinical practice and support the provision of specialized pharmacy practices and specialty pharmacy services.
7. APhA supports the availability of education and training for pharmacists and student pharmacists related to specialized pharmacy practices and specialty pharmacy services.

(JAPhA. 60(5):e10; September/October 2020)

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) (Reviewed 2015)

2004, 1968

Manufacturers' Pricing Policies

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

(JAPhA. NS8:362; July 1968) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016) (Reviewed 2018) (Reviewed 2021)

1994

Product Licensing Agreements and Restricted Distribution

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

(Am Pharm. NS34(6):55; June 1994) (Reviewed 2004) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016) (Reviewed 2021)

1989

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

APhA encourages the development and use of quality-control procedures by all persons or entities involved in the distribution and dispensing of drug products. Such procedures should assure drug product integrity and stability in accordance with official compendia standards.

(Am Pharm. NS29(7):464; July 1989) (Reviewed 2004) (Reviewed 2006) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2023)

1985

Pharmaceutical Pricing

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

(Am Pharm. NS25(5):52; May 1985) (Reviewed 2004) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016) (Reviewed 2022)

DRUG PRODUCT PACKAGING

2024, 2019, 2006, 2003

Unit-of-Use Packaging

1. APhA supports development, distribution, and use of unit-of-use packaging as the pharmaceutical industry standard to enhance patient safety, patient adherence, drug distribution efficiencies, and Drug Supply Chain Security Act (DSCSA) regulations.
2. APhA encourages collaboration with the pharmaceutical industry, repackagers, third-party payers, and appropriate federal agencies to effect the changes necessary for the adoption of unit-of-use packaging as the industry standard.
3. APhA supports the enactment of laws, regulations, and policies to permit pharmacists to modify prescribed quantities to correspond with commercially available unit-of-use packages.

(JAPhA. NS43(5:)(suppl 1):S57; September/October 2003) (JAPhA. NS46(5):562; September/October 2006) (Reviewed 2007) (Reviewed 2012) (Reviewed 2013) (Reviewed 2018) (JAPhA. 59(4):e17; July/August 2019) (Reviewed 2020) (JAPhA 64(4);102117, July/August 2024)

2012, 2004, 1992

Drug Product Packaging

1. 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 patient 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.

(Am Pharm. NS32(6):515; June 1992) (JAPhA. NS44(5): 551; September/October 2004) (Reviewed 2006) (Reviewed 2007) (JAPhA. NS52(4):458; July/August 2012) (Reviewed 2013) (Reviewed 2017) (Reviewed 2020)

2012

Drug Product Packaging.

APhA supports the use of tamper-evident packaging on pharmaceutical products throughout the supply chain before dispensing to reduce the potential of counterfeit and/or adulterated medications reaching patients.

(JAPhA. N552(4):58; July/August 2012) (Reviewed 2018)

2012

Medication Verification

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

(JAPhA. NS52(4): 458; July/August 2012) (Reviewed 2017) (Reviewed 2018) (Reviewed 2024)

2004, 1971

Single-Dose Containers for Parenteral Use

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

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

DRUG PRODUCT SELECTION

2024, 2009

Non-FDA-Approved Drugs and Patient Safety

1. APhA calls for education and collaboration among health professional organizations, federal agencies, and other stakeholders to ensure that all manufacturer, distributor, and repackaged marketed prescription drugs used in patient care have been FDA-approved as safe and effective.
2. APhA supports initiatives aimed at closing legislative, regulatory, policy 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) (Reviewed 2014) (Reviewed 2019) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2018, 2013

Revisions to the Medication Classification System

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

5. APhA urges manufacturers, FDA, and other stakeholders to include pharmacists' input in the development and adoption of technology and standardized processes for services related to medications and medical devices under FDA's defined conditions of safe use.
6. APhA supports the utilization of best practices, treatment algorithms, and clinical judgment of pharmacists and other health care providers to guide the evaluation and management of care delivery related to medications and medical devices under FDA's approved conditions of safe use.
7. APhA encourages the inclusion of medications, medical devices, and their associated services provided under FDA's defined conditions of safe use within health benefit coverage.
8. APhA supports compensation of pharmacists and other health care professionals for the provision of services related to FDA's defined conditions of safe use programs.

(JAPhA. 53(4):365; July/August 2013) (JAPhA. 58(4):356; July/August 2018) (Reviewed 2022) (JAPhA 64(4);102117, July/August 2024)

2017

Patient Access to Pharmacist-Prescribed Medications

1. APhA asserts that pharmacists' patient care services and related prescribing by pharmacists help improve patient access to care, patient outcomes, and community health, and they align with coordinated, team-based care.
2. APhA supports increased patient access to care through pharmacist prescriptive authority models.
3. APhA opposes requirements and restrictions that impede patient access to pharmacist-prescribed medications and related services.
4. APhA urges prescribing pharmacists to coordinate care with patients' other health care providers through appropriate documentation, communication, and referral.
5. APhA advocates that medications and services associated with prescribing by pharmacists must be covered and compensated in the same manner as for other prescribers.
6. APhA supports the right of patients to receive pharmacist-prescribed medications at the pharmacy of their choice.

(JAPhA. 57(4):442; July/August 2017) (Reviewed 2019) (Reviewed 2020) (Reviewed 2021) (Reviewed 2023) (Reviewed 2024)

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) (Reviewed 2016) (Reviewed 2022) (Reviewed 2023)

2005, 1997

Complementary/Alternative Medications and/Integrative Health

1. APhA supports pharmacists using professional judgment to make informed decisions 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.

(JAPhA. NS37(4):459; July/August 1997) (Reviewed 2002) (JAPhA. NS45(5):556-557; September/October 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

2004, 1970

Licensure/Registration of Drug Manufacturers

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.

(JAPhA. NS10:347; June 1970) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2006) (Reviewed 2010) (Reviewed 2015) (Reviewed 2021)

2001, 1989

Uniform Designation for Drug Product Selection Authority

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

(Am Pharm. NS29(1):67; January 1989) (JAPhA. NS41(5)(suppl 1):58; September/October 2001) (Reviewed 2004) (Reviewed 2006) (Reviewed 2011) (Reviewed 2012) (Reviewed 2017)

Anti-Substitution Laws

2024, 2004, 1971

Anti-Substitution Laws: Pharmacists' Responsibility

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

(JAPhA. NS11:260; May 1971) (JAPhA. NS 44(5):551; September/October 2004) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016) (Reviewed 2017) (JAPhA 64(4);102117, July/August 2024)

Therapeutic Equivalence

2024, 2016

Biologic, Biosimilar, and Interchangeable Biologic Drug Products

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

(JAPhA. 56(4):369; July/August 2016) (JAPhA 64(4);102117, July/August 2024)

2024, 2017, 1982

Legislative Restrictions on Clinical Judgment

APhA opposes the enactment of laws, regulations, and policies that would act to restrict the clinical judgments of medical practitioners and other health professionals.

(Am Pharm. NS22(7):32; July 1982) (Reviewed 2004) (Reviewed 2006) (Reviewed 2007) (Reviewed 2012) (JAPhA. 57(4):441; July/August 2017) (JAPhA 64(4);102117, July/August 2024)

2012, 2007

Biologic Drug Products

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

(JAPhA. NS45(5):580; September/October 2007) (JAPhA. NS52(4):457; July/August 2012) (Reviewed 2016) (Reviewed 2017)

1987

Therapeutic Equivalence

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

(JAPhA. NS27:424; June 1987) (Reviewed 2003) (Reviewed 2006) (Reviewed 2011) (Reviewed 2012) (Reviewed 2017)

1983

Pharmaceutical Alternates

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

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

DRUG RECALLS

2011, 2004, 1995

Product Recall Policy

APhA supports;

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

(Am Pharm. NS35(6):38; June 1995) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2006) (JAPhA. NS51(4): 483; July/August 2011) (Reviewed 2016) (Reviewed 2021)

EDUCATION, CURRICULUM AND COMPETENCE FOR PHARMACY

Competency and Training in Specific Areas

2024, 2014

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

1. APhA supports education for pharmacists and student pharmacists to address issues of pain management, palliative care, appropriate use of opioid reversal agents in opioid-associated emergencies, drug diversion, and substance use disorders.
2. APhA supports recognition of pharmacists as the health care providers who must exercise professional judgment in the assessment of a patient's conditions to fulfill corresponding responsibility for the use of controlled substances and other medications with the potential for misuse and/or diversion.
3. APhA supports pharmacists' access to and use of prescription monitoring programs to identify and prevent drug misuse and/or diversion.
4. APhA supports the development and implementation of state and federal laws, regulations, and policies that permit pharmacists to independently prescribe opioid reversal agents to prevent deaths due to opioid-associated emetgencies.
5. APhA supports the pharmacist's role in selecting appropriate therapy and dosing and initiating and providing education about the proper use of opioid reversal agents to prevent deaths due to opioid-associated emergencies.

(JAPhA. 54(4):358; July/August 2014) (Reviewed 2015)(Reviewed 2018) (Reviewed 2021) (Reviewed 2022) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024

Artificial Intelligence Use in Pharmacy Practice

1. APhA opposes the replacement of a pharmacist's professional judgment or patient's access to their pharmacist with artificial intelligence.
2. APhA calls on the profession of pharmacy and all related organizations to proactively assess and respond to the evolving role of artificial intelligence in pharmacy practice and workforce dynamics.
3. APhA encourages judicious use of artificial intelligence by pharmacists and pharmacy personnel as a tool to elevate pharmacy practice and enhance patient care.
4. APhA advocates for the integration of pharmacists into the development, design, validation, implementation, and maintenance of artificial intelligence solutions.
5. APhA calls on regulatory bodies, employers, and other relevant parties to develop laws, regulations, and policies as applicable for artificial intelligence to ensure patient safety, privacy, public awareness, and public protection.
6. APhA calls on those providing artificial intelligence solutions to implement processes that identify and mitigate bias and misinformation in artificial intelligence.
7. APhA advocates for education providers to facilitate, and pharmacy personnel to seek out, education and training on the lawful, ethical, and clinical use of artificial intelligence.

(JAPhA 64(4);102117, July/August 2024)

2024

Community Pharmacy Methadone Dispensing for Opioid Use Disorder

1. APhA supports changes in laws, regulations, and policies to permit DEA-registered and trained opioid treatment program clinicians and other providers the ability to prescribe methadone for opioid use disorder and refer patients for additional services as needed.
2. APhA supports changes in laws, regulations, and policies to permit community pharmacy dispensing of methadone for opioid use disorder and appropriate compensation for these services.
3. APhA supports partnerships and collaborations to increase patient access to opioid treatment programs (OTPs) and clinicians.
4. APhA advocates for interprofessional education on laws, regulations, and policies regarding office-based prescribing and community pharmacy dispensing of methadone in curricula, postgraduate training, and continuing professional development programs of all health professions.

(JAPhA 64(4);102117, July/August 2024)

2024, 2020

Community-Based Pharmacists as Providers of Care

1. APhA advocates for the identification of medical conditions that may be safely and effectively treated by community-based pharmacists.
2. APhA encourages the training and education of pharmacists and student pharmacists regarding identification, treatment, monitoring, documentation, follow-up, and referral for medical conditions treated by community-based pharmacists
3. APhA advocates for laws, regulations, and policies that allow pharmacists to identify and manage medical conditions treated by community-based pharmacists.
4. APhA advocates for appropriate remuneration for the assessment and treatment of medical conditions treated by community-based pharmacists from government and private payers to ensure sustainability and access for patients.
5. APhA supports research to examine the outcomes of services that focus on medical conditions treated by community-based pharmacists.

(JAPhA. 60(5):e10; September/October 2020) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2017, 2012

Contemporary Pharmacy Practice

1. APhA asserts that pharmacists should have the authority and support to practice to the full extent of their education, training, and experience in delivering patient care.
2. APhA opposes burdensome legal and regulatory requirements beyond continuing professional development for the provision of patient care services.
3. APhA supports continuing efforts toward establishing a consistent and accurate perception of the contemporary role and practice of pharmacists by the general public, patients, and all persons and institutions engaged in health care policy, administration, payment, and delivery.
4. APhA supports continued collaboration with stakeholders to facilitate adoption of standardized practice acts, appropriate related laws, regulations, and policies that reflect contemporary pharmacy practice.
5. APhA supports the establishment of multistate pharmacist licensure agreements to address the evolving needs of the pharmacy profession and pharmacist-provided patient care.
6. APhA urges the continued development of consensus documents, in collaboration with medical associations and other stakeholders, that recognize and support pharmacists' roles in patient care as health care providers.
7. APhA urges universal recognition of pharmacists as health care providers and compensation based on the level of patient care provided using standardized and future health care payment models.

(JAPhA. NS52(4):457; July/August 2012) (Reviewed 2016) (JAPhA. 57(4):441; July/August 2017) (Reviewed 2019) (Reviewed 2021) (Reviewed 2022) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2019

Creating Safe Work and Learning Environments for Student Pharmacists, Pharmacists, and Pharmacy Technicians

1. APhA strongly believes that all pharmacists, student pharmacists, and pharmacy technicians should be safe in their work and learning environments and be free from firearm-related violence.
2. APhA strongly recommends that technician training programs, schools and colleges of pharmacy, postgraduate training programs, and employers should develop programs to increase readiness in the event of an active shooter.

3. APhA strongly believes pharmacists, student pharmacists, and pharmacy technicians should be trained to recognize and refer patients at high risk of violence to themselves or others.
4. APhA encourages pharmacists, student pharmacists, and pharmacy technicians who are survivors of firearm-related violence to seek the help of counselors and other trained mental health professionals.

(JAPhA. 59(4):e17; July/August 2019) (JAPhA 64(4);102117, July/August 2024)

2024

Cybersecurity in Pharmacy

1. APhA advocates for implementation and maintenance of cybersecurity systems, safeguards, and response mechanisms to mitigate risk and minimize harm or disruption for all pharmacies and related parties who manage or access electronic health and business information.
2. APhA advocates for all pharmacies and related business entities responsible for electronic health and business information to have cyber liability insurance or an equivalent self-funded plan to protect all relevant parties in the event of a cyberattack and data breach.
3. APhA advocates for education providers to facilitate, and pharmacy personnel to seek out, education and training on cybersecurity laws, regulations, and best practices.

(JAPhA 64(4);102117, July/August 2024)

2024, 2018

Efforts to Reduce the Stigma Associated with Mental Health Disorders or Diseases

1. APhA encourages all stakeholders to develop and adopt evidence-based approaches to educate the public and all health care professionals to reduce the stigma associated with mental health diagnoses.
2. APhA supports the increased utilization of pharmacists and student pharmacists with appropriate training to actively participate in the care of patients with mental health conditions as members of interprofessional health care teams in all practice settings.
3. APhA supports the expansion of mental health education and training in the curriculum of all schools and colleges of pharmacy, post-graduate training, and within continuing professional development programs.
4. APhA supports the development of education and resources to address health care professional resiliency and burnout.

(JAPhA. 58(4):356; July/August 2018) (JAPhA 64(4);102117, July/August 2024)

2024, 2023

Just Culture Approach to Patient Safety

1. APhA calls for employers to adopt and implement just culture principles to improve patient safety and support pharmacy personnel.
2. APhA encourages transparency between employers and employees by sharing deidentified medication error and near-miss data and trends as well as actions taken to promote continuous quality improvement.
3. APhA urges the integration of non-disciplinary and non-punitive mechanisms for use by boards of pharmacy to promote just culture principles when addressing people, systems, and processes involved in medication errors.
4. APhA encourages national and state associations to advocate for laws, regulations, and policies to provide protections to individuals utilizing error reporting systems to promote just culture.
5. APhA encourages the creation of a mechanism for an industrywide effort to engage in confidential and transparent sharing of learnings and root cause findings helpful in reducing the risk of medication errors.
6. APhA supports the integration of just culture principles in PharmD and pharmacy technician education, postgraduate training, and continuing professional development programs.

(JAPhA. 63(4):1265; July/August 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2009

Non-FDA-Approved Drugs and Patient Safety

1. APhA calls for education and collaboration among health professional organizations, federal agencies, and other stakeholders to ensure that all manufacturer, distributor, and repackaged marketed prescription drugs used in patient care have been FDA-approved as safe and effective.
2. APhA supports initiatives aimed at closing legislative, regulatory, policy and distribution-system loopholes that facilitate market entry of new prescription drugs products without FDA approval.
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(JAPhA. NS49(4):492; July/August 2009) (Reviewed 2014) (Reviewed 2019) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2019

Pharmacist and Pharmacy Personnel Safety and Well-Being

1. APhA calls for employers to develop policies and procedures to support pharmacy personnel's ability to retreat or withdraw, without retaliation, from interactions that threaten their safety and well-being.
2. APhA encourages the development or utilization of educational programs and resources by the Association, employers, and other institutions to prepare pharmacy personnel to respond to situations that threaten their safety and well-being.

(JAPhA. 59(4):e17; July/August 2019) (Reviewed 2021) (Reviewed 2024) (JAPhA 64(4);102117, July/August 2024)

2024

Pharmacists Roles in Sexually Transmitted Infection Prevention and Treatment in Underserved Patients

1. APhA affirms that pharmacists play a vital role in improving outcomes in patients with or at risk of sexually transmitted infections.
2. APhA supports the pharmacist's role in the development of education and resources for individuals with Sexually Transmitted Infections (STIs), Expedited Partner Therapy (EPT), Pre-Exposure Prophylaxis (PrEP), and Post-Exposure Prophylaxis (PEP) in order to increase awareness and access.
3. APhA advocates for revision of state practice acts to permit pharmacists to independently prescribe for individuals with Sexually Transmitted Infections (STIs), Expedited Partner Therapy (EPT), Pre-Exposure Prophylaxis (PrEP), and Post-Exposure Prophylaxis (PEP) therapy.

(JAPhA 64(4);102117, July/August 2024)

2024, 2023

Transgender and Nonbinary Health Care

1. APhA supports the enactment of laws, regulations, and policies to end discriminatory practices that limit access to care for persons who are transgender or gender-diverse.
2. APhA encourages equity in care for persons who are transgender or gender-diverse through:

(a) Continuing education on the pharmacist's role in transgender care, gender-affirming therapy, and health disparities in patients who are transgender or gender-diverse.
(b) Systematic integration and utilization of affirmed name and pronouns, gender identity, and anatomical inventory.
(c) Availability and implementation of education and resources related to gender-diverse care for all persons employed in health care settings.

(JAPhA. 63(4):1266; July/August 2023) (JAPhA 64(4);102117, July/August 2024)

2023

Development of Veterinary Pharmacy Education Opportunities in Schools and Colleges of Pharmacy and Pharmacy Technician Training

1. APhA encourages schools and colleges of pharmacy and pharmacy technician training programs to facilitate educational opportunities for student pharmacists, and student pharmacy technicians in the principles of veterinary pharmacotherapy.
2. APhA encourages the availability of professional development opportunities in the principles of veterinary pharmacotherapy for pharmacists, student pharmacists, and pharmacy technicians.

(JAPhA. 63(4):1265; July/August 2023)

2021

Diversity, Equity, Inclusion, and Belonging

1. APhA denounces all forms of racism.
2. APhA affirms that racism is a social determinant of health that contributes to persistent health inequities.
3. APhA urges the entire pharmacy community to actively work to dismantle racism.
4. APhA urges the integration of anti-racism education within pharmacy curricula, post-graduate training, and continuing education requirements.
5. APhA urges pharmacy leaders, decision-makers, and employers to create sustainable opportunities, incentives, and initiatives in education, research, and practice to address racism.
6. APhA urges pharmacy leaders, decision-makers, and employers to routinely and systematically evaluate organizational policies and programs for their impact on racial inequities.

(JAPhA. 61(4):e15; July/August 2021) (Reviewed 2023) (Review 2024)

2021

Increasing Awareness and Accountability to End Harassment, Intimidation, Abuse of Power, Position or Authority in Pharmacy Practice

1. APhA calls on all national and state pharmacy organizations, colleges/schools of pharmacy, and other stakeholders to support the development of a profession-wide effort to address harassment, intimidation, and abuse of power or position.
2. APhA supports the development of a profession-wide guideline on reporting harassment, intimidation, or abuse of power or position in their pharmacy education and training, professional practice, or volunteer service to pharmacy organizations.
3. APhA recommends all pharmacy organizations incorporate harassment, intimidation, and abuse training in their member professional development and education activities.

(JAPhA. 61(4):e15-e16; July/August 2021) (Reviewed 2024)

2021

Social Determinants of Health

1. APhA supports the integration of social determinants of health screening as a vital component of pharmacy services.
2. APhA urges the integration of social determinants of health education within pharmacy curricula, post-graduate training, and continuing education requirements.
3. APhA supports incentivizing community engaged research, driven by meaningful partnerships and shared decision-making with community members.
4. APhA urges pharmacists to create opportunities for community engagement to best meet the needs of the patients they serve.
5. APhA encourages the integration of community health workers in pharmacy practice to provide culturally sensitive care, address health disparities, and promote health equity.

(JAPhA. 61(4):e16; July/August 2021) (Reviewed 2023) (Reviewed 2024)

2020

Digital Health Integration in Pharmacy

1. APhA supports education about digital health technologies and integration in pharmacy practice, in pharmacy school curricula, and for the pharmacy workforce.
2. APhA supports inclusion of pharmacists in the design and development of digital health technologies.
3. APhA supports that digital health technologies be interoperable with and integrated into pharmacy management systems and electronic health records.
4. APhA supports pharmacists applying digital health technologies to optimize patient care outcomes.

(JAPhA. 60(5):e11; September/October 2020)

2019, 2018

Gluten Content and Labeling in Medications

1. APhA supports labeling of all prescription and nonprescription products, as well as dietary supplement products, to indicate the presence of gluten.
2. APhA encourages manufacturers to formulate drug products without use of wheat, barley, rye, or their derivatives whenever possible.
3. APhA supports additional research on the effects of gluten intolerance and celiac malabsorption, particularly as it relates to medication absorption.
4. APhA supports pharmacist education regarding celiac disease and non-celiac gluten sensitivity.
5. APhA encourages the development of analytical methods that can accurately detect lower levels of gluten than the current standard (20 ppm) and for the establishment of evidence-based gluten-free standards for the labeling of foods, excipients, dietary supplements, and prescription and nonprescription products.

(JAPhA. 58(4):356; July/August 2018) (JAPhA. 59(4):e16; July/August 2019) (Reviewed 2020)

2019

Pharmacists' Role in Mental Health and Emotional Well-Being

1. APhA encourages all health care personnel to receive training and provide services to identify, assist, and refer people at risk for, or currently experiencing, a mental health crisis.
2. APhA encourages employers and policy makers to provide the support, resources, culture, and authority necessary for all pharmacy personnel to engage and assist individuals regarding mental health and emotional well-being.
3. APhA supports integration of a mental health assessment as a vital component of pharmacist-provided patient care services.

(JAPhA. 59(4):e16; July/August 2019) (Reviewed 2024)

2018

Use of Genomic Data Within Pharmacy Practice

1. APhA emphasizes genomics as an essential aspect of pharmacy practice.
2. APhA recognizes pharmacists as the health care professional best suited to provide medication-related consults and services based on a patient's genomic information. All pharmacists involved in the care of the patient should have access to relevant genomic information.
3. APhA supports processes to protect patient data confidentiality and opposes unethical utilization of genomic data.
4. APhA demands payers include pharmacists as eligible providers for covered genomic interpretation and related services to support sustainable models that optimize patient care and outcomes.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the exchange, storage, utilization, and documentation of clinically actionable genetic variations and actions taken by the pharmacist in the provision of patient care.
6. APhA recommends pharmacists and pharmaceutical scientists lead the collaborative development of evidence-based practice guidelines for pharmacogenomics and related services.
7. APhA recommends the inclusion of pharmacists and pharmaceutical scientists in the collaborative development of pharmacogenomics clinical support tools and resources.
8. APhA encourages pharmacists to use their professional judgment and published guidelines and resources when providing access to testing or utilizing direct-to-consumer genomic test results in their patient care services.
9. APhA urges schools and colleges of pharmacy to include clinical application of genomics as a required element of the Doctor of Pharmacy curriculum.
10. APhA encourages the creation of continuing professional development and post-graduate education and training programs for pharmacists in genomics and its clinical application to meet varying practice needs.
11. APhA encourages the funding of pharmacist-led research examining the cost effectiveness of care models that utilize pharmacists providing genomic services.

(JAPhA. 58(4):355; July/August 2018) (Reviewed 2023)

2012, 1981

Pharmacist Training in Nutrition

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

(Am Pharm. NS21(5):40; May 1981) (Reviewed 2003) (Reviewed 2006) (Reviewed 2007) (JAPhA. NS52(4):458; July/August 2012) (Reviewed 2017) (Reviewed 2023)

2012, 1981

Pharmacist Training in Physical Assessments

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

(Am Pharm. NS21(5):40; May 1981) (Reviewed 2003) (Reviewed 2006) (Reviewed 2007) (JAPhA. NS52(4):458; July/August 2012) (Reviewed 2017)

2005, 1997

Complementary/Alternative Medications and/Integrative Health

1. APhA supports pharmacists using professional judgment to make informed decisions 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.

(JAPhA. NS37(4):459; July/August 1997) (Reviewed 2002) (JAPhA. NS45(5):556-557; September/October 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

2005, 1988

Pharmaceutical Biotechnology Products

APhA recognizes the urgent need for education and training of pharmacists and student pharmacists relative to the therapeutic and diagnostic use of pharmaceutical biotechnology products. APhA, therefore, supports the continuing development and implementation of such education and training.

(Am Pharm. NS28(6):394; June 1988) (JAPhA. NS45(5):559; September/October 2005) (Reviewed 2006) (Reviewed 2007) (Reviewed 2010) (Reviewed 2015) (Reviewed 2016) (Reviewed 2017)

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 professions 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 websites, 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, that provide the opportunity to promote the profession and its impact on clinical, economic, and humanistic patient outcomes.

(JAPhA. NS41(5)(suppl 1):S8; September/October 2001) (Reviewed 2003) (Reviewed 2005) (Reviewed 2006) (Reviewed 2008) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

1987

Drug Product Equivalence

APhA shall continue to support educational programs for pharmacists on issues regarding generic drugs.

(Am Pharm. NS27(6):424; June 1987) (Reviewed 2003) (Reviewed 2006) (Reviewed 2007) (Reviewed 2012)

1981

Pharmacist Training in Medical Technology

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

(Am Pharm. NS21(5):40; May 1981) (Reviewed 2003) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016) (Reviewed 2017)

Continuing Education

2024

Artificial Intelligence Use in Pharmacy Practice

1. APhA opposes the replacement of a pharmacist's professional judgment or patient's access to their pharmacist with artificial intelligence.
2. APhA calls on the profession of pharmacy and all related organizations to proactively assess and respond to the evolving role of artificial intelligence in pharmacy practice and workforce dynamics.
3. APhA encourages judicious use of artificial intelligence by pharmacists and pharmacy personnel as a tool to elevate pharmacy practice and enhance patient care.
4. APhA advocates for the integration of pharmacists into the development, design, validation, implementation, and maintenance of artificial intelligence solutions.
5. APhA calls on regulatory bodies, employers, and other relevant parties to develop laws, regulations, and policies as applicable for artificial intelligence to ensure patient safety, privacy, public awareness, and public protection.
6. APhA calls on those providing artificial intelligence solutions to implement processes that identify and mitigate bias and misinformation in artificial intelligence.
7. APhA advocates for education providers to facilitate, and pharmacy personnel to seek out, education and training on the lawful, ethical, and clinical use of artificial intelligence.

(JAPhA 64(4);102117, July/August 2024)

2024

Community Pharmacy Methadone Dispensing for Opioid Use Disorder

1. APhA supports changes in laws, regulations, and policies to permit DEA-registered and trained opioid treatment program clinicians and other providers the ability to prescribe methadone for opioid use disorder and refer patients for additional services as needed.
2. APhA supports changes in laws, regulations, and policies to permit community pharmacy dispensing of methadone for opioid use disorder and appropriate compensation for these services.
3. APhA supports partnerships and collaborations to increase patient access to opioid treatment programs (OTPs) and clinicians.

4. APhA advocates for interprofessional education on laws, regulations, and policies regarding office-based prescribing and community pharmacy dispensing of methadone in curricula, postgraduate training, and continuing professional development programs of all health professions.

(JAPhA 64(4);102117, July/August 2024)

2024

Cybersecurity in Pharmacy

1. APhA advocates for implementation and maintenance of cybersecurity systems, safeguards, and response mechanisms to mitigate risk and minimize harm or disruption for all pharmacies and related parties who manage or access electronic health and business information.
2. APhA advocates for all pharmacies and related business entities responsible for electronic health and business information to have cyber liability insurance or an equivalent self-funded plan to protect all relevant parties in the event of a cyberattack and data breach.
3. APhA advocates for education providers to facilitate, and pharmacy personnel to seek out, education and training on cybersecurity laws, regulations, and best practices.

(JAPhA 64(4);102117, July/August 2024)

2024, 2020, 2015

Integrated Nationwide Prescribing Drug Monitoring Program

1. APhA advocates for nationwide integration and uniformity of prescription drug monitoring programs (PDMP) that incorporate federal, state, and territory databases for the purpose of providing health care professionals with accurate and real-time information to assist in clinical decision making when providing patient care services related to controlled substances.
2. APhA supports pharmacist involvement in the development of uniform standards for an integrated nationwide prescription drug monitoring program (PDMP) that includes the definition of authorized registered users, documentation, reporting requirements, system response time, security of information, minimum reporting data sets, and standard transaction format.
3. APhA supports mandatory prescription drug monitoring program (PDMP) enrollment by all health care providers, mandatory reporting by all those who dispense controlled substances, and appropriate system query by registrants during the patient care process related to controlled substances.
4. APhA advocates for the development of seamless workflow integration systems that would enable consistent use of a nationwide prescription drug monitoring program (PDMP) by registrants to facilitate prospective drug review as part of the patient care process related to controlled substances.
5. APhA advocates for continuous, sustainable federal funding sources for practitioners and system operators to utilize and maintain a standardized integrated and real-time nationwide prescription drug monitoring program (PDMP).
6. APhA supports the use of interprofessional advisory boards that include pharmacists to coordinate collaborative efforts for
   (a) compiling, analyzing, and using prescription drug monitoring program (PDMP) data trends to identify misuse of controlled substances and/or fraud;
   (b) providing focused provider education and patient referral to treatment programs; and
   (c) supporting research activities on the impact of PDMPs.
7. APhA supports education and training for registrants about a nationwide prescription drug monitoring program (PDMP) to ensure proper data integrity, use, and confidentiality.

(JAPhA. N55(4):364-365; July/August 2015) (JAPhA. 60(5):e10; September/October 2020) (JAPhA 64(4);102117, July/August 2024)

2024, 2014

The Use and Sale of Electronic Cigarettes (e-cigarettes)

1. APhA opposes the sale of e-cigarettes and other vaporized nicotine products in pharmacies until such time that scientific data support the health and environmental safety of these products.
2. APhA opposes the use of e-cigarettes and other vaporized nicotine products in areas subject to current clean air laws, regulations, and policies for combustible tobacco products until such time that scientific data support the health and environmental safety of these products.
3. APhA urges pharmacists to become more knowledgeable about e-cigarettes and other vaporized nicotine products.

(JAPhA. 54(4): 358; July/August 2014) (Reviewed 2019) (JAPhA 64(4);102117, July/August 2024)

2015

Interoperability of Communications Among Health Care Providers to Improve Quality of Patient Care

1. APhA supports the establishment of secure, portable, and interoperable electronic patient health care records.
2. APhA supports the engagement of pharmacists with other stakeholders in the development and implementation of multidirectional electronic communication systems to improve patient safety, enhance quality care, facilitate care transitions, increase efficiency, and reduce waste.
3. APhA advocates for the inclusion of pharmacists in the establishment and enhancement of electronic health care information technologies and systems that must be interoperable, HIPAA compliant, integrated with claims processing, updated in a timely fashion, allow for data analysis, and do not place disproportionate financial burden on any one health care provider or stakeholder.
4. APhA advocates for pharmacists and other health care providers to have access to view, download and transmit electronic health records. Information shared among providers using a health information exchange should utilize a standardized secure interface based on recognized international health record standards for the transmission of health information.
5. APhA supports the integration of federal, state, and territory health information exchanges into an accessible, standardized, nationwide system.
6. APhA opposes business practices and policies that obstruct the electronic access and exchange of patient health information because these practices compromise patient safety and the provision of optimal patient care.
7. APhA advocates for the development of systems that facilitate and support electronic communication between pharmacists and prescribers concerning patient adherence, medication discontinuation, and other clinical factors that support quality care transitions.
8. APhA supports the development of education and training programs for pharmacists, student pharmacists, and other health care professionals on the appropriate use of electronic health records to reduce errors and improve the quality and safety of patient care.
9. APhA supports the creation and non-punitive application of a standardized, interoperable system for voluntary reporting of errors associated with the use of electronic health care information technologies and systems to enable aggregation of protected data and develop recommendations for improved quality.

(JAPhA. N55(4):364; July/August 2015) (Reviewed 2019) (Reviewed 2023) (Reviewed 2024)

2009

Health Information Technology

1. APhA supports the delivery of informatics education within pharmacy schools and continuing education programs to improve patient care, understand interoperability among systems, understand where to find information, increase productivity, and 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 definition, 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, the certification of systems, and the integration of medication use systems with health information technology.

(JAPhA. NS49(4):492; July/August 2009) (Reviewed 2010)(Reviewed 2013) (Reviewed 2014) (Reviewed 2015) (Reviewed 2019)

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) (Reviewed 2015) (Reviewed 2019) (Reviewed 2021)

2005

Continuing Professional Development

1. APhA supports continuing professional development, a self-directed, individualized, systematic approach to life-long learning, to support pharmacist's 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 2006) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

2005, 1992

Cross-Discipline Accreditation of Continuing Education

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

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

2003, 1997

Continued Competence Assessment Examination

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

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

2003, 1974

Continuing Education

APhA strongly endorses continuing education for pharmacists.

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

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 that 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 that preserve the integrity of the academic credit.

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

1975

Pharmacists' Responsibility for Continuing Competence

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

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

Degree/Designation

2011, 2003

Distance Education in First Professional Pharmacy Degree Programs

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

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

1991

Doctor of Pharmacy Attainment through Non-traditional Mechanisms

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

(Am Pharm. NS31(6):28; June 1991) (Reviewed 2003) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016) (Reviewed 2022)

Internships/Externships and Residencies

2013, 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 pharmacists' patient 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 (PBRNs).

(JAPhA. NS48(4):471; July/August 2008) (JAPhA. 53(4): 366; July/August 2013) (Reviewed 2018)

2013, 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 the nation.
2. APhA encourages active involvement of schools and colleges of pharmacy in the development and advancement of accredited pharmacy practice residency programs.
3. APhA advocates for the allocation of adequate funding for accredited pharmacy residencies in all practice settings by governmental and other entities.
4. APhA supports postgraduate training for new PharmD graduates.
5. APhA supports accreditation of all pharmacy residency programs by federally recognized accrediting bodies to ensure quality training experiences.

(JAPhA. NS48(4):470; July/August 2008) (JAPhA. 53(4):366; July/August 2013) (Reviewed 2018)

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) (Reviewed 2015)

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) (Reviewed 2015)

2008

Experiential Education

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; and
   (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.

(JAPhA. NS48(4):470; July August 2008) (Reviewed 2013) (Reviewed 2018)

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.

(JAPhA. NS45(5):554; September/October 2005) (Reviewed 2006) (Reviewed 2008) (Reviewed 2009) (Reviewed 2013) (Reviewed 2018)

Pharmacy School Curriculum

2024

Artificial Intelligence Use in Pharmacy Practice

1. APhA opposes the replacement of a pharmacist's professional judgment or patient's access to their pharmacist with artificial intelligence.
2. APhA calls on the profession of pharmacy and all related organizations to proactively assess and respond to the evolving role of artificial intelligence in pharmacy practice and workforce dynamics.
3. APhA encourages judicious use of artificial intelligence by pharmacists and pharmacy personnel as a tool to elevate pharmacy practice and enhance patient care.
4. APhA advocates for the integration of pharmacists into the development, design, validation, implementation, and maintenance of artificial intelligence solutions.
5. APhA calls on regulatory bodies, employers, and other relevant parties to develop laws, regulations, and policies as applicable for artificial intelligence to ensure patient safety, privacy, public awareness, and public protection.
6. APhA calls on those providing artificial intelligence solutions to implement processes that identify and mitigate bias and misinformation in artificial intelligence.

7. APhA advocates for education providers to facilitate, and pharmacy personnel to seek out, education and training on the lawful, ethical, and clinical use of artificial intelligence.

(JAPhA 64(4);102117, July/August 2024)

2024

Community Pharmacy Methadone Dispensing for Opioid Use Disorder

1. APhA supports changes in laws, regulations, and policies to permit DEA-registered and trained opioid treatment program clinicians and other providers the ability to prescribe methadone for opioid use disorder and refer patients for additional services as needed.
2. APhA supports changes in laws, regulations, and policies to permit community pharmacy dispensing of methadone for opioid use disorder and appropriate compensation for these services.
3. APhA supports partnerships and collaborations to increase patient access to opioid treatment programs (OTPs) and clinicians.
4. APhA advocates for interprofessional education on laws, regulations, and policies regarding office-based prescribing and community pharmacy dispensing of methadone in curricula, postgraduate training, and continuing professional development programs of all health professions.

(JAPhA 64(4);102117, July/August 2024)

2024, 2019

Creating Safe Work and Learning Environments for Student Pharmacists, Pharmacists, and Pharmacy Technicians

1. APhA strongly believes that all pharmacists, student pharmacists, and pharmacy technicians should be safe in their work and learning environments and be free from firearm-related violence.
2. APhA strongly recommends that technician training programs, schools and colleges of pharmacy, postgraduate training programs, and employers should develop programs to increase readiness in the event of an active shooter.
3. APhA strongly believes pharmacists, student pharmacists, and pharmacy technicians should be trained to recognize and refer patients at high risk of violence to themselves or others.
4. APhA encourages pharmacists, student pharmacists, and pharmacy technicians who are survivors of firearm-related violence to seek the help of counselors and other trained mental health professionals.

(JAPhA. 59(4):e17; July/August 2019) (JAPhA 64(4);102117, July/August 2024)

2024

Cybersecurity in Pharmacy

1. APhA advocates for implementation and maintenance of cybersecurity systems, safeguards, and response mechanisms to mitigate risk and minimize harm or disruption for all pharmacies and related parties who manage or access electronic health and business information.
2. APhA advocates for all pharmacies and related business entities responsible for electronic health and business information to have cyber liability insurance or an equivalent self-funded plan to protect all relevant parties in the event of a cyberattack and data breach.
3. APhA advocates for education providers to facilitate, and pharmacy personnel to seek out, education and training on cybersecurity laws, regulations, and best practices.

(JAPhA 64(4);102117, July/August 2024)

2024, 2018

Efforts to Reduce the Stigma Associated with Mental Health Disorders or Diseases

1. APhA encourages all stakeholders to develop and adopt evidence-based approaches to educate the public and all health care professionals to reduce the stigma associated with mental health diagnoses.
2. APhA supports the increased utilization of pharmacists and student pharmacists with appropriate training to actively participate in the care of patients with mental health conditions as members of interprofessional health care teams in all practice settings.
3. APhA supports the expansion of mental health education and training in the curriculum of all schools and colleges of pharmacy, post-graduate training, and within continuing professional development programs.
4. APhA supports the development of education and resources to address health care professional resiliency and burnout.

(JAPhA. 58(4):356; July/August 2018) (JAPhA 64(4);102117, July/August 2024)

2024, 2019

Patient-Centered Care of People Who Uset Non-Medically Sanctioned Psychotropic or Psychoactive Substances

1. APhA encourages state legislatures and boards of pharmacy to revise laws, regulations, and policies to support the patient-centered care of people who use non-medically sanctioned psychotropic or psychoactive substances.
2. To reduce the consequences of stigma associated with drug use, APhA supports the expansion of interprofessional harm reduction education in the curriculum of schools and colleges of pharmacy, postgraduate training, and continuing professional development programs.
3. APhA encourages pharmacists to initiate, sustain, and integrate evidence-based harm reduction principles and programs into their practice to optimize the health of people who use non-medically sanctioned psychotropic or psychoactive substances.
4. APhA supports pharmacists' roles to provide and promote consistent, unrestricted, and immediate access to evidence-based, mortality- and morbidity-reducing interventions to enhance the health of people who inject nonmedically sanctioned psychotropic or psychoactive substances and their communities, including sterile syringes, needles, and other safe injection equipment, syringe disposal, fentanyl test strips, immunizations, condoms, wound care supplies, pre- and post-exposure prophylaxis medications for human immunodeficiency virus (HIV), point-of-care testing for HIV and hepatitis C virus (HCV), opioid reversal agents, and medications for opioid use disorder.
5. APhA urges pharmacists to refer people who use non-medically sanctioned psychotropic or psychoactive substances to specialists in mental health, infectious diseases, and substance use disorder treatment; to housing, vocational, harm reduction, and recovery support services; and to safe consumption facilities and syringe service programs.

(JAPhA. 59(4):e17; July/August 2019) (Reviewed 2021) (Reviewed 2022) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2023

Development of Veterinary Pharmacy Education Opportunities in Schools and Colleges of Pharmacy and Pharmacy Technician Training

1. APhA encourages schools and colleges of pharmacy and pharmacy technician training programs to facilitate educational opportunities for student pharmacists, and student pharmacy technicians in the principles of veterinary pharmacotherapy.
2. APhA encourages the availability of professional development opportunities in the principles of veterinary pharmacotherapy for pharmacists, student pharmacists, and pharmacy technicians.

(JAPhA. 63(4):1265; July/August 2023)

2022, 2014

Use of Social Media

1. APhA encourages the use of social media in ways that advance patient care and uphold pharmacists as trusted and accessible health care providers.
2. APhA supports the use of social media as a mechanism for the delivery of patient-specific care in a platform that allows for appropriate patient and provider protections and access to necessary health care information.
3. APhA supports the inclusion of social media education, including but not limited to appropriate use and professionalism, as a component of pharmacy education and continuing professional development.
4. APhA affirms that the patient's right to privacy and confidentiality shall not be compromised through the use of social media.
5. APhA urges pharmacists, pharmacy technicians and student pharmacists to self-monitor their social media presence for professionalism and that posted clinical information is accurate and appropriate.
6. APhA advocates for continued development and utilization of social media by pharmacists and other health care professionals during public health emergencies.

(JAPhA. 54(4):357; July/August 2014) (Reviewed 2019)(Amended 2022)

2021

Promoting Financial Preparedness for Student Pharmacists, Applicants, and Recent Graduates

APhA encourages schools and colleges of pharmacy to provide financial literacy resources for student pharmacists and applicants to assess the potential financial burden associated with pursuing a PharmD and entry into the profession by:

(a) Offering instruction on financial literacy (including but not limited to personal finance and loan repayment) as part of a required course or elective in their curriculum; and
(b) Providing student pharmacists and potential applicants the comprehensive costs of pursuing a pharmacy education at their respective institutions along with financial aid costs and options; and
(c) Providing student pharmacists and potential applicants with initial and periodic updates of the professional employment outlook.

(JAPhA. 61(4):e16; July/August 2021)

2018, 2005, 1990

Pharmacy Schools' Curriculum and Contemporary Pharmacy Needs

1. APhA supports adopting and maintaining continuous quality improvement processes at the national school/college level to identify differences between contemporary pharmacy practice and curriculum offerings, and to provide information and resources to encourage up-to-date curricula.
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.

(Am Pharm. NS30(6):45; June 1990) (Reviewed 2001) (Reviewed 2003) (JAPhA. NS45(5):560; September/October 2005) (Reviewed 2006) (Reviewed 2008) (Reviewed 2013) (JAPhA. 58(4):356; July/August 2018)

2018

Use of Genomic Data Within Pharmacy Practice

1. APhA emphasizes genomics as an essential aspect of pharmacy practice.
2. APhA recognizes pharmacists as the health care professional best suited to provide medication-related consults and services based on a patient's genomic information. All pharmacists involved in the care of the patient should have access to relevant genomic information.
3. APhA supports processes to protect patient data confidentiality and opposes unethical utilization of genomic data.
4. APhA demands payers include pharmacists as eligible providers for covered genomic interpretation and related services to support sustainable models that optimize patient care and outcomes.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the exchange, storage, utilization, and documentation of clinically actionable genetic variations and actions taken by the pharmacist in the provision of patient care.
6. APhA recommends pharmacists and pharmaceutical scientists lead the collaborative development of evidence-based practice guidelines for pharmacogenomics and related services.
7. APhA recommends the inclusion of pharmacists and pharmaceutical scientists in the collaborative development of pharmacogenomics clinical support tools and resources.
8. APhA encourages pharmacists to use their professional judgment and published guidelines and resources when providing access to testing or utilizing direct-to-consumer genomic test results in their patient care services.
9. APhA urges schools and colleges of pharmacy to include clinical application of genomics as a required element of the Doctor of Pharmacy curriculum.
10. APhA encourages the creation of continuing professional development and post-graduate education and training programs for pharmacists in genomics and its clinical application to meet varying practice needs.
11. APhA encourages the funding of pharmacist-led research examining the cost effectiveness of care models that utilize pharmacists providing genomic services.

(JAPhA. 58(4):355; July/August 2018) (Reviewed 2023)

2016, 2005, 1995

Professional Development of Student Pharmacists

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

(Am Pharm. NS35(6):36; June 1995) (Reviewed 2003) (JAPhA. NS45(5):554; September/October 2005) (Reviewed 2006) (Reviewed 2011) (JAPhA. 56(4);379; July/August 2016)

2015

Interoperability of Communications Among Health Care Providers to Improve Quality of Patient Care

1. APhA supports the establishment of secure, portable, and interoperable electronic patient health care records.
2. APhA supports the engagement of pharmacists with other stakeholders in the development and implementation of multidirectional electronic communication systems to improve patient safety, enhance quality care, facilitate care transitions, increase efficiency, and reduce waste.
3. APhA advocates for the inclusion of pharmacists in the establishment and enhancement of electronic health care information technologies and systems that must be interoperable, HIPAA compliant, integrated with claims processing, updated in a timely fashion, allow for data analysis, and do not place disproportionate financial burden on any one health care provider or stakeholder.
4. APhA advocates for pharmacists and other health care providers to have access to view, download and transmit electronic health records. Information shared among providers using a health information exchange should utilize a standardized secure interface based on recognized international health record standards for the transmission of health information.
5. APhA supports the integration of federal, state, and territory health information exchanges into an accessible, standardized, nationwide system.
6. APhA opposes business practices and policies that obstruct the electronic access and exchange of patient health information because these practices compromise patient safety and the provision of optimal patient care.
7. APhA advocates for the development of systems that facilitate and support electronic communication between pharmacists and prescribers concerning patient adherence, medication discontinuation, and other clinical factors that support quality care transitions.
8. APhA supports the development of education and training programs for pharmacists, student pharmacists, and other health care professionals on the appropriate use of electronic health records to reduce errors and improve the quality and safety of patient care.
9. APhA supports the creation and non-punitive application of a standardized, interoperable system for voluntary reporting of errors associated with the use of electronic health care information technologies and systems to enable aggregation of protected data and develop recommendations for improved quality.

(JAPhA. N55(4):364; July/August 2015) (Reviewed 2019) (Reviewed 2023) (Reviewed 2024)

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) (Reviewed 2015)

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) (Reviewed 2015)

2009

Health Information Technology

1. APhA supports the delivery of informatics education within pharmacy schools and continuing education programs to improve patient care, understand interoperability among systems, understand where to find information, increase productivity, and 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 definition, 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, the certification of systems, and the integration of medication use systems with health information technology.

(JAPhA. NS49(4):492; July/August 2009) (Reviewed 2010)(Reviewed 2013) (Reviewed 2014) (Reviewed 2015) (Reviewed 2019)

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) (Reviewed 2015) (Reviewed 2019) (Reviewed 2021)

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.

(JAPhA. NS45(5):554; September/October 2005) (Reviewed 2006) (Reviewed 2008) (Reviewed 2009) (Reviewed 2013) (Reviewed 2018)

1993

Payment System Reform Curriculum

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

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

1988

Professional Ethics in Educational Curricula and Practice

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

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

1984

Primary and Secondary Education in Science, Mathematics, and English

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

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

EMPLOYER/EMPLOYEE RELATIONS

Other Employment Issues

2024, 2013, 2009

Independent Practice of Pharmacists

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

(JAPhA. NS49(4):492; July/August 2009) (Reviewed 2012) (JAPhA. 53(4):366; July/August 2013) (Reviewed 2018) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2023

Just Culture Approach to Patient Safety

1. APhA calls for employers to adopt and implement just culture principles to improve patient safety and support pharmacy personnel.
2. APhA encourages transparency between employers and employees by sharing deidentified medication error and near-miss data and trends as well as actions taken to promote continuous quality improvement.
3. APhA urges the integration of non-disciplinary and non-punitive mechanisms for use by boards of pharmacy to promote just culture principles when addressing people, systems, and processes involved in medication errors.
4. APhA encourages national and state associations to advocate for laws, regulations, and policies to provide protections to individuals utilizing error reporting systems to promote just culture.
5. APhA encourages the creation of a mechanism for an industrywide effort to engage in confidential and transparent sharing of learnings and root cause findings helpful in reducing the risk of medication errors.
6. APhA supports the integration of just culture principles in PharmD and pharmacy technician education, postgraduate training, and continuing professional development programs.

(JAPhA. 63(4):1265; July/August 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2011

Requiring Vaccination for All Pharmacy Personnel

APhA supports vaccinations, as recommended by the Centers for Disease Control and Prevention, as a condition of employment, training, or volunteering within an organization that provides pharmacy services or operates a pharmacy or pharmacy department (unless a valid medical or religious reason precludes vaccination).

(JAPhA. NS51(4):482; July/August 2011) (Reviewed 2012) (Reviewed 2017) (JAPhA 64(4);102117, July/August 2024

2023

Pharmacist Representation on Medical Staff

1. APhA advocates for pharmacists to be included as members of medical staffs and eligible to vote on the bylaws, standards, rules, regulations, and policies that govern those institutions' medical staffs.
2. APhA supports pharmacists, as part of the medical staff, have parity in their opportunity to be credentialed and privileged as independent medical providers.

(JAPhA. 63(4):1266; July/August 2023)

2022 2007

Pharmacy Personnel Immunization Rates

1. APhA supports efforts to increase immunization rates of health care 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 (e.g., physicians, nurses, police) and to prioritize pharmacists to receive medications and immunizations.

3. APhA encourages federal, state, and local officials and agencies to recognize pharmacists, student pharmacists, pharmacy technicians, and pharmacy support staff as among the highest priority groups to receive medications, vaccinations, and other protective measures as essential healthcare workers.

(JAPhA. NS45(5):580; September/October 2007) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019) (JAPhA. 62(4):942; July 2022) (Reviewed 2023)

2021

Diversity, Equity, Inclusion, and Belonging

1. APhA denounces all forms of racism.
2. APhA affirms that racism is a social determinant of health that contributes to persistent health inequities.
3. APhA urges the entire pharmacy community to actively work to dismantle racism.
4. APhA urges the integration of anti-racism education within pharmacy curricula, post-graduate training, and continuing education requirements.
5. APhA urges pharmacy leaders, decision-makers, and employers to create sustainable opportunities, incentives, and initiatives in education, research, and practice to address racism.
6. APhA urges pharmacy leaders, decision-makers, and employers to routinely and systematically evaluate organizational policies and programs for their impact on racial inequities.

(JAPhA. 61(4):e15; July/August 2021) (Reviewed 2023) (Review 2024)

2019

Qualification Standards for Pharmacists

APhA adamantly opposes the basic education requirement within the Office of Personnel Management's Classification and Qualifications –General Schedule Qualification Standard – Pharmacy Series, 0660, requiring a Doctor of Pharmacy degree as the minimum qualifications to practice pharmacy that are inconsistent with pharmacist licensure requirements by state boards of pharmacy.

(JAPhA. 59(4):e17; July/August 2019) (Reviewed 2024)

2017, 2012, 1989

Equal Rights and Opportunities for Pharmacy Personnel

APhA reaffirms its unequivocal support of equal opportunities for employment and advancement, compensation, and organizational leadership positions. APhA opposes discrimination based on sex, gender identity or expression, race, color, religion, national origin, age, disability, genetic information, sexual orientation, or any other category protected by federal or state law.

(Am Pharm. NS 29(7):464; July 1989) (Reviewed 2001) (Reviewed 2007) (JAPhA. NS52(4):459; July/August 2012) (JAPhA. 57(4):441; July/August 2017) (Reviewed 2022) (Reviewed 2024)

2012, 2001, 1969

Pharmacist Workforce Census

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

(JAPhA. NS9:361; July 1969) (JAPhA. NS41(5)(suppl 1):S9; September/October 2001) (Reviewed 2007) (JAPhA. NS52(4):458; July/August 2012) (Reviewed 2017) (Reviewed 2024)

2008

Internet Access by Pharmacists

APhA supports ready access to Internet resources by pharmacists at their practice sites to facilitate delivery of patient care and to support professional development.

(JAPhA. NS48(4):471; July/August 2008) (Reviewed 2013) (Reviewed 2018)

2001

Employee Benefits

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

(JAPhA. NS(5)(suppl 1):S10; September/October 2001)(Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2019) (Reviewed 2024)

1979

Consideration of the Equal Rights Amendment

APhA supports efforts to ensure equal rights of all persons.

(AmPharm. NS19(7):60; June 1979) (Reviewed 2009) (Reviewed 2014) (Reviewed 2018) (Reviewed 2022) (Reviewed 2024)

Productivity Requirements

2024, 2018

Pharmacist Workplace Environment and Patient Safety

1. APhA supports staffing models that promote safe provision of patient care services and access to medications.
2. APhA encourages the adoption of patient centered quality and performance measures that align with safe delivery of patient care services and opposes the setting and use of operational quotas or time-oriented metrics that negatively impact patient care and safety.
3. APhA denounces any policies or practices of third-party administrators, processors, and payers that contribute to a workplace environment that negatively impacts patient safety. APhA calls upon public and private policy makers to establish provider payment laws, regulations, and policies that support the safe provision of medications and delivery of effective patient care.
4. APhA urges pharmacy personnel to establish collaborative mechanisms that engage the pharmacist in charge of each practice, pharmacists, pharmacy technicians, and pharmacy staff in addressing workplace issues that may have an impact on patient safety.
5. APhA urges employers to collaborate with the pharmacy staff to regularly and systematically examine and resolve workplace issues that may have a negative impact on patient safety.
6. APhA opposes retaliation against pharmacy personnel for reporting workplace issues that may negatively impact patient safety.

(JAPhA. 58(4):355; July/August 2018) (Reviewed 2020) (Reviewed 2021) (Reviewed 2022) (JAPhA 64(4);102117, July/August 2024)

1999, 1970

Unionization of Pharmacists: State Participation in Employer/Employee Relations

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

(JAPhA. NS10:353; June 1970) (JAPhA. 39(4):447; July/August 1999) (Reviewed 2001) (Reviewed 2007)(Reviewed 2012) (Reviewed 2017)

Unionization

2024, 2012, 1999

Collective Bargaining

1. APhA affirms the United Nations' Universal Declaration of Human Rights that collective bargaining is a fundamental human right.
2. APhA supports pharmacists' participation in organizations that promote the discretion or professional prerogatives exercised by pharmacists in their practice, including the provision of patient care.
3. APhA supports the rights of pharmacists to negotiate with their respective employers for working conditions that will foster compliance with the standards of patient care as established by the profession.

(JAPhA. 39(4) 447; July/August 1999) (Reviewed 2001) (Reviewed 2007) (JAPhA. NS52(4):458; July/August 2012) (Reviewed 2017) (Reviewed 2019) (Reviewed 2020) (JAPhA 64(4);102117, July/August 2024)

1999, 1971

Unionization of Pharmacists

1. The committee recommends that no change be made in the present policy of APhA with regard to becoming a collective bargaining unit.
2. The committee recommends that APhA continue its educational efforts concerning the mutual responsibilities of the employer and employee pharmacist inherent in the employment relationship.
3. The committee recommends that APhA continue to urge state associations to develop employee/employer relations committees to
   (a) study all aspects of both the professional and employment relationships that exist between the employer and the employee;

(b) develop and recommend guidelines to provide direction and guidance to both the employed pharmacist and the employer in developing a mutually acceptable relationship;
(c) conduct necessary surveys designed to provide information on salaries, benefits, and specific problems with attention given to possible regional variations in the data obtained; and
(d) consider the establishment of an employment standards committee where feasible in each appropriate area of the state to act in an advisory and/or arbitrating capacity on matters pertaining to employment standards and employment grievances.

4. The committee recommends that colleges of pharmacy include the subject of employer/ employee relations within an appropriate course of the curriculum.

(JAPhA. NS11:273; May 1971) (JAPhA. 39(4):447; July/August 1999) (Reviewed 2001) (Reviewed 2007)(Reviewed 2012) (Reviewed 2017)

Working Conditions

2024, 2012, 2007, 1970

Employment Standards Policy Statement

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

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

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

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

1. Encouraging and assisting state and national 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 and national pharmacy associations to use their good offices, whenever invited, to resolve specific issues that may arise.
3. Assisting state pharmacists associations and national specialty associations to develop procedures for mediation or arbitration of disputes that 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.

(JAPhA. NS10:363; June 1970) (Reviewed 2001) (JAPhA. NS45(5):580; September-October 2007) (JAPhA. NS52(4): 458; July/August 2012) (Reviewed 2017) (Reviewed 2018) (Reviewed 2020) (JAPhA 64(4);102117, July/August 2024)

2024, 2019

Pharmacist and Pharmacy Personnel Safety and Well-Being

1. APhA calls for employers to develop policies and procedures to support pharmacy personnel's ability to retreat or withdraw, without retaliation, from interactions that threaten their safety and well-being.
2. APhA encourages the development or utilization of educational programs and resources by the Association, employers, and other institutions to prepare pharmacy personnel to respond to situations that threaten their safety and well-being.

(JAPhA. 59(4):e17; July/August 2019) (Reviewed 2021) (Reviewed 2024) (JAPhA 64(4);102117, July/August 2024)

2024, 2018

Pharmacist Workplace Environment and Patient Safety

1. APhA supports staffing models that promote safe provision of patient care services and access to medications.
2. APhA encourages the adoption of patient centered quality and performance measures that align with safe delivery of patient care services and opposes the setting and use of operational quotas or time-oriented metrics that negatively impact patient care and safety.
3. APhA denounces any policies or practices of third-party administrators, processors, and payers that contribute to a workplace environment that negatively impacts patient safety. APhA calls upon public and private policy makers to establish provider payment laws, regulations, and policies that support the safe provision of medications and delivery of effective patient care.
4. APhA urges pharmacy personnel to establish collaborative mechanisms that engage the pharmacist in charge of each practice, pharmacists, pharmacy technicians, and pharmacy staff in addressing workplace issues that may have an impact on patient safety.
5. APhA urges employers to collaborate with the pharmacy staff to regularly and systematically examine and resolve workplace issues that may have a negative impact on patient safety.
6. APhA opposes retaliation against pharmacy personnel for reporting workplace issues that may negatively impact patient safety.

(JAPhA. 58(4):355; July/August 2018) (Reviewed 2020) (Reviewed 2021) (Reviewed 2022) (JAPhA 64(4);102117, July/August 2024)

2023

Employer Responsibilities Related to Comprehensive Reproductive Health Care Access

1. APhA advocates for employers to provide coverage and access to comprehensive reproductive health care services.
2. APhA demands that pharmacists and pharmacy personnel receive accommodations before, during and after pregnancy, including but not limited to sufficient time and space for breaks, opportunities to sit while working, and access to food and water between breaks.

(JAPhA. 63(4):1266; July/August 2023)

2023

Workplace Conditions

1. APhA calls for employers to provide fair, realistic, and equitable workplace conditions for pharmacy personnel that promote a safe, healthy, and sustainable working environment.
2. APhA urges all entities that impact pharmacy personnel workplace conditions to adopt the Pharmacists Fundamental Responsibilities and Rights.
3. APhA urges employers to develop and empower pharmacy personnel to use flexible practice management models based on available staffing, expertise, and resources that balance workloads to minimize distractions.
4. APhA advocates for employers to provide workplace onboarding and training for pharmacy personnel to optimize employee performance and satisfaction.
5. APhA encourages pharmacy personnel, starting with leaders, to model and facilitate individualized healthy working behaviors that improve well-being and to encourage and empower colleagues to do the same.
6. APhA opposes the sole use of productivity and fiscal measures for employee performance evaluations.
7. APhA calls for employers and employees to collaborate in the development and use of behavioral performance competencies in performance evaluations.

(JAPhA. 63(4):1265; July/August 2023)

2021

Increasing Awareness and Accountability to End Harassment, Intimidation, Abuse of Power, Position or Authority in Pharmacy Practice

1. APhA calls on all national and state pharmacy organizations, colleges/schools of pharmacy, and other stakeholders to support the development of a profession-wide effort to address harassment, intimidation, and abuse of power or position.
2. APhA supports the development of a profession-wide guideline on reporting harassment, intimidation, or abuse of power or position in their pharmacy education and training, professional practice, or volunteer service to pharmacy organizations.
3. APhA recommends all pharmacy organizations incorporate harassment, intimidation, and abuse training in their member professional development and education activities.

(JAPhA. 61(4):e15-e16; July/August 2021) (Reviewed 2024)

2020

Protecting Pharmacy Personnel During Public Health Crisis

1. APhA strongly urges all employers of pharmacists and pharmacy personnel, and the settings in which they practice, to implement protection and control measures and procedures, per consensus recommendations when available, and access to protective gear and cleaning supplies that ensure the safety of pharmacy personnel and that of their family members and the public.
2. APhA urges federal and state government officials, manufacturers, distributors, and health system administrators to recognize pharmacists and pharmacy personnel as "front-line providers" who should receive appropriate personal protective equipment and other resources to protect their personal safety and support their ability to continue to provide patient care.

(JAPhA. 60(5):e11; September/October 2020)

2019

Pharmacists' Role in Mental Health and Emotional Well-Being

1. APhA encourages all health care personnel to receive training and provide services to identify, assist, and refer people at risk for, or currently experiencing, a mental health crisis.
2. APhA encourages employers and policy makers to provide the support, resources, culture, and authority necessary for all pharmacy personnel to engage and assist individuals regarding mental health and emotional well-being.
3. APhA supports integration of a mental health assessment as a vital component of pharmacist-provided patient care services.

(JAPhA. 59(4):e16; July/August 2019) (Reviewed 2024)

2004, 1994

Sexual Harassment in the Workplace

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

(AmPharm. NS34(6):55; June 1994) (Reviewed 2001) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015) (Reviewed 2022)

2001

Stress and Conflict in the Workplace

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

(JAPhA. NS41(5)(suppl 1):S9; September/October 2001) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2019)

ENVIRONMENTAL CONCERNS

2024, 2017

Drug Disposal Program Involvement

APhA urges pharmacists to expand patient access to secure, convenient, and environmentally responsible drug disposal options, in accordance with the Secure and Responsible Drug Disposal Act of 2010, by implementing disposal programs they deem appropriate for their individual practice sites, patient care settings, and business models in an effort to reduce the amount of dispensed but unused prescription drug product available for diversion and misuse.

(JAPhA. 57(4):441; July/August 2017) (JAPhA 64(4);102117, July/August 2024)

2024, 2013

Medication Take-Back/Disposal Programs

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

(JAPhA. 53(4):365; July/August 2013) (Reviewed 2018) (JAPhA 64(4);102117, July/August 2024)

2024, 2007, 1992

Recycling of Pharmaceutical Packaging

APhA supports research and development of pharmaceutical packaging disposal by pharmacists, pharmaceutical manufacturers, waste product managers, and other stakeholders to increase recycling, reduce unnecessary waste, and minimize the opportunity for counterfeiters to use discarded packaging.

(Am Pharm. NS32(6):516; June 1992) (Reviewed 2004) (JAPhA. NS45(5):580; September/October 2007) (Reviewed 2012) (Reviewed 2017) (JAPhA 64(4);102117, July/August 2024)

2024, 2014

The Use and Sale of Electronic Cigarettes (e-cigarettes)

1. APhA opposes the sale of e-cigarettes and other vaporized nicotine products in pharmacies until such time that scientific data support the health and environmental safety of these products.
2. APhA opposes the use of e-cigarettes and other vaporized nicotine products in areas subject to current clean air laws, regulations, and policies for combustible tobacco products until such time that scientific data support the health and environmental safety of these products.
3. APhA urges pharmacists to become more knowledgeable about e-cigarettes and other vaporized nicotine products.

(JAPhA. 54(4): 358; July/August 2014) (Reviewed 2019) (JAPhA 64(4);102117, July/August 2024)

2023

Greenhouse Gas Emissions

APhA urges implementation of strategies throughout the pharmaceutical product lifecycle (e.g., research, development, manufacturing, marketing, distribution, dispensing, use, and disposal) to achieve net zero emissions by 2050.

(JAPhA. 63(4):1266; July/August 2023)

2009

Medication Disposal

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

(JAPhA. NS49(4):493; July/August 2009) (Reviewed 2012) (Reviewed 2013) (Reviewed 2018)

2007

Redistribution of Previously Dispensed Medications

1. As a matter of patient safety, APhA opposes the re-dispensing of a previously dispensed medication once it has been out of the control of a health care professional.

2. APhA supports a public awareness program to explain why the re-dispensing of a previously dispensed medication once it is out of the control of the healthcare professional is a public health safety concern.

(JAPhA. NS45(5):580; September/October 2007) (Reviewed 2012) (Reviewed 2017)

2001

Syringe Disposal

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

(JAPhA. NS41(5)(suppl 1):S9; September/October 2001) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2020) (Reviewed 2023) (Reviewed 2024)

1990

Proper Handling and Disposal of Hazardous Pharmaceuticals and Associated Supplies and Materials

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

(Am Pharm. NS30(6):45; June 1990) (Reviewed 2004) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2018)

ETHICAL ISSUES

2024, 2020

Non-execution-Related Use of Pharmaceuticals in Correctional Facilities

1. APhA opposes drug manufacturers' refusal to supply certain drugs to correctional health services units necessary to provide medical treatment of those who are incarcerated.
2. APhA advocates for those who are incarcerated to have an opportunity, equal to that of nonmates, to access medications that correctional healthcare providers deem medically necessary for appropriate and humane health care treatment.
3. APhA advocates for correctional healthcare providers to have opportunity, equal to that of non-correctional healthcare providers, to access, prescribe, and procure pharmaceuticals deemed necessary for medical treatment of those incarcerated.

(JAPhA. 60(5):e11; September/October 2020) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2004, 1985

Pharmacist Involvement in Execution by Lethal Injection

1. APhA opposes the use of the term "drug" for chemicals when used in lethal injections.
2. APhA opposes laws, regulations, and policies that 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) (Reviewed 2015) (JAPhA 64(4);102117, July/August 2024)

2024, 2004, 1997

Physician-Assisted Suicide

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, regulations, and policies that mandate or prohibit the participation of pharmacists in physician-assisted suicide.

(JAPhA. NS37(4):459; July/August 1997) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015) (JAPhA 64(4);102117, July/August 2024)

2022

Data to Advance Health Equity

APhA urges pharmacists to use patient-specific data and social determinants of health to address health inequities and drive decision-making in practice and advocacy.

(JAPhA. 62(4):941; July 2022) (Reviewed 2024)

2019

Referral System for the Pharmacy Profession

1. APhA supports referrals of patients to pharmacists, among pharmacists, or between pharmacists and other health care providers to promote optimal patient outcomes.
2. APhA supports referrals to and by pharmacists that ensure timely patient access to quality services and promote patient freedom of choice.
3. APhA advocates for pharmacists' engagement in referral systems that are aligned with those of other health care providers and facilitate collaboration and information sharing to ensure continuity of care.
4. APhA supports attribution and equitable payment to pharmacists providing patient care services as a result of a referral.
5. APhA promotes the pharmacist's professional responsibility to uphold ethical and legal standards of care in referral practices.
6. APhA reaffirms its support of development, adoption, and use of policies and procedures by pharmacists to manage potential conflicts of interest in practice, including in referral systems.

(JAPhA. 59(4):e16; July/August 2019) (Reviewed 2022) (Reviewed 2023) (Reviewed 2024)

2015

Pharmacist Participation in Executions

The American Pharmacists Association discourages pharmacist participation in executions on the basis that such activities are fundamentally contrary to the role of pharmacists as providers of health care.

(JAPhA. 55(4):365; July/August 2015)

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) (Reviewed 2016) (Reviewed 2022) (Reviewed 2023)

2004, 1998

Pharmacist Conscience Clause

1. APhA recognizes the individual pharmacist's right to exercise conscientious refusal and supports the establishment of systems to ensure patient's access to legally prescribed therapy without compromising the pharmacist's right of conscientious refusal.
2. APhA shall appoint a council on an as needed basis to serve as a resource for the profession in addressing and understanding ethical issues.

(JAPhA. 38(4):417; July/August 1998) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015) (Reviewed 2023)

1994

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) on 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.

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

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

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

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

VIII. A pharmacist seeks justice in the distribution of health resources.
When health resources are allocated, a pharmacist is fair and equitable, balancing the needs of patients and society.

(Adopted October 27, 1994)

1991

Biotechnology

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

(Am Pharm. NS31(6):29; June 1991) (Reviewed 2004) (Reviewed 2007) (Reviewed 2010) (Reviewed 2015)(Reviewed 2016) (Reviewed 2017)

1989

Ethics and Technology

APhA, in recognition of pharmacists' professional and ethical responsibility to society, endorses the consideration of ethical principles in the design, conduct, and application of scientific research.

(Am Pharm. NS29(1):76; January 1989) (Reviewed 2004) (Reviewed 2010) (Reviewed 2015)

FEDERAL PROGRAMS AND POLICIES

2024, 2016

Biologic, Biosimilar, and Interchangeable Biologic Drug Products

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

(JAPhA. 56(4):369; July/August 2016) (JAPhA 64(4);102117, July/August 2024)

2024, 2012

Drug Supply Shortages and Patient Care

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

(a) creating a practice site drug shortage plan as well as policies and procedures;
(b) using reputable drug shortage management and information resources in decision making;
(c) communicating with patients and coordinating with other health care providers;
(d) avoiding excessive ordering and stockpiling of drugs;
(e) acquiring drugs from reputable distributors; and
(f) heightening their awareness of the potential for counterfeit or adulterated drugs entering the drug distribution system.

6. APhA encourages accrediting and regulatory agencies and the pharmaceutical science and manufacturing communities to evaluate policies/procedures related to the establishment and use of drug expiration dates and any impact those policies/procedures may have on drug shortages.
7. APhA encourages the active investigation and appropriate prosecution of entities that engage in price gouging and profiteering of medically necessary drug products in response to drug shortages.

(JAPhA. NS52(4): 457; July/August 2012) (Reviewed 2017) (Reviewed 2021) (JAPhA 64(4);102117, July/August 2024)

2024, 2020, 2015

Integrated Nationwide Prescribing Drug Monitoring Program

1. APhA advocates for nationwide integration and uniformity of prescription drug monitoring programs (PDMP) that incorporate federal, state, and territory databases for the purpose of providing health care professionals with accurate and real-time information to assist in clinical decision making when providing patient care services related to controlled substances.
2. APhA supports pharmacist involvement in the development of uniform standards for an integrated nationwide prescription drug monitoring program (PDMP) that includes the definition of authorized registered users, documentation, reporting requirements, system response time, security of information, minimum reporting data sets, and standard transaction format.
3. APhA supports mandatory prescription drug monitoring program (PDMP) enrollment by all health care providers, mandatory reporting by all those who dispense controlled substances, and appropriate system query by registrants during the patient care process related to controlled substances.
4. APhA advocates for the development of seamless workflow integration systems that would enable consistent use of a nationwide prescription drug monitoring program (PDMP) by registrants to facilitate prospective drug review as part of the patient care process related to controlled substances.
5. APhA advocates for continuous, sustainable federal funding sources for practitioners and system operators to utilize and maintain a standardized integrated and real-time nationwide prescription drug monitoring program (PDMP).
6. APhA supports the use of interprofessional advisory boards that include pharmacists to coordinate collaborative efforts for
   (a) compiling, analyzing, and using prescription drug monitoring program (PDMP) data trends to identify misuse of controlled substances and/or fraud;
   (b) providing focused provider education and patient referral to treatment programs; and
   (c) supporting research activities on the impact of PDMPs.
7. APhA supports education and training for registrants about a nationwide prescription drug monitoring program (PDMP) to ensure proper data integrity, use, and confidentiality.

(JAPhA. N55(4):364-365; July/August 2015) (JAPhA. 60(5):e10; September/October 2020) (JAPhA 64(4);102117, July/August 2024)

2024, 2004, 1980

Internal Revenue Service Drug Deduction

APhA supports amendment of personal income tax laws, regulations, and policies to permit all personal expenditures for medicines and drugs to be totally deductible and exempt from any exclusionary limits.

(Am Pharm. NS20(7):61; July 1980) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015) (JAPhA 64(4);102117, July/August 2024)

2024, 2020

Non-execution-Related Use of Pharmaceuticals in Correctional Facilities

1. APhA opposes drug manufacturers' refusal to supply certain drugs to correctional health services units necessary to provide medical treatment of those who are incarcerated.
2. APhA advocates for those who are incarcerated to have an opportunity, equal to that of nonmates, to access medications that correctional healthcare providers deem medically necessary for appropriate and humane health care treatment.
3. APhA advocates for correctional healthcare providers to have opportunity, equal to that of non-correctional healthcare providers, to access, prescribe, and procure pharmaceuticals deemed necessary for medical treatment of those incarcerated.

(JAPhA. 60(5):e11; September/October 2020) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2020

Protecting Pharmaceuticals as a Strategic Asset

1. APhA asserts that the quality and safety of pharmaceutical and other medical products and the global pharmaceutical and medical product supply chain are essential to the United States national security and public health.
2. APhA advocates for pharmacist engagement in the development and implementation of national and global strategies to ensure the availability, quality, and safety of pharmaceutical and other medical products.
3. APhA calls for the development, implementation, and oversight of enhanced and transparent processes, standards, and information that ensure quality and safety of all pharmaceutical ingredients and manufacturing processes.
4. APhA calls on the federal government to penalize entities who create barriers that threaten the availability, quality, and safety of United States pharmaceutical and other medical product supplies.
5. APhA calls for the development of redundancy and risk mitigation strategies in the manufacturing process to ensure reliable and consistent availability of safe and high-quality pharmaceutical and other medical products.
6. APhA advocates for legal regulatory, policy and market incentives that bolster the availability, quality, and safety of pharmaceutical and other medical products.
7. APhA calls for greater transparency, accuracy, and timeliness of information and notification to health care professionals regarding drug shortages, product quality and manufacturing issues, supply disruption, and recalls.
8. APhA encourages pharmacy providers, health systems, and payers to develop coordinated response plans, including the use of therapeutic alternatives, to mitigate the impact of drug shortages and supply disruptions.
9. APhA supports federal legislation and regulations that engages pharmacists, other health professionals, and manufacturers in developing a United States-specific essential medicines list and provides funding mechanisms to ensure consistent availability of these products.
10. APhA recommends the use of pharmacists in the delivery of public messages, through media and other communication channels, regarding pharmaceutical supply and quality issues.

(JAPhA. 60(5):e9; September/October 2020) (JAPhA 64(4);102117, July/August 2024)

2024, 1985

Reduction of Federal Laws and Regulations (Paperwork Burden)

APhA supports the reduction and simplification of laws, regulations, and policies for record-keeping requirements that affect pharmacy practice and are not beneficial in protecting the public welfare.

(Am Pharm. NS25(5):51; May 1985) (Reviewed 2001) (Reviewed 2004) (Reviewed 2010) (Reviewed 2015)(Reviewed 2021) (JAPhA 64(4);102117, July/August 2024)

2024, 2018, 2013

Revisions to the Medication Classification System

1. APhA supports the Food and Drug Administration's (FDA) efforts to revise the drug and medical device classification paradigms for prescription and nonprescription medications and medical devices to allow greater access to certain medications and medical devices under conditions of safe use while maintaining patients' relationships with their pharmacists and other health care providers.
2. APhA supports the implementation or modification of state laws, regulations, and policies to facilitate pharmacists' implementation and provision of services related to a revised drug and medical device classification system.

3. APhA supports a patient care delivery model built on coordination and communication between pharmacists and other health care team members in the evaluation and management of care delivery.
4. APhA affirms that pharmacists are qualified to provide clinical interventions on medications and medical devices under FDA's approved conditions of safe use.
5. APhA urges manufacturers, FDA, and other stakeholders to include pharmacists' input in the development and adoption of technology and standardized processes for services related to medications and medical devices under FDA's defined conditions of safe use.
6. APhA supports the utilization of best practices, treatment algorithms, and clinical judgment of pharmacists and other health care providers to guide the evaluation and management of care delivery related to medications and medical devices under FDA's approved conditions of safe use.
7. APhA encourages the inclusion of medications, medical devices, and their associated services provided under FDA's defined conditions of safe use within health benefit coverage.
8. APhA supports compensation of pharmacists and other health care professionals for the provision of services related to FDA's defined conditions of safe use programs.

(JAPhA. 53(4):365; July/August 2013) (JAPhA. 58(4):356; July/August 2018) (Reviewed 2022) (JAPhA 64(4);102117, July/August 2024)

2023

Uncompensated Care Mandates in Pharmacy

APhA calls for commensurate compensation for the provision of compulsory or mandated pharmacy services that include all products, supplies, labor, expertise, and administrative fees based on transparent economic analyses of existing and future services.

(JAPhA. 63(4):1265; July/August 2023)

2022

Access and Reimbursement for Diabetes Education, Support, and Prevention Services

1. APhA supports the expansion of patient access to diabetes education, support, and prevention, including but not limited to the National Diabetes Prevention Program or DSMES.
2. APhA calls upon public and private payers to expand reimbursement for pharmacist-based services as providers of diabetes education, support, and prevention regardless of practice setting.
3. APhA advocates for campaigns focused on increased community wellness awareness and health benefits for diabetes education, support, and prevention.

(JAPhA. 62(4):941; July 2022)

2019

Consolidation Within Health Care

1. APhA advocates that health care mergers and acquisitions must preserve the pharmacist–patient relationship.
2. APhA supports optimizing the role of pharmacists in the provision of team-based care following health care mergers and acquisitions in order to:
   (a) enhance patient experience and safety;
   (b) improve population health;
   (c) reduce health care costs; and
   (d) improve the work life of health care providers.
3. APhA asserts that the scope of review by federal agencies must have a focus on the impact of health care mergers and acquisitions on patient access and the provision of care to ensure optimal patient outcomes. Therefore, APhA calls for
   (a) reform of the pre–health care mergers and acquisitions process;
   (b) implementation of an ongoing post–health care mergers and acquisitions evaluation process to preserve patient choice and access to established patient–pharmacist relationships, and
   (c) continuous transparent dialogue among stakeholders throughout the process.
4. APhA calls for the Federal Trade Commission (FTC) to develop a task force to monitor health care mergers and acquisitions activity.

(JAPhA. 59(4):e16; July/August 2019) (Reviewed 2021) (Reviewed 2023) (Reviewed 2024)

2019

Qualification Standards for Pharmacists

APhA adamantly opposes the basic education requirement within the Office of Personnel Management's Classification and Qualifications–General Schedule Qualification Standard–Pharmacy Series, 0660, requiring a Doctor of Pharmacy degree as the

minimum qualifications to practice pharmacy that are inconsistent with pharmacist licensure requirements by state boards of pharmacy.
(JAPhA. 59(4):e17; July/August 2019) (Reviewed 2024)

2016, 2011

Pharmacists as Providers Under the Social Security Act

APhA supports changes to the Social Security Act to allow pharmacists to be recognized and paid as providers of patient care services.
(JAPhA. NS51(4):482; July/August 2011) (JAPhA. 56(4): 379; July/August 2016) (Reviewed 2022)

2013

Ensuring Access to Pharmacists' Services

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

(JAPhA. 53(4):365; July/August 2013) (Reviewed 2018) (Reviewed 2019) (Reviewed 2021) (Reviewed 2024)

2013

Pharmacists Providing Primary Care Services

APhA advocates for the recognition and utilization of pharmacists as providers to address gaps in primary care.
(JAPhA. 53(4):365; July/August 2013) (Reviewing 2018) (Reviewed 2019) (Reviewed 2020) (Reviewed 2023) (Reviewed 2024)

2012

Controlled Substances Regulation and Patient Care

1. APhA encourages the Drug Enforcement Administration (DEA) and other regulatory agencies to recognize pharmacists as partners that are committed to ensuring that patients in legitimate need of controlled substances are able to receive the medications.
2. APhA supports efforts to modernize and harmonize state and federal controlled substance laws.
3. APhA urges DEA and other regulatory agencies to balance patient care and regulatory issues when developing, interpreting, and enforcing laws and regulations.
4. APhA encourages DEA and other regulatory agencies to recognize the changes occurring in health care delivery and to establish a transparent and inclusive process for the timely updating of laws and regulations.
5. APhA encourages the U.S. Department of Justice to collaborate with professional organizations to identify and reduce
   (a) the burdens on health care providers,
   (b) the cost of health care delivery, and
   (c) the barriers to patient care in the establishment and enforcement of controlled substance laws.

(JAPhA. NS52(4):457; July/August 2012) (Reviewed 2015)

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) (Reviewed 2015)

2004, 1994

Small Business Set-Asides

APhA encourages all federal agencies (such as the Office of Personnel Management) to eliminate inconsistencies in federal contracts that in any way affect community pharmacies operating as small businesses.

(Am Pharm. NS34(6):60; June 1994) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015)

FREEDOM OF ACCESS (FREEDOM OF CHOICE)

2024, 2023

Access to Comprehensive Reproductive Health Care

1. APhA supports equitable patient access to evidence-based comprehensive reproductive health care, including, but not limited to, the management of pregnancy loss, ectopic pregnancy, infertility, pregnancy termination, contraception, and permanent contraception.
2. APhA recognizes patient autonomy in choosing reproductive health care services and the essential role of all health care professionals in facilitating access and advancing informed decision making.
3. APhA supports evidence-based laws, regulations, and policies that ensures patient access to comprehensive reproductive health care services.
4. APhA opposes legal actions against pharmacies, pharmacists, and pharmacy personnel that provide patient access to, or information regarding, reproductive health care services that are within pharmacist scope of practice.

(JAPhA. 63(4):1266; July/August 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2020

Non-execution-Related Use of Pharmaceuticals in Correctional Facilities

1. APhA opposes drug manufacturers' refusal to supply certain drugs to correctional health services units necessary to provide medical treatment of those who are incarcerated.
2. APhA advocates for those who are incarcerated to have an opportunity, equal to that of nonmates, to access medications that correctional healthcare providers deem medically necessary for appropriate and humane health care treatment.
3. APhA advocates for correctional healthcare providers to have opportunity, equal to that of non-correctional healthcare providers, to access, prescribe, and procure pharmaceuticals deemed necessary for medical treatment of those incarcerated.

(JAPhA. 60(5):e11; September/October 2020) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2023

Enforcing Antidiscrimination in the Dispensing of Medicines

APhA affirms that discrimination and stigma should not impact a patient's ability to obtain medications.

(JAPhA. 63(4):1266; July/August 2023)

2023

Site of Care Patient Steerage

1. APhA calls for the elimination of payer-driven medication administration policies and provisions that restrict access points, interfere with shared provider–patient decision-making, cause delays in care, or otherwise adversely impact the patient.
2. APhA asserts that care coordination services associated with provider-administered medications are essential to safe and effective medication use and calls for the development of broadly applicable compensation mechanisms for these essential services.

(JAPhA. 63(4):1265; July/August 2023)

2022

Procurement Strategies and Patient Steerage

1. APhA opposes mandated procurement strategies that restrict patients' and providers' ability to choose treatment options and that compromise patient safety and quality of care.
2. APhA calls for procurement strategies and care models that lower total costs, do not restrict or delay care, and ensure continuity of care.

(JAPhA. 62(4):942; July 2022) (Reviewed 2024)

2004, 1990

Freedom to Choose

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

(Am Pharm. NS30(6):45; June 1990) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015) (Reviewed 2018) (Reviewed 2021) (Reviewed 2023) (Reviewed 2024)

HEALTHCARE REFORM

2024, 2016, 1994

Pharmacy Services Benefits in Health Care Reform

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

1. Universal coverage for pharmacy service benefits that include both medications and pharmacists' services;
2. Specific provisions for the access to and payment for pharmacists' patient care services;
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, regulations, and policies 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.

(Am Pharm. NS34(6):58; June 1994) (Reviewed 2004) (Reviewed 2010) (Reviewed 2011) (JAPhA. 56(4):379; July/August 2016) (Reviewed 2018) (Reviewed 2021) (JAPhA 64(4);102117, July/August 2024)

2024, 2020

Providing Affordable and Comprehensive Pharmacy Services to the Underserved

1. APhA supports the expansion and increased sources of funding for pharmacies and pharmacist-provided care services that serve the needs of underserved populations to provide better health outcomes and lower healthcare costs.
2. APhA supports charitable pharmacies and pharmacy services that ensure the quality, safety, drug storage, and integrity of the drug product and supply chain, in accordance with applicable laws, regulations, and policies.

(JAPhA. 60(5):e11; September/October 2020) (Reviewed 2022) (JAPhA 64(4);102117, July/August 2024)

2021

Social Determinants of Health

1. APhA supports the integration of social determinants of health screening as a vital component of pharmacy services.
2. APhA urges the integration of social determinants of health education within pharmacy curricula, post-graduate training, and continuing education requirements.
3. APhA supports incentivizing community engaged research, driven by meaningful partnerships and shared decision-making with community members.
4. APhA urges pharmacists to create opportunities for community engagement to best meet the needs of the patients they serve.
5. APhA encourages the integration of community health workers in pharmacy practice to provide culturally sensitive care, address health disparities, and promote health equity.

(JAPhA. 61(4):e16; July/August 2021) (Reviewed 2023) (Reviewed 2024)

2020

Coordination of the Pharmacy and Medical Benefit

APhA supports coordination of patients' comprehensive pharmacy and medical benefits that allows for provision of and compensation for pharmacists' patient care services; aligns incentives to optimize patient outcomes; streamlines administrative processes; reduces overall health care costs and preserves patients' right to choose providers under their pharmacy and medical benefits.

(JAPhA. 60(5):e10; September/October 2020)

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) (Reviewed 2016) (Reviewed 2021) (Reviewed 2023)

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

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

INTERNET PHARMACY

2024, 2005, 2004, 1999

Telemedicine/Telehealth/Telepharmacy

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.
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 laws, regulations, policies, 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 laws, regulations, and policies that facilitate the practice of telepharmacy and maintain appropriate guidelines to protect the public health and patient confidentiality.

(JAPhA. 39(4):447; July/August 1999) (JAPhA. NS44(5):551; September/October 2004) (JAPhA. NS45(5):559; September/October 2005) (Reviewed 2009) (Reviewed 2012) (Reviewed 2014) (Reviewed 2019) (JAPhA 64(4);102117, July/August 2024)

INTERPROFESSIONAL RELATIONS

2024, 2020

Pharmaceutical Safety and Access During Emergencies

1. APhA urges government authorities to hold pharmaceutical manufacturers, wholesalers, pharmacies, and other pharmaceutical supply distributors and providers accountable to state and federal price gouging laws, regulations and policies in selling those items to patients, pharmacies, hospitals, and other health care providers during times of local, state, or national emergency.
2. APhA urges government authorities to aggressively enforce laws and regulations against adulterated products and false and misleading claims by entities offering to sell pharmaceutical and medical products to health care providers and consumers.

(JAPhA. 60(5):e11; September/October 2020) (JAPhA 64(4);102117, July/August 2024)

2023

Pharmacist Representation on Medical Staff

1. APhA advocates for pharmacists to be included as members of medical staffs and eligible to vote on the bylaws, standards, rules, regulations, and policies that govern those institutions' medical staffs.
2. APhA supports pharmacists, as part of the medical staff, have parity in their opportunity to be credentialed and privileged as independent medical providers.

(JAPhA. 63(4):1266; July/August 2023)

2020

Accountability of Pharmacists

1. APhA affirms pharmacists' professional accountability within their role in all practice settings.
2. APhA advocates that pharmacists be granted and accept authority, autonomy, and accountability for patient-centric actions to improve health and medication outcomes, in coordination with other health professionals, as appropriate.
3. APhA reaffirms 2017 Pharmacists' Role Within Value-based Payment Models and supports continued expansion of interprofessional patient care models that leverage pharmacists as accountable members of the health care team.
4. APhA advocates for sustainable payment and attribution models to support pharmacists as accountable patient care providers.
5. APhA supports continued expansion of resources and health information infrastructures that empower pharmacists as accountable health care providers.
6. APhA supports the enhancement of comprehensive and affordable professional liability insurance coverage that aligns with evolving pharmacist accountability and responsibility.

(JAPhA. 60(5):e9; September/October 2020) (Reviewed 2023)

Consumer

2004, 1970

Consumer Organizations

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.

(JAPhA. NS10:350; June 1970) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015)

General Health Care Organizations

2022

Addressing American Medical Association's Policy Related to Pharmacists Scope of Practice

1. APhA opposes policies, practices, and statements by the American Medical Association (AMA) and other professional organizations that impede interprofessional care, patient access to pharmacist-provided care, and health equity.
2. APhA calls on the American Medical Association (AMA) to rescind its policies opposing expanded scopes of practice for pharmacists.
3. APhA adamantly supports the continuation and expansion of collaborative patient care models among pharmacists, physicians, and other healthcare professionals to improve patient access to care, health equity, and health outcomes.

(JAPhA. 62(4):942; July 2022)

2004, 1975

Other Health Care Professional Organizations

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

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

1989

The Joint Commission

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

(Am Pharm. NS29(7):464; July 1989) (Reviewed 2004) (Reviewed 2009) (Reviewed 2010) (Reviewed 2011) (Reviewed 2016)

Mental Health

2024, 2018

Efforts to Reduce the Stigma Associated with Mental Health Disorders or Diseases

1. APhA encourages all stakeholders to develop and adopt evidence-based approaches to educate the public and all health care professionals to reduce the stigma associated with mental health diagnoses.
2. APhA supports the increased utilization of pharmacists and student pharmacists with appropriate training to actively participate in the care of patients with mental health conditions as members of interprofessional health care teams in all practice settings.
3. APhA supports the expansion of mental health education and training in the curriculum of all schools and colleges of pharmacy, post-graduate training, and within continuing professional development programs.
4. APhA supports the development of education and resources to address health care professional resiliency and burnout.

(JAPhA. 58(4):356; July/August 2018) (JAPhA 64(4);102117, July/August 2024)

Physicians

2024, 2019, 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 supports the establishment of collaborative practice agreements between one or multiple pharmacists and one or multiple prescribers or entities.
3. APhA supports state laws, regulations, and policies that do not require a referral or a prior provider–patient relationship as a prerequisite to access services provided under a collaborative practice agreement.
4. APhA opposes state laws, regulations, and policies that limit collaborative practice agreements to specific patients.
5. APhA supports state laws, regulations, and policies that allow for pharmacists' prescriptive authority.
6. APhA supports state collaborative practice laws, regulations, and policies that allow all licensed pharmacists, in all practice settings, to establish collaborative practice agreements with other health care professionals or entities.
7. APhA shall promote the establishment and dissemination of guidelines and information to pharmacists and other health care professionals to facilitate the development of collaborative practice agreements.

(JAPhA. NS37(4):459; July/August 1997) (Reviewed 2003) (Reviewed 2007) (Reviewed 2009) (Reviewed 2011) (Reviewed 2012) (Reviewed 2017) (JAPhA. 59(4):e17; July/August 2019) (Reviewed 2020) (JAPhA 64(4);102117, July/August 2024)

2024, 2017, 2012

Contemporary Pharmacy Practice

1. APhA asserts that pharmacists should have the authority and support to practice to the full extent of their education, training, and experience in delivering patient care.
2. APhA opposes burdensome legal and regulatory requirements beyond continuing professional development for the provision of patient care services.
3. APhA supports continuing efforts toward establishing a consistent and accurate perception of the contemporary role and practice of pharmacists by the general public, patients, and all persons and institutions engaged in health care policy, administration, payment, and delivery.

4. APhA supports continued collaboration with stakeholders to facilitate adoption of standardized practice acts, appropriate related laws, regulations, and policies that reflect contemporary pharmacy practice.
5. APhA supports the establishment of multistate pharmacist licensure agreements to address the evolving needs of the pharmacy profession and pharmacist-provided patient care.
6. APhA urges the continued development of consensus documents, in collaboration with medical associations and other stakeholders, that recognize and support pharmacists' roles in patient care as health care providers.
7. APhA urges universal recognition of pharmacists as health care providers and compensation based on the level of patient care provided using standardized and future health care payment models.

(JAPhA. NS52(4):457; July/August 2012) (Reviewed 2016) (JAPhA. 57(4):441; July/August 2017) (Reviewed 2019) (Reviewed 2021) (Reviewed 2022) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2015

Antimicrobial Stewardship

1. APhA supports the role of pharmacists in antimicrobial stewardship in all practice settings.
2. APhA supports pharmacists working in collaboration with others to lead the development and implementation of antimicrobial stewardship programs and initiatives.
3. APhA supports pharmacists advising prescribers and educating patients on the appropriate use of antimicrobials.

(JAPhA. N55(4):365; July/August 2015)

2014

Care Transitions

1. APhA supports pharmacists leading medication management activities during care transitions to ensure safe and effective medication use.
2. APhA supports the integral role of pharmacists during care transitions for improving quality of patient-centered care and reducing overall costs to the health care system.
3. APhA strongly encourages collaboration and shared accountability among patients, family members, caregivers, pharmacists, and other health care providers during care transitions.
4. APhA supports the development and utilization of standardized processes that facilitate real-time, bidirectional communication of protected health information during care transitions.
5. APhA supports that documentation of health outcomes is an essential component of any care transition program to demonstrate value and ensure continuous quality improvement.
6. APhA supports financially viable payment models that recognize the value of pharmacists' services, including, but not limited to, those provided during care transitions.
7. APhA strongly urges the development and implementation of multidisciplinary, interprofessional, and team-based training for health care professionals and students to improve the quality and consistency of care transition services.
8. APhA urges the collaboration and partnership of community pharmacies with health care systems, institutions, and other entities involved in care transitions.

(JAPhA. 54(4):357; July/August 2014) (Reviewed 2019) (Reviewed 2023)

2011, 2004, 1963

Pharmacists and Other Health Practitioners: Relationships and Compensation Among Health Care Practitioners

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

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

2004, 1965

Guidelines for Physician Ownership

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

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

Public Health

2024, 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, regulations, and policies amended to require that a pharmacist serve on the state

and local boards of health. One part of this effort should be an increased interest on the part of the pharmacist in his local health boards and commissions.
(JAPhA. NS7:324; June 1967) (Reviewed 2002) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (JAPhA 64(4);102117, July/August 2024)

2021
Social Determinants of Health
1. APhA supports the integration of social determinants of health screening as a vital component of pharmacy services.
2. APhA urges the integration of social determinants of health education within pharmacy curricula, post-graduate training, and continuing education requirements.
3. APhA supports incentivizing community engaged research, driven by meaningful partnerships and shared decision-making with community members.
4. APhA urges pharmacists to create opportunities for community engagement to best meet the needs of the patients they serve.
5. APhA encourages the integration of community health workers in pharmacy practice to provide culturally sensitive care, address health disparities, and promote health equity.

(JAPhA. 61(4):e16; July/August 2021) (Reviewed 2023) (Reviewed 2024)

2011
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) (Reviewed 2012) (Reviewed 2016) (Reviewed 2020) (Reviewed 2022)

2004, 1964
Community Health Councils
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.
(JAPhA. NS4:428; August 1964) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015)

Referral Programs

2024, 2019
Patient-Centered Care of People Who Use Non-Medically Sanctioned Psychotropic or Psychoactive Substances
1. APhA encourages state legislatures and boards of pharmacy to revise laws, regulations, and policies to support the patient-centered care of people who use non-medically sanctioned psychotropic or psychoactive substances.
2. To reduce the consequences of stigma associated with drug use, APhA supports the expansion of interprofessional harm reduction education in the curriculum of schools and colleges of pharmacy, postgraduate training, and continuing professional development programs.
3. APhA encourages pharmacists to initiate, sustain, and integrate evidence-based harm reduction principles and programs into their practice to optimize the health of people who use non-medically sanctioned psychotropic or psychoactive substances.
4. APhA supports pharmacists' roles to provide and promote consistent, unrestricted, and immediate access to evidence-based, mortality- and morbidity-reducing interventions to enhance the health of people who inject nonmedically sanctioned psychotropic or psychoactive substances and their communities, including sterile syringes, needles, and other safe injection equipment, syringe disposal, fentanyl test strips, immunizations, condoms, wound care supplies, pre- and post-exposure prophylaxis medications for human immunodeficiency virus (HIV), point-of-care testing for HIV and hepatitis C virus (HCV), opioid reversal agents, and medications for opioid use disorder.
5. APhA urges pharmacists to refer people who use non-medically sanctioned psychotropic or psychoactive substances to specialists in mental health, infectious diseases, and substance use disorder treatment; to housing, vocational, harm reduction, and recovery support services; and to safe consumption facilities and syringe service programs.

(JAPhA. 59(4):e17; July/August 2019) (Reviewed 2021) (Reviewed 2022) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2019
Referral System for the Pharmacy Profession
1. APhA supports referrals of patients to pharmacists, among pharmacists, or between pharmacists and other health care providers to promote optimal patient outcomes.

2. APhA supports referrals to and by pharmacists that ensure timely patient access to quality services and promote patient freedom of choice.
3. APhA advocates for pharmacists' engagement in referral systems that are aligned with those of other health care providers and facilitate collaboration and information sharing to ensure continuity of care.
4. APhA supports attribution and equitable payment to pharmacists providing patient care services as a result of a referral.
5. APhA promotes the pharmacist's professional responsibility to uphold ethical and legal standards of care in referral practices.
6. APhA reaffirms its support of development, adoption, and use of policies and procedures by pharmacists to manage potential conflicts of interest in practice, including in referral systems.

(JAPhA. 59(4):e16; July/August 2019) (Reviewed 2022) (Reviewed 2023) (Reviewed 2024)

Veterinary Medicine

2023

Development of Veterinary Pharmacy Education Opportunities in Schools and Colleges of Pharmacy and Pharmacy Technician Training

1. APhA encourages schools and colleges of pharmacy and pharmacy technician training programs to facilitate educational opportunities for student pharmacists, and student pharmacy technicians in the principles of veterinary pharmacotherapy.
2. APhA encourages the availability of professional development opportunities in the principles of veterinary pharmacotherapy for pharmacists, student pharmacists, and pharmacy technicians.

(JAPhA. 63(4):1265; July/August 2023)

2022, 2004, 1988

Pharmacists' Relationship to Veterinarians

APhA encourages pharmacists, student pharmacists, and pharmacy technicians to become more knowledgeable about veterinary drugs and their usage.

(Am Pharm. NS28(6):395; June 1988) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015) (Amended 2022) (Reviewed 2024)

2021

Definition of Patient

APhA calls for the adoption, by pharmacy organizations and regulatory and professional entities, of the expanded definition for patient to include human or non-human species.

(JAPhA. 61(4):e16; July/August 2021) (Reviewed 2024)

LABELING

2017

Indication on Prescription Labels and Medication Safety

APhA supports pharmacists' authority to include a medication's purpose on prescription labels, on the basis of professional knowledge, judgment, and patient preference, using vocabulary that is appropriate for their unique practice sites and that addresses the needs of their specific patient populations.

(JAPhA. 57(4):442; July/August 2017)

2016

Labeling and Measurement of Oral Liquid Medications

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

(JAPhA. 56(4):369; July/August 2016)

Expiration Dating and Drug Storage Instructions

2024, 2012

Drug Supply Shortages and Patient Care

1. APhA supports the immediate reporting by manufacturers to the U.S. Food and Drug Administration (FDA) of disruptions that may impact the market supply of medically necessary drug products to prevent, mitigate, or resolve drug shortage issues and supports the authority for FDA to impose penalties for failing to report.
2. APhA supports revising current laws, regulations, and policies that restrict the FDA's ability to provide timely communication to pharmacists, other health care providers, health systems, and professional associations regarding potential or real drug shortages.
3. APhA encourages the FDA, the Drug Enforcement Administration (DEA), and other stakeholders to collaborate in order to minimize barriers (e.g., aggregate production quotas, annual assessment of needs, unapproved drug initiatives) that contribute to or exacerbate drug shortages.
4. APhA should actively support legislation to hasten the development of an efficient regulatory process to approve therapeutically equivalent generic versions of biologic drug products.
5. APhA encourages pharmacists and other health care providers to assist in maintaining continuity of care during drug shortage situations by
   (a) creating a practice site drug shortage plan as well as policies and procedures;
   (b) using reputable drug shortage management and information resources in decision making;
   (c) communicating with patients and coordinating with other health care providers;
   (d) avoiding excessive ordering and stockpiling of drugs;
   (e) acquiring drugs from reputable distributors; and
   (f) heightening their awareness of the potential for counterfeit or adulterated drugs entering the drug distribution system.
6. APhA encourages accrediting and regulatory agencies and the pharmaceutical science and manufacturing communities to evaluate policies/procedures related to the establishment and use of drug expiration dates and any impact those policies/procedures may have on drug shortages.
7. APhA encourages the active investigation and appropriate prosecution of entities that engage in price gouging and profiteering of medically necessary drug products in response to drug shortages.

(JAPhA. NS52(4): 457; July/August 2012) (Reviewed 2017) (Reviewed 2021) (JAPhA 64(4);102117, July/August 2024)

2004, 1989

"Beyond-Use Dating" by Pharmacists

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

(Am Pharm. NS29(7):465; July 1989) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

2004, 1971

Expiration Dating

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

(JAPhA. NS11:271; May 1971) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

Identification of Drug and Manufacturer

2024, 2004, 1980

Identification of Prescription Drug Products

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

(Am Pharm. NS20(7):62; July 1980) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015) (JAPhA 64(4);102117, July/August 2024)

2024, 2004, 1969

Manufacturer's Name Included on Labels

APhA supports requirements for the name of the actual manufacturer of the dosage forms on all drug products.

(JAPhA. NS9:361; July 1969) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015) (JAPhA 64(4);102117, July/August 2024)

2012
Medication Verification
APhA encourages including a description of a medication's appearance on the pharmacy label or receipt as a means of reducing medication errors and distribution of counterfeit medications.
(JAPhA. NS52(4): 458; July/August 2012) (Reviewed 2017) (Reviewed 2018) (Reviewed 2024)

2004, 1975
National Drug Code: Uniform Identification Numbers
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.
(JAPhA. NS15:332; June 1975) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015)

2004, 1968
Standardized Manufacturers' Control Numbers
APhA encourages manufacturers to adopt a standardized system of control numbers that meets the following guidelines:
(a) The number should be legible.
(b) The numbers should be placed in a standard position on the label.
(c) The date of manufacture should be obvious from the control number.
(d) The number should be on both the carton and the original container.
(JAPhA. NS8:380; July 1968) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015)

Ingredients

2024, 2004, 1970
Disclosure of Ingredients in Drug Products
APhA supports requirements for full disclosure of therapeutically inactive, as well as active ingredients of all drug products.
(JAPhA. NS10:357; June 1970) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015) (Reviewed 2019) (JAPhA 64(4);102117, July/August 2024)

2024, 2000
Regulation of Dietary Supplements
1. APhA shall work with Congress to modify the Dietary Supplement Health and Education Act or enact other laws, regulation, or policies 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 ensure quality, safe, contaminant-free products.
5. APhA encourages health care professionals, manufacturers, and consumers to report adverse health events associated with dietary supplements. APhA encourages the FDA to create a database with this information and make it available to all interested parties.

(JAPhA. NS1(9):40; September/October 2000) (Reviewed 2005) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (JAPhA 64(4);102117, July/August 2024)

2019, 2018
Gluten Content and Labeling in Medications
1. APhA supports labeling of all prescription and nonprescription products, as well as dietary supplement products, to indicate the presence of gluten.
2. APhA encourages manufacturers to formulate drug products without use of wheat, barley, rye, or their derivatives whenever possible.
3. APhA supports additional research on the effects of gluten intolerance and celiac malabsorption, particularly as it relates to medication absorption.
4. APhA supports pharmacist education regarding celiac disease and non-celiac gluten sensitivity.
5. APhA encourages the development of analytical methods that can accurately detect lower levels of gluten than the current standard (20 ppm) and for the establishment of evidence-based gluten-free standards for the labeling of foods, excipients, dietary supplements, and prescription and nonprescription products.

(JAPhA. 58(4):356; July/August 2018) (JAPhA. 59(4):e16; July/August 2019) (Reviewed 2020)

LICENSURE, REGISTRATION, AND REGULATION

2024, 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 legal, regulatory, and policy 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 websites personal addresses, phone numbers, email, and other non-business contact information of pharmacists, student pharmacists, and pharmacy technicians.

(JAPhA. NS45(5):580; September-October 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

Composition of State Boards of Pharmacy

2024, 1972

Boards of Pharmacy: Consumer Representation

APhA encourages state pharmaceutical associations to actively seek appointment of public members to their respective boards of pharmacy and other health profession licensing and regulatory agencies.

(JAPhA. NS12:281; June 1972) (Reviewed 2004) (Reviewed 2010) (Reviewed 2015) (JAPhA 64(4);102117, July/August 2024)

Licensure and Registration of Personnel

2024, 2019

Expanding Technician Roles

1. APhA encourages state boards of pharmacy to develop laws, regulations, and policies allowing expanded pharmacy technician roles that allow both technicians and pharmacists to practice at the top of their training and license or certification.
2. APhA supports state board of pharmacy regulations that standardize and set minimum didactic and experiential standards for technicians to allow for functioning in expanded roles.

(JAPhA. 59(4):e17; July/August 2019) (JAPhA 64(4);102117, July/August 2024)

2024, 2017

Pharmacy Technician Education, Training, and Development

1. APhA supports the following minimum requirements for all new pharmacy technicians:
   (a) Successful completion of an accredited or state-approved education and training program.
   (b) Certification by the Pharmacy Technician Certification Board (PTCB).
2. APhA supports state board of pharmacy laws, regulations, and policies that require pharmacy technicians to meet minimum standards of education, training, certification, and recertification. APhA encourages state boards of pharmacy to develop a phase-in process for current pharmacy technicians. APhA also encourages boards of pharmacy to delineate between pharmacy technicians and student pharmacists for the purposes of education, training, certification, and recertification.
3. APhA recognizes the important contribution and role of pharmacy technicians in assisting pharmacists and student pharmacists with the delivery of patient care.
4. APhA supports the development of resources and programs that promote the recruitment and retention of qualified pharmacy technicians.
5. APhA supports the development of continuing pharmacy education programs that enhance and support the continued professional development of pharmacy technicians.
6. APhA encourages the development of compensation models for pharmacy technicians that promote sustainable career opportunities.

(JAPhA. 57(4):442; July/August 2017) (Reviewed 2021) (JAPhA 64(4);102117, July/August 2024)

2004, 1996

Technician Licensure and Registration

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.

(JAPhA. NS36(6):396; June 1996) (Reviewed 2001) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2008) (Reviewed 2010) (Reviewed 2015) (Reviewed 2018)

2003, 1997

Continued Competence Assessment Examination

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

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

1980

Reciprocity

APhA supports systems of reciprocity that recognize a current license issued by any state and eliminate the requirement for pharmacists to maintain active practice licenses in the states of initial licensure.

(Am Pharm. NS20(7):76; July 1980) (Reviewed 2004) (Reviewed 2010) (Reviewed 2015)

Licensure, Registration and Inspection of Facilities

2024, 2012

Registration of Facilities

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

(JAPhA. NS52(4):458; July/August 2012) (Reviewed 2017) (JAPhA 64(4);102117, July/August 2024)

2024, 1985

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

APhA supports enactment of laws, regulations, and policies that would require registration with the state boards of pharmacy of all facilities involved in the storage and issuing of legend drugs to patients, provided that such registration does not restrict the pharmacist from providing professional services independent of a facility.

(Am Pharm. NS25(5):51 May; 1985) (Reviewed 2004) (Reviewed 2010) (Reviewed 2012) (Reviewed 2013) (Reviewed 2018) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 1985

Regulation of Mobile Facilities

APhA supports enactment of laws, regulations and policies which would govern the dispensing and issuing of legend drugs from mobile facilities.

(Am Pharm. NS25(5):51; May 1985) (Reviewed 2004) (Reviewed 2010) (Reviewed 2015) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2012

Controlled Substances Regulation and Patient Care

1. APhA encourages the Drug Enforcement Administration (DEA) and other regulatory agencies to recognize pharmacists as partners that are committed to ensuring that patients in legitimate need of controlled substances are able to receive the medications.
2. APhA supports efforts to modernize and harmonize state and federal controlled substance laws.
3. APhA urges DEA and other regulatory agencies to balance patient care and regulatory issues when developing, interpreting, and enforcing laws and regulations.
4. APhA encourages DEA and other regulatory agencies to recognize the changes occurring in health care delivery and to establish a transparent and inclusive process for the timely updating of laws and regulations.
5. APhA encourages the U.S. Department of Justice to collaborate with professional organizations to identify and reduce
   (a) the burdens on health care providers,
   (b) the cost of health care delivery, and
   (c) the barriers to patient care in the establishment and enforcement of controlled substance laws.

(JAPhA. NS52(4):457; July/August 2012) (Reviewed 2015)

2011

Pharmacy Practice Accreditation

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

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

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) (Reviewed 2015)

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 compounding through the Board of Pharmaceutical Specialties (BPS).

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

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) (JAPhA. NS48(4):470; July/August 2008) (Reviewed 2013) (Reviewed 2018)

2004, 1977

Licensing Boards: Inspection of Pharmacies

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.

(JAPhA. NS17:456; July 1977) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2009) (Reviewed 2010) (Reviewed 2015)

2004, 1970

Licensure/Registration of Drug Manufacturers

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.
(JAPhA. NS10:347; June 1970) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2006) (Reviewed 2010) (Reviewed 2015) (Reviewed 2021)

2004, 1978

State Boards of Pharmacy/Inspections

1. APhA supports inspections of pharmacies and peer review of pharmacists that promote high-quality pharmaceutical service and thereby serve to improve public health.
2. APhA opposes the use of criminal investigative techniques during routine noncriminal pharmacy inspections.
3. APhA supports regulation and inspection by boards of pharmacy of all facilities within a state at which drugs are dispensed, stored, or offered for sale in the same manner as pharmacies.

(Am Pharm. NS18(8):36; July 1978) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2008) (Reviewed 2013) (Reviewed 2018)

Pharmacy Law and Practice Acts

2024, 2023

Access to Comprehensive Reproductive Health Care

1. APhA supports equitable patient access to evidence-based comprehensive reproductive health care, including, but not limited to, the management of pregnancy loss, ectopic pregnancy, infertility, pregnancy termination, contraception, and permanent contraception.
2. APhA recognizes patient autonomy in choosing reproductive health care services and the essential role of all health care professionals in facilitating access and advancing informed decision making.
3. APhA supports evidence-based laws, regulations, and policies that ensures patient access to comprehensive reproductive health care services.
4. APhA opposes legal actions against pharmacies, pharmacists, and pharmacy personnel that provide patient access to, or information regarding, reproductive health care services that are within pharmacist scope of practice.

(JAPhA. 63(4):1266; July/August 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2017, 2012

Contemporary Pharmacy Practice

1. APhA asserts that pharmacists should have the authority and support to practice to the full extent of their education, training, and experience in delivering patient care.
2. APhA opposes burdensome legal and regulatory requirements beyond continuing professional development for the provision of patient care services.
3. APhA supports continuing efforts toward establishing a consistent and accurate perception of the contemporary role and practice of pharmacists by the general public, patients, and all persons and institutions engaged in health care policy, administration, payment, and delivery.
4. APhA supports continued collaboration with stakeholders to facilitate adoption of standardized practice acts, appropriate related laws, regulations, and policies that reflect contemporary pharmacy practice.

5. APhA supports the establishment of multistate pharmacist licensure agreements to address the evolving needs of the pharmacy profession and pharmacist-provided patient care.
6. APhA urges the continued development of consensus documents, in collaboration with medical associations and other stakeholders, that recognize and support pharmacists' roles in patient care as health care providers.
7. APhA urges universal recognition of pharmacists as health care providers and compensation based on the level of patient care provided using standardized and future health care payment models.

(JAPhA. NS52(4):457; July/August 2012) (Reviewed 2016) (JAPhA. 57(4):441; July/August 2017) (Reviewed 2019) (Reviewed 2021) (Reviewed 2022) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2021

Continuity of Care and the Role of Pharmacists During Public Health and Other Emergencies

1. APhA asserts that pharmacists, student pharmacists, pharmacy technicians, and pharmacy support staff are essential members of the healthcare team and should be actively engaged and supported in surveillance, mitigation, preparedness, planning, response, recovery, and countermeasure activities related to public health and other emergencies.
2. APhA reaffirms the 2016 policy on the Role of the Pharmacist in National Defense, and calls for the active and coordinated engagement of all pharmacists in public health and other emergency planning and response activities.
3. APhA advocates for the timely removal of legal, regulatory, and policy restrictions; practice limitations; and financial barriers during public health and other emergencies to meet immediate patient care needs.
4. APhA urges regulatory bodies and government agencies to recognize pharmacists' training and ability to evaluate patient needs, provide care, and appropriately refer patients during public health and other emergencies.
5. APhA advocates for pharmacists' authority to ensure patient access to care through the prescribing, dispensing, and administering of medications, as well as provision of other patient care services during times of public health and other emergencies.
6. APhA calls for processes to ensure that any willing and able pharmacy and pharmacy practitioner is not excluded from providing pharmacist patient care services during public health and other emergencies.
7. APhA calls on public and private payers to establish and implement payment policies that compensate pharmacists providing patient care services, including during public health and other emergencies, within their recognized authority.
8. APhA advocates for the inclusion of pharmacists as essential members in the planning, development, and implementation of alternate care sites or delivery models during public health and other emergencies.
9. APhA reaffirms the 2015 Interoperability of Communications Among Health Care Providers to Improve Quality of Care and encourages pharmacists, as members of the healthcare team, to communicate care decisions made during public health and other emergencies with other members of the healthcare team to ensure continuity of care.

(JAPhA. 61(4):e15; July/August 2021) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2023

Just Culture Approach to Patient Safety

1. APhA calls for employers to adopt and implement just culture principles to improve patient safety and support pharmacy personnel.
2. APhA encourages transparency between employers and employees by sharing deidentified medication error and near-miss data and trends as well as actions taken to promote continuous quality improvement.
3. APhA urges the integration of non-disciplinary and non-punitive mechanisms for use by boards of pharmacy to promote just culture principles when addressing people, systems, and processes involved in medication errors.
4. APhA encourages national and state associations to advocate for laws, regulations, and policies to provide protections to individuals utilizing error reporting systems to promote just culture.
5. APhA encourages the creation of a mechanism for an industrywide effort to engage in confidential and transparent sharing of learnings and root cause findings helpful in reducing the risk of medication errors.
6. APhA supports the integration of just culture principles in PharmD and pharmacy technician education, postgraduate training, and continuing professional development programs.

(JAPhA. 63(4):1265; July/August 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2021

Multi-State Practice of Pharmacy

1. APhA affirms that pharmacists are trained to provide patient care, and have the ability to address patient needs, regardless of geographic location.
2. APhA advocates for the continued development of uniform laws, regulations and policies that facilitate pharmacists', student pharmacists', and pharmacy technicians' timely ability to practice in multiple states to meet practice and patient care needs.

3. APhA supports individual pharmacists' and student pharmacists' authority to provide patient care services across state lines whether in person or remotely.
4. APhA supports consistent and efficient centralized processes across all states for obtaining and maintaining pharmacist, pharmacy intern, and pharmacy technician licensure and/or registration.
5. APhA urges state boards of pharmacy to reduce administratively and financially burdensome requirements for licensure while continuing to uphold patient safety.
6. APhA encourages the evaluation of current law exam requirements for obtaining and maintaining initial state licensure, as well as licensure in additional states, to enhance uniformity and reduce duplicative requirements.
7. APhA urges state boards of pharmacy and the National Association of Boards of Pharmacy (NABP) to involve a member of the board of pharmacy and a practicing pharmacist in the review and updating of state jurisprudence licensing exam questions.
8. APhA calls for development of profession-wide consensus on licensing requirements for pharmacists and pharmacy personnel to support contemporary pharmacy practice.

(JAPhA. 61(4):e14-e15;July/August 2021) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024

Pharmacists Roles in Sexually Transmitted Infection Prevention and Treatment in Underserved Patients

1. APhA affirms that pharmacists play a vital role in improving outcomes in patients with or at risk of sexually transmitted infections.
2. APhA supports the pharmacist's role in the development of education and resources for individuals with Sexually Transmitted Infections (STIs), Expedited Partner Therapy (EPT), Pre-Exposure Prophylaxis (PrEP), and Post-Exposure Prophylaxis (PEP) in order to increase awareness and access.
3. APhA advocates for revision of state practice acts to permit pharmacists to independently prescribe for individuals with Sexually Transmitted Infections (STIs), Expedited Partner Therapy (EPT), Pre-Exposure Prophylaxis (PrEP), and Post-Exposure Prophylaxis (PEP) therapy.

(JAPhA 64(4);102117, July/August 2024)

2024, 2002

Professional Practice Regulation

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

(JAPhA. NS42(5)(suppl 1):S60; September/October 2002) (Reviewed 2007) (Reviewed 2008) (Reviewed 2011) (Reviewed 2016) (Reviewed 2021) (JAPhA 64(4);102117, July/August 2024)

2022

Standards of Care Regulatory Model for State Pharmacy Practice Acts

1. APhA requests that state boards of pharmacy and legislative bodies regulate pharmacy practice using a standard of care regulatory model similar to other health professions' regulatory models, thereby allowing pharmacists to practice at the level consistent with their individual education, training, experience, and practice setting.
2. To support implementation of a standard of care regulatory model, APhA reaffirms 2002 policy that encourages states to provide pharmacy boards with the following:
    (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 encourages NABP as well as state and national pharmacy associations to support and collaborate with state boards of pharmacy in adopting and implementing a standard of care regulatory model.
4. APhA and other pharmacy stakeholders should provide educational programs, information, and resources regarding the standard of care regulatory model and its impact on pharmacy practice.

(JAPhA. 62(4):941; July 2022)

2012

Controlled Substances Regulation and Patient Care

1. APhA encourages the Drug Enforcement Administration (DEA) and other regulatory agencies to recognize pharmacists as partners that are committed to ensuring that patients in legitimate need of controlled substances are able to receive the medications.
2. APhA supports efforts to modernize and harmonize state and federal controlled substance laws.
3. APhA urges DEA and other regulatory agencies to balance patient care and regulatory issues when developing, interpreting, and enforcing laws and regulations.
4. APhA encourages DEA and other regulatory agencies to recognize the changes occurring in health care delivery and to establish a transparent and inclusive process for the timely updating of laws and regulations.
5. APhA encourages the U.S. Department of Justice to collaborate with professional organizations to identify and reduce
   (a) the burdens on health care providers,
   (b) the cost of health care delivery, and
   (c) the barriers to patient care in the establishment and enforcement of controlled substance laws.

(JAPhA. NS52(4):457; July/August 2012) (Reviewed 2015)

2004,1991

Updating of State Pharmacy Practice Acts

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

(Am Pharm. NS31(6):28; June 1991) (JAPhA. NS44(5):(551; September/October 2004) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2022) (Reviewed 2023)

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 with
   (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.

(JAPhA. NS2(5)(suppl 1):563; September/October 2002) (Reviewed 2007) (Reviewed 2008) (Reviewed 2013) (Reviewed 2015) (Reviewed 2020) (Reviewed 2023)

MAIL SERVICE PRESCRIPTIONS

2012, 1992

Patient Care and Medication Distribution System

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

(Am Pharm. NS32(6):515; June 1992) (Reviewed 2001) (Reviewed 2007) (JAPhA. NS52(4):459; July/August 2012) (Reviewed 2017)

MEDICAL AND PHARMACEUTICAL EQUIPMENT AND PRODUCTS

2024, 2017

Support for Clinically Validated Blood Pressure Measurement Devices

1. APhA supports the use of manual and automated blood pressure measurement devices that are clinically validated initially and then undergo routine calibration to ensure accurate results.
2. APhA supports laws, regulations, policies, and peer-reviewed clinical validation testing for automated blood pressure measurement devices.
3. APhA promotes public awareness of accuracy of automated blood pressure measurement devices.

(JAPhA. 57(4):442; July/August 2017) (JAPhA 64(4);102117, July/August 2024)

2020

Digital Health Integration in Pharmacy

1. APhA supports education about digital health technologies and integration in pharmacy practice, in pharmacy school curricula, and for the pharmacy workforce.
2. APhA supports inclusion of pharmacists in the design and development of digital health technologies.
3. APhA supports that digital health technologies be interoperable with and integrated into pharmacy management systems and electronic health records.
4. APhA supports pharmacists applying digital health technologies to optimize patient care outcomes.

(JAPhA. 60(5):e11; September/October 2020)

2016

Labeling and Measurement of Oral Liquid Medications

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

(JAPhA. 56(4):369; July/August 2016)

2016

Point-of-Care Testing

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

(JAPhA. 56(4):369; July/August 2016) (Reviewed 2018) (Reviewed 2019) (Reviewed 2020) (Reviewed 2021)

2013, 2008

Re-Use of Devices Intended for "Single Use"

APhA opposes the reuse of devices intended for "single use" in the screening and management 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) (JAPhA. 53(4):366; July/August 2013) (Reviewed 2018)

2013, 2008, 1987

Sale of Home-Use Diagnostic and Monitoring Products

1. APhA supports the need to protect the health of the American people through proper instruction in the safe and effective use of the more complex home-use diagnostic and monitoring products.
2. APhA supports the promotion of the pharmacist as a widely available and qualified health care professional to advise patients in the use of home-use diagnostic and monitoring products.

(Am Pharm. NS27(6):424; June 1987) (Reviewed 2003) (JAPhA. NS48(4):470; July/August 2008) (JAPhA. 53(4):366; July/August 2013) (Reviewed 2016) (Reviewed 2017)

2001

Pharmacist Counseling on Administration Devices

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

(JAPhA. NS41(5)(suppl.1):S9; September/October 2001) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

2001

Syringe Disposal

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

(JAPhA. NS41(5)(suppl 1):S9; September/October 2001) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2020) (Reviewed 2023) (Reviewed 2024)

MINORITIES IN PHARMACY

2021

Diversity, Equity, Inclusion, and Belonging

1. APhA denounces all forms of racism.
2. APhA affirms that racism is a social determinant of health that contributes to persistent health inequities.
3. APhA urges the entire pharmacy community to actively work to dismantle racism.
4. APhA urges the integration of anti-racism education within pharmacy curricula, post-graduate training, and continuing education requirements.
5. APhA urges pharmacy leaders, decision-makers, and employers to create sustainable opportunities, incentives, and initiatives in education, research, and practice to address racism.
6. APhA urges pharmacy leaders, decision-makers, and employers to routinely and systematically evaluate organizational policies and programs for their impact on racial inequities.

(JAPhA. 61(4):e15; July/August 2021) (Reviewed 2023) (Review 2024)

2021

Social Determinants of Health

1. APhA supports the integration of social determinants of health screening as a vital component of pharmacy services.
2. APhA urges the integration of social determinants of health education within pharmacy curricula, post-graduate training, and continuing education requirements.
3. APhA supports incentivizing community engaged research, driven by meaningful partnerships and shared decision-making with community members.
4. APhA urges pharmacists to create opportunities for community engagement to best meet the needs of the patients they serve.
5. APhA encourages the integration of community health workers in pharmacy practice to provide culturally sensitive care, address health disparities, and promote health equity.

(JAPhA. 61(4):e16; July/August 2021) (Reviewed 2023) (Reviewed 2024)

2017, 2012, 1989

Equal Rights and Opportunities for Pharmacy Personnel

APhA reaffirms its unequivocal support of equal opportunities for employment and advancement, compensation, and organizational leadership positions. APhA opposes discrimination based on sex, gender identity or expression, race, color, religion, national origin, age, disability, genetic information, sexual orientation, or any other category protected by federal or state law.

(Am Pharm. NS 29(7):464; July 1989) (Reviewed 2001) (Reviewed 2007) (JAPhA. NS52(4):459; July/August 2012) (JAPhA. 57(4):441; July/August 2017) (Reviewed 2022) (Reviewed 2024)

2012, 1991

Recruitment of a Diverse Population into Pharmacy

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

(Am Pharm. NS31(6):28; June 1991) (Reviewed 2001) (Reviewed 2007) (JAPhA. NS52(4):459; July/August 2012)(Reviewed 2017) (Reviewed 2018) (Reviewed 2022)

1979

Consideration of the Equal Rights Amendment

APhA supports efforts to ensure equal rights of all persons.

(AmPharm. NS19(7):60; June 1979) (Reviewed 2009) (Reviewed 2014) (Reviewed 2018) (Reviewed 2022) (Reviewed 2024)

MISCELLANEOUS POLICIES

2021

Increasing Awareness and Accountability to End Harassment, Intimidation, Abuse of Power, Position or Authority in Pharmacy Practice

1. APhA calls on all national and state pharmacy organizations, colleges/schools of pharmacy, and other stakeholders to support the development of a profession-wide effort to address harassment, intimidation, and abuse of power or position.
2. APhA supports the development of a profession-wide guideline on reporting harassment, intimidation, or abuse of power or position in their pharmacy education and training, professional practice, or volunteer service to pharmacy organizations.
3. APhA recommends all pharmacy organizations incorporate harassment, intimidation, and abuse training in their member professional development and education activities.

(JAPhA. 61(4):e15-e16; July/August 2021) (Reviewed 2024)

2021

Social Determinants of Health

1. APhA supports the integration of social determinants of health screening as a vital component of pharmacy services.
2. APhA urges the integration of social determinants of health education within pharmacy curricula, post-graduate training, and continuing education requirements.
3. APhA supports incentivizing community engaged research, driven by meaningful partnerships and shared decision-making with community members.
4. APhA urges pharmacists to create opportunities for community engagement to best meet the needs of the patients they serve.
5. APhA encourages the integration of community health workers in pharmacy practice to provide culturally sensitive care, address health disparities, and promote health equity.

(JAPhA. 61(4):e16; July/August 2021) (Reviewed 2023) (Reviewed 2024)

2004, 1984

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.

(Am Pharm. NS24(7):61; July 1984) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015) (Reviewed 2023)

2004, 1986

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.

(Am Pharm. NS26(6):420; June 1986) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015)

1979

Child Abuse Reporting

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

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

NEW DRUG APPLICATIONS AND INVESTIGATIONAL NEW DRUGS

Investigational New Drugs

2019, 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) (Reviewed 2015) (JAPhA. 59(4):e17; July/August 2019) (Reviewed 2023)

2004, 1980

Therapeutic Orphans

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) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015)

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) (Reviewed 2015)

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) (Reviewed 2015) (Reviewed 2023)

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) (Reviewe4d 2004) (Reviewed 2010) (Reviewed 2015) (Reviewed 2023)

ORPHAN DRUGS

2004, 1981

Needed Drugs of Limited Commercial Value (Orphan Drugs)

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.

(Am Pharm. NS21(5):41; May 1981) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015)

PATIENT/PHARMACIST RELATIONSHIPS

2024, 2001

Administrative Contributions to Medication Errors

1. APhA encourages implementation of a standard pharmacy benefit 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 clear communication during the pharmacy claims adjudication process. APhA supports the communication of all plan management options available 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 online claims processing systems to eliminate redundant and/or repetitive messages.
7. APhA encourages the transmission of pre-adjudication drug utilization review messages (i.e., drug utilization review communication between the prescriber and claims processor) to the pharmacist.
8. APhA supports efforts to:
   (a) improve on-line drug utilization review messages by the establishment of evidence-based criteria to prevent drug-related conflicts that have the potential for causing serious harm; and
   (b) eliminate drug utilization review messages that have questionable or inconsequential impact on patient outcomes.

(JAPhA. NS4(5)(suppl 1):57; September/October 2001) (Reviewed 2003) (Reviewed 2007) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019) (JAPhA 64(4);102117, July/August 2024)

2024, 2000

Medication Errors

1. APhA will work to ensure 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. APhA supports identifying the system-based causes of errors and building systems to support safe medication practice.

(JAPhA. NS(9):40; September/October 2000) (Reviewed 2007) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019) (JAPhA 64(4);102117, July/August 2024)

2022

Data to Advance Health Equity

APhA urges pharmacists to use patient-specific data and social determinants of health to address health inequities and drive decision-making in practice and advocacy.

(JAPhA. 62(4):941; July 2022) (Reviewed 2024)

2022

Data Use and Access Rights in Pharmacy Practice

1. APhA supports organization and patient care provider rights to use patient data for improvement of patient and public health outcomes and enhancement of patient care delivery processes in accordance with ethical practices and industry standards regarding data privacy and transparency.

2. APhA urges ongoing transparent, accessible, and comprehensible disclosure to patients by all HIPAA-covered and noncovered entities as to how personally identifiable information may be utilized.
3. APhA calls for all entities with access to patient health data, including those with digital applications, to be required to adhere to established standards for patient data use.
4. APhA supports the right of patients to have full and timely access to their personal health data from all entities.

(JAPhA. 62(4):941; July 2022) (Reviewed 2023)

2022, 2014

Use of Social Media

1. APhA encourages the use of social media in ways that advance patient care and uphold pharmacists as trusted and accessible health care providers.
2. APhA supports the use of social media as a mechanism for the delivery of patient-specific care in a platform that allows for appropriate patient and provider protections and access to necessary health care information.
3. APhA supports the inclusion of social media education, including but not limited to appropriate use and professionalism, as a component of pharmacy education and continuing professional development.
4. APhA affirms that the patient's right to privacy and confidentiality shall not be compromised through the use of social media.
5. APhA urges pharmacists, pharmacy technicians and student pharmacists to self-monitor their social media presence for professionalism and that posted clinical information is accurate and appropriate.
6. APhA advocates for continued development and utilization of social media by pharmacists and other health care professionals during public health emergencies.

(JAPhA. 54(4):357; July/August 2014) (Reviewed 2019)(Amended 2022)

2021

People First Language

APhA encourages the use of people first language in all written and oral forms of communication.

(JAPhA. 61(4):e15; July/August 2021) (Reviewed 2023) (Reviewed 2024)

2021

Social Determinants of Health

1. APhA supports the integration of social determinants of health screening as a vital component of pharmacy services.
2. APhA urges the integration of social determinants of health education within pharmacy curricula, post-graduate training, and continuing education requirements.
3. APhA supports incentivizing community engaged research, driven by meaningful partnerships and shared decision-making with community members.
4. APhA urges pharmacists to create opportunities for community engagement to best meet the needs of the patients they serve.
5. APhA encourages the integration of community health workers in pharmacy practice to provide culturally sensitive care, address health disparities, and promote health equity.

(JAPhA. 61(4):e16; July/August 2021) (Reviewed 2023) (Reviewed 2024)

2018

Use of Genomic Data Within Pharmacy Practice

1. APhA emphasizes genomics as an essential aspect of pharmacy practice.
2. APhA recognizes pharmacists as the health care professional best suited to provide medication-related consults and services based on a patient's genomic information. All pharmacists involved in the care of the patient should have access to relevant genomic information.
3. APhA supports processes to protect patient data confidentiality and opposes unethical utilization of genomic data.
4. APhA demands payers include pharmacists as eligible providers for covered genomic interpretation and related services to support sustainable models that optimize patient care and outcomes.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the exchange, storage, utilization, and documentation of clinically actionable genetic variations and actions taken by the pharmacist in the provision of patient care.
6. APhA recommends pharmacists and pharmaceutical scientists lead the collaborative development of evidence-based practice guidelines for pharmacogenomics and related services.
7. APhA recommends the inclusion of pharmacists and pharmaceutical scientists in the collaborative development of pharmacogenomics clinical support tools and resources.

8. APhA encourages pharmacists to use their professional judgment and published guidelines and resources when providing access to testing or utilizing direct-to-consumer genomic test results in their patient care services.
9. APhA urges schools and colleges of pharmacy to include clinical application of genomics as a required element of the Doctor of Pharmacy curriculum.
10. APhA encourages the creation of continuing professional development and post-graduate education and training programs for pharmacists in genomics and its clinical application to meet varying practice needs.
11. APhA encourages the funding of pharmacist-led research examining the cost effectiveness of care models that utilize pharmacists providing genomic services.

(JAPhA. 58(4):355; July/August 2018) (Reviewed 2023)

2016

Point-of-Care Testing

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

(JAPhA. 56(4):369; July/August 2016) (Reviewed 2018) (Reviewed 2019) (Reviewed 2020) (Reviewed 2021)

2014

Care Transitions

1. APhA supports pharmacists leading medication management activities during care transitions to ensure safe and effective medication use.
2. APhA supports the integral role of pharmacists during care transitions for improving quality of patient-centered care and reducing overall costs to the health care system.
3. APhA strongly encourages collaboration and shared accountability among patients, family members, caregivers, pharmacists, and other health care providers during care transitions.
4. APhA supports the development and utilization of standardized processes that facilitate real-time, bidirectional communication of protected health information during care transitions.
5. APhA supports that documentation of health outcomes is an essential component of any care transition program to demonstrate value and ensure continuous quality improvement.
6. APhA supports financially viable payment models that recognize the value of pharmacists' services, including, but not limited to, those provided during care transitions.
7. APhA strongly urges the development and implementation of multidisciplinary, interprofessional, and team-based training for health care professionals and students to improve the quality and consistency of care transition services.
8. APhA urges the collaboration and partnership of community pharmacies with health care systems, institutions, and other entities involved in care transitions.

(JAPhA. 54(4):357; July/August 2014) (Reviewed 2019) (Reviewed 2023)

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) (Reviewed 2015)

2009

Disparities in Health Care

APhA supports elimination of disparities in health care delivery.

(JAPhA. NS49(4):493; July/August 2009) (Reviewed 2013) (Reviewed 2018) (Reviewed 2020) (Reviewed 2022) (Reviewed 2024)

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) (Reviewed 2014) (Reviewed 2019) (Reviewed 2022)

2005

Cultural Competence

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

(JAPhA. NS45(5):554; September/October 2005) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016) (Reviewed 2022)

2005, 2002

Health Literacy

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.

(JAPhA. NS42(5)(suppl 1):S60; September/October 2002) (JAPhA. NS45(5):556; September/October 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

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.

(JAPhA. NS45(5):554; September/October 2005) (Reviewed 2009) (Reviewed 2011) (Reviewed 2016) (Reviewed 2019) (Reviewed 2020) (Reviewed 2023)

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 that 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 payer 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.

(JAPhA. NS43(5)(suppl 1):S58; September/October 2003) (Reviewed 2008) (Reviewed 2013) (Reviewed 2015) (Reviewed 2023)

2002, 1991, 1977

Pharmacist/Patient Communication

1. APhA acknowledges the following:
   (a) Patients have the right to be informed participants in decisions related to their personal health care.
   (b) Pharmacists have a professional obligation to contribute to the education of patients to help achieve optimal drug therapy.

(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.

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.
3. APhA encourages the research and development of ancillary communication aids and techniques to maximize patient understanding of medication and its proper use.

(JAPhA. NS17:464; July 1977) (Am Pharm. NS3(16):28; June 1991) (JAPhA. NS2(5)(suppl 1):563; September/October 2002) (Reviewed 2006) (Reviewed 2010) (Reviewed 2015) (Reviewed 2019)

1995

Continuum of Patient Care

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

(Am Pharm. NS35(6):36 June; 1995) (Reviewed 2004) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016) (Reviewed 2019) (Reviewed 2023)

1991

Biotechnology

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

(Am Pharm. NS31(6):29; June 1991) (Reviewed 2004) (Reviewed 2007) (Reviewed 2010) (Reviewed 2015)(Reviewed 2016) (Reviewed 2017)

1987

Cost Effectiveness of Drug Products and Pharmacy Services

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

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

1971

Communications with Patients: Drug Delivery Practice

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

(JAPhA. NS11:272; May 1971) (Reviewed 2001) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

PHARMACEUTICAL CARE

2024, 2022

Pharmacists' Application of Professional Judgment

1. APhA supports pharmacists, as licensed health care professionals, in their use of professional judgment throughout the course of their practice to act in the best interest of patients.
2. APhA asserts that a pharmacist's independent medication review and use of professional judgment in the medication distribution process is essential to patient safety.
3. APhA opposes laws, regulations, and policies that limit a pharmacist's responsibility to exercise professional judgment in the best interest of patients.
4. APhA calls for civil, criminal, and professional liability protections for pharmacists and pharmacies if the pharmacist's responsibility to use professional judgment is limited by laws, regulations, and policies.

(JAPhA. 62(4):942; July 2022) (JAPhA 64(4);102117, July/August 2024)

2024, 2012, 2003

The Pharmacist's Role in Laboratory Monitoring and Health Screening

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

(JAPhA. NS43(5)(suppl 1):S58; September/October 2003) (Reviewed 2007) (Reviewed 2009) (Reviewed 2010) (JAPhA. NS52(4):460; July/August 2012) (Reviewed 2013) (Reviewing 2016) (Reviewed 2017) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2022, 2008

Billing and Documentation of Medication Therapy Management (MTM) Services

1. APhA encourages the development and use of a system for billing of medication therapy management (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 health care providers, and
(c) utilizes a billing platform that is accepted by the Centers for Medicare and Medicaid Services (CMS) and is compliant with the Health Insurance Portability and Accountability Act (HIPAA).

2. APhA supports the pharmacist's or pharmacy's choice of a documentation system that allows for transmission of any MTM billing claim and interfaces with the billing platform used by the insurer or payer.
3. APhA encourages pharmacists to use the American Medical Association (AMA) Current Procedural Terminology (CPT) codes for billing of MTM services.
4. APhA supports efforts to further develop CPT codes for billing of pharmacists' services, through the work of the Pharmacist Services Technical Advisory Coalition (PSTAC) and Pharmacy e-HIT Collaborative.

(JAPhA. NS48(4):471; July/August 2008) (Reviewed 2010) (Reviewed 2015) (Reviewed 2016) (Amended 2022)

2020

Accountability of Pharmacists

1. APhA affirms pharmacists' professional accountability within their role in all practice settings.
2. APhA advocates that pharmacists be granted and accept authority, autonomy, and accountability for patient-centric actions to improve health and medication outcomes, in coordination with other health professionals, as appropriate.
3. APhA reaffirms 2017 Pharmacists' Role Within Value-based Payment Models and supports continued expansion of interprofessional patient care models that leverage pharmacists as accountable members of the health care team.
4. APhA advocates for sustainable payment and attribution models to support pharmacists as accountable patient care providers.
5. APhA supports continued expansion of resources and health information infrastructures that empower pharmacists as accountable health care providers.
6. APhA supports the enhancement of comprehensive and affordable professional liability insurance coverage that aligns with evolving pharmacist accountability and responsibility.

(JAPhA. 60(5):e9; September/October 2020) (Reviewed 2023)

2019, 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) (Reviewed 2015) (JAPhA. 59(4):e17; July/August 2019) (Reviewed 2023)

2016

Point-of-Care Testing

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

(JAPhA. 56(4):369; July/August 2016) (Reviewed 2018) (Reviewed 2019) (Reviewed 2020) (Reviewed 2021)

2013

Ensuring Access to Pharmacists' Services

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

(JAPhA. 53(4):365; July/August 2013) (Reviewed 2018) (Reviewed 2019) (Reviewed 2021) (Reviewed 2024)

2013, 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 pharmacists' patient 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 (PBRNs).

(JAPhA. NS48(4):471; July/August 2008) (JAPhA. 53(4): 366; July/August 2013) (Reviewed 2018)

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) (Reviewed 2016) (Reviewed 2021) (Reviewed 2023)

1989

Pharmacy-Based Screening and Monitoring Services

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

(Am Pharm. NS29(7):463; July 1989) (Reviewed 2006) (Reviewed 2007) (Reviewed 2012) (Reviewed 2013) (Reviewed 2017)

PHARMACY CRIME AND SECURITY

2024, 2019

Creating Safe Work and Learning Environments for Student Pharmacists, Pharmacists, and Pharmacy Technicians

1. APhA strongly believes that all pharmacists, student pharmacists, and pharmacy technicians should be safe in their work and learning environments and be free from firearm-related violence.
2. APhA strongly recommends that technician training programs, schools and colleges of pharmacy, postgraduate training programs, and employers should develop programs to increase readiness in the event of an active shooter.
3. APhA strongly believes pharmacists, student pharmacists, and pharmacy technicians should be trained to recognize and refer patients at high risk of violence to themselves or others.
4. APhA encourages pharmacists, student pharmacists, and pharmacy technicians who are survivors of firearm-related violence to seek the help of counselors and other trained mental health professionals.

(JAPhA. 59(4):e17; July/August 2019) (JAPhA 64(4);102117, July/August 2024)

2024, 2019

Pharmacist and Pharmacy Personnel Safety and Well-Being

1. APhA calls for employers to develop policies and procedures to support pharmacy personnel's ability to retreat or withdraw, without retaliation, from interactions that threaten their safety and well-being.
2. APhA encourages the development or utilization of educational programs and resources by the Association, employers, and other institutions to prepare pharmacy personnel to respond to situations that threaten their safety and well-being.

(JAPhA. 59(4):e17; July/August 2019) (Reviewed 2021) (Reviewed 2024) (JAPhA 64(4);102117, July/August 2024)

2024, 1971

Prescription Department Security

The committee recommends that APhA support laws, regulations, and policies to require that a prescription department must be secured whenever the pharmacist or persons authorized by the pharmacist are not present.

(JAPhA. NS11:267; May 1971) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016) (JAPhA 64(4);102117, July/August 2024)

2024, 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 legal, regulatory, and policy 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 websites personal addresses, phone numbers, email, and other non-business contact information of pharmacists, student pharmacists, and pharmacy technicians.

(JAPhA. NS45(5):580; September-October 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2022

Data Security in Pharmacy Practice

1. APhA advocates that all organizations and healthcare providers adopt best practices in data security to ensure ongoing protection of patient data from loss, alteration, and all forms of cybercrime.

2. APhA recommends that organizations understand the flow of information, both internally and externally, to apply and maintain reasonable and appropriate administrative, technical, and physical safeguards to protect the privacy and identity of their patients.
3. APhA calls on organizations to provide ongoing employee education and training regarding patient data protection, best practices, and cybersecurity standards.

(JAPhA. 62(4):941; July 2022) (Reviewed 2023)

2003, 1971

Security: Pharmacists' Responsibility

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

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

1982

Innovative Approaches to Combating 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).
3. APhA encourages pharmaceutical associations to work with state legislators in an effort to provide mandatory imprisonment for the theft of controlled substances and the restriction of bail for such crimes.

(Am Pharm. NS22(7):32 July; 1982) (Reviewed 2003) (Reviewed 2004) (Reviewed 2006) (Reviewed 2010) (Reviewed 2015)

PHARMACY PRACTICE

2024, 2023

Access to Comprehensive Reproductive Health Care

1. APhA supports equitable patient access to evidence-based comprehensive reproductive health care, including, but not limited to, the management of pregnancy loss, ectopic pregnancy, infertility, pregnancy termination, contraception, and permanent contraception.
2. APhA recognizes patient autonomy in choosing reproductive health care services and the essential role of all health care professionals in facilitating access and advancing informed decision making.
3. APhA supports evidence-based laws, regulations, and policies that ensures patient access to comprehensive reproductive health care services.
4. APhA opposes legal actions against pharmacies, pharmacists, and pharmacy personnel that provide patient access to, or information regarding, reproductive health care services that are within pharmacist scope of practice.

(JAPhA. 63(4):1266; July/August 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2023

Access to Essential Medicines

APhA advocates for laws, regulations, and policies that recognize access to quality and affordable essential medicines as a fundamental human right.

(JAPhA. 63(4):1266; July/August 2023) (JAPhA 64(4);102117, July/August 2024)

2024

Access to Radiopharmaceuticals

APhA advocates for policy and legislation laws, regulations, and policies that increase patient access to radiopharmaceuticals.

(JAPhA 64(4);102117, July/August 2024)

2024, 2001

Administrative Contributions to Medication Errors

1. APhA encourages implementation of a standard pharmacy benefit 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 clear communication during the pharmacy claims adjudication process. APhA supports the communication of all plan management options available 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 online claims processing systems to eliminate redundant and/or repetitive messages.
7. APhA encourages the transmission of pre-adjudication drug utilization review messages (i.e., drug utilization review communication between the prescriber and claims processor) to the pharmacist.
8. APhA supports efforts to:

(a) improve on-line drug utilization review messages by the establishment of evidence-based criteria to prevent drug-related conflicts that have the potential for causing serious harm; and

(b) eliminate drug utilization review messages that have questionable or inconsequential impact on patient outcomes.

(JAPhA. NS4(5)(suppl 1):57; September/October 2001) (Reviewed 2003) (Reviewed 2007) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019) (JAPhA 64(4);102117, July/August 2024)

2024

Artificial Intelligence Use in Pharmacy Practice

1. APhA opposes the replacement of a pharmacist's professional judgment or patient's access to their pharmacist with artificial intelligence.
2. APhA calls on the profession of pharmacy and all related organizations to proactively assess and respond to the evolving role of artificial intelligence in pharmacy practice and workforce dynamics.
3. APhA encourages judicious use of artificial intelligence by pharmacists and pharmacy personnel as a tool to elevate pharmacy practice and enhance patient care.
4. APhA advocates for the integration of pharmacists into the development, design, validation, implementation, and maintenance of artificial intelligence solutions.
5. APhA calls on regulatory bodies, employers, and other relevant parties to develop laws, regulations, and policies as applicable for artificial intelligence to ensure patient safety, privacy, public awareness, and public protection.
6. APhA calls on those providing artificial intelligence solutions to implement processes that identify and mitigate bias and misinformation in artificial intelligence.
7. APhA advocates for education providers to facilitate, and pharmacy personnel to seek out, education and training on the lawful, ethical, and clinical use of artificial intelligence.

(JAPhA 64(4);102117, July/August 2024)

2024, 2019, 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 supports the establishment of collaborative practice agreements between one or multiple pharmacists and one or multiple prescribers or entities.
3. APhA supports state laws, regulations, and policies that do not require a referral or a prior provider–patient relationship as a prerequisite to access services provided under a collaborative practice agreement.
4. APhA opposes state laws, regulations, and policies that limit collaborative practice agreements to specific patients.
5. APhA supports state laws, regulations, and policies that allow for pharmacists' prescriptive authority.
6. APhA supports state collaborative practice laws, regulations, and policies that allow all licensed pharmacists, in all practice settings, to establish collaborative practice agreements with other health care professionals or entities.
7. APhA shall promote the establishment and dissemination of guidelines and information to pharmacists and other health care professionals to facilitate the development of collaborative practice agreements.

(JAPhA. NS37(4):459; July/August 1997) (Reviewed 2003) (Reviewed 2007) (Reviewed 2009) (Reviewed 2011) (Reviewed 2012) (Reviewed 2017) (JAPhA. 59(4):e17; July/August 2019) (Reviewed 2020) (JAPhA 64(4);102117, July/August 2024)

2024, 2020

Community-Based Pharmacists as Providers of Care

1. APhA advocates for the identification of medical conditions that may be safely and effectively treated by community-based pharmacists.
2. APhA encourages the training and education of pharmacists and student pharmacists regarding identification, treatment, monitoring, documentation, follow-up, and referral for medical conditions treated by community-based pharmacists
3. APhA advocates for laws, regulations, and policies that allow pharmacists to identify and manage medical conditions treated by community-based pharmacists.
4. APhA advocates for appropriate remuneration for the assessment and treatment of medical conditions treated by community-based pharmacists from government and private payers to ensure sustainability and access for patients.
5. APhA supports research to examine the outcomes of services that focus on medical conditions treated by community-based pharmacists.

(JAPhA. 60(5):e10; September/October 2020) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2021

Continuity of Care and the Role of Pharmacists During Public Health and Other Emergencies

1. APhA asserts that pharmacists, student pharmacists, pharmacy technicians, and pharmacy support staff are essential members of the healthcare team and should be actively engaged and supported in surveillance, mitigation, preparedness, planning, response, recovery, and countermeasure activities related to public health and other emergencies.
2. APhA reaffirms the 2016 policy on the Role of the Pharmacist in National Defense, and calls for the active and coordinated engagement of all pharmacists in public health and other emergency planning and response activities.
3. APhA advocates for the timely removal of legal, regulatory, and policy restrictions; practice limitations; and financial barriers during public health and other emergencies to meet immediate patient care needs.
4. APhA urges regulatory bodies and government agencies to recognize pharmacists' training and ability to evaluate patient needs, provide care, and appropriately refer patients during public health and other emergencies.
5. APhA advocates for pharmacists' authority to ensure patient access to care through the prescribing, dispensing, and administering of medications, as well as provision of other patient care services during times of public health and other emergencies.
6. APhA calls for processes to ensure that any willing and able pharmacy and pharmacy practitioner is not excluded from providing pharmacist patient care services during public health and other emergencies.
7. APhA calls on public and private payers to establish and implement payment policies that compensate pharmacists providing patient care services, including during public health and other emergencies, within their recognized authority.
8. APhA advocates for the inclusion of pharmacists as essential members in the planning, development, and implementation of alternate care sites or delivery models during public health and other emergencies.
9. APhA reaffirms the 2015 Interoperability of Communications Among Health Care Providers to Improve Quality of Care and encourages pharmacists, as members of the healthcare team, to communicate care decisions made during public health and other emergencies with other members of the healthcare team to ensure continuity of care.

(JAPhA. 61(4):e15; July/August 2021) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2014

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

1. APhA supports education for pharmacists and student pharmacists to address issues of pain management, palliative care, appropriate use of opioid reversal agents in opioid-associated emergencies, drug diversion, and substance use disorders.
2. APhA supports recognition of pharmacists as the health care providers who must exercise professional judgment in the assessment of a patient's conditions to fulfill corresponding responsibility for the use of controlled substances and other medications with the potential for misuse and/or diversion.
3. APhA supports pharmacists' access to and use of prescription monitoring programs to identify and prevent drug misuse and/or diversion.
4. APhA supports the development and implementation of state and federal laws, regulations, and policies that permit pharmacists to independently prescribe opioid reversal agents to prevent deaths due to opioid-associated emetgencies.
5. APhA supports the pharmacist's role in selecting appropriate therapy and dosing and initiating and providing education about the proper use of opioid reversal agents to prevent deaths due to opioid-associated emergencies.

(JAPhA. 54(4):358; July/August 2014) (Reviewed 2015)(Reviewed 2018) (Reviewed 2021) (Reviewed 2022) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2012

Drug Supply Shortages and Patient Care

1. APhA supports the immediate reporting by manufacturers to the U.S. Food and Drug Administration (FDA) of disruptions that may impact the market supply of medically necessary drug products to prevent, mitigate, or resolve drug shortage issues and supports the authority for FDA to impose penalties for failing to report.
2. APhA supports revising current laws, regulations, and policies that restrict the FDA's ability to provide timely communication to pharmacists, other health care providers, health systems, and professional associations regarding potential or real drug shortages.
3. APhA encourages the FDA, the Drug Enforcement Administration (DEA), and other stakeholders to collaborate in order to minimize barriers (e.g., aggregate production quotas, annual assessment of needs, unapproved drug initiatives) that contribute to or exacerbate drug shortages.
4. APhA should actively support legislation to hasten the development of an efficient regulatory process to approve therapeutically equivalent generic versions of biologic drug products.
5. APhA encourages pharmacists and other health care providers to assist in maintaining continuity of care during drug shortage situations by
   (a) creating a practice site drug shortage plan as well as policies and procedures;
   (b) using reputable drug shortage management and information resources in decision making;
   (c) communicating with patients and coordinating with other health care providers;
   (d) avoiding excessive ordering and stockpiling of drugs;
   (e) acquiring drugs from reputable distributors; and
   (f) heightening their awareness of the potential for counterfeit or adulterated drugs entering the drug distribution system.
6. APhA encourages accrediting and regulatory agencies and the pharmaceutical science and manufacturing communities to evaluate policies/procedures related to the establishment and use of drug expiration dates and any impact those policies/procedures may have on drug shortages.
7. APhA encourages the active investigation and appropriate prosecution of entities that engage in price gouging and profiteering of medically necessary drug products in response to drug shortages.

(JAPhA. NS52(4): 457; July/August 2012) (Reviewed 2017) (Reviewed 2021) (JAPhA 64(4);102117, July/August 2024)

2024, 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 patients or caregivers 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.

(Am Pharm. NS28(6):394; June 1988) (Reviewed 2004) (Reviewed 2010) (Reviewed 2015) (JAPhA 64(4);102117, July/August 2024)

2024, 2018

Efforts to Reduce the Stigma Associated with Mental Health Disorders or Diseases

1. APhA encourages all stakeholders to develop and adopt evidence-based approaches to educate the public and all health care professionals to reduce the stigma associated with mental health diagnoses.
2. APhA supports the increased utilization of pharmacists and student pharmacists with appropriate training to actively participate in the care of patients with mental health conditions as members of interprofessional health care teams in all practice settings.
3. APhA supports the expansion of mental health education and training in the curriculum of all schools and colleges of pharmacy, post-graduate training, and within continuing professional development programs.
4. APhA supports the development of education and resources to address health care professional resiliency and burnout.

(JAPhA. 58(4):356; July/August 2018) (JAPhA 64(4);102117, July/August 2024)

2024, 2020, 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.
5. APhA supports laws, regulations, and policies that require e-prescribing of controlled substances to reduce fraudulent prescriptions.

(JAPhA. NS40(4):471; July/August 2010) (Reviewed 2012) (Reviewed 2014) (Reviewed 2015) (JAPhA. 60:(5):e10); September/October 2020) (JAPhA 64(4);102117, July/August 2024)

2024, 2013, 2009

Independent Practice of Pharmacists

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

(JAPhA. NS49(4):492; July/August 2009) (Reviewed 2012) (JAPhA. 53(4):366; July/August 2013) (Reviewed 2018) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2020, 2015

Integrated Nationwide Prescribing Drug Monitoring Program

1. APhA advocates for nationwide integration and uniformity of prescription drug monitoring programs (PDMP) that incorporate federal, state, and territory databases for the purpose of providing health care professionals with accurate and real-time information to assist in clinical decision making when providing patient care services related to controlled substances.
2. APhA supports pharmacist involvement in the development of uniform standards for an integrated nationwide prescription drug monitoring program (PDMP) that includes the definition of authorized registered users, documentation, reporting requirements, system response time, security of information, minimum reporting data sets, and standard transaction format.
3. APhA supports mandatory prescription drug monitoring program (PDMP) enrollment by all health care providers, mandatory reporting by all those who dispense controlled substances, and appropriate system query by registrants during the patient care process related to controlled substances.
4. APhA advocates for the development of seamless workflow integration systems that would enable consistent use of a nationwide prescription drug monitoring program (PDMP) by registrants to facilitate prospective drug review as part of the patient care process related to controlled substances.
5. APhA advocates for continuous, sustainable federal funding sources for practitioners and system operators to utilize and maintain a standardized integrated and real-time nationwide prescription drug monitoring program (PDMP).
6. APhA supports the use of interprofessional advisory boards that include pharmacists to coordinate collaborative efforts for
   (a) compiling, analyzing, and using prescription drug monitoring program (PDMP) data trends to identify misuse of controlled substances and/or fraud;
   (b) providing focused provider education and patient referral to treatment programs; and
   (c) supporting research activities on the impact of PDMPs.
7. APhA supports education and training for registrants about a nationwide prescription drug monitoring program (PDMP) to ensure proper data integrity, use, and confidentiality.

(JAPhA. N55(4):364-365; July/August 2015) (JAPhA. 60(5):e10; September/October 2020) (JAPhA 64(4);102117, July/August 2024)

2024, 2023

Just Culture Approach to Patient Safety

1. APhA calls for employers to adopt and implement just culture principles to improve patient safety and support pharmacy personnel.
2. APhA encourages transparency between employers and employees by sharing deidentified medication error and near-miss data and trends as well as actions taken to promote continuous quality improvement.

3. APhA urges the integration of non-disciplinary and non-punitive mechanisms for use by boards of pharmacy to promote just culture principles when addressing people, systems, and processes involved in medication errors.
4. APhA encourages national and state associations to advocate for laws, regulations, and policies to provide protections to individuals utilizing error reporting systems to promote just culture.
5. APhA encourages the creation of a mechanism for an industrywide effort to engage in confidential and transparent sharing of learnings and root cause findings helpful in reducing the risk of medication errors.
6. APhA supports the integration of just culture principles in PharmD and pharmacy technician education, postgraduate training, and continuing professional development programs.

(JAPhA. 63(4):1265; July/August 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2013

Medication Take-Back/Disposal Programs

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

(JAPhA. 53(4):365; July/August 2013) (Reviewed 2018) (JAPhA 64(4);102117, July/August 2024)

2024, 2021

Multi-State Practice of Pharmacy

1. APhA affirms that pharmacists are trained to provide patient care, and have the ability to address patient needs, regardless of geographic location.
2. APhA advocates for the continued development of uniform laws, regulations and policies that facilitate pharmacists', student pharmacists', and pharmacy technicians' timely ability to practice in multiple states to meet practice and patient care needs.
3. APhA supports individual pharmacists' and student pharmacists' authority to provide patient care services across state lines whether in person or remotely.
4. APhA supports consistent and efficient centralized processes across all states for obtaining and maintaining pharmacist, pharmacy intern, and pharmacy technician licensure and/or registration.
5. APhA urges state boards of pharmacy to reduce administratively and financially burdensome requirements for licensure while continuing to uphold patient safety.
6. APhA encourages the evaluation of current law exam requirements for obtaining and maintaining initial state licensure, as well as licensure in additional states, to enhance uniformity and reduce duplicative requirements.
7. APhA urges state boards of pharmacy and the National Association of Boards of Pharmacy (NABP) to involve a member of the board of pharmacy and a practicing pharmacist in the review and updating of state jurisprudence licensing exam questions.
8. APhA calls for development of profession-wide consensus on licensing requirements for pharmacists and pharmacy personnel to support contemporary pharmacy practice.

(JAPhA. 61(4):e14-e15;July/August 2021) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2020

Non-execution-Related Use of Pharmaceuticals in Correctional Facilities

1. APhA opposes drug manufacturers' refusal to supply certain drugs to correctional health services units necessary to provide medical treatment of those who are incarcerated.
2. APhA advocates for those who are incarcerated to have an opportunity, equal to that of nonmates, to access medications that correctional healthcare providers deem medically necessary for appropriate and humane health care treatment.
3. APhA advocates for correctional healthcare providers to have opportunity, equal to that of non-correctional healthcare providers, to access, prescribe, and procure pharmaceuticals deemed necessary for medical treatment of those incarcerated.

(JAPhA. 60(5):e11; September/October 2020) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2009

Non-FDA-Approved Drugs and Patient Safety

1. APhA calls for education and collaboration among health professional organizations, federal agencies, and other stakeholders to ensure that all manufacturer, distributor, and repackaged marketed prescription drugs used in patient care have been FDA-approved as safe and effective.
2. APhA supports initiatives aimed at closing legislative, regulatory, policy 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) (Reviewed 2014) (Reviewed 2019) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2019

Patient-Centered Care of People Who Use Non-Medically Sanctioned Psychotropic or Psychoactive Substances

1. APhA encourages state legislatures and boards of pharmacy to revise laws, regulations, and policies to support the patient-centered care of people who use non-medically sanctioned psychotropic or psychoactive substances.
2. To reduce the consequences of stigma associated with drug use, APhA supports the expansion of interprofessional harm reduction education in the curriculum of schools and colleges of pharmacy, postgraduate training, and continuing professional development programs.
3. APhA encourages pharmacists to initiate, sustain, and integrate evidence-based harm reduction principles and programs into their practice to optimize the health of people who use non-medically sanctioned psychotropic or psychoactive substances.
4. APhA supports pharmacists' roles to provide and promote consistent, unrestricted, and immediate access to evidence-based, mortality- and morbidity-reducing interventions to enhance the health of people who inject nonmedically sanctioned psychotropic or psychoactive substances and their communities, including sterile syringes, needles, and other safe injection equipment, syringe disposal, fentanyl test strips, immunizations, condoms, wound care supplies, pre- and post-exposure prophylaxis medications for human immunodeficiency virus (HIV), point-of-care testing for HIV and hepatitis C virus (HCV), opioid reversal agents, and medications for opioid use disorder.
5. APhA urges pharmacists to refer people who use non-medically sanctioned psychotropic or psychoactive substances to specialists in mental health, infectious diseases, and substance use disorder treatment; to housing, vocational, harm reduction, and recovery support services; and to safe consumption facilities and syringe service programs.

(JAPhA. 59(4):e17; July/August 2019) (Reviewed 2021) (Reviewed 2022) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2005, 2003, 1996

Pharmacist's Role in Immunizations

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) administering vaccines to patients facing barriers to health.
2. APhA encourages the availability of all vaccines to all pharmacies in order to meet public health needs.
3. APhA supports the compensation of pharmacists for the administration of immunizations and the reimbursement for vaccine distribution.
4. APhA should facilitate the development of programs that educate pharmacists about their role in immunizations in public health.

(JAPhA. NS36(6):395; June 1996) (JAPhA. NS43(5)(suppl 1):S57; September/October 2003) (JAPhA. NS45(5):556; September/October 2005) (Reviewed 2007) (Reviewed 2009) (Reviewed 2012) (Reviewed 2014) (Reviewed 2019) (Reviewed 2020) (Reviewed 2021) (JAPhA 64(4);102117, July/August 2024)

2024

Pharmacists Roles in Sexually Transmitted Infection Prevention and Treatment in Underserved Patients

1. APhA affirms that pharmacists play a vital role in improving outcomes in patients with or at risk of sexually transmitted infections.
2. APhA supports the pharmacist's role in the development of education and resources for individuals with Sexually Transmitted Infections (STIs), Expedited Partner Therapy (EPT), Pre-Exposure Prophylaxis (PrEP), and Post-Exposure Prophylaxis (PEP) in order to increase awareness and access.

3. APhA advocates for revision of state practice acts to permit pharmacists to independently prescribe for individuals with Sexually Transmitted Infections (STIs), Expedited Partner Therapy (EPT), Pre-Exposure Prophylaxis (PrEP), and Post-Exposure Prophylaxis (PEP) therapy.

(JAPhA 64(4);102117, July/August 2024)

2024, 2022

Pharmacists' Application of Professional Judgment

1. APhA supports pharmacists, as licensed health care professionals, in their use of professional judgment throughout the course of their practice to act in the best interest of patients.
2. APhA asserts that a pharmacist's independent medication review and use of professional judgment in the medication distribution process is essential to patient safety.
3. APhA opposes laws, regulations, and policies that limit a pharmacist's responsibility to exercise professional judgment in the best interest of patients.
4. APhA calls for civil, criminal, and professional liability protections for pharmacists and pharmacies if the pharmacist's responsibility to use professional judgment is limited by laws, regulations, and policies.

(JAPhA. 62(4):942; July 2022) (JAPhA 64(4);102117, July/August 2024)

2024, 2020

Providing Affordable and Comprehensive Pharmacy Services to the Underserved

1. APhA supports the expansion and increased sources of funding for pharmacies and pharmacist-provided care services that serve the needs of underserved populations to provide better health outcomes and lower healthcare costs.
2. APhA supports charitable pharmacies and pharmacy services that ensure the quality, safety, drug storage, and integrity of the drug product and supply chain, in accordance with applicable laws, regulations, and policies.

(JAPhA. 60(5):e11; September/October 2020) (Reviewed 2022) (JAPhA 64(4);102117, July/August 2024)

2024, 2001, 1990

Regulatory Infringements on Professional Practice

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

(Am Pharm. NS30(6):45; June 1990) (JAPhA. NS4(5)(suppl 1):S7; September/October, 2001) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2020) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2018, 2013

Revisions to the Medication Classification System

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

8. APhA supports compensation of pharmacists and other health care professionals for the provision of services related to FDA's defined conditions of safe use programs.

(JAPhA. 53(4):365; July/August 2013) (JAPhA. 58(4):356; July/August 2018) (Reviewed 2022) (JAPhA 64(4);102117, July/August 2024)

2024, 2015

Role of the Pharmacist in the Care of Patients Using Cannabis

1. APhA supports legal, regulatory, and policy changes to further facilitate clinical research related to the clinical efficacy and safety associated with the use of cannabis and its various components.
2. APhA encourages health care provider education related to the clinical efficacy, safety, and management of patients using cannabis and its various components.
3. APhA advocates that the pharmacist collect and document information in the pharmacy patient profile about patient use of cannabis and its various components and provide appropriate patient counseling.
4. APhA supports pharmacist participation in independently prescribing cannabis and its various components when scientific data support the legitimate medical use of the products and delivery mechanisms, and federal, state, or territory laws or regulations permit pharmacists to independently prescribe them.
5. APhA opposes pharmacist involvement in independently prescribing cannabis and its various components for recreational use.

(JAPhA. N55(4):365; July/August 2015) (JAPhA 64(4);102117, July/August 2024)

2024, 2014

The Use and Sale of Electronic Cigarettes (e-cigarettes)

1. APhA opposes the sale of e-cigarettes and other vaporized nicotine products in pharmacies until such time that scientific data support the health and environmental safety of these products.
2. APhA opposes the use of e-cigarettes and other vaporized nicotine products in areas subject to current clean air laws, regulations, and policies for combustible tobacco products until such time that scientific data support the health and environmental safety of these products.
3. APhA urges pharmacists to become more knowledgeable about e-cigarettes and other vaporized nicotine products.

(JAPhA. 54(4): 358; July/August 2014) (Reviewed 2019) (JAPhA 64(4);102117, July/August 2024)

2024, 2020

Transfer of Schedule III–V Prescriptions for Purposes of Initial Fill as Well as Refill

APhA supports laws, regulations, and policies that would allow pharmacies to transfer prescriptions for controlled substances for the purposes of an initial fill.

(JAPhA. 60(5):e10); September/October 2020) (JAPhA 64(4);102117, July/August 2024)

2024, 2023

Transgender and Nonbinary Health Care

1. APhA supports the enactment of laws, regulations, and policies to end discriminatory practices that limit access to care for persons who are transgender or gender-diverse.
2. APhA encourages equity in care for persons who are transgender or gender-diverse through:
   (a) Continuing education on the pharmacist's role in transgender care, gender-affirming therapy, and health disparities in patients who are transgender or gender-diverse.
   (b) Systematic integration and utilization of affirmed name and pronouns, gender identity, and anatomical inventory.
   (c) Availability and implementation of education and resources related to gender-diverse care for all persons employed in health care settings.

(JAPhA. 63(4):1266; July/August 2023) (JAPhA 64(4);102117, July/August 2024)

2023

Enforcing Antidiscrimination in the Dispensing of Medicines

APhA affirms that discrimination and stigma should not impact a patient's ability to obtain medications.

(JAPhA. 63(4):1266; July/August 2023)

2023, 2016

Medication-Assisted Treatment

APhA supports expanding access to medications indicated for opioid use disorders (MOUDs) and other substance use disorders, including but not limited to pharmacist-administered injection services for treatment and maintenance of substance use disorders that are based on a valid prescription.

(JAPhA. 56(4):370; July/August 2016) (Reviewed 2021) (JAPhA. 63(4):1268; July/August 2023)

2023

Pharmacy Shortage Areas

1. APhA recognizes geographic proximity and transportation to pharmacies as key determinants in equitable access to medications, vaccines, and patient care services.
2. APhA calls for laws, regulations, and policies that reduce pharmacy shortage areas and ensure equitable access to essential services.
3. APhA supports the development of financial incentives to establish physical pharmacy locations in pharmacy shortage areas and to prevent the closure of pharmacies in underserved areas.

(JAPhA. 63(4):1266; July/August 2023)

2023

Site of Care Patient Steerage

1. APhA calls for the elimination of payer-driven medication administration policies and provisions that restrict access points, interfere with shared provider–patient decision-making, cause delays in care, or otherwise adversely impact the patient.
2. APhA asserts that care coordination services associated with provider-administered medications are essential to safe and effective medication use and calls for the development of broadly applicable compensation mechanisms for these essential services.

(JAPhA. 63(4):1265; July/August 2023)

2023

Workplace Conditions

1. APhA calls for employers to provide fair, realistic, and equitable workplace conditions for pharmacy personnel that promote a safe, healthy, and sustainable working environment.
2. APhA urges all entities that impact pharmacy personnel workplace conditions to adopt the Pharmacists Fundamental Responsibilities and Rights.
3. APhA urges employers to develop and empower pharmacy personnel to use flexible practice management models based on available staffing, expertise, and resources that balance workloads to minimize distractions.
4. APhA advocates for employers to provide workplace onboarding and training for pharmacy personnel to optimize employee performance and satisfaction.
5. APhA encourages pharmacy personnel, starting with leaders, to model and facilitate individualized healthy working behaviors that improve well-being and to encourage and empower colleagues to do the same.
6. APhA opposes the sole use of productivity and fiscal measures for employee performance evaluations.
7. APhA calls for employers and employees to collaborate in the development and use of behavioral performance competencies in performance evaluations.

(JAPhA. 63(4):1265; July/August 2023)

2022, 2008

Billing and Documentation of Medication Therapy Management (MTM) Services

1. APhA encourages the development and use of a system for billing of medication therapy management (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 health care providers, and
   (c) utilizes a billing platform that is accepted by the Centers for Medicare and Medicaid Services (CMS) and is compliant with the Health Insurance Portability and Accountability Act (HIPAA).
2. APhA supports the pharmacist's or pharmacy's choice of a documentation system that allows for transmission of any MTM billing claim and interfaces with the billing platform used by the insurer or payer.
3. APhA encourages pharmacists to use the American Medical Association (AMA) Current Procedural Terminology (CPT) codes for billing of MTM services.
4. APhA supports efforts to further develop CPT codes for billing of pharmacists' services, through the work of the Pharmacist Services Technical Advisory Coalition (PSTAC) and Pharmacy e-HIT Collaborative.

(JAPhA. NS48(4):471; July/August 2008) (Reviewed 2010) (Reviewed 2015) (Reviewed 2016) (Amended 2022)

2022

Data to Advance Health Equity

APhA urges pharmacists to use patient-specific data and social determinants of health to address health inequities and drive decision-making in practice and advocacy.

(JAPhA. 62(4):941; July 2022) (Reviewed 2024)

2022, 2018

Proactive Immunization Assessment and Immunization Information Systems

1. APhA supports mandatory requirements for ALL immunization providers to report pertinent immunization data into Immunization Information Systems (IIS).
2. APhA calls for government entities to fund enrollment and engagement of all immunization providers in Immunization Information Systems (IIS). This engagement should support lifetime tracking of immunizations for patients.
3. APhA supports nationwide integration of Immunization Information Systems (IIS) that incorporate federal, state, and local databases for the purpose of providing health care professionals with accurate and timely information to assist in clinical decision making related to immunization services.
3. APhA calls for a National Immunization Information System (IIS) to receive and report vaccination data from all registries for the purpose of providing health care professionals, patients, and their caregivers with accurate and timely information to assist in clinical decision-making.
4. APhA advocates that all appropriate health care personnel involved in the patient care process have timely access to Immunization Information Systems (IIS) and other pertinent data sources to support proactive patient assessment and delivery of immunization services while maintaining confidentiality.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the bidirectional exchange of data with Immunization Information Systems (IIS).

(JAPhA. 58(4):355-365 July/August 2018) (JAPhA. 62 (4):941; July 2022)

2022

Procurement Strategies and Patient Steerage

1. APhA opposes mandated procurement strategies that restrict patients' and providers' ability to choose treatment options and that compromise patient safety and quality of care.
2. APhA calls for procurement strategies and care models that lower total costs, do not restrict or delay care, and ensure continuity of care.

(JAPhA. 62(4):942; July 2022) (Reviewed 2024)

2022

Standards of Care Regulatory Model for State Pharmacy Practice Acts

1. APhA requests that state boards of pharmacy and legislative bodies regulate pharmacy practice using a standard of care regulatory model similar to other health professions' regulatory models, thereby allowing pharmacists to practice at the level consistent with their individual education, training, experience, and practice setting.
2. To support implementation of a standard of care regulatory model, APhA reaffirms 2002 policy that encourages states to provide pharmacy boards with the following:
   (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 encourages NABP as well as state and national pharmacy associations to support and collaborate with state boards of pharmacy in adopting and implementing a standard of care regulatory model.
4. APhA and other pharmacy stakeholders should provide educational programs, information, and resources regarding the standard of care regulatory model and its impact on pharmacy practice.

(JAPhA. 62(4):941; July 2022)

2022, 2014

Use of Social Media

1. APhA encourages the use of social media in ways that advance patient care and uphold pharmacists as trusted and accessible health care providers.
2. APhA supports the use of social media as a mechanism for the delivery of patient-specific care in a platform that allows for appropriate patient and provider protections and access to necessary health care information.
3. APhA supports the inclusion of social media education, including but not limited to appropriate use and professionalism, as a component of pharmacy education and continuing professional development.

4. APhA affirms that the patient's right to privacy and confidentiality shall not be compromised through the use of social media.
5. APhA urges pharmacists, pharmacy technicians and student pharmacists to self-monitor their social media presence for professionalism and that posted clinical information is accurate and appropriate.
6. APhA advocates for continued development and utilization of social media by pharmacists and other health care professionals during public health emergencies.

(JAPhA. 54(4):357; July/August 2014) (Reviewed 2019)(Amended 2022)

2021

Definition of Patient

APhA calls for the adoption, by pharmacy organizations and regulatory and professional entities, of the expanded definition for patient to include human or non-human species.

(JAPhA. 61(4):e16; July/August 2021) (Reviewed 2024)

2021

People First Language

APhA encourages the use of people first language in all written and oral forms of communication.

(JAPhA. 61(4):e15; July/August 2021) (Reviewed 2023) (Reviewed 2024)

2021

Social Determinants of Health

1. APhA supports the integration of social determinants of health screening as a vital component of pharmacy services.
2. APhA urges the integration of social determinants of health education within pharmacy curricula, post-graduate training, and continuing education requirements.
3. APhA supports incentivizing community engaged research, driven by meaningful partnerships and shared decision-making with community members.
4. APhA urges pharmacists to create opportunities for community engagement to best meet the needs of the patients they serve.
5. APhA encourages the integration of community health workers in pharmacy practice to provide culturally sensitive care, address health disparities, and promote health equity.

(JAPhA. 61(4):e16; July/August 2021) (Reviewed 2023) (Reviewed 2024)

2020

Accountability of Pharmacists

1. APhA affirms pharmacists' professional accountability within their role in all practice settings.
2. APhA advocates that pharmacists be granted and accept authority, autonomy, and accountability for patient-centric actions to improve health and medication outcomes, in coordination with other health professionals, as appropriate.
3. APhA reaffirms 2017 Pharmacists' Role Within Value-based Payment Models and supports continued expansion of interprofessional patient care models that leverage pharmacists as accountable members of the health care team.
4. APhA advocates for sustainable payment and attribution models to support pharmacists as accountable patient care providers.
5. APhA supports continued expansion of resources and health information infrastructures that empower pharmacists as accountable health care providers.
6. APhA supports the enhancement of comprehensive and affordable professional liability insurance coverage that aligns with evolving pharmacist accountability and responsibility.

(JAPhA. 60(5):e9; September/October 2020) (Reviewed 2023)

2020

Protecting Pharmacy Personnel During Public Health Crisis

1. APhA strongly urges all employers of pharmacists and pharmacy personnel, and the settings in which they practice, to implement protection and control measures and procedures, per consensus recommendations when available, and access to protective gear and cleaning supplies that ensure the safety of pharmacy personnel and that of their family members and the public.
2. APhA urges federal and state government officials, manufacturers, distributors, and health system administrators to recognize pharmacists and pharmacy personnel as "front-line providers" who should receive appropriate personal protective equipment and other resources to protect their personal safety and support their ability to continue to provide patient care.

(JAPhA. 60(5):e11; September/October 2020)

2020

Specialty Pharmacy and Specialized Pharmacy Services

1. APhA recognizes that certain complex medications require more specialized care and resources. Further, APhA asserts that delineation of medications as specialty versus non-specialty, and associated payer and manufacturer practices, may introduce continuity of care disruption, patient access issues, and financial inequities.
2. APhA supports pharmacists and pharmacies choosing to specialize or incorporate specialty pharmacy services into their practice to optimize patient outcomes.
3. APhA opposes payer policies and practices that limit patient choice of pharmacy providers, disrupt continuity of care, or compromise patient safety through the creation of specialty drug lists, and restrictive specialty pharmacy networks
4. APhA opposes manufacturer distribution and related business practices that restrict patient or pharmacy access to medications, medical products, and patient care services.
5. APhA advocates for the adoption of pharmacy profession-developed, harmonized practice standards for specialized pharmacy practices, and specialty pharmacy services and products.
6. APhA encourages increased availability and use of data integration, patient financial assistance, and other resources to inform clinical practice and support the provision of specialized pharmacy practices and specialty pharmacy services.
7. APhA supports the availability of education and training for pharmacists and student pharmacists related to specialized pharmacy practices and specialty pharmacy services.

(JAPhA. 60(5):e10; September/October 2020)

2019

Consolidation Within Health Care

1. APhA advocates that health care mergers and acquisitions must preserve the pharmacist–patient relationship.
2. APhA supports optimizing the role of pharmacists in the provision of team-based care following health care mergers and acquisitions in order to:
   (a) enhance patient experience and safety;
   (b) improve population health;
   (c) reduce health care costs; and
   (d) improve the work life of health care providers.
3. APhA asserts that the scope of review by federal agencies must have a focus on the impact of health care mergers and acquisitions on patient access and the provision of care to ensure optimal patient outcomes. Therefore, APhA calls for
   (a) reform of the pre–health care mergers and acquisitions process;
   (b) implementation of an ongoing post–health care mergers and acquisitions evaluation process to preserve patient choice and access to established patient–pharmacist relationships, and
   (c) continuous transparent dialogue among stakeholders throughout the process.
4. APhA calls for the Federal Trade Commission (FTC) to develop a task force to monitor health care mergers and acquisitions activity.

(JAPhA. 59(4):e16; July/August 2019) (Reviewed 2021) (Reviewed 2023) (Reviewed 2024)

2019

Pharmacists' Role in Mental Health and Emotional Well-Being

1. APhA encourages all health care personnel to receive training and provide services to identify, assist, and refer people at risk for, or currently experiencing, a mental health crisis.
2. APhA encourages employers and policy makers to provide the support, resources, culture, and authority necessary for all pharmacy personnel to engage and assist individuals regarding mental health and emotional well-being.
3. APhA supports integration of a mental health assessment as a vital component of pharmacist-provided patient care services.

(JAPhA. 59(4):e16; July/August 2019) (Reviewed 2024)

2019, 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) (Reviewed 2015) (JAPhA. 59(4):e17; July/August 2019) (Reviewed 2023)

2019

Referral System for the Pharmacy Profession

1. APhA supports referrals of patients to pharmacists, among pharmacists, or between pharmacists and other health care providers to promote optimal patient outcomes.
2. APhA supports referrals to and by pharmacists that ensure timely patient access to quality services and promote patient freedom of choice.
3. APhA advocates for pharmacists' engagement in referral systems that are aligned with those of other health care providers and facilitate collaboration and information sharing to ensure continuity of care.
4. APhA supports attribution and equitable payment to pharmacists providing patient care services as a result of a referral.
5. APhA promotes the pharmacist's professional responsibility to uphold ethical and legal standards of care in referral practices.
6. APhA reaffirms its support of development, adoption, and use of policies and procedures by pharmacists to manage potential conflicts of interest in practice, including in referral systems.

(JAPhA. 59(4):e16; July/August 2019) (Reviewed 2022) (Reviewed 2023) (Reviewed 2024)

2018

Use of Genomic Data Within Pharmacy Practice

1. APhA emphasizes genomics as an essential aspect of pharmacy practice.
2. APhA recognizes pharmacists as the health care professional best suited to provide medication-related consults and services based on a patient's genomic information. All pharmacists involved in the care of the patient should have access to relevant genomic information.
3. APhA supports processes to protect patient data confidentiality and opposes unethical utilization of genomic data.
4. APhA demands payers include pharmacists as eligible providers for covered genomic interpretation and related services to support sustainable models that optimize patient care and outcomes.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the exchange, storage, utilization, and documentation of clinically actionable genetic variations and actions taken by the pharmacist in the provision of patient care.
6. APhA recommends pharmacists and pharmaceutical scientists lead the collaborative development of evidence-based practice guidelines for pharmacogenomics and related services.
7. APhA recommends the inclusion of pharmacists and pharmaceutical scientists in the collaborative development of pharmacogenomics clinical support tools and resources.
8. APhA encourages pharmacists to use their professional judgment and published guidelines and resources when providing access to testing or utilizing direct-to-consumer genomic test results in their patient care services.
9. APhA urges schools and colleges of pharmacy to include clinical application of genomics as a required element of the Doctor of Pharmacy curriculum.
10. APhA encourages the creation of continuing professional development and post-graduate education and training programs for pharmacists in genomics and its clinical application to meet varying practice needs.
11. APhA encourages the funding of pharmacist-led research examining the cost effectiveness of care models that utilize pharmacists providing genomic services.

(JAPhA. 58(4):355; July/August 2018) (Reviewed 2023)

2017

Patient Access to Pharmacist-Prescribed Medications

1. APhA asserts that pharmacists' patient care services and related prescribing by pharmacists help improve patient access to care, patient outcomes, and community health, and they align with coordinated, team-based care.
2. APhA supports increased patient access to care through pharmacist prescriptive authority models.
3. APhA opposes requirements and restrictions that impede patient access to pharmacist-prescribed medications and related services.
4. APhA urges prescribing pharmacists to coordinate care with patients' other health care providers through appropriate documentation, communication, and referral.
5. APhA advocates that medications and services associated with prescribing by pharmacists must be covered and compensated in the same manner as for other prescribers.
6. APhA supports the right of patients to receive pharmacist-prescribed medications at the pharmacy of their choice.

(JAPhA. 57(4):442; July/August 2017) (Reviewed 2019) (Reviewed 2020) (Reviewed 2021) (Reviewed 2023) (Reviewed 2024)

2017

Pharmacists' Role Within Value-based Payment Models

1. APhA supports value-based payment models that include pharmacists as essential health care team members and that promote coordinated care, improved health outcomes, and lower total costs of health care.
2. APhA encourages the development and implementation of meaningful, consistent, process-based and outcomes-based quality measures that allow attribution of pharmacist impact within value-based payment models.
3. APhA advocates for mechanisms that recognize and compensate pharmacists for their contributions toward meeting goals of quality and total costs of care in value-based payment models, separate and distinct from the full product and dispensing cost reimbursement.
4. APhA advocates that pharmacists must have real-time access to and exchange of electronic health record data within value-based payment models in order to achieve optimal health and medication-related outcomes.
5. APhA supports education, training, and resources that help pharmacists transform and integrate their practices with value-based payment models and programs.

(JAPhA. 57(4):441; July/August 2017) (Reviewed 2021)

2017

Pharmacy Performance Networks

1. APhA supports performance networks that improve patient care and health outcomes, reduce costs, use pharmacists as an integral part of the health care team, and include evidence-based quality measures.
2. APhA urges collaboration between pharmacists and payers to develop distinct, transparent, fair, and equitable payment strategies for achieving performance measures associated with providing pharmacists' patient care services that are separate from the reimbursement methods used for product fulfillment.
3. APhA advocates for prospective notification of evidence-based quality measures that will be used by a performance network to assess provider and practice performance. Furthermore, updates on provider and practice performance against these measures should be provided in a timely and regular manner.
4. APhA supports pharmacists' professional autonomy to determine processes that improve performance on evidence-based quality measures.

(JAPhA. 57(4):441; July/August 2017) (Reviewed 2019) (Reviewed 2024)

2016

Labeling and Measurement of Oral Liquid Medications

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

(JAPhA. 56(4):369; July/August 2016)

2016, 2011

Pharmacists as Providers Under the Social Security Act

APhA supports changes to the Social Security Act to allow pharmacists to be recognized and paid as providers of patient care services.

(JAPhA. NS51(4):482; July/August 2011) (JAPhA. 56(4): 379; July/August 2016) (Reviewed 2022)

2016

Point-of-Care Testing

1. APhA recognizes the value of pharmacist-provided point-of-care testing and related clinical services and promotes the provision of those tests and services in accordance with the Joint Commission of Pharmacy Practitioners Pharmacists' Patient Care Process.
2. APhA advocates for laws, regulations, and policies that enable pharmacist-provided point-of-care testing and related clinical services that are consistent with the pharmacists' role in team-based care.
3. APhA opposes laws, regulations, and policies that create barriers to the tests that have been waived by the Clinical Laboratory Improvement Amendments (CLIA) and that are administered and interpreted by pharmacists.
4. APhA encourages use of educational programming and resources to facilitate practice implementation of pharmacist-provided point-of-care testing and related clinical services.

5. APhA supports patients taking active roles in the management of their health, including their ability to request and obtain pharmacist-provided point-of-care tests and related clinical services.
6. APhA advocates for access to, coverage of, and payment for both pharmacist-provided point-of-care tests and any related clinical services.

(JAPhA. 56(4):369; July/August 2016) (Reviewed 2018) (Reviewed 2019) (Reviewed 2020) (Reviewed 2021)

2015

Antimicrobial Stewardship

1. APhA supports the role of pharmacists in antimicrobial stewardship in all practice settings.
2. APhA supports pharmacists working in collaboration with others to lead the development and implementation of antimicrobial stewardship programs and initiatives.
3. APhA supports pharmacists advising prescribers and educating patients on the appropriate use of antimicrobials.

(JAPhA. N55(4):365; July/August 2015)

2015

Interoperability of Communications Among Health Care Providers to Improve Quality of Patient Care

1. APhA supports the establishment of secure, portable, and interoperable electronic patient health care records.
2. APhA supports the engagement of pharmacists with other stakeholders in the development and implementation of multidirectional electronic communication systems to improve patient safety, enhance quality care, facilitate care transitions, increase efficiency, and reduce waste.
3. APhA advocates for the inclusion of pharmacists in the establishment and enhancement of electronic health care information technologies and systems that must be interoperable, HIPAA compliant, integrated with claims processing, updated in a timely fashion, allow for data analysis, and do not place disproportionate financial burden on any one health care provider or stakeholder.
4. APhA advocates for pharmacists and other health care providers to have access to view, download and transmit electronic health records. Information shared among providers using a health information exchange should utilize a standardized secure interface based on recognized international health record standards for the transmission of health information.
5. APhA supports the integration of federal, state, and territory health information exchanges into an accessible, standardized, nationwide system.
6. APhA opposes business practices and policies that obstruct the electronic access and exchange of patient health information because these practices compromise patient safety and the provision of optimal patient care.
7. APhA advocates for the development of systems that facilitate and support electronic communication between pharmacists and prescribers concerning patient adherence, medication discontinuation, and other clinical factors that support quality care transitions.
8. APhA supports the development of education and training programs for pharmacists, student pharmacists, and other health care professionals on the appropriate use of electronic health records to reduce errors and improve the quality and safety of patient care.
9. APhA supports the creation and non-punitive application of a standardized, interoperable system for voluntary reporting of errors associated with the use of electronic health care information technologies and systems to enable aggregation of protected data and develop recommendations for improved quality.

(JAPhA. N55(4):364; July/August 2015) (Reviewed 2019) (Reviewed 2023) (Reviewed 2024)

2015

Pharmacists' Role in Promoting Medication Adherence

1. APhA supports pharmacists leading the process of assessing and improving patient medication adherence in collaboration with the health care team.
2. APhA advocates for pharmacists taking leadership roles in working with administrators, health care professionals, payers, patients and other stakeholders to design processes, systems, and technology that promote interoperability and care coordination across settings to improve medication adherence.
3. APhA advocates for the profession of pharmacy to continually study, evaluate, and disseminate evidence-based methods to improve medication adherence.
4. APhA advocates for raising awareness about the issue of medication non-adherence and the importance of engaging patients in their treatment.
5. APhA supports education of the public, employee benefit managers, third-party payers, and other health care decision makers regarding the value and cost-effectiveness of the role of the pharmacist in improving medication adherence.

(JAPhA. N55(4):365; July/August 2015)

2014

Audits of Health Care Practices

1. APhA recognizes that audits of health care practices, when used appropriately, may improve patient care and deter fraud, waste, and abuse.
2. APhA advocates for the use of standardized and efficient audit procedures with transparent criteria clearly communicated by the payor and readily accessible to providers in advance.
3. APhA advocates that audit processes should result in minimal disruption to practice workflow, minimal financial burden, and no impact on patient care.
4. APhA urges timely notification and scheduling of claims audits to minimize disruption of patient care delivery.
5. APhA supports the inclusion of education as a component of the audit process to improve documentation of services, meet payor requirements, and enhance the quality-of-care delivery.
6. APhA opposes incentive-based auditor compensation and the use of statistical methodologies, such as sample extrapolation, for determining the recoupment of funds from health care providers or health care organizations.
7. APhA advocates that audit reports include complete information listing audit discrepancies and appropriate guidelines for documenting and appealing these findings.
8. APhA advocates that pharmacy audits be performed in a professional manner by a pharmacist or certified pharmacy technician.

(JAPhA. 54(4): 357; July/August 2014) (Reviewed 2019)

2014

Care Transitions

1. APhA supports pharmacists leading medication management activities during care transitions to ensure safe and effective medication use.
2. APhA supports the integral role of pharmacists during care transitions for improving quality of patient-centered care and reducing overall costs to the health care system.
3. APhA strongly encourages collaboration and shared accountability among patients, family members, caregivers, pharmacists, and other health care providers during care transitions.
4. APhA supports the development and utilization of standardized processes that facilitate real-time, bidirectional communication of protected health information during care transitions.
5. APhA supports that documentation of health outcomes is an essential component of any care transition program to demonstrate value and ensure continuous quality improvement.
6. APhA supports financially viable payment models that recognize the value of pharmacists' services, including, but not limited to, those provided during care transitions.
7. APhA strongly urges the development and implementation of multidisciplinary, interprofessional, and team-based training for health care professionals and students to improve the quality and consistency of care transition services.
8. APhA urges the collaboration and partnership of community pharmacies with health care systems, institutions, and other entities involved in care transitions.

(JAPhA. 54(4):357; July/August 2014) (Reviewed 2019) (Reviewed 2023)

2013

Ensuring Access to Pharmacists' Services

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

(JAPhA. 53(4):365; July/August 2013) (Reviewed 2018) (Reviewed 2019) (Reviewed 2021) (Reviewed 2024)

2013

Pharmacists Providing Primary Care Services

APhA advocates for the recognition and utilization of pharmacists as providers to address gaps in primary care.

(JAPhA. 53(4):365; July/August 2013) (Reviewing 2018) (Reviewed 2019) (Reviewed 2020) (Reviewed 2023) (Reviewed 2024)

2013, 1995

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

1. APhA advocates direct involvement of pharmacists in the development, evaluation, and implementation of evidence-based clinical guidelines. Well-designed guidelines promote an interdisciplinary team approach to patient care that utilizes pharmacists' expertise in optimizing patient outcomes.
2. APhA believes that evidence-based clinical guidelines should promote optimal patient care built on the best available scientific data. These guidelines should be developed using an interdisciplinary approach and should be evaluated regularly to ensure that they reflect current practice standards.
3. APhA should promote educational programs, products, and services that facilitate the participation of pharmacists in the development, evaluation, and implementation of evidence-based practice guidelines in all practice settings.
4. APhA advocates the use by pharmacists, in all practice settings, of evidence-based practice guidelines for pharmaceutical care built on the best scientific data to optimize patient outcomes. These guidelines should be developed using an interdisciplinary approach and should be evaluated regularly to ensure that they reflect current practice standards.

(Am Pharm. NS35(6):37; June 1995) (Reviewed 2003) (Reviewed 2008) (JAPhA. 53(4):366; July/August 2013) (Reviewed 2018)

2013, 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 pharmacists' patient 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 (PBRNs).

(JAPhA. NS48(4):471; July/August 2008) (JAPhA. 53(4): 366; July/August 2013) (Reviewed 2018)

2013, 2008

Re-Use of Devices Intended for "Single Use"

APhA opposes the reuse of devices intended for "single use" in the screening and management 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) (JAPhA. 53(4):366; July/August 2013) (Reviewed 2018)

2012

Controlled Substances Regulation and Patient Care

1. APhA encourages the Drug Enforcement Administration (DEA) and other regulatory agencies to recognize pharmacists as partners that are committed to ensuring that patients in legitimate need of controlled substances are able to receive the medications.
2. APhA supports efforts to modernize and harmonize state and federal controlled substance laws.
3. APhA urges DEA and other regulatory agencies to balance patient care and regulatory issues when developing, interpreting, and enforcing laws and regulations.
4. APhA encourages DEA and other regulatory agencies to recognize the changes occurring in health care delivery and to establish a transparent and inclusive process for the timely updating of laws and regulations.
5. APhA encourages the U.S. Department of Justice to collaborate with professional organizations to identify and reduce
   (a) the burdens on health care providers,
   (b) the cost of health care delivery, and
   (c) the barriers to patient care in the establishment and enforcement of controlled substance laws.

(JAPhA. NS52(4):457; July/August 2012) (Reviewed 2015)

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) (Reviewed 2016) (Reviewed 2021) (Reviewed 2023)

2011

Pharmacy Practice Accreditation

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

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

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) (Reviewed 2016) (Reviewed 2022) (Reviewed 2023)

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) (Reviewed 2012) (Reviewed 2016) (Reviewed 2020) (Reviewed 2022)

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) (Reviewed 2013) (Reviewed 2014) (Reviewed 2015) (Reviewed 2019) (Reviewed 2023)

2009

Health Information Technology

1. APhA supports the delivery of informatics education within pharmacy schools and continuing education programs to improve patient care, understand interoperability among systems, understand where to find information, increase productivity, and 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 definition, 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, the certification of systems, and the integration of medication use systems with health information technology.

(JAPhA. NS49(4):492; July/August 2009) (Reviewed 2010)(Reviewed 2013) (Reviewed 2014) (Reviewed 2015) (Reviewed 2019)

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) (Reviewed 2015) (Reviewed 2019) (Reviewed 2021)

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 compounding through the Board of Pharmaceutical Specialties (BPS).

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

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) (JAPhA. NS48(4):470; July/August 2008) (Reviewed 2013) (Reviewed 2018)

2007

Re-Distribution of Previously Dispensed Medications

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

(JAPhA. NS45(5):580; September/October 2007) (Reviewed 2012) (Reviewed 2017)

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.

(JAPhA. NS46(5):561; September/October 2006) (Reviewed 2007) (Reviewed 2009) (Reviewed 2010) (Reviewed 2014) (Reviewed 2019)

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 multicomponent vehicles, APhA encourages pharmacists to secure bioavailability data in support of such claims.

(JAPhA. NS45(5):555; September/October 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

2004, 1980

Development of the Cost Effectiveness of Clinical Pharmacy Services

APhA encourages development and maintenance of programs, tools, and data useful in assessing the cost effective nature and benefits of patient-oriented services within all areas of pharmacy practice.

(Am Pharm. NS20(7):77; July 1980) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2007) (Reviewed 2010) (Reviewed 2015)

2004, 1978

Drug Information

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.

(Am Pharm. NS18(8):42 July; 1978) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2007) (Reviewed 2010) (Reviewed 2015)

2004, 1979

Drug Regimen Review (DRR) by Pharmacists

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

(Am Pharm. NS19(7):61; June 1979) (APhA. NS44(5):551; September/October 2004) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

2004, 1971

Drug Storage and Return Goods Policy

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

(JAPhA. NS11:271; May 1971) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

2004, 1989

Drug Use Control by Pharmacists for All Prescription Drugs

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.

(Am Pharm. NS29(1):66; January 1989) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015)

2004, 1978

Roles in Health Care for Pharmacists

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.

(Am Pharm. NS18(8):42; July 1978) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2007) (Reviewed 2011) (Reviewed 2012) (Reviewed 2013) (Reviewed 2018) (Reviewed 2020) (Reviewed 2021) (Reviewed 2023)

2003, 1993

The Pharmacist's Role with Diagnostic Drugs in Therapeutic Outcomes

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

(Am Pharm. NS33(7):56; July 1993) (JAPhA. NS43(5)(suppl 1):S57; September/October 2003) (Reviewed 2007) (Reviewed 2009) (Reviewed 2010) (Reviewed 2011) (Reviewed 2016) (Reviewed 2023)

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 pharmacists' provision of pharmaceutical care.

(JAPhA. NS41(5)(suppl 1):S8; September/October 2001) (Reviewed 2004) (Reviewed 2007) (Reviewed 2008)(Reviewed 2013) (Reviewed 2015)

2001

Pharmacist Counseling on Administration Devices

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

(JAPhA. NS41(5)(suppl.1):S9; September/October 2001) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

2000

Use of the Phrase "Community Pharmacy"

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

(JAPhA. NS40(5)(suppl 1):S8; September/October 2000) (Reviewed 2002) (Reviewed 2007) (Reviewed 2012)(Reviewed 2017)

1996

Quality Assurance and Improvement in Pharmacy Practice

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

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

1993

Patient Counseling Environment

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

(Am Pharm. NS33(7):56; July 1993) (Reviewed 2002) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2019)

1991

Emerging Technologies

1. APhA supports programs to monitor the development of emerging technologies and their impact on the delivery of pharmaceutical care.
2. APhA supports education of pharmacists regarding emerging technology including their development and impact on the delivery of pharmaceutical care.
3. APhA supports the inclusion of pharmacists in the development and application of the emerging technologies in the delivery of pharmaceutical care.

(Am Pharm. NS31(6):28; June 1991) (Reviewed 2004) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

1991

Mission of Pharmacy

APhA affirms that the mission of pharmacy is to serve society as the profession responsible for the appropriate use of medications, devices, and services to achieve optimal therapeutic outcomes.

(Am Pharm. NS31(6):29; June 1991) (Reviewed 2004) (Reviewed 2010) (Reviewed 2015) (Reviewed 2018) (Reviewed 2022)

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 on the pharmacist/patient relationship.
4. APhA affirms that the utilization of technologies by pharmacists shall not compromise the patient's right to confidentiality.

(Am Pharm. NS32(6):515; June 1991) (Reviewed 2001) (Reviewed 2007) (Reviewed 2009) (Reviewed 2013) (Reviewed 2014) (Reviewed 2019) (Reviewed 2023)

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.

(Am Pharm. NS23(6):52; June 1983) (Reviewed 2004) (Reviewed 2010) (Reviewed 2015) (Reviewed 2021) (Reviewed 2022)

Facility Design and Face-to-Face Communication

2012, 1992

Patient 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 patient care.

(Am Pharm. NS32(6):515; June 1992) (Reviewed 2001) (Reviewed 2007) (JAPhA. NS52(4):459; July/August 2012) (Reviewed 2017)

1993

Patient Counseling Environment

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

(Am Pharm. NS33(7):56; July 1993) (Reviewed 2002) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2019)

PHARMACY TECHNICIANS

2024, 2019

Creating Safe Work and Learning Environments for Student Pharmacists, Pharmacists, and Pharmacy Technicians

1. APhA strongly believes that all pharmacists, student pharmacists, and pharmacy technicians should be safe in their work and learning environments and be free from firearm-related violence.

2. APhA strongly recommends that technician training programs, schools and colleges of pharmacy, postgraduate training programs, and employers should develop programs to increase readiness in the event of an active shooter.
3. APhA strongly believes pharmacists, student pharmacists, and pharmacy technicians should be trained to recognize and refer patients at high risk of violence to themselves or others.
4. APhA encourages pharmacists, student pharmacists, and pharmacy technicians who are survivors of firearm-related violence to seek the help of counselors and other trained mental health professionals.

(JAPhA. 59(4):e17; July/August 2019) (JAPhA 64(4);102117, July/August 2024)

2024, 2019

Expanding Technician Roles

1. APhA encourages state boards of pharmacy to develop laws, regulations, and policies allowing expanded pharmacy technician roles that allow both technicians and pharmacists to practice at the top of their training and license or certification.
2. APhA supports state board of pharmacy regulations that standardize and set minimum didactic and experiential standards for technicians to allow for functioning in expanded roles.

(JAPhA. 59(4):e17; July/August 2019) (JAPhA 64(4);102117, July/August 2024)

2024, 2017

Pharmacy Technician Education, Training, and Development

1. APhA supports the following minimum requirements for all new pharmacy technicians:
   (a) Successful completion of an accredited or state-approved education and training program.
   (b) Certification by the Pharmacy Technician Certification Board (PTCB).

2. APhA supports state board of pharmacy laws, regulations, and policies that require pharmacy technicians to meet minimum standards of education, training, certification, and recertification. APhA encourages state boards of pharmacy to develop a phase-in process for current pharmacy technicians. APhA also encourages boards of pharmacy to delineate between pharmacy technicians and student pharmacists for the purposes of education, training, certification, and recertification.
3. APhA recognizes the important contribution and role of pharmacy technicians in assisting pharmacists and student pharmacists with the delivery of patient care.
4. APhA supports the development of resources and programs that promote the recruitment and retention of qualified pharmacy technicians.
5. APhA supports the development of continuing pharmacy education programs that enhance and support the continued professional development of pharmacy technicians.
6. APhA encourages the development of compensation models for pharmacy technicians that promote sustainable career opportunities.

(JAPhA. 57(4):442; July/August 2017) (Reviewed 2021) (JAPhA 64(4);102117, July/August 2024)

2024, 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 legal, regulatory, and policy 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 websites personal addresses, phone numbers, email, and other non-business contact information of pharmacists, student pharmacists, and pharmacy technicians.

(JAPhA. NS45(5):580; September-October 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2020

Pharmacy Technician's Role in Immunization Administration

1. APhA supports the development of standardized training in immunization administration and continuing education opportunities for immunizing pharmacy technicians.
2. APhA supports immunizing pharmacist's individual discretion in delegating immunization administration to pharmacy technicians with the requisite education, training, and experience.
3. APhA supports voluntary participation by pharmacy technicians in the training and provision of immunization administration.
4. APhA supports the role of immunizing pharmacists as the healthcare professional providing clinical patient assessment, decision making, and patient counseling when delegating immunization administration to a pharmacy technician.

(JAPhA. 60(5):e10; September/October)

2014

Audits of Health Care Practices

1. APhA recognizes that audits of health care practices, when used appropriately, may improve patient care and deter fraud, waste, and abuse.
2. APhA advocates for the use of standardized and efficient audit procedures with transparent criteria clearly communicated by the payor and readily accessible to providers in advance.
3. APhA advocates that audit processes should result in minimal disruption to practice workflow, minimal financial burden, and no impact on patient care.
4. APhA urges timely notification and scheduling of claims audits to minimize disruption of patient care delivery.
5. APhA supports the inclusion of education as a component of the audit process to improve documentation of services, meet payor requirements, and enhance the quality-of-care delivery.
6. APhA opposes incentive-based auditor compensation and the use of statistical methodologies, such as sample extrapolation, for determining the recoupment of funds from health care providers or health care organizations.
7. APhA advocates that audit reports include complete information listing audit discrepancies and appropriate guidelines for documenting and appealing these findings.
8. APhA advocates that pharmacy audits be performed in a professional manner by a pharmacist or certified pharmacy technician.

(JAPhA. 54(4): 357; July/August 2014) (Reviewed 2019)

2004, 1996

Technician Licensure and Registration

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.

(JAPhA. NS36(6):396; June 1996) (Reviewed 2001) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2008) (Reviewed 2010) (Reviewed 2015) (Reviewed 2018)

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 pharmacists' provision of pharmaceutical care.

(JAPhA. NS41(5)(suppl 1):S8; September/October 2001) (Reviewed 2004) (Reviewed 2007) (Reviewed 2008)(Reviewed 2013) (Reviewed 2015)

POISON PREVENTION

2004, 1967

Poison Control, Information, and Treatment: Pharmacists' Responsibilities

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.

(JAPhA. NS7:323; June 1967) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015)

2004, 1968

Poison Control, Information, and Treatment: Pharmacists' Responsibility

1. APhA encourages pharmacists to familiarize themselves with the available resources on poisons and toxicology.
2. APhA encourages pharmacists to become familiar with the poison control, information and treatment center in their localities.

(JAPhA. NS8:383; July 1968) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015)

POST-MARKETING SURVEILLANCE

2019, 2010

Pharmacogenomics/Personalized Medicine

4. APhA supports the inclusion of pharmacogenomic analysis in the drug development/approval and postmarketing surveillance processes.

(JAPhA. NS50(4):471; July/August 2010) (Reviewed 2015) (JAPhA. 59(4):e17; July/August 2019) (Reviewed 2023)

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) (Reviewed 2015) (Reviewed 2019) (Reviewed 2021)

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.

(Am Pharm. NS28(6):396; June 1988) (Reviewed 2004) (Reviewed 2009) (Reviewed 2010) (Reviewed 2015)

PRESCRIBING AUTHORITY

2024

Community Pharmacy Methadone Dispensing for Opioid Use Disorder

1. APhA supports changes in laws, regulations, and policies to permit DEA-registered and trained opioid treatment program clinicians and other providers the ability to prescribe methadone for opioid use disorder and refer patients for additional services as needed.
2. APhA supports changes in laws, regulations, and policies to permit community pharmacy dispensing of methadone for opioid use disorder and appropriate compensation for these services.
3. APhA supports partnerships and collaborations to increase patient access to opioid treatment programs (OTPs) and clinicians.
4. APhA advocates for interprofessional education on laws, regulations, and policies regarding office-based prescribing and community pharmacy dispensing of methadone in curricula, postgraduate training, and continuing professional development programs of all health professions.

(JAPhA 64(4);102117, July/August 2024)

2024, 2017, 2012

Contemporary Pharmacy Practice

1. APhA asserts that pharmacists should have the authority and support to practice to the full extent of their education, training, and experience in delivering patient care.
2. APhA opposes burdensome legal and regulatory requirements beyond continuing professional development for the provision of patient care services.
3. APhA supports continuing efforts toward establishing a consistent and accurate perception of the contemporary role and practice of pharmacists by the general public, patients, and all persons and institutions engaged in health care policy, administration, payment, and delivery.
4. APhA supports continued collaboration with stakeholders to facilitate adoption of standardized practice acts, appropriate related laws, regulations, and policies that reflect contemporary pharmacy practice.
5. APhA supports the establishment of multistate pharmacist licensure agreements to address the evolving needs of the pharmacy profession and pharmacist-provided patient care.
6. APhA urges the continued development of consensus documents, in collaboration with medical associations and other stakeholders, that recognize and support pharmacists' roles in patient care as health care providers.
7. APhA urges universal recognition of pharmacists as health care providers and compensation based on the level of patient care provided using standardized and future health care payment models.

(JAPhA. NS52(4):457; July/August 2012) (Reviewed 2016) (JAPhA. 57(4):441; July/August 2017) (Reviewed 2019) (Reviewed 2021) (Reviewed 2022) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024

Cybersecurity in Pharmacy

1. APhA advocates for implementation and maintenance of cybersecurity systems, safeguards, and response mechanisms to mitigate risk and minimize harm or disruption for all pharmacies and related parties who manage or access electronic health and business information.
2. APhA advocates for all pharmacies and related business entities responsible for electronic health and business information to have cyber liability insurance or an equivalent self-funded plan to protect all relevant parties in the event of a cyberattack and data breach.
3. APhA advocates for education providers to facilitate, and pharmacy personnel to seek out, education and training on cybersecurity laws, regulations, and best practices.

(JAPhA 64(4);102117, July/August 2024)

2024, 2013, 2009

Independent Practice of Pharmacists

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

(JAPhA. NS49(4):492; July/August 2009) (Reviewed 2012) (JAPhA. 53(4):366; July/August 2013) (Reviewed 2018) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024

Pharmacists Roles in Sexually Transmitted Infection Prevention and Treatment in Underserved Patients

1. APhA affirms that pharmacists play a vital role in improving outcomes in patients with or at risk of sexually transmitted infections.
2. APhA supports the pharmacist's role in the development of education and resources for individuals with Sexually Transmitted Infections (STIs), Expedited Partner Therapy (EPT), Pre-Exposure Prophylaxis (PrEP), and Post-Exposure Prophylaxis (PEP) in order to increase awareness and access.
3. APhA advocates for revision of state practice acts to permit pharmacists to independently prescribe for individuals with Sexually Transmitted Infections (STIs), Expedited Partner Therapy (EPT), Pre-Exposure Prophylaxis (PrEP), and Post-Exposure Prophylaxis (PEP) therapy.

(JAPhA 64(4);102117, July/August 2024)

2020

Accountability of Pharmacists

1. APhA affirms pharmacists' professional accountability within their role in all practice settings.
2. APhA advocates that pharmacists be granted and accept authority, autonomy, and accountability for patient-centric actions to improve health and medication outcomes, in coordination with other health professionals, as appropriate.
3. APhA reaffirms 2017 Pharmacists' Role Within Value-based Payment Models and supports continued expansion of interprofessional patient care models that leverage pharmacists as accountable members of the health care team.
4. APhA advocates for sustainable payment and attribution models to support pharmacists as accountable patient care providers.
5. APhA supports continued expansion of resources and health information infrastructures that empower pharmacists as accountable health care providers.
6. APhA supports the enhancement of comprehensive and affordable professional liability insurance coverage that aligns with evolving pharmacist accountability and responsibility.

(JAPhA. 60(5):e9; September/October 2020) (Reviewed 2023)

2017

Patient Access to Pharmacist-Prescribed Medications

1. APhA asserts that pharmacists' patient care services and related prescribing by pharmacists help improve patient access to care, patient outcomes, and community health, and they align with coordinated, team-based care.
2. APhA supports increased patient access to care through pharmacist prescriptive authority models.
3. APhA opposes requirements and restrictions that impede patient access to pharmacist-prescribed medications and related services.
4. APhA urges prescribing pharmacists to coordinate care with patients' other health care providers through appropriate documentation, communication, and referral.
5. APhA advocates that medications and services associated with prescribing by pharmacists must be covered and compensated in the same manner as for other prescribers.
6. APhA supports the right of patients to receive pharmacist-prescribed medications at the pharmacy of their choice.

(JAPhA. 57(4):442; July/August 2017) (Reviewed 2019) (Reviewed 2020) (Reviewed 2021) (Reviewed 2023) (Reviewed 2024)

2003, 2000

Emergency Contraception

APhA supports the voluntary involvement of pharmacists, in collaboration with other health care providers, in emergency contraceptive programs that include patient evaluation, patient education, and direct provision of emergency contraceptive medications.

(JAPhA. NS40(5)(suppl 1):S8; September/October 2000) (JAPhA. NS43(5)(suppl 1):S58; September/October 2003) (Reviewed 2006) (Reviewed 2008) (Reviewed 2009) (Reviewed 2014) (Reviewed 2018)

PRESCRIPTIONS AND PRESCRIPTION ORDERS

2024, 2020

Increasing Access to and Advocacy for Medications for Opioid Use Disorder– (MOUD)

1. APhA supports the use of evidence-based medicine as first-line treatment for patients with opioid-use disorder, including healthcare professionals in and out of the workplace, for as long as needed to treat their disease.
2. APhA encourages pharmacies to maintain an inventory of medications used in treatment of opioid-use disorder (MOUD), to ensure access for patients.
3. APhA encourages pharmacists and payers to ensure patients have equitable access to, and coverage for, at least one medication from each class of medications used in the treatment of opioid-use disorder.

(JAPhA. 60(5):e11; September/October 2020) (JAPhA 64(4);102117, July/August 2024)

2024, 2020, 2015

Integrated Nationwide Prescribing Drug Monitoring Program

1. APhA advocates for nationwide integration and uniformity of prescription drug monitoring programs (PDMP) that incorporate federal, state, and territory databases for the purpose of providing health care professionals with accurate and real-time information to assist in clinical decision making when providing patient care services related to controlled substances.

2. APhA supports pharmacist involvement in the development of uniform standards for an integrated nationwide prescription drug monitoring program (PDMP) that includes the definition of authorized registered users, documentation, reporting requirements, system response time, security of information, minimum reporting data sets, and standard transaction format.
3. APhA supports mandatory prescription drug monitoring program (PDMP) enrollment by all health care providers, mandatory reporting by all those who dispense controlled substances, and appropriate system query by registrants during the patient care process related to controlled substances.
4. APhA advocates for the development of seamless workflow integration systems that would enable consistent use of a nationwide prescription drug monitoring program (PDMP) by registrants to facilitate prospective drug review as part of the patient care process related to controlled substances.
5. APhA advocates for continuous, sustainable federal funding sources for practitioners and system operators to utilize and maintain a standardized integrated and real-time nationwide prescription drug monitoring program (PDMP).
6. APhA supports the use of interprofessional advisory boards that include pharmacists to coordinate collaborative efforts for
   (a) compiling, analyzing, and using prescription drug monitoring program (PDMP) data trends to identify misuse of controlled substances and/or fraud;
   (b) providing focused provider education and patient referral to treatment programs; and
   (c) supporting research activities on the impact of PDMPs.
7. APhA supports education and training for registrants about a nationwide prescription drug monitoring program (PDMP) to ensure proper data integrity, use, and confidentiality.

(JAPhA. N55(4):364-365; July/August 2015) (JAPhA. 60(5):e10; September/October 2020) (JAPhA 64(4);102117, July/August 2024)

2024, 2020

Transfer of Schedule III–V Prescriptions for Purposes of Initial Fill as Well as Refill

APhA supports laws, regulations, and policies that would allow pharmacies to transfer prescriptions for controlled substances for the purposes of an initial fill.

(JAPhA. 60(5):e10); September/October 2020) (JAPhA 64(4);102117, July/August 2024)

2017

Indication on Prescription Labels and Medication Safety

APhA supports pharmacists' authority to include a medication's purpose on prescription labels, on the basis of professional knowledge, judgment, and patient preference, using vocabulary that is appropriate for their unique practice sites and that addresses the needs of their specific patient populations.

(JAPhA. 57(4):442; July/August 2017)

2011, 1995

Adequacy of Directions for Use on Prescriptions and Prescription Orders

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

(Am Pharm. NS35(6):37; June 1995) (Reviewed 2006) (JAPhA. NS51(4):484; July/August 2011) (Reviewed 2016) (Reviewed 2017)

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) (Reviewed 2015) (Reviewed 2019) (Reviewed 2021)

2001

Prescription Order Requirements

1. APhA supports the use of technology to facilitate the transmission of prescription order information from the prescriber to the pharmacist of the patient's choice at no additional cost to the pharmacy.
2. APhA supports the use of technology where appropriate standards for patient confidentiality and prescriber and pharmacist verification are established.
3. APhA supports the transmission of complete prescriber information on or with the prescription order that enables the pharmacist to readily identify and facilitate communication with the prescriber.
4. APhA supports the use of specific instructions with prescription orders. Use of potentially confusing terminology (e.g.,"as directed," unclear use of Latin phrases, confusing abbreviations) should be avoided.
5. APhA supports the inclusion of the diagnosis or indication for use for which the medication is ordered on or with the transmission of the prescription order by use of standard diagnosis codes or within the directions for use. APhA further supports the inclusion of patient-specific information on or with the prescription order where appropriate.
6. APhA supports public education about the benefits and risks of technological advances in pharmacy practice.

(JAPhA. NS41(5)(suppl 1):S8; September/October 2001) (Reviewed 2007) (Reviewed 2009) (Reviewed 2010) (Reviewed 2012) (Reviewed 2017) (Reviewed 2018)

1989

Multiple Copy Prescription Order Programs

1. APhA opposes federally mandated, multiple copy, prescription order programs.
2. APhA supports the right of individual states to develop programs to prevent drug abuse and drug diversion.

(Am Pharm. NS29(7):464 July; 1989) (Reviewed 2001) (Reviewed 2006) (Reviewed 2011) (Reviewed 2015)

PUBLIC HEALTH

2024, 2023

Access to Essential Medicines

APhA advocates for laws, regulations, and policies that recognize access to quality and affordable essential medicines as a fundamental human right.

(JAPhA. 63(4):1266; July/August 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2020

Providing Affordable and Comprehensive Pharmacy Services to the Underserved

1. APhA supports the expansion and increased sources of funding for pharmacies and pharmacist-provided care services that serve the needs of underserved populations to provide better health outcomes and lower healthcare costs.
2. APhA supports charitable pharmacies and pharmacy services that ensure the quality, safety, drug storage, and integrity of the drug product and supply chain, in accordance with applicable laws, regulations, and policies.

(JAPhA. 60(5):e11; September/October 2020) (Reviewed 2022) (JAPhA 64(4);102117, July/August 2024)

2024, 2019, 2016

Substance Use Disorder

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

(JAPhA. 56(4):369; July/August 2016) (JAPhA. 59(4): e28; July/August 2019) (Reviewed 2022) (JAPhA 64(4);102117, July/August 2024)

2020

Pharmacy Technician's Role in Immunization Administration

1. APhA supports the development of standardized training in immunization administration and continuing education opportunities for immunizing pharmacy technicians.

2. APhA supports immunizing pharmacist's individual discretion in delegating immunization administration to pharmacy technicians with the requisite education, training, and experience.
3. APhA supports voluntary participation by pharmacy technicians in the training and provision of immunization administration.
4. APhA supports the role of immunizing pharmacists as the healthcare professional providing clinical patient assessment, decision making, and patient counseling when delegating immunization administration to a pharmacy technician.

(JAPhA. 60(5):e10; September/October)

Alcohol and Tobacco

2024, 2014

The Use and Sale of Electronic Cigarettes (e-cigarettes)

1. APhA opposes the sale of e-cigarettes and other vaporized nicotine products in pharmacies until such time that scientific data support the health and environmental safety of these products.
2. APhA opposes the use of e-cigarettes and other vaporized nicotine products in areas subject to current clean air laws, regulations, and policies for combustible tobacco products until such time that scientific data support the health and environmental safety of these products.
3. APhA urges pharmacists to become more knowledgeable about e-cigarettes and other vaporized nicotine products.

(JAPhA. 54(4): 358; July/August 2014) (Reviewed 2019) (JAPhA 64(4);102117, July/August 2024)

2016, 2006

Tobacco and Nicotine Use Data Entry Field in Pharmacy Patient Records

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

(JAPhA. NS46(5):561; September/October 2006) (Reviewed 2011) (JAPhA. 56(4):380; July/August 2016)

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) (Reviewed 2015)

2005, 1971

Cigarette Sales in Pharmacies

1. APhA recommends that tobacco products not be sold in pharmacies.
2. APhA recommends that state and local pharmacist associations develop similar policy statements for their membership and increase their involvement in public educational programs regarding the health hazards of smoking.
3. APhA recommends that individual pharmacists give particular attention to educating young people on the health hazards of smoking.
4. APhA recommends that APhA-ASP develop projects aimed at educating young people on the health hazards of smoking, such as visiting schools and conducting health education programs.

(JAPhA. NS11:270; May 1971) (JAPhA. NS45(5):555; September/October 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2018)

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.

(JAPhA. NS36(6):396; June 1996) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

Community Awareness and Education

2024, 2012, 2005, 1992

The Role of Pharmacy Personnel in Public Health Awareness

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

(Am Pharm. NS32(6):515; June 1992) (JAPhA. 45(5):556; September/October 2005) (Reviewed 2009) (Reviewed 2010) (JAPhA. NS52(4):460; July/August 2012) (Reviewed 2017) (Reviewed 2020) (JAPhA 64(4);102117, July/August 2024)

2022, 2014

Use of Social Media

1. APhA encourages the use of social media in ways that advance patient care and uphold pharmacists as trusted and accessible health care providers.
2. APhA supports the use of social media as a mechanism for the delivery of patient-specific care in a platform that allows for appropriate patient and provider protections and access to necessary health care information.
3. APhA supports the inclusion of social media education, including but not limited to appropriate use and professionalism, as a component of pharmacy education and continuing professional development.
4. APhA affirms that the patient's right to privacy and confidentiality shall not be compromised through the use of social media.
5. APhA urges pharmacists, pharmacy technicians and student pharmacists to self-monitor their social media presence for professionalism and that posted clinical information is accurate and appropriate.
6. APhA advocates for continued development and utilization of social media by pharmacists and other health care professionals during public health emergencies.

(JAPhA. 54(4):357; July/August 2014) (Reviewed 2019)(Amended 2022)

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. NS1(9):40; September/October 2000) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

HIV/AIDS

2024

Pharmacists Roles in Sexually Transmitted Infection Prevention and Treatment in Underserved Patients

1. APhA affirms that pharmacists play a vital role in improving outcomes in patients with or at risk of sexually transmitted infections.
2. APhA supports the pharmacist's role in the development of education and resources for individuals with Sexually Transmitted Infections (STIs), Expedited Partner Therapy (EPT), Pre-Exposure Prophylaxis (PrEP), and Post-Exposure Prophylaxis (PEP) in order to increase awareness and access.
3. APhA advocates for revision of state practice acts to permit pharmacists to independently prescribe for individuals with Sexually Transmitted Infections (STIs), Expedited Partner Therapy (EPT), Pre-Exposure Prophylaxis (PrEP), and Post-Exposure Prophylaxis (PEP) therapy.

(JAPhA 64(4);102117, July/August 2024)

2020, 1996

Human Immunodeficiency Virus (HIV) Testing in Women

APhA encourages pharmacists to provide pharmaceutical care for women, including education about the availability and benefits of opt-out Human Immunodeficiency Virus (HIV) testing in prenatal and perinatal care, to decrease the risk of HIV transmission to unborn children and between partners. APhA encourages pharmacists to provide education about the availability and benefits of opt-out HIV testing in prenatal and perinatal care, including offering and/or performing testing to the patients and their partners.

(Am Pharm. NS36(6):395; June 1996) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)(JAPhA. 2020; 60(5): e9)

2005, 1993

Human Immunodeficiency Virus (HIV) Testing

1. APhA opposes mandatory Human Immunodeficiency Virus (HIV) testing of pharmacists, student pharmacists, and pharmacy personnel.
2. APhA supports voluntary and confidential Human Immunodeficiency Virus (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 Human Immunodeficiency Virus (HIV) positive health care professionals and students.

(Am Pharm. NS33(7):54; July 1993) (JAPhA NS45(5):556; September/October 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019) (Reviewed 2020) (Reviewed 2021)

Immunizations

2024, 2005, 2003, 1996

Pharmacist's Role in Immunizations

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) administering vaccines to patients facing barriers to health.
2. APhA encourages the availability of all vaccines to all pharmacies in order to meet public health needs.
3. APhA supports the compensation of pharmacists for the administration of immunizations and the reimbursement for vaccine distribution.
4. APhA should facilitate the development of programs that educate pharmacists about their role in immunizations in public health.

(JAPhA. NS36(6):395; June 1996) (JAPhA. NS43(5)(suppl 1):S57; September/October 2003) (JAPhA. NS45(5):556; September/October 2005) (Reviewed 2007) (Reviewed 2009) (Reviewed 2012) (Reviewed 2014) (Reviewed 2019) (Reviewed 2020) (Reviewed 2021) (JAPhA 64(4);102117, July/August 2024)

2024, 2011

Requiring Vaccination for All Pharmacy Personnel

APhA supports vaccinations, as recommended by the Centers for Disease Control and Prevention, as a condition of employment, training, or volunteering within an organization that provides pharmacy services or operates a pharmacy or pharmacy department (unless a valid medical or religious reason precludes vaccination).

(JAPhA. NS51(4):482; July/August 2011) (Reviewed 2012) (Reviewed 2017) (JAPhA 64(4);102177, July/August 2024)

2022 2007

Pharmacy Personnel Immunization Rates

1. APhA supports efforts to increase immunization rates of health care 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 (e.g., physicians, nurses, police) and to prioritize pharmacists to receive medications and immunizations.
3. APhA encourages federal, state, and local officials and agencies to recognize pharmacists, student pharmacists, pharmacy technicians, and pharmacy support staff as among the highest priority groups to receive medications, vaccinations, and other protective measures as essential healthcare workers.

(JAPhA. NS45(5):580; September/October 2007) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019) (JAPhA. 62(4):942; July 2022) (Reviewed 2023)

2022, 2018

Proactive Immunization Assessment and Immunization Information Systems

1. APhA supports mandatory requirements for ALL immunization providers to report pertinent immunization data into Immunization Information Systems (IIS).
2. APhA calls for government entities to fund enrollment and engagement of all immunization providers in Immunization Information Systems (IIS). This engagement should support lifetime tracking of immunizations for patients.

3. APhA supports nationwide integration of Immunization Information Systems (IIS) that incorporate federal, state, and local databases for the purpose of providing health care professionals with accurate and timely information to assist in clinical decision making related to immunization services.
3. APhA calls for a National Immunization Information System (IIS) to receive and report vaccination data from all registries for the purpose of providing health care professionals, patients, and their caregivers with accurate and timely information to assist in clinical decision-making.
4. APhA advocates that all appropriate health care personnel involved in the patient care process have timely access to Immunization Information Systems (IIS) and other pertinent data sources to support proactive patient assessment and delivery of immunization services while maintaining confidentiality.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the bidirectional exchange of data with Immunization Information Systems (IIS).

(JAPhA. 58(4):355-365 July/August 2018) (JAPhA. 62 (4):941; July 2022)

Other Public Health Issues

2024, 2023

Access to Comprehensive Reproductive Health Care

1. APhA supports equitable patient access to evidence-based comprehensive reproductive health care, including, but not limited to, the management of pregnancy loss, ectopic pregnancy, infertility, pregnancy termination, contraception, and permanent contraception.
2. APhA recognizes patient autonomy in choosing reproductive health care services and the essential role of all health care professionals in facilitating access and advancing informed decision making.
3. APhA supports evidence-based laws, regulations, and policies that ensures patient access to comprehensive reproductive health care services.
4. APhA opposes legal actions against pharmacies, pharmacists, and pharmacy personnel that provide patient access to, or information regarding, reproductive health care services that are within pharmacist scope of practice.

(JAPhA. 63(4):1266; July/August 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2021

Continuity of Care and the Role of Pharmacists During Public Health and Other Emergencies

1. APhA asserts that pharmacists, student pharmacists, pharmacy technicians, and pharmacy support staff are essential members of the healthcare team and should be actively engaged and supported in surveillance, mitigation, preparedness, planning, response, recovery, and countermeasure activities related to public health and other emergencies.
2. APhA reaffirms the 2016 policy on the Role of the Pharmacist in National Defense, and calls for the active and coordinated engagement of all pharmacists in public health and other emergency planning and response activities.
3. APhA advocates for the timely removal of legal, regulatory, and policy restrictions; practice limitations; and financial barriers during public health and other emergencies to meet immediate patient care needs.
4. APhA urges regulatory bodies and government agencies to recognize pharmacists' training and ability to evaluate patient needs, provide care, and appropriately refer patients during public health and other emergencies.
5. APhA advocates for pharmacists' authority to ensure patient access to care through the prescribing, dispensing, and administering of medications, as well as provision of other patient care services during times of public health and other emergencies.
6. APhA calls for processes to ensure that any willing and able pharmacy and pharmacy practitioner is not excluded from providing pharmacist patient care services during public health and other emergencies.
7. APhA calls on public and private payers to establish and implement payment policies that compensate pharmacists providing patient care services, including during public health and other emergencies, within their recognized authority.
8. APhA advocates for the inclusion of pharmacists as essential members in the planning, development, and implementation of alternate care sites or delivery models during public health and other emergencies.
9. APhA reaffirms the 2015 Interoperability of Communications Among Health Care Providers to Improve Quality of Care and encourages pharmacists, as members of the healthcare team, to communicate care decisions made during public health and other emergencies with other members of the healthcare team to ensure continuity of care.

(JAPhA. 61(4):e15; July/August 2021) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2015

Disaster Preparedness

APhA encourages pharmacist involvement in surveillance, mitigation, preparedness, planning, response, and recovery related to terrorism and infectious diseases.

APhA encourages pharmacist involvement in surveillance, mitigation, preparedness, planning, response, and recovery related to natural, technological, or human-caused incidents.

(JAPhA. N55(4):365; July/August 2015) (Reviewed 2021)(JAPhA 64(4);102117, July/August 2024)

2024, 2017

Drug Disposal Program Involvement

APhA urges pharmacists to expand patient access to secure, convenient, and environmentally responsible drug disposal options, in accordance with the Secure and Responsible Drug Disposal Act of 2010, by implementing disposal programs they deem appropriate for their individual practice sites, patient care settings, and business models in an effort to reduce the amount of dispensed but unused prescription drug product available for diversion and misuse.

(JAPhA. 57(4):441; July/August 2017) (JAPhA 64(4);102117, July/August 2024)

2024, 2018

Efforts to Reduce the Stigma Associated with Mental Health Disorders or Diseases

1. APhA encourages all stakeholders to develop and adopt evidence-based approaches to educate the public and all health care professionals to reduce the stigma associated with mental health diagnoses.
2. APhA supports the increased utilization of pharmacists and student pharmacists with appropriate training to actively participate in the care of patients with mental health conditions as members of interprofessional health care teams in all practice settings.
3. APhA supports the expansion of mental health education and training in the curriculum of all schools and colleges of pharmacy, post-graduate training, and within continuing professional development programs.
4. APhA supports the development of education and resources to address health care professional resiliency and burnout.

(JAPhA. 58(4):356; July/August 2018) (JAPhA 64(4);102117, July/August 2024)

2024, 2013

Medication Take-Back/Disposal Programs

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

(JAPhA. 53(4):365; July/August 2013) (Reviewed 2018) (JAPhA 64(4);102117, July/August 2024)

2024, 2021

Multi-State Practice of Pharmacy

1. APhA affirms that pharmacists are trained to provide patient care, and have the ability to address patient needs, regardless of geographic location.
2. APhA advocates for the continued development of uniform laws, regulations and policies that facilitate pharmacists', student pharmacists', and pharmacy technicians' timely ability to practice in multiple states to meet practice and patient care needs.
3. APhA supports individual pharmacists' and student pharmacists' authority to provide patient care services across state lines whether in person or remotely.
4. APhA supports consistent and efficient centralized processes across all states for obtaining and maintaining pharmacist, pharmacy intern, and pharmacy technician licensure and/or registration.
5. APhA urges state boards of pharmacy to reduce administratively and financially burdensome requirements for licensure while continuing to uphold patient safety.
6. APhA encourages the evaluation of current law exam requirements for obtaining and maintaining initial state licensure, as well as licensure in additional states, to enhance uniformity and reduce duplicative requirements.
7. APhA urges state boards of pharmacy and the National Association of Boards of Pharmacy (NABP) to involve a member of the board of pharmacy and a practicing pharmacist in the review and updating of state jurisprudence licensing exam questions.

8. APhA calls for development of profession-wide consensus on licensing requirements for pharmacists and pharmacy personnel to support contemporary pharmacy practice.

(JAPhA. 61(4):e14-e15;July/August 2021) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2020

Pharmaceutical Safety and Access During Emergencies

1. APhA urges government authorities to hold pharmaceutical manufacturers, wholesalers, pharmacies, and other pharmaceutical supply distributors and providers accountable to state and federal price gouging laws, regulations and policies in selling those items to patients, pharmacies, hospitals, and other health care providers during times of local, state, or national emergency.
2. APhA urges government authorities to aggressively enforce laws and regulations against adulterated products and false and misleading claims by entities offering to sell pharmaceutical and medical products to health care providers and consumers.

(JAPhA. 60(5):e11; September/October 2020) (JAPhA 64(4);102117, July/August 2024)

2024, 2000

Regulation of Dietary Supplements

1. APhA shall work with Congress to modify the Dietary Supplement Health and Education Act or enact other laws, regulation, or policies 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 ensure quality, safe, contaminant-free products.
5. APhA encourages health care professionals, manufacturers, and consumers to report adverse health events associated with dietary supplements. APhA encourages the FDA to create a database with this information and make it available to all interested parties.

(JAPhA. NS1(9):40; September/October 2000) (Reviewed 2005) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (JAPhA 64(4);102117, July/August 2024)

2024, 2015

Role of the Pharmacist in the Care of Patients Using Cannabis

1. APhA supports legal, regulatory, and policy changes to further facilitate clinical research related to the clinical efficacy and safety associated with the use of cannabis and its various components.
2. APhA encourages health care provider education related to the clinical efficacy, safety, and management of patients using cannabis and its various components.
3. APhA advocates that the pharmacist collect and document information in the pharmacy patient profile about patient use of cannabis and its various components and provide appropriate patient counseling.
4. APhA supports pharmacist participation in independently prescribing cannabis and its various components when scientific data support the legitimate medical use of the products and delivery mechanisms, and federal, state, or territory laws or regulations permit pharmacists to independently prescribe them.
5. APhA opposes pharmacist involvement in independently prescribing cannabis and its various components for recreational use.

(JAPhA. N55(4):365; July/August 2015) (JAPhA 64(4);102117, July/August 2024)

2024, 2017

Support for Clinically Validated Blood Pressure Measurement Devices

1. APhA supports the use of manual and automated blood pressure measurement devices that are clinically validated initially and then undergo routine calibration to ensure accurate results.
2. APhA supports laws, regulations, policies, and peer-reviewed clinical validation testing for automated blood pressure measurement devices.
3. APhA promotes public awareness of accuracy of automated blood pressure measurement devices.

(JAPhA. 57(4):442; July/August 2017) (JAPhA 64(4);102117, July/August 2024)

2024, 2023

Transgender and Nonbinary Health Care

1. APhA supports the enactment of laws, regulations, and policies to end discriminatory practices that limit access to care for persons who are transgender or gender-diverse.
2. APhA encourages equity in care for persons who are transgender or gender-diverse through:
   (a) Continuing education on the pharmacist's role in transgender care, gender-affirming therapy, and health disparities in patients who are transgender or gender-diverse.
   (b) Systematic integration and utilization of affirmed name and pronouns, gender identity, and anatomical inventory.
   (c) Availability and implementation of education and resources related to gender-diverse care for all persons employed in health care settings.

(JAPhA. 63(4):1266; July/August 2023) (JAPhA 64(4);102117, July/August 2024)

2023, 2016

Medication-Assisted Treatment

APhA supports expanding access to medications indicated for opioid use disorders (MOUDs) and other substance use disorders, including but not limited to pharmacist-administered injection services for treatment and maintenance of substance use disorders that are based on a valid prescription.

(JAPhA. 56(4):370; July/August 2016) (Reviewed 2021) (JAPhA. 63(4):1268; July/August 2023)

2021

Diversity, Equity, Inclusion, and Belonging

1. APhA denounces all forms of racism.
2. APhA affirms that racism is a social determinant of health that contributes to persistent health inequities.
3. APhA urges the entire pharmacy community to actively work to dismantle racism.
4. APhA urges the integration of anti-racism education within pharmacy curricula, post-graduate training, and continuing education requirements.
5. APhA urges pharmacy leaders, decision-makers, and employers to create sustainable opportunities, incentives, and initiatives in education, research, and practice to address racism.
6. APhA urges pharmacy leaders, decision-makers, and employers to routinely and systematically evaluate organizational policies and programs for their impact on racial inequities.

(JAPhA. 61(4):e15; July/August 2021) (Reviewed 2023) (Review 2024)

2021

Social Determinants of Health

1. APhA supports the integration of social determinants of health screening as a vital component of pharmacy services.
2. APhA urges the integration of social determinants of health education within pharmacy curricula, post-graduate training, and continuing education requirements.
3. APhA supports incentivizing community engaged research, driven by meaningful partnerships and shared decision-making with community members.
4. APhA urges pharmacists to create opportunities for community engagement to best meet the needs of the patients they serve.
5. APhA encourages the integration of community health workers in pharmacy practice to provide culturally sensitive care, address health disparities, and promote health equity.

(JAPhA. 61(4):e16; July/August 2021) (Reviewed 2023) (Reviewed 2024)

2020

Protecting Pharmacy Personnel During Public Health Crisis

1. APhA strongly urges all employers of pharmacists and pharmacy personnel, and the settings in which they practice, to implement protection and control measures and procedures, per consensus recommendations when available, and access to protective gear and cleaning supplies that ensure the safety of pharmacy personnel and that of their family members and the public.
2. APhA urges federal and state government officials, manufacturers, distributors, and health system administrators to recognize pharmacists and pharmacy personnel as "front-line providers" who should receive appropriate personal protective equipment and other resources to protect their personal safety and support their ability to continue to provide patient care.

(JAPhA. 60(5):e11; September/October 2020)

2016

Point-of-Care Testing

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

(JAPhA. 56(4):369; July/August 2016) (Reviewed 2018) (Reviewed 2019) (Reviewed 2020) (Reviewed 2021)

2015

Prenatal and Perinatal Care and Maternal Health

APhA supports pharmacists, in collaboration with the health care team, providing adequate and comprehensive prenatal and perinatal care for overall maternal and newborn health and wellness.

(JAPhA. N55(4):365; July/August 2015) (Reviewed 2024)

2013

Pharmacists Providing Primary Care Services

APhA advocates for the recognition and utilization of pharmacists as providers to address gaps in primary care.

(JAPhA. 53(4):365; July/August 2013) (Reviewing 2018) (Reviewed 2019) (Reviewed 2020) (Reviewed 2023) (Reviewed 2024)

2013, 2008

Re-Use of Devices Intended for "Single Use"

APhA opposes the reuse of devices intended for "single use" in the screening and management 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) (JAPhA. 53(4):366; July/August 2013) (Reviewed 2018)

2011, 1996

Fluoridation of Water Supplies

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

(JAPhA. NS6:293; June 1996) (Reviewed 2005) (Reviewed 2009) (JAPhA. NS51(4):484; July/August 2011) (Reviewed 2016)

2011

The Role and Contributions of the Pharmacist in Public Health

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

(JAPhA. NS51(4):482; July/August 2011) (Reviewed 2012) (Reviewed 2016) (Reviewed 2020) (Reviewed 2022)

2009

Medication Disposal

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

(JAPhA. NS49(4):493; July/August 2009) (Reviewed 2012) (Reviewed 2013) (Reviewed 2018)

2007

Re-Distribution of Previously Dispensed Medications

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

(JAPhA. NS45(5):580; September/October 2007) (Reviewed 2012) (Reviewed 2017)

2007

WHO Policy on Infectious Diseases

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

(JAPhA. NS45(5):580; September/October 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2022)

2005, 1997

Complementary/Alternative Medications and/Integrative Health

1. APhA supports pharmacists using professional judgment to make informed decisions 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.

(JAPhA. NS37(4):459; July/August 1997) (Reviewed 2002) (JAPhA. NS45(5):556-557; September/October 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

2005, 2002

Health Literacy

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.

(JAPhA. NS42(5)(suppl 1):S60; September/October 2002) (JAPhA. NS45(5):556; September/October 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

2005, 1972

Prevention and Control of Sexually Transmitted Infections

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 infections.
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 infections.

(JAPhA. NS12:304; June 1972) (JAPhA. NS45(5):557; September/October 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019) (Reviewed 2020)

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 supports the modification of the Food, Drug and Cosmetic Act to require that homeopathic manufacturers provide evidence of efficacy and safety for all products, including products currently in the marketplace.

(JAPhA. NS42(5)(suppl 1):S60; September/October 2002) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

1986

Reye Syndrome

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

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

PUBLIC RELATIONS

2024, 2012, 2002, 1964

Health Education: Selection of Pharmacist

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

(JAPhA. NS4:429; August 1964) (JAPhA. NS42(5)(suppl 1):S62; September/October 2002) (Reviewed 2007) (JAPhA. NS52(4):459; July/August 2012) (Reviewed 2017) (Reviewed 2018) (JAPhA 64(4);102117, July/August 2024)

2021

People First Language

APhA encourages the use of people first language in all written and oral forms of communication.

(JAPhA. 61(4):e15; July/August 2021) (Reviewed 2023) (Reviewed 2024)

2002, 1971

Promotion of Pharmacists' Value

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

(JAPhA. NS11:264; May 1971) (JAPhA. NS42(5)(suppl 1):S62; September/October 2002) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

1999

Promotion of Pharmaceutical Care

1. APhA should continue to promote to the public the concepts and benefits of pharmaceutical care, differentiating pharmaceutical care practice from other pharmacy services.
2. 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.

(JAPhA. NS39(4):447-48; July/August 1999) (Reviewed 2002) (Reviewed 2008) (Reviewed 2013) (Reviewed 2018)

1986

Use of the Title "Pharmacist"

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

(Am Pharm. NS26(6):421; June 1986) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

QUALITY ASSURANCE

2024, 2023

Just Culture Approach to Patient Safety

1. APhA calls for employers to adopt and implement just culture principles to improve patient safety and support pharmacy personnel.
2. APhA encourages transparency between employers and employees by sharing deidentified medication error and near-miss data and trends as well as actions taken to promote continuous quality improvement.
3. APhA urges the integration of non-disciplinary and non-punitive mechanisms for use by boards of pharmacy to promote just culture principles when addressing people, systems, and processes involved in medication errors.
4. APhA encourages national and state associations to advocate for laws, regulations, and policies to provide protections to individuals utilizing error reporting systems to promote just culture.
5. APhA encourages the creation of a mechanism for an industrywide effort to engage in confidential and transparent sharing of learnings and root cause findings helpful in reducing the risk of medication errors.
6. APhA supports the integration of just culture principles in PharmD and pharmacy technician education, postgraduate training, and continuing professional development programs.

(JAPhA. 63(4):1265; July/August 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2018

Pharmacist Workplace Environment and Patient Safety

1. APhA supports staffing models that promote safe provision of patient care services and access to medications.

2. APhA encourages the adoption of patient centered quality and performance measures that align with safe delivery of patient care services and opposes the setting and use of operational quotas or time-oriented metrics that negatively impact patient care and safety.
3. APhA denounces any policies or practices of third-party administrators, processors, and payers that contribute to a workplace environment that negatively impacts patient safety. APhA calls upon public and private policy makers to establish provider payment laws, regulations, and policies that support the safe provision of medications and delivery of effective patient care.
4. APhA urges pharmacy personnel to establish collaborative mechanisms that engage the pharmacist in charge of each practice, pharmacists, pharmacy technicians, and pharmacy staff in addressing workplace issues that may have an impact on patient safety.
5. APhA urges employers to collaborate with the pharmacy staff to regularly and systematically examine and resolve workplace issues that may have a negative impact on patient safety.
6. APhA opposes retaliation against pharmacy personnel for reporting workplace issues that may negatively impact patient safety.

(JAPhA. 58(4):355; July/August 2018) (Reviewed 2020) (Reviewed 2021) (Reviewed 2022) (JAPhA 64(4);102117, July/August 2024)

2024, 2013, 2001, 1994

Stakeholder Responsibilities in Appropriate Medication Use

1. Recognizing pharmacists work in all facets of the medication use system and have varying responsibilities, APhA advocates pharmacist responsibilities align with the Joint Commission of Pharmacy Practitioners (JCPP) Pharmacist Patient Care Process and the Oath of a Pharmacist.
2. Recognizing patients are the focus of the medication use system, APhA advocates patients and caregivers assume responsibility for their health and well-being, actively engage in their care plan, communicate with health professionals, and learn more about their options for accessing care and associated costs for products and services.
3. Recognizing prescribers play a vital role in the medication use system, APhA advocates prescribers engage with patients and caregivers, in the assessment, development and implementation of the patient care plan. APhA also advocates that prescribers communicate, engage, and provide necessary information for pharmacists to engage in the care plan to ensure optimal patient care.
4. Recognizing payers' role in the medication use system, APhA advocates payers fairly design coverage benefits for products and services utilizing patient, pharmacist, and prescriber input to optimize health outcomes. Additionally, APhA advocates payers assume responsibility for providing efficient, clear, and uniform communication, as well as administrative and payment processes that are adaptable for advances in care.

(Am Pharm. NS34(6):57; June 1994) (JAPhA NS41(5)(suppl 1):S9; September/October 2001) (Reviewed 2008) (Reviewed 2010) (Reviewed 2011) (Reviewed 2012) (JAPhA. 53(4):367; July/August 2013) (Reviewed 2018) (JAPhA 64(4);102117, July/August 2024)

2019

Consolidation Within Health Care

1. APhA advocates that health care mergers and acquisitions must preserve the pharmacist–patient relationship.
2. APhA supports optimizing the role of pharmacists in the provision of team-based care following health care mergers and acquisitions in order to:
   (a) enhance patient experience and safety;
   (b) improve population health;
   (c) reduce health care costs; and
   (d) improve the work life of health care providers.
3. APhA asserts that the scope of review by federal agencies must have a focus on the impact of health care mergers and acquisitions on patient access and the provision of care to ensure optimal patient outcomes. Therefore, APhA calls for
   (a) reform of the pre–health care mergers and acquisitions process;
   (b) implementation of an ongoing post–health care mergers and acquisitions evaluation process to preserve patient choice and access to established patient–pharmacist relationships, and
   (c) continuous transparent dialogue among stakeholders throughout the process.
4. APhA calls for the Federal Trade Commission (FTC) to develop a task force to monitor health care mergers and acquisitions activity.

(JAPhA. 59(4):e16; July/August 2019) (Reviewed 2021) (Reviewed 2023) (Reviewed 2024)

2014

Audits of Health Care Practices

1. APhA recognizes that audits of health care practices, when used appropriately, may improve patient care and deter fraud, waste, and abuse.
2. APhA advocates for the use of standardized and efficient audit procedures with transparent criteria clearly communicated by the payor and readily accessible to providers in advance.
3. APhA advocates that audit processes should result in minimal disruption to practice workflow, minimal financial burden, and no impact on patient care.
4. APhA urges timely notification and scheduling of claims audits to minimize disruption of patient care delivery.
5. APhA supports the inclusion of education as a component of the audit process to improve documentation of services, meet payor requirements, and enhance the quality-of-care delivery.
6. APhA opposes incentive-based auditor compensation and the use of statistical methodologies, such as sample extrapolation, for determining the recoupment of funds from health care providers or health care organizations.
7. APhA advocates that audit reports include complete information listing audit discrepancies and appropriate guidelines for documenting and appealing these findings.
8. APhA advocates that pharmacy audits be performed in a professional manner by a pharmacist or certified pharmacy technician.

(JAPhA. 54(4): 357; July/August 2014) (Reviewed 2019)

2011, 1995

Measuring the Quality of Patient Care

1. APhA believes that quality assessment measures must evaluate the accessibility, acceptability, and technical quality of pharmacy services, as well as the patient-centered and economic outcomes of patient care. These measures must consider the perspectives of patients, pharmacists, and other 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.

(Am Pharm. NS35(6):37; June 1995) (Reviewed 2006) (JAPhA. NS51(4):484;July/August 2011) (Reviewed 2016)

2011

Pharmacy Practice Accreditation

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

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

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) (Reviewed 2015) (Reviewed 2019) (Reviewed 2021)

2005

Continuing Professional Development

1. APhA supports continuing professional development, a self-directed, individualized, systematic approach to life-long learning, to support pharmacist's 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 2006) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

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 professions 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 websites, 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, that provide the opportunity to promote the profession and its impact on clinical, economic, and humanistic patient outcomes.

(JAPhA. NS41(5)(suppl 1):S8; September/October 2001) (Reviewed 2003) (Reviewed 2005) (Reviewed 2006) (Reviewed 2008) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

1996

Quality Assurance and Improvement in Pharmacy Practice

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

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

Drug Product

2024, 2020

Protecting Pharmaceuticals as a Strategic Asset

1. APhA asserts that the quality and safety of pharmaceutical and other medical products and the global pharmaceutical and medical product supply chain are essential to the United States national security and public health.
2. APhA advocates for pharmacist engagement in the development and implementation of national and global strategies to ensure the availability, quality, and safety of pharmaceutical and other medical products.
3. APhA calls for the development, implementation, and oversight of enhanced and transparent processes, standards, and information that ensure quality and safety of all pharmaceutical ingredients and manufacturing processes.
4. APhA calls on the federal government to penalize entities who create barriers that threaten the availability, quality, and safety of United States pharmaceutical and other medical product supplies.

5. APhA calls for the development of redundancy and risk mitigation strategies in the manufacturing process to ensure reliable and consistent availability of safe and high-quality pharmaceutical and other medical products.
6. APhA advocates for legal regulatory, policy and market incentives that bolster the availability, quality, and safety of pharmaceutical and other medical products.
7. APhA calls for greater transparency, accuracy, and timeliness of information and notification to health care professionals regarding drug shortages, product quality and manufacturing issues, supply disruption, and recalls.
8. APhA encourages pharmacy providers, health systems, and payers to develop coordinated response plans, including the use of therapeutic alternatives, to mitigate the impact of drug shortages and supply disruptions.
9. APhA supports federal legislation and regulations that engages pharmacists, other health professionals, and manufacturers in developing a United States-specific essential medicines list and provides funding mechanisms to ensure consistent availability of these products.
10. APhA recommends the use of pharmacists in the delivery of public messages, through media and other communication channels, regarding pharmaceutical supply and quality issues.

(JAPhA. 60(5):e9; September/October 2020) (JAPhA 64(4);102117, July/August 2024)

RECORD SYSTEMS

2024, 2020, 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.
5. APhA supports laws, regulations, and policies that require e-prescribing of controlled substances to reduce fraudulent prescriptions.

(JAPhA. NS40(4):471; July/August 2010) (Reviewed 2012) (Reviewed 2014) (Reviewed 2015) (JAPhA. 60:(5):e10); September/October 2020) (JAPhA 64(4);102117, July/August 2024)

2024, 2020, 2015

Integrated Nationwide Prescribing Drug Monitoring Program

1. APhA advocates for nationwide integration and uniformity of prescription drug monitoring programs (PDMP) that incorporate federal, state, and territory databases for the purpose of providing health care professionals with accurate and real-time information to assist in clinical decision making when providing patient care services related to controlled substances.
2. APhA supports pharmacist involvement in the development of uniform standards for an integrated nationwide prescription drug monitoring program (PDMP) that includes the definition of authorized registered users, documentation, reporting requirements, system response time, security of information, minimum reporting data sets, and standard transaction format.
3. APhA supports mandatory prescription drug monitoring program (PDMP) enrollment by all health care providers, mandatory reporting by all those who dispense controlled substances, and appropriate system query by registrants during the patient care process related to controlled substances.
4. APhA advocates for the development of seamless workflow integration systems that would enable consistent use of a nationwide prescription drug monitoring program (PDMP) by registrants to facilitate prospective drug review as part of the patient care process related to controlled substances.
5. APhA advocates for continuous, sustainable federal funding sources for practitioners and system operators to utilize and maintain a standardized integrated and real-time nationwide prescription drug monitoring program (PDMP).
6. APhA supports the use of interprofessional advisory boards that include pharmacists to coordinate collaborative efforts for
   (a) compiling, analyzing, and using prescription drug monitoring program (PDMP) data trends to identify misuse of controlled substances and/or fraud;
   (b) providing focused provider education and patient referral to treatment programs; and
   (c) supporting research activities on the impact of PDMPs.

7. APhA supports education and training for registrants about a nationwide prescription drug monitoring program (PDMP) to ensure proper data integrity, use, and confidentiality.

(JAPhA. N55(4):364-365; July/August 2015) (JAPhA. 60(5):e10; September/October 2020) (JAPhA 64(4);102117, July/August 2024)

2022, 2008

Billing and Documentation of Medication Therapy Management (MTM) Services

1. APhA encourages the development and use of a system for billing of medication therapy management (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 health care providers, and
   (c) utilizes a billing platform that is accepted by the Centers for Medicare and Medicaid Services (CMS) and is compliant with the Health Insurance Portability and Accountability Act (HIPAA).
2. APhA supports the pharmacist's or pharmacy's choice of a documentation system that allows for transmission of any MTM billing claim and interfaces with the billing platform used by the insurer or payer.
3. APhA encourages pharmacists to use the American Medical Association (AMA) Current Procedural Terminology (CPT) codes for billing of MTM services.
4. APhA supports efforts to further develop CPT codes for billing of pharmacists' services, through the work of the Pharmacist Services Technical Advisory Coalition (PSTAC) and Pharmacy e-HIT Collaborative.

(JAPhA. NS48(4):471; July/August 2008) (Reviewed 2010) (Reviewed 2015) (Reviewed 2016) (Amended 2022)

2022

Data Security in Pharmacy Practice

1. APhA advocates that all organizations and healthcare providers adopt best practices in data security to ensure ongoing protection of patient data from loss, alteration, and all forms of cybercrime.
2. APhA recommends that organizations understand the flow of information, both internally and externally, to apply and maintain reasonable and appropriate administrative, technical, and physical safeguards to protect the privacy and identity of their patients.
3. APhA calls on organizations to provide ongoing employee education and training regarding patient data protection, best practices, and cybersecurity standards.

(JAPhA. 62(4):941; July 2022) (Reviewed 2023)

2022

Data Use and Access Rights in Pharmacy Practice

1. APhA supports organization and patient care provider rights to use patient data for improvement of patient and public health outcomes and enhancement of patient care delivery processes in accordance with ethical practices and industry standards regarding data privacy and transparency.
2. APhA urges ongoing transparent, accessible, and comprehensible disclosure to patients by all HIPAA-covered and noncovered entities as to how personally identifiable information may be utilized.
3. APhA calls for all entities with access to patient health data, including those with digital applications, to be required to adhere to established standards for patient data use.
4. APhA supports the right of patients to have full and timely access to their personal health data from all entities.

(JAPhA. 62(4):941; July 2022) (Reviewed 2023)

2022, 2018

Proactive Immunization Assessment and Immunization Information Systems

1. APhA supports mandatory requirements for ALL immunization providers to report pertinent immunization data into Immunization Information Systems (IIS).
2. APhA calls for government entities to fund enrollment and engagement of all immunization providers in Immunization Information Systems (IIS). This engagement should support lifetime tracking of immunizations for patients.
3. APhA supports nationwide integration of Immunization Information Systems (IIS) that incorporate federal, state, and local databases for the purpose of providing health care professionals with accurate and timely information to assist in clinical decision making related to immunization services.
3. APhA calls for a National Immunization Information System (IIS) to receive and report vaccination data from all registries for the purpose of providing health care professionals, patients, and their caregivers with accurate and timely information to assist in clinical decision-making.
4. APhA advocates that all appropriate health care personnel involved in the patient care process have timely access to Immunization Information Systems (IIS) and other pertinent data sources to support proactive patient assessment and delivery of immunization services while maintaining confidentiality.

5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the bidirectional exchange of data with Immunization Information Systems (IIS).

(JAPhA. 58(4):355-365 July/August 2018) (JAPhA. 62 (4):941; July 2022)

2018

Pharmacists Electronic Referral Tracking

1. APhA supports the development of electronic systems that enhance and simplify the ability of pharmacists in all practice settings to receive, send, and track referrals among all members of the health care team, including other pharmacists, irrespective of the health care system, model, or network in which the patient participates.
2. APhA supports the interoperability and integration of referral tracking systems with electronic health records so patients can receive the benefit of optimally coordinated care from all members of the health care team.

(JAPhA. 58(4):356; July/August 2018) (Reviewed 2020)

2015, 1994

Confidentiality of Computer-generated Patient Records

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

(Am Pharm. NS34(6):60; June 1994) (Reviewed 2005) (Reviewed 2009) (Reviewed 2010) (JAPhA. 55(4):375; July/August 2015) (Reviewed 2023)

2015

Interoperability of Communications Among Health Care Providers to Improve Quality of Patient Care

1. APhA supports the establishment of secure, portable, and interoperable electronic patient health care records.
2. APhA supports the engagement of pharmacists with other stakeholders in the development and implementation of multidirectional electronic communication systems to improve patient safety, enhance quality care, facilitate care transitions, increase efficiency, and reduce waste.
3. APhA advocates for the inclusion of pharmacists in the establishment and enhancement of electronic health care information technologies and systems that must be interoperable, HIPAA compliant, integrated with claims processing, updated in a timely fashion, allow for data analysis, and do not place disproportionate financial burden on any one health care provider or stakeholder.
4. APhA advocates for pharmacists and other health care providers to have access to view, download and transmit electronic health records. Information shared among providers using a health information exchange should utilize a standardized secure interface based on recognized international health record standards for the transmission of health information.
5. APhA supports the integration of federal, state, and territory health information exchanges into an accessible, standardized, nationwide system.
6. APhA opposes business practices and policies that obstruct the electronic access and exchange of patient health information because these practices compromise patient safety and the provision of optimal patient care.
7. APhA advocates for the development of systems that facilitate and support electronic communication between pharmacists and prescribers concerning patient adherence, medication discontinuation, and other clinical factors that support quality care transitions.
8. APhA supports the development of education and training programs for pharmacists, student pharmacists, and other health care professionals on the appropriate use of electronic health records to reduce errors and improve the quality and safety of patient care.
9. APhA supports the creation and non-punitive application of a standardized, interoperable system for voluntary reporting of errors associated with the use of electronic health care information technologies and systems to enable aggregation of protected data and develop recommendations for improved quality.

(JAPhA. N55(4):364; July/August 2015) (Reviewed 2019) (Reviewed 2023) (Reviewed 2024)

2015, 1993

Patient Information

1. APhA shall facilitate the development, dissemination, and use of an information system that documents the components of comprehensive medication management services.
2. APhA encourages development of quality assurance standards that guarantee the integrity and accuracy of information included in proprietary and non-proprietary information systems.

(Am Pharm. NS33(7):53; July 1993) (Reviewed 2005) (Reviewed 2009) (Reviewed 2010) (JAPhA. 55(4):375; July/August) (Reviewed 2019)

2013

Ensuring Access to Pharmacists' Services

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

(JAPhA. 53(4):365; July/August 2013) (Reviewed 2018) (Reviewed 2019) (Reviewed 2021) (Reviewed 2024)

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) (Reviewed 2013) (Reviewed 2014) (Reviewed 2015) (Reviewed 2019) (Reviewed 2023)

2009

Health Information Technology

1. APhA supports the delivery of informatics education within pharmacy schools and continuing education programs to improve patient care, understand interoperability among systems, understand where to find information, increase productivity, and 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 definition, 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, the certification of systems, and the integration of medication use systems with health information technology.

(JAPhA. NS49(4):492; July/August 2009) (Reviewed 2010)(Reviewed 2013) (Reviewed 2014) (Reviewed 2015) (Reviewed 2019)

2005, 1993

Documentation

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.

(Am Pharm. NS33(7):54; July 1993) (JAPhA. NS45(5):560; September/October 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

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 when the patient has consented to such research or when the patient's identity is protected.
4. APhA encourages interdisciplinary discussion regarding accountability and oversight for appropriate use of health information.

(JAPhA. 38(4):417; July/August 1998) (Reviewed 2005) (Reviewed 2009) (Reviewed 2010) (Reviewed 2013) (Reviewed 2014) (Reviewed 2015)

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.
3. APhA supports utilization of universal and comprehensive standards for On-line Realtime Drug Utilization Review (ORDUR).
4. APhA encourages the development of a standardized method of electronic transfer of patient medical data between all health professionals involved in the care of a patient.

(Am Pharm. NS34(6):58; June 1994) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

1983

Patient Counseling and Information Program

1. APhA shall strongly and actively encourage pharmacists to be available for and provide patient consultation, including written drug information, when requested or professionally appropriate.
2. APhA supports patient information programs that include reference to seeking medication information from pharmacists and does not endorse programs which, by ignoring the professional capabilities of pharmacists, may limit the patient's ability to receive needed drug information and consultation.

(Am Pharm. NS23(6):53; June 1983) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

REIMBURSEMENT AND COMPENSATION

2024, 2020

Community-Based Pharmacists as Providers of Care

1. APhA advocates for the identification of medical conditions that may be safely and effectively treated by community-based pharmacists.
2. APhA encourages the training and education of pharmacists and student pharmacists regarding identification, treatment, monitoring, documentation, follow-up, and referral for medical conditions treated by community-based pharmacists
3. APhA advocates for laws, regulations, and policies that allow pharmacists to identify and manage medical conditions treated by community-based pharmacists.
4. APhA advocates for appropriate remuneration for the assessment and treatment of medical conditions treated by community-based pharmacists from government and private payers to ensure sustainability and access for patients.
5. APhA supports research to examine the outcomes of services that focus on medical conditions treated by community-based pharmacists.

(JAPhA. 60(5):e10; September/October 2020) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2017, 2012

Contemporary Pharmacy Practice

1. APhA asserts that pharmacists should have the authority and support to practice to the full extent of their education, training, and experience in delivering patient care.
2. APhA opposes burdensome legal and regulatory requirements beyond continuing professional development for the provision of patient care services.

3. APhA supports continuing efforts toward establishing a consistent and accurate perception of the contemporary role and practice of pharmacists by the general public, patients, and all persons and institutions engaged in health care policy, administration, payment, and delivery.
4. APhA supports continued collaboration with stakeholders to facilitate adoption of standardized practice acts, appropriate related laws, regulations, and policies that reflect contemporary pharmacy practice.
5. APhA supports the establishment of multistate pharmacist licensure agreements to address the evolving needs of the pharmacy profession and pharmacist-provided patient care.
6. APhA urges the continued development of consensus documents, in collaboration with medical associations and other stakeholders, that recognize and support pharmacists' roles in patient care as health care providers.
7. APhA urges universal recognition of pharmacists as health care providers and compensation based on the level of patient care provided using standardized and future health care payment models.

(JAPhA. NS52(4):457; July/August 2012) (Reviewed 2016) (JAPhA. 57(4):441; July/August 2017) (Reviewed 2019) (Reviewed 2021) (Reviewed 2022) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2013, 2009

Independent Practice of Pharmacists

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

(JAPhA. NS49(4):492; July/August 2009) (Reviewed 2012) (JAPhA. 53(4):366; July/August 2013) (Reviewed 2018) (Reviewed 2023) (JAPhA 64(4);102117, July/August 2024)

2024, 2018

Pharmacist Workplace Environment and Patient Safety

1. APhA supports staffing models that promote safe provision of patient care services and access to medications.
2. APhA encourages the adoption of patient centered quality and performance measures that align with safe delivery of patient care services and opposes the setting and use of operational quotas or time-oriented metrics that negatively impact patient care and safety.
3. APhA denounces any policies or practices of third-party administrators, processors, and payers that contribute to a workplace environment that negatively impacts patient safety. APhA calls upon public and private policy makers to establish provider payment laws, regulations, and policies that support the safe provision of medications and delivery of effective patient care.
4. APhA urges pharmacy personnel to establish collaborative mechanisms that engage the pharmacist in charge of each practice, pharmacists, pharmacy technicians, and pharmacy staff in addressing workplace issues that may have an impact on patient safety.
5. APhA urges employers to collaborate with the pharmacy staff to regularly and systematically examine and resolve workplace issues that may have a negative impact on patient safety.
6. APhA opposes retaliation against pharmacy personnel for reporting workplace issues that may negatively impact patient safety.

(JAPhA. 58(4):355; July/August 2018) (Reviewed 2020) (Reviewed 2021) (Reviewed 2022) (JAPhA 64(4);102117, July/August 2024)

2024, 2005, 2003, 1996

Pharmacist's Role in Immunizations

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) administering vaccines to patients facing barriers to health.
2. APhA encourages the availability of all vaccines to all pharmacies in order to meet public health needs.
3. APhA supports the compensation of pharmacists for the administration of immunizations and the reimbursement for vaccine distribution.
4. APhA should facilitate the development of programs that educate pharmacists about their role in immunizations in public health.

(JAPhA. NS36(6):395; June 1996) (JAPhA. NS43(5)(suppl 1):S57; September/October 2003) (JAPhA. NS45(5):556; September/October 2005) (Reviewed 2007) (Reviewed 2009) (Reviewed 2012) (Reviewed 2014) (Reviewed 2019) (Reviewed 2020) (Reviewed 2021) (JAPhA 64(4);102117, July/August 2024)

2024, 2020

Providing Affordable and Comprehensive Pharmacy Services to the Underserved

1. APhA supports the expansion and increased sources of funding for pharmacies and pharmacist-provided care services that serve the needs of underserved populations to provide better health outcomes and lower healthcare costs.
2. APhA supports charitable pharmacies and pharmacy services that ensure the quality, safety, drug storage, and integrity of the drug product and supply chain, in accordance with applicable laws, regulations, and policies.

(JAPhA. 60(5):e11; September/October 2020) (Reviewed 2022) (JAPhA 64(4);102117, July/August 2024)

2024, 2018, 2013

Revisions to the Medication Classification System

1. APhA supports the Food and Drug Administration's (FDA) efforts to revise the drug and medical device classification paradigms for prescription and nonprescription medications and medical devices to allow greater access to certain medications and medical devices under conditions of safe use while maintaining patients' relationships with their pharmacists and other health care providers.
2. APhA supports the implementation or modification of state laws, regulations, and policies to facilitate pharmacists' implementation and provision of services related to a revised drug and medical device classification system.
3. APhA supports a patient care delivery model built on coordination and communication between pharmacists and other health care team members in the evaluation and management of care delivery.
4. APhA affirms that pharmacists are qualified to provide clinical interventions on medications and medical devices under FDA's approved conditions of safe use.
5. APhA urges manufacturers, FDA, and other stakeholders to include pharmacists' input in the development and adoption of technology and standardized processes for services related to medications and medical devices under FDA's defined conditions of safe use.
6. APhA supports the utilization of best practices, treatment algorithms, and clinical judgment of pharmacists and other health care providers to guide the evaluation and management of care delivery related to medications and medical devices under FDA's approved conditions of safe use.
7. APhA encourages the inclusion of medications, medical devices, and their associated services provided under FDA's defined conditions of safe use within health benefit coverage.
8. APhA supports compensation of pharmacists and other health care professionals for the provision of services related to FDA's defined conditions of safe use programs.

(JAPhA. 53(4):365; July/August 2013) (JAPhA. 58(4):356; July/August 2018) (Reviewed 2022) (JAPhA 64(4);102117, July/August 2024)

2023

Uncompensated Care Mandates in Pharmacy

APhA calls for commensurate compensation for the provision of compulsory or mandated pharmacy services that include all products, supplies, labor, expertise, and administrative fees based on transparent economic analyses of existing and future services.

(JAPhA. 63(4):1265; July/August 2023)

2022

Access and Reimbursement for Diabetes Education, Support, and Prevention Services

1. APhA supports the expansion of patient access to diabetes education, support, and prevention, including but not limited to the National Diabetes Prevention Program or DSMES.
2. APhA calls upon public and private payers to expand reimbursement for pharmacist-based services as providers of diabetes education, support, and prevention regardless of practice setting.
3. APhA advocates for campaigns focused on increased community wellness awareness and health benefits for diabetes education, support, and prevention.

(JAPhA. 62(4):941; July 2022)

2020

Accountability of Pharmacists

1. APhA affirms pharmacists' professional accountability within their role in all practice settings.
2. APhA advocates that pharmacists be granted and accept authority, autonomy, and accountability for patient-centric actions to improve health and medication outcomes, in coordination with other health professionals, as appropriate.
3. APhA reaffirms 2017 Pharmacists' Role Within Value-based Payment Models and supports continued expansion of interprofessional patient care models that leverage pharmacists as accountable members of the health care team.
4. APhA advocates for sustainable payment and attribution models to support pharmacists as accountable patient care providers.

5. APhA supports continued expansion of resources and health information infrastructures that empower pharmacists as accountable health care providers.
6. APhA supports the enhancement of comprehensive and affordable professional liability insurance coverage that aligns with evolving pharmacist accountability and responsibility.

(JAPhA. 60(5):e9; September/October 2020) (Reviewed 2023)

2020

Coordination of the Pharmacy and Medical Benefit

APhA supports coordination of patients' comprehensive pharmacy and medical benefits that allows for provision of and compensation for pharmacists' patient care services; aligns incentives to optimize patient outcomes; streamlines administrative processes; reduces overall health care costs and preserves patients' right to choose providers under their pharmacy and medical benefits.

(JAPhA. 60(5):e10; September/October 2020)

2019

Referral System for the Pharmacy Profession

1. APhA supports referrals of patients to pharmacists, among pharmacists, or between pharmacists and other health care providers to promote optimal patient outcomes.
2. APhA supports referrals to and by pharmacists that ensure timely patient access to quality services and promote patient freedom of choice.
3. APhA advocates for pharmacists' engagement in referral systems that are aligned with those of other health care providers and facilitate collaboration and information sharing to ensure continuity of care.
4. APhA supports attribution and equitable payment to pharmacists providing patient care services as a result of a referral.
5. APhA promotes the pharmacist's professional responsibility to uphold ethical and legal standards of care in referral practices.
6. APhA reaffirms its support of development, adoption, and use of policies and procedures by pharmacists to manage potential conflicts of interest in practice, including in referral systems.

(JAPhA. 59(4):e16; July/August 2019) (Reviewed 2022) (Reviewed 2023) (Reviewed 2024)

2018

Direct and Indirect Remuneration Fees

APhA opposes retroactive direct and indirect remuneration (DIR) fees and supports initiatives to prohibit such fees on pharmacies.

(JAPhA. 58(4):356; July/August 2018) (Reviewed 2022)

2018

Use of Genomic Data Within Pharmacy Practice

1. APhA emphasizes genomics as an essential aspect of pharmacy practice.
2. APhA recognizes pharmacists as the health care professional best suited to provide medication-related consults and services based on a patient's genomic information. All pharmacists involved in the care of the patient should have access to relevant genomic information.
3. APhA supports processes to protect patient data confidentiality and opposes unethical utilization of genomic data.
4. APhA demands payers include pharmacists as eligible providers for covered genomic interpretation and related services to support sustainable models that optimize patient care and outcomes.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the exchange, storage, utilization, and documentation of clinically actionable genetic variations and actions taken by the pharmacist in the provision of patient care.
6. APhA recommends pharmacists and pharmaceutical scientists lead the collaborative development of evidence-based practice guidelines for pharmacogenomics and related services.
7. APhA recommends the inclusion of pharmacists and pharmaceutical scientists in the collaborative development of pharmacogenomics clinical support tools and resources.
8. APhA encourages pharmacists to use their professional judgment and published guidelines and resources when providing access to testing or utilizing direct-to-consumer genomic test results in their patient care services.
9. APhA urges schools and colleges of pharmacy to include clinical application of genomics as a required element of the Doctor of Pharmacy curriculum.
10. APhA encourages the creation of continuing professional development and post-graduate education and training programs for pharmacists in genomics and its clinical application to meet varying practice needs.

11. APhA encourages the funding of pharmacist-led research examining the cost effectiveness of care models that utilize pharmacists providing genomic services.

(JAPhA. 58(4):355; July/August 2018) (Reviewed 2023)

2017

Pharmacists' Role Within Value-based Payment Models

1. APhA supports value-based payment models that include pharmacists as essential health care team members and that promote coordinated care, improved health outcomes, and lower total costs of health care.
2. APhA encourages the development and implementation of meaningful, consistent, process-based and outcomes-based quality measures that allow attribution of pharmacist impact within value-based payment models.
3. APhA advocates for mechanisms that recognize and compensate pharmacists for their contributions toward meeting goals of quality and total costs of care in value-based payment models, separate and distinct from the full product and dispensing cost reimbursement.
4. APhA advocates that pharmacists must have real-time access to and exchange of electronic health record data within value-based payment models in order to achieve optimal health and medication-related outcomes.
5. APhA supports education, training, and resources that help pharmacists transform and integrate their practices with value-based payment models and programs.

(JAPhA. 57(4):441; July/August 2017) (Reviewed 2021)

2017

Pharmacy Performance Networks

1. APhA supports performance networks that improve patient care and health outcomes, reduce costs, use pharmacists as an integral part of the health care team, and include evidence-based quality measures.
2. APhA urges collaboration between pharmacists and payers to develop distinct, transparent, fair, and equitable payment strategies for achieving performance measures associated with providing pharmacists' patient care services that are separate from the reimbursement methods used for product fulfillment.
3. APhA advocates for prospective notification of evidence-based quality measures that will be used by a performance network to assess provider and practice performance. Furthermore, updates on provider and practice performance against these measures should be provided in a timely and regular manner.
4. APhA supports pharmacists' professional autonomy to determine processes that improve performance on evidence-based quality measures.

(JAPhA. 57(4):441; July/August 2017) (Reviewed 2019) (Reviewed 2024)

2014

Audits of Health Care Practices

1. APhA recognizes that audits of health care practices, when used appropriately, may improve patient care and deter fraud, waste, and abuse.
2. APhA advocates for the use of standardized and efficient audit procedures with transparent criteria clearly communicated by the payor and readily accessible to providers in advance.
3. APhA advocates that audit processes should result in minimal disruption to practice workflow, minimal financial burden, and no impact on patient care.
4. APhA urges timely notification and scheduling of claims audits to minimize disruption of patient care delivery.
5. APhA supports the inclusion of education as a component of the audit process to improve documentation of services, meet payor requirements, and enhance the quality-of-care delivery.
6. APhA opposes incentive-based auditor compensation and the use of statistical methodologies, such as sample extrapolation, for determining the recoupment of funds from health care providers or health care organizations.
7. APhA advocates that audit reports include complete information listing audit discrepancies and appropriate guidelines for documenting and appealing these findings.
8. APhA advocates that pharmacy audits be performed in a professional manner by a pharmacist or certified pharmacy technician.

(JAPhA. 54(4): 357; July/August 2014) (Reviewed 2019)

2013

Ensuring Access to Pharmacists' Services

1. Pharmacists are health care providers who must be recognized and compensated by payers for their professional services.
2. APhA actively supports the adoption of standardized processes for the provision, documentation, and claims submission of pharmacists' services.

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

(JAPhA. 53(4):365; July/August 2013) (Reviewed 2018) (Reviewed 2019) (Reviewed 2021) (Reviewed 2024)

2005, 1987

Catastrophic Illness: Coverage for Pharmacist Services Included

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.

(Am Pharm. NS27(6):422; June 1987) (JAPhA. NS45(5):557; September/October 2005) (Reviewed 2009)(Reviewed 2014) (Reviewed 2019)

2005, 1985

Pharmacists and Home Health Care

1. APhA supports establishment of pharmacist consulting services for home care.
2. Medicaid and other third-party programs should recognize the consulting role of the pharmacist in reducing the misuse of drugs and maximizing their therapeutic effectiveness through fair and equitable reimbursement for consulting functions which is not tied to the provision of medications.
3. Medicaid and other third-party programs also should reimburse pharmacists for innovative packaging and services that will maximize adherence, increase the opportunity for drug utilization review, and better meet the informational needs of the patient and the care giver.

(Am Pharm. NS25(5):51; May 1985) (JAPhA. NS45(5):557; September/October 2005) (Reviewed 2009) (Reviewed 2012) (Reviewed 2014) (Reviewed 2019)

2005, 1990

Reimbursement for Unapproved (Off-Label) Uses of FDA-Approved Drug Products

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.

(Am Pharm. NS30(6):45; June 1990) (JAPhA. NS45(5):557; September/October 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

1993

Pharmacists' Services

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

(Am Pharm. NS33(7):53; July 1993) (Reviewed 2005) (Reviewed 2007) (Reviewed 2009) (Reviewed 2010) (Reviewed 2011) (Reviewed 2012) (Reviewed 2017) (Reviewed 2022) (Reviewed 2023)

Federal Programs

2024, 2012, 2005, 1969

Medicare and Patient Care Service

1. APhA believes that Health care, including the essential component of patient care services, should be made available to as many people as possible in our society through the most economical system compatible with an acceptable standard of quality.
2. APhA should support the Part B mechanism which is the voluntary supplementary medical insurance program financed equally by beneficiaries and the government.
3. APhA should oppose laws, regulations, and policies that would restrict the Medicare drug benefit to specific, chronic diseases.

4. APhA should support the inclusion of patient care services under Medicare or any other federal financing mechanism, providing the program is designed to help persons who need it most and is administratively efficient and economical.

(JAPhA. NS9:363; July 1969) (JAPhA. NS45(5):558; September/October 2005) (Reviewed 2009) (JAPhA. NS52(4):460; July/August 2012) (Reviewed 2017) (Reviewed 2018) (JAPhA 64(4);102117, July/August 2024)

2016, 2011

Pharmacists as Providers Under the Social Security Act

APhA supports changes to the Social Security Act to allow pharmacists to be recognized and paid as providers of patient care services.

(JAPhA. NS51(4):482; July/August 2011) (JAPhA. 56(4): 379; July/August 2016) (Reviewed 2022)

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) (Reviewed 2016) (Reviewed 2021) (Reviewed 2023)

2005, 1977

Government-Financed Reimbursement

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

(JAPhA. NS17:452; July 1977) (JAPhA. NS45(5):558; September/October 2005) (Reviewed 2009) (Reviewed 2011) (Reviewed 2012) (Reviewed 2017) (Reviewed 2021) (Reviewed 2022)

2005, 1980

Inclusion of Pharmacist-Provided Patient Care Services in Health Programs

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

(Am Pharm. NS20(7):69; July 1980) (JAPhA. NS45(5):558; September/October 2005) (Reviewed 2009) (Reviewed 2010) (Reviewed 2011) (Reviewed 2012) (Reviewed 2017)

2005, 1970

Medicare, Medicaid, and Other Third-Party Payment Programs

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.

(JAPhA. NS10:346; June 1970) (JAPhA. NS45(5):558; September/October 2005) (Reviewed 2009) (Reviewed 2010) (Reviewed 2012) (Reviewed 2014) (Reviewed 2019)

2005, 1968

Medicare: Reimbursement Procedures

APhA should educate pharmacists on aspects of reimbursement procedures and concepts associated with Medicare.

(JAPhA. NS8:368; July 1968) (JAPhA. NS45(5):558; September/October 2005) (Reviewed 2009 (Reviewed 2012) (Reviewed 2014) (Reviewed 2019)

2004

Tablet Splitting

APhA opposes mandatory tablet splitting.

(JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015)

1969

Medicare Task Force: Policy Guidelines

The following guidelines supplement those adopted by APhA in 1967:

(a) Provide for beneficiary contribution toward program financing.
(b) Provide for government reimbursement of claims directly to the pharmacist.
(c) 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.
(d) Establish a per-prescription, fixed amount (co-payment) which must be paid by the beneficiary when obtaining drugs.
(e) 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.
(f) Include all drugs having therapeutic use, whether for chronic or acute conditions.
(g) Include all persons eligible for Part B Medicare coverage.

(JAPhA. NS9:343; July 1969) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

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:

(a) Permit pharmacists to select and dispense a quality drug product;
(b) Establish some mechanism to assist pharmacists in selecting quality, drug products under the cost and other criteria established;
(c) Permit the use of any available drug product when unique medical circumstances so require;
(d) Establish a reasonable remuneration base for pharmacists rendering services under the program;
(e) Guarantee recipients free choice of pharmacy; and
(f) Limit the reimbursement for pharmacists' services to those provided by duly licensed pharmacists.

(JAPhA. NS7:315; June 1967) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

National Health Insurance

2005, 1971

National Health Insurance (NHI)

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.

(JAPhA. NS11:265; May 1971) (JAPhA. NS45(5):558; September/October 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

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 an 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. An NHI, pharmaceutical service benefit must optimize administrative efficiency and minimize administrative costs.

(JAPhA. NS17:451; July 1977) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

New Payment Systems

2011, 1994

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

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

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

1995

Integrated Risk/Capitation Payment Systems

1. APhA should provide pharmacists with tools to evaluate compensation for their pharmaceutical care services through mechanisms based on concepts other than fee-for-service.
2. APhA must facilitate both economic and clinical research on cost-to-outcomes benefits of pharmaceutical care services under integrated risk/capitated health care systems.
3. APhA affirms the principle that any pharmacist or pharmacy that adheres to a program's quality standards and agrees to accept its compensation plan shall be able to participate in an integrated risk/capitated system or network.

(Am Pharm. NS35(6):37; June 1995) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

1994

Product and Payment Systems

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

(Am Pharm. NS34(6):56; June 1994) (Reviewed 2005) (Reviewed 2009) (Reviewed 2010) (Reviewed 2018)

1993

Payment System Reform

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

(Am Pharm. NS33(7):53; July 1993) (Reviewed 2005) (Reviewed 2009) (Reviewed 2011) (Reviewed 2016) (Reviewed 2018)

Professional Fees

2024, 1975

Periodic Adjustments of Professional Fees in Federal Programs

It is essential that laws, regulations, and policies governing pharmacist professional fees in federally-supported, health care programs require review and equitable adjustments on a regularized, periodic basis.

(JAPhA. NS15:330; June 1975) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019) (JAPhA 64(4);102117, July/August 2024)

2022, 2008

Billing and Documentation of Medication Therapy Management (MTM) Services

1. APhA encourages the development and use of a system for billing of medication therapy management (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 health care providers, and
   (c) utilizes a billing platform that is accepted by the Centers for Medicare and Medicaid Services (CMS) and is compliant with the Health Insurance Portability and Accountability Act (HIPAA).
2. APhA supports the pharmacist's or pharmacy's choice of a documentation system that allows for transmission of any MTM billing claim and interfaces with the billing platform used by the insurer or payer.
3. APhA encourages pharmacists to use the American Medical Association (AMA) Current Procedural Terminology (CPT) codes for billing of MTM services.
4. APhA supports efforts to further develop CPT codes for billing of pharmacists' services, through the work of the Pharmacist Services Technical Advisory Coalition (PSTAC) and Pharmacy e-HIT Collaborative.

(JAPhA. NS48(4):471; July/August 2008) (Reviewed 2010) (Reviewed 2015) (Reviewed 2016) (Amended 2022)

1987

Compensation for Cognitive Services

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

(Am Pharm. NS27(6):422; June 1987) (Reviewed 2005) (Reviewed 2009) (Reviewed 2011) (Reviewed 2013) (Reviewed 2018)

Third Party and Prepaid Programs

2024, 1984

Exemption from the Employee Retirement Income Security Act (ERISA)

APhA seeks introduction of laws, regulations, and policies exempting state, third-party, and prescription programs from preemption by ERISA.

(Am Pharm. NS24(7):61; July 1984) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019) (JAPhA 64(4);102117, July/August 2024)

2024, 1981

Third-party Reimbursement Legislation

APhA supports enactment of laws, regulations, and policies requiring that third-party program reimbursement to pharmacists be at least equal to the pharmacists prevailing charges to the self-paying public for comparable services and products, plus additional documented direct and indirect costs, which are generated by participating in the program.

(Am Pharm. NS21(5):40; May 1981) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019) (Reviewed 2021) (Reviewed 2022) (JAPhA 64(4);102117, July/August 2024)

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

4. APhA encourages interdisciplinary collaboration in research efforts within and between the public and private research communities.

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

RESEARCH

2024, 2016

Biologic, Biosimilar, and Interchangeable Biologic Drug Products

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

(JAPhA. 56(4):369; July/August 2016) (JAPhA 64(4);102117, July/August 2024)

2024,1989

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 agencies to eliminate laws, regulations, and policies 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.

(Am Pharm. NS29(7):465; July 1989) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019) (Reviewed 2022) (JAPhA 64(4);102117, July/August 2024)

2024, 2015

Role of the Pharmacist in the Care of Patients Using Cannabis

1. APhA supports legal, regulatory, and policy changes to further facilitate clinical research related to the clinical efficacy and safety associated with the use of cannabis and its various components.
2. APhA encourages health care provider education related to the clinical efficacy, safety, and management of patients using cannabis and its various components.
3. APhA advocates that the pharmacist collect and document information in the pharmacy patient profile about patient use of cannabis and its various components and provide appropriate patient counseling.
4. APhA supports pharmacist participation in independently prescribing cannabis and its various components when scientific data support the legitimate medical use of the products and delivery mechanisms, and federal, state, or territory laws or regulations permit pharmacists to independently prescribe them.
5. APhA opposes pharmacist involvement in independently prescribing cannabis and its various components for recreational use.

(JAPhA. N55(4):365; July/August 2015) (JAPhA 64(4);102117, July/August 2024)

2024, 2005, 1986, 1981

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 laws, regulations, and policies, 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 laws, regulations, and policies that would penalize the properly controlled and conducted use of animals for biomedical research and testing.

(Am Pharm. NS21(5):41; May 1981) (Am Pharm. NS26(6):420; June 1986) (JAPhA. NS45(5):559; September/October 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019) (JAPhA 64(4);102117, July/August 2024)

2024, 2019, 2005, 1990

Use of Representative Populations in Clinical Studies

1. APhA supports the use of representative populations in clinical studies, including, but not limited to protected populations such as women, persons who are underrepresented or historically marginalized, older adults, persons who are transgender and gender-diverse, 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.

(Am Pharm. NS30(6):46; June 1990) (JAPhA. NS45(5):559; September/October 2005) (Reviewed 2009) (Reviewed 2014) (JAPhA. 59(4):e28; July/August 2019) (JAPhA 64(4);102117, July/August 2024)

2019,1990

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 the pharmacy profession.

(Am Pharm. NS30(6):46; June 1990) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (JAPhA. 59(4):e28; July/August 2019) (Reviewed 2022)

2019, 2018

Gluten Content and Labeling in Medications

1. APhA supports labeling of all prescription and nonprescription products, as well as dietary supplement products, to indicate the presence of gluten.
2. APhA encourages manufacturers to formulate drug products without use of wheat, barley, rye, or their derivatives whenever possible.
3. APhA supports additional research on the effects of gluten intolerance and celiac malabsorption, particularly as it relates to medication absorption.
4. APhA supports pharmacist education regarding celiac disease and non-celiac gluten sensitivity.
5. APhA encourages the development of analytical methods that can accurately detect lower levels of gluten than the current standard (20 ppm) and for the establishment of evidence-based gluten-free standards for the labeling of foods, excipients, dietary supplements, and prescription and nonprescription products.

(JAPhA. 58(4):356; July/August 2018) (JAPhA. 59(4):e16; July/August 2019) (Reviewed 2020)

2018

Use of Genomic Data Within Pharmacy Practice

1. APhA emphasizes genomics as an essential aspect of pharmacy practice.
2. APhA recognizes pharmacists as the health care professional best suited to provide medication-related consults and services based on a patient's genomic information. All pharmacists involved in the care of the patient should have access to relevant genomic information.
3. APhA supports processes to protect patient data confidentiality and opposes unethical utilization of genomic data.
4. APhA demands payers include pharmacists as eligible providers for covered genomic interpretation and related services to support sustainable models that optimize patient care and outcomes.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the exchange, storage, utilization, and documentation of clinically actionable genetic variations and actions taken by the pharmacist in the provision of patient care.
6. APhA recommends pharmacists and pharmaceutical scientists lead the collaborative development of evidence-based practice guidelines for pharmacogenomics and related services.
7. APhA recommends the inclusion of pharmacists and pharmaceutical scientists in the collaborative development of pharmacogenomics clinical support tools and resources.
8. APhA encourages pharmacists to use their professional judgment and published guidelines and resources when providing access to testing or utilizing direct-to-consumer genomic test results in their patient care services.
9. APhA urges schools and colleges of pharmacy to include clinical application of genomics as a required element of the Doctor of Pharmacy curriculum.
10. APhA encourages the creation of continuing professional development and post-graduate education and training programs for pharmacists in genomics and its clinical application to meet varying practice needs.

11. APhA encourages the funding of pharmacist-led research examining the cost effectiveness of care models that utilize pharmacists providing genomic services.

(JAPhA. 58(4):355; July/August 2018) (Reviewed 2023)

2013, 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 pharmacists' patient 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 (PBRNs).

(JAPhA. NS48(4):471; July/August 2008) (JAPhA. 53(4): 366; July/August 2013) (Reviewed 2018)

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) (Reviewed 2016) (Reviewed 2021) (Reviewed 2023)

2005

Public Access to Clinical Trials Data

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) (Reviewed 2014) (Reviewed 2019)

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

(a) Dissemination of information to create awareness about graduate programs and career opportunities.
(b) Pursuit of increased government, industry, and foundation funding.
(c) Encouragement of innovative recruitment programs and curricula to facilitate career development.

(Am Pharm. NS29(7):463; July 1989) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

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.

(Am Pharm. NS27(6):424; June 1987) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

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.

(Am Pharm. NS26(6):420; June 1986) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

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.

(Am Pharm. NS24(7):61; July 1984) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

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.

(Am Pharm. NS21(5):41; May 1981) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

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.

(Am Pharm. NS2(5):40; July 1981) (Reviewed 2004) (Reviewed 2009) (Reviewed 2010) (Reviewed 2015) (Reviewed 2023)

SAMPLING

2002, 1993

Traditional Sampling and Pharmacy-based,Starter Dose Programs

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

(Am Pharm. NS33(7):55; July 1993) (JAPhA. NS42(5)(suppl 1):S60; September/October 2002) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

SPECIALTIES IN PHARMACY

2024, 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 laws, regulations, and policies for the practice of nuclear pharmacy, using the NABP Model Regulations for the Licensure of Nuclear Pharmacies as a model.

(Am Pharm. NS20:69; July 1980) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016) (JAPhA 64(4);102117, July/August 2024)

2020

Specialty Pharmacy and Specialized Pharmacy Services

1. APhA recognizes that certain complex medications require more specialized care and resources. Further, APhA asserts that delineation of medications as specialty versus non-specialty, and associated payer and manufacturer practices, may introduce continuity of care disruption, patient access issues, and financial inequities.
2. APhA supports pharmacists and pharmacies choosing to specialize or incorporate specialty pharmacy services into their practice to optimize patient outcomes.
3. APhA opposes payer policies and practices that limit patient choice of pharmacy providers, disrupt continuity of care, or compromise patient safety through the creation of specialty drug lists, and restrictive specialty pharmacy networks
4. APhA opposes manufacturer distribution and related business practices that restrict patient or pharmacy access to medications, medical products, and patient care services.
5. APhA advocates for the adoption of pharmacy profession-developed, harmonized practice standards for specialized pharmacy practices, and specialty pharmacy services and products.
6. APhA encourages increased availability and use of data integration, patient financial assistance, and other resources to inform clinical practice and support the provision of specialized pharmacy practices and specialty pharmacy services.
7. APhA supports the availability of education and training for pharmacists and student pharmacists related to specialized pharmacy practices and specialty pharmacy services.

(JAPhA. 60(5):e10; September/October 2020)

2012, 1989

Recognition of Pharmacy Practice Specialties

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

(Am Pharm. NS29(7):464; July 1989) (Reviewed 2001) (Reviewed 2007) (JAPhA. NS52(4):460; July/August 2012) (Reviewed 2017)

TITLES/DESIGNATIONS

Community Pharmacy

2000

Use of the Phrase "Community Pharmacy"

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

(JAPhA. NS40(5)(suppl 1):S8; September/October 2000) (Reviewed 2002) (Reviewed 2007) (Reviewed 2012)(Reviewed 2017)

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.

(JAPhA. 39(4):447; July/August 1999) (Reviewed 2006) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

Pharmacist

1981

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

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

(Am Pharm. NS21(5):40; May 1981) (Reviewed 2002) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

1977

Uniform Designation for Pharmacists

1. The profession of pharmacy should establish and use a uniform designation to identify an individual as a pharmacist.
2. The profession should adopt and use the designation "Pharmacist" following an individual's name as the uniform designation identifying that individual as a pharmacist.

3. At the discretion of individual pharmacists, earned academic degrees or state licensure designation may be indicated following the uniform designation.

(JAPhA. NS17:454; July 1977) (Reviewed 2002) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

Student Pharmacist

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.

(JAPhA. NS45(5):554; September/October 2005) (Reviewed 2006) (Reviewed 2008) (Reviewed 2009) (Reviewed 2013) (Reviewed 2018)

VACCINES

2024, 2005, 2003, 1996

Pharmacist's Role in Immunizations

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) administering vaccines to patients facing barriers to health.
2. APhA encourages the availability of all vaccines to all pharmacies in order to meet public health needs.
3. APhA supports the compensation of pharmacists for the administration of immunizations and the reimbursement for vaccine distribution.
4. APhA should facilitate the development of programs that educate pharmacists about their role in immunizations in public health.

(JAPhA. NS36(6):395; June 1996) (JAPhA. NS43(5)(suppl 1):S57; September/October 2003) (JAPhA. NS45(5):556; September/October 2005) (Reviewed 2007) (Reviewed 2009) (Reviewed 2012) (Reviewed 2014) (Reviewed 2019) (Reviewed 2020) (Reviewed 2021) (JAPhA 64(4);102117, July/August 2024)

2024, 2011

Requiring Influenza Vaccination for All Pharmacy Personnel

APhA supports vaccinations, as recommended by the Centers for Disease Control and Prevention, as a condition of employment, training, or volunteering within an organization that provides pharmacy services or operates a pharmacy or pharmacy department (unless a valid medical or religious reason precludes vaccination).

(JAPhA. NS51(4):482; July/August 2011) (Reviewed 2012) (Reviewed 2017) (JAPhA 64(4);102117, July/August 2024)

2022 2007

Pharmacy Personnel Immunization Rates

1. APhA supports efforts to increase immunization rates of health care 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 (e.g., physicians, nurses, police) and to prioritize pharmacists to receive medications and immunizations.
3. APhA encourages federal, state, and local officials and agencies to recognize pharmacists, student pharmacists, pharmacy technicians, and pharmacy support staff as among the highest priority groups to receive medications, vaccinations, and other protective measures as essential healthcare workers.

(JAPhA. NS45(5):580; September/October 2007) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019) (JAPhA. 62(4):942; July 2022) (Reviewed 2023)

2022, 2018

Proactive Immunization Assessment and Immunization Information Systems

1. APhA supports mandatory requirements for ALL immunization providers to report pertinent immunization data into Immunization Information Systems (IIS).

2. APhA calls for government entities to fund enrollment and engagement of all immunization providers in Immunization Information Systems (IIS). This engagement should support lifetime tracking of immunizations for patients.
3. APhA supports nationwide integration of Immunization Information Systems (IIS) that incorporate federal, state, and local databases for the purpose of providing health care professionals with accurate and timely information to assist in clinical decision making related to immunization services.
3. APhA calls for a National Immunization Information System (IIS) to receive and report vaccination data from all registries for the purpose of providing health care professionals, patients, and their caregivers with accurate and timely information to assist in clinical decision-making.
4. APhA advocates that all appropriate health care personnel involved in the patient care process have timely access to Immunization Information Systems (IIS) and other pertinent data sources to support proactive patient assessment and delivery of immunization services while maintaining confidentiality.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the bidirectional exchange of data with Immunization Information Systems (IIS).

(JAPhA. 58(4):355-365 July/August 2018) (JAPhA. 62 (4):941; July 2022)

2020

Pharmacy Technician's Role in Immunization Administration

1. APhA supports the development of standardized training in immunization administration and continuing education opportunities for immunizing pharmacy technicians.
2. APhA supports immunizing pharmacist's individual discretion in delegating immunization administration to pharmacy technicians with the requisite education, training, and experience.
3. APhA supports voluntary participation by pharmacy technicians in the training and provision of immunization administration.
4. APhA supports the role of immunizing pharmacists as the healthcare professional providing clinical patient assessment, decision making, and patient counseling when delegating immunization administration to a pharmacy technician.

(JAPhA. 60(5):e10; September/October)

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.

(JAPhA. NS37(4):460; July/August 1997) (Reviewed 2005) (Reviewed 2009) (Reviewed 2012) (Reviewed 2014) (Reviewed 2019)

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.

(Am Pharm. NS27(6):424; June 1987) (Reviewed 2005) (Reviewed 2009) (Reviewed 2012) (Reviewed 2014) (Reviewed 2019) (Reviewed 2020)

VITAMINS, MINERALS, NUTRITIONAL SUPPLEMENTS AND FOOD

2024, 2000

Regulation of Dietary Supplements

1. APhA shall work with Congress to modify the Dietary Supplement Health and Education Act or enact other laws, regulation, or policies 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 ensure quality, safe, contaminant-free products.
5. APhA encourages health care professionals, manufacturers, and consumers to report adverse health events associated with dietary supplements. APhA encourages the FDA to create a database with this information and make it available to all interested parties.

(JAPhA. NS1(9):40; September/October 2000) (Reviewed 2005) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (JAPhA 64(4);102117, July/August 2024)

2005, 1997

Complementary/Alternative Medications and/Integrative Health

1. APhA supports pharmacists using professional judgment to make informed decisions 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.

(JAPhA. NS37(4):459; July/August 1997) (Reviewed 2002) (JAPhA. NS45(5):556-557; September/October 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

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 supports the modification of the Food, Drug and Cosmetic Act to require that homeopathic manufacturers provide evidence of efficacy and safety for all products, including products currently in the marketplace.

(JAPhA. NS42(5)(suppl 1):S60; September/October 2002) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

2002, 1986

Medication Claims Associated With Foods

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.

(Am Pharm. NS26(6):420; June 1986) (JAPhA. NS42(5)(suppl 1):S62; September/October 2002) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

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.

(Am Pharm. NS28 (6):395; June 1988) (Reviewed 2002) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

1981

Restriction of Salt Content in Processed Foods

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

(Am Pharm. NS21(5):41; May 1981) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

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.

(Am Pharm. NS20(7):73; July 1980) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

WOMEN IN PHARMACY

1979

Consideration of the Equal Rights Amendment

APhA supports efforts to ensure equal rights of all persons.

(AmPharm. NS19(7):60; June 1979) (Reviewed 2009) (Reviewed 2014) (Reviewed 2018) (Reviewed 2022) (Reviewed 2024)

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ADMINISTRATIVE POLICIES

1995

Administrative Procedures (2004.arc)

The APhA staff creates an "Administrative Procedures Handbook," which consolidates into one source the various rules and procedures which this House has adopted.

(Am Pharm. NS35(6):38;June 1995)

1995

House of Delegates Rules Review Committee (2004.arc)

A Special Committee on House Rules Procedures of the APhA House of Delegates shall be appointed annually by the Speaker of the House of Delegates.

(Am Pharm. NS35(6):38; June 1995)

ADVERTISING

Drug Names

1982

Misleading Brand Names for Nonprescription Drug Products (2004.arc) (2021.arc)

APhA opposes the use of brand names for nonprescription drug products of different companies.

(Am Pharm. NS22(7):32; July 1982)

Prescription & Nonprescription Drugs

1977

Prescription Drug Advertising (2004.arc)

2. Advertisements about prescription drugs provided to patients, including prescription drug prices, should not encourage or induce the obtaining or use of drugs in excess of a patient's therapeutic requirements.

(JAPhA. NS17:448; July 1977)

1971

Nonprescription Drug Advertising (2004.arc)

1. The committee recommends that APhA urges the development of guidelines for pre-use clearance of nonprescription drug advertising by a government agency or joint government/industry committee to ensure that such advertising does not contain invalid or unsupported claims, and that such advertising will not contribute to the drug abuse problem.
2. The committee recommends that APhA not support a flat ban on nonprescription drug advertising at this time.
3. The committee recommends that APhA urges manufacturers to voluntarily comply with guidelines for advertising nonprescription drugs such as those issued by the National Association of Broadcasters.

(JAPhA. NS11:261; May 1971)

1970

Nonprescription Drug Advertising (2004.arc)

1. The committee recommends that APhA adopts a policy condemning misleading and fallacious advertising for nonprescription drugs or any promotional efforts that encourage indiscriminate use of medication.
2. The committee further recommends that APhA assists FTC, FDA, the National Association of Broadcasters, the National Better Business Bureau, the Proprietary Association, and such other involved organizations and agencies in developing responsible advertising and promotional practices for nonprescription medication.
3. Each nonprescription drug product pharmacists carry or intend to carry in stock should be subjected to their critical review. Pharmacists should evaluate products with respect to label, advertised claims, and sound drug therapy.

(JAPhA. NS10:356; June 1970)

1980

Non Prescription Drug Advertising (2016.arc)

1. APhA supports a legislative or regulatory requirement that advertising of nonprescription 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 nonprescription drugs in advertising directed to the public.

(Am Pharm. NS20(7):62; July 1980) (Reviewed 2004) (Reviewed 2006) (Reviewed 2011)

AUTOMATION AND TECHNOLOGY IN PHARMACY PRACTICE

2018

Proactive Immunization Assessment and Immunization Information Systems (2022.arc)

3. APhA supports nationwide integration of Immunization Information Systems (IIS) that incorporate federal, state, and local databases for the purpose of providing health care professionals with accurate and timely information to assist in clinical decision making related to immunization services.

(JAPhA. 58(4):355-365 July/August 2018)

1988

Computerized and/or Automated Pharmacy Systems (2004.arc)

1. APhA endorses the development and application of computer and/or automation technology by pharmacists to enhance pharmacy services.
2. APhA recommends that pharmacists maintain authority and responsibility for drug-use control in the utilization of computerized and/or automated pharmacy systems.

(Am Pharm. NS28(6):395; June 1988) (Reviewed 2001)

BIOTECHNOLOGY

2012, 2007

Biologic Drug Products (2017.arc)

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

(JAPhA. NS45(5):580; September/October 2007) (JAPhA. NS52(4):457; July/August 2012) (Reviewed 2016) (Reviewed 2017)

2012, 2007

Biologic Drug Products (2017.arc)

1. APhA encourages the development of safe, effective, and affordable therapeutically equivalent generic/biosimilar versions of biologic drug products, including clinical trials that assess safety.
2. APhA encourages FDA to develop a scientifically based process to approve therapeutically equivalent generic/biosimilar versions of biologic drug products.
4. APhA should actively support legislation to hasten the development of an efficient regulatory process to approve therapeutically equivalent generic versions of biologic drug products.

(JAPhA. NS40(5)(suppl 1):S8; September/October 2000) (Reviewed 2002) (Reviewed 2007) (Reviewed 2012) (Reviewed 2016) (Archived 2017)

2010

Pharmacogenomics/Personalized Medicine (2019.arc)

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.

(JAPhA. NS50(4):471; July/August 2010) (Reviewed 2015)

2005, 2000

Pharmacogenomics (2019.arc)

1. Recognizing the benefits and risks of pharmacogenomics and applications of this technology, 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 in order 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.

(JAPhA. NS40(5)(suppl 1):S8; September/October 2000) (JAPhA. NS45(5):555; September/October 2005) (Reviewed 2009) (Reviewed 2010) (Reviewed 2015)

DISASTER PREPAREDNESS

2016, 2011, 2002, 1963

Role of the Pharmacist in National Defense (2022.arc)

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.

(JAPhA. NS3:330; June 1963) (JAPhA. NS42(5)(suppl 1):S62; September/October 2002) (Reviewed 2006) (Reviewed 2010) (JAPhA. NS51(4): 483; July/August 2011) (JAPhA. 56(4):379; July/August 2016)

2015

Disaster Preparedness (2022.arc)

APhA encourages pharmacist involvement in surveillance, mitigation, preparedness, planning, response, and recovery related to terrorism and infectious diseases.

(JAPhA. N55(4):365; July/August 2015) (Reviewed 2021)

2007, 2022

Pharmacy Personnel Immunization Rates (2022.arc)

3. APhA encourages federal, state, and local public health officials to recognize pharmacists as first responders (e.g., physicians, nurses, police) and to prioritize pharmacists to receive medications and immunizations.

(JAPhA. NS45(5):580; September/October 2007) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)(2022)

2005, 2002

Emergency Preparedness (2019.arc)

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.

(JAPhA. NS42(5)(suppl 1):S61; September/October 2002) (JAPhA NS45(5):559; September/October 2005) (Reviewed 2006) (Reviewed 2009) (Reviewed 2014)

2001

Biological Terrorism, Infectious Diseases, and Pharmacy (2015.arc)

APhA supports pharmacist involvement in bioterrorism preparedness planning.

(JAPhA. NS41(5)(suppl 1):S9; September/October 2001) (Reviewed 2006)

1966

Health Mobilization (2002.arc)

1. Encourages development of a national drug stockpile program, similar to the Summit plan, to supplement existing programs and continue in its efforts to obtain a contract from the government to study a program of this type since it is the pharmacist's responsibility to provide high-quality pharmaceutical services under all types of circumstances.

(JAPhA. NS6:328; June 1966)

DISPENSING AUTHORITY

2005, 2001, 1996

Control of Distribution System (2008.arc)

APhA supports the pharmacists' authority to control the medication distribution process and maintain the responsibility for all completed medication orders regardless of practice setting

(JAPhA. NS36(6):396; June 1996) (Reviewed 2000) (JAPhA. NS41(5)(suppl 1):S9; September/October 2001) (JAPhA. NS45(5):560; September/October 2005) (Reviewed 2006)

2004, 1987

Non-pharmacist Dispensing (2010.arc)

APhA supports the principle that all patients receiving prescription medications are entitled to comprehensive patient care services. These services include, but are not limited to, medication therapy management (MTM), and patient counseling as well as maintaining patient profiles, and providing the check-and-balance system with other health professionals to help prevent prescriber errors and adverse drug interactions.

(Am Pharm. NS27(6):424; June 1987) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2006)

1987

Non-pharmacist Dispensing (2004.arc)

2. APhA opposes non-pharmacist dispensing of prescription medications.

(Am Pharm. NS27(6):424; June 1987)

1978

Dispensing Criteria (2004.arc)

1. APhA supports amendments to laws, where necessary, to require that all those who dispense prescription and nonprescription drugs be subjected to uniform requirements for dispensing.

(Am Pharm. NS18(8):42; July 1978)

DRUG ABUSE, CONTROL AND EDUCATION

Methadone

1972

Methadone Used as Analgesic and Antitussive (2003.arc)

2. The committee recommends that APhA seek the withdrawal of FDA approval of methadone for its indications as an analgesic and antitussive.
3. The committee recommends that until FDA approval of methadone for its indications as an analgesic and antitussive is withdrawn, APhA should urge pharmacists to discourage the prescribing of methadone as an analgesic or antitussive.
4. The committee recommends that APhA urge pharmacists receiving prescription orders for methadone to ensure that the drug has been prescribed for a currently acceptable, medical use; and if such insurance can not be obtained, the prescription order should not be dispensed.

(JAPhA. NS12:308; June 1972)

1970

Methadone in Treatment of Narcotic Addiction (2003.arc)

1. The committee recommends that APhA alert the profession to the basis of using maintenance doses of methadone in the treatment of narcotic addiction.
2. The committee recommends that APhA endorses continued research in the supervised use of methadone in the treatment of narcotic addiction.
3. The committee recommends that APhA urge that methadone treatment programs be conducted only in centers that are capable of meeting federal and state requirements, and that methadone treatment not be considered, at this time, as suitable for use by the private medical practitioner in his office practice.
4. The committee recommends that APhA provide assistance in terms of advice on drug control procedures, whenever possible, to those centers and pharmacists engaging in approved methadone treatment programs.

(JAPhA. NS10:355; June 1970)

State Drug Laws and Legalization Issues

2016, 1990

Legalization or Decriminalization of Illicit Drugs (2023.arc)

2. APhA supports the use of drug courts or other evidence-based mechanisms—when appropriate as determined by the courts—to provide alternate pathways within the criminal justice system for the treatment and rehabilitation of individuals who are charged with drug-related offenses and who have substance use or other related medical disorders.

(Am Pharm. NS30(6):46; June 1990) (Reviewed 2003) (Reviewed 2006) (Reviewed 2011) (JAPhA 56(4):369; July/August 2016)

2006

Conversion of Nonprescription Products Into Drugs of Abuse (2016.arc)

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 (2016.arc)

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

(JAPhA. NS45(5):555; September/October 2005)(Reviewed 2006) (Reviewed 2011)

1999

Sale of Sterile Syringes (2023.arc)

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.

(JAPhA. 39(4):447; July/August 1999) (Reviewed 2003) (Reviewed 2006) (Reviewed 2008) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019) (Reviewed 2020)

1971

Uniform State Controlled Substances Act (2002.arc)

The committee recommends that APhA actively supports enactment of the Uniform State Controlled Substances Act and, urge that a provision that would ban the mailing of controlled substances in each state be included at the state level.

(JAPhA. NS11:268; May 1971)

1966

Uniform State Narcotic Act — Exempt Narcotics (2002.arc)

Requiring that exempt narcotics be sold by a pharmacist will eliminate some of the social and public health problems associated with their use and distribution. But this committee recognizes a need for additional controls. The committee recommends that APhA study the feasibility of legislation requiring that the purchaser properly identify himself/herself to the pharmacist in order to prevent the use of fictitious names and addresses in the exempt narcotic book, that preparations be labeled with the pharmacy name and address to assist narcotic enforcement officials in quickly ascertaining whether a preparation has been obtained through legitimate channels and that time and quantity limitations be placed on the sale of exempt preparations to reduce excessive use.

(JAPhA. NS6:314; June 1966)

1963

Uniform Narcotic Act — Exempt Narcotics (2002.arc)

APhA proposes that any state narcotic drug act contain within its exempt narcotic section a provision for consumer sales of exempt narcotics being made only in a pharmacy, by a pharmacist.

(JAPhA. NS3:298; June 1963)

2016, 2003, 1987

Substance Use Disorder Education (2019.arc)

APhA supports comprehensive Substance Use Disorder education, prevention, treatment, and recovery programs.

(Am Pharm. NS27(6):424; June 1987) (JAPhA. NS43(5)(suppl 1):S58; September/October 2003) (Reviewed 2006) (Reviewed 2011) (JAPhA. 56(4):369; July/August 2016)

2003

Drug Addiction/Chemical Dependency Education (2019.arc)

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

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

DRUG CLASSIFICATION

2005, 2001

NonPrescription Availability of Nonsedating Antihistamines (2014.arc)

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.

(JAPhA. NS41(5)S:8; September /October 2001) (JAPhA. NS45(5):557; September/October 2005) (Reviewed 2009)

DRUG PRICING AND DISTRIBUTION

2004

Protecting the Integrity of the Medication Supply (2021.arc)

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 others, adopt appropriate technology, tracking mechanisms, business practices, and other initiatives to protect the integrity of the drug supply.

(JAPhA. NS44(5):551; September/October 2004) (Reviewed 2006) (Reviewed 2007) (Reviewed 2012) (Reviewed 2013) (Reviewed 2018) (Reviewed 2021)

1991

Biotechnology-Based Products (2004.arc)

APhA reaffirms the principle of the 1966 policy that opposed circumvention of the pharmacist in drug distribution. The association strongly opposes programs and policies by manufactures, governmental agencies, and health groups which circumvent the pharmacist's authority and responsibility to counsel patients regarding biotechnology-based products, dispense those products, and monitor their therapeutic outcome.

(Am Pharm. NS31(6):29; June 1991)

1989

Patient Education on Medication Storage (2015.arc)

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

(Am Pharm. NS29(7):464; July 1989) (Reviewed 2004) (Reviewed 2006) (Reviewed 2010)

1986

Nonprofit Institutions Act (2004.arc)

1. APhA shall actively seek enactment of legislation to eliminate manufacturer and distributor differential pricing of prescription drugs and devices.
2. APhA shall actively seek enactment of legislation to modify the Nonprofit Institutions Act to eliminate exemptions for all health care institutions that dispense, issue, or supply prescription drugs.

(Am Pharm. NS26(6):420; June 1986)

1983

Export of Drugs Manufactured in, But Not Approved for Use in, the U.S. (2011.arc)

1. APhA supports the export from the U.S. of drug products that have not been approved for use in the U.S. by FDA, except
    a. When a drug product to be exported has not been so approved (or approval has been rescinded) by reasons of an affirmative FDA determination that it is unsafe or ineffective when used under the conditions prescribed, recommended, or suggested in the labeling with which the drug product would be exported; or
    b. When the methods used in, and the facilities and controls used for, the manufacturing, processing, and packing of a drug product to be exported are inadequate to preserve its identity, strength, quality, and purity.

(Am Pharm. NS23(6):52; June 1983) (Reviewed 2004) (Reviewed 2006)

1968

Wholesaler Distribution Functions (2004.arc)

The current distribution system for drugs in our society relies heavily upon the wholesaling function. Pharmacists find it impossible and frequently uneconomical to purchase all drug supplies directly from pharmaceutical manufacturers. The committee recommends that APhA explore with members of the wholesale drug industry means by which pharmacists can assist them to strengthen and improve their position and services in the drug distribution network.

(JAPhA. NS8:363; July 1968)

1967

Manufacturers' Distribution Policies (2004.arc) (2021.arc)

The committee has recommended in the past—and recommends again—that APhA seeks the assistance of FDA in preventing the shipment of prescription, legend drugs to institutions that are not qualified by state law to possess drugs. The committee recommends that this also include the shipment of drugs to voluntary health agencies and others who most frequently possess and dispense prescription legend drugs under nominal professional supervision.

(JAPhA. NS7:305; June 1967)

1966

Manufacturers' Pricing Policies (Discriminatory Pricing) (2004.arc)

The committee recommends that APhA supports the equality of opportunity concept and again urge the pharmaceutical manufacturing industry to eliminate policies and practices that establish de facto discrimination in cost prices, package sizes, and services available in the same or interacting markets. The committee believes that the problem is sufficiently acute to justify recourse to the public at large and the legislature, if necessary.

(JAPhA. NS6:314; June 1966)

1963

Manufacturers' Distribution Policies (2004.arc)

1. APhA, having previously called upon manufacturers to review their distribution policies, recommends those manufacturers whose policies make drugs available to community pharmacies on the same terms and conditions made available to all hospitals and other institutions for medical care that similarly engages in dispensing prescription medication to the public.
2. APhA urges all manufacturers to again review their distribution policies to nonprofit, tax-exempt institutions to ensure that drug purchases and usage are consistent with the terms and conditions of their sale.

(JAPhA. NS3:298; June 1963)

DRUG PRODUCT PACKAGING

2012

Counterfeit Medication and Unit-of-Use Packaging (2020.arc)

APhA encourages the continued development, distribution, and use of unit-of-use packaging as the industry standard to enhance patient safety, patient adherence, and efficiencies in drug distribution, in addition to reducing potential for counterfeiting.

(JAPhA. NS52(4):458; July/August 2012) (Reviewed 2013) (Reviewed 2017)

2001

Unit-of-Use Packaging (2006.arc)

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

(JAPhA. NS(5)(suppl 1):S10; September/October 2001)

DRUG PRODUCT SELECTION

Antisubstitution Laws

1970

Antisubstitution Laws (2004.arc)

The committee recommends that APhA seek the repeal of antisubstitution laws.

(JAPhA. NS10:348; June 1970)

Therapeutic Equivalence

2012, 2007

Biologic Drug Products (2017.arc)

1. APhA encourages the development of safe, effective, and affordable therapeutically equivalent generic/biosimilar versions of biologic drug products, including clinical trials that assess safety.
2. APhA encourages FDA to develop a scientifically based process to approve therapeutically equivalent generic/biosimilar versions of biologic drug products.
4. APhA should actively support legislation to hasten the development of an efficient regulatory process to approve therapeutically equivalent generic versions of biologic drug products.

(JAPhA. NS40(5)(suppl 1):S8; September/October 2000) (Reviewed 2002) (Reviewed 2007) (Reviewed 2012) (Reviewed 2016)

1989

Uniform Designation for Drug Product Selection Authority (2001.arc)

2. APhA supports a uniform nationwide procedure for designating the source of the drug product selection decision on a prescription claim.

(Am Pharm. NS29(1):67; January 1989)

1972

Endorsement of "White Paper on..." — Drug Product Selection, Overview (2004.arc)

The House of Delegates endorses the "White Paper on... The Pharmacist's Role in Drug Product election," with a critique on the paper by the APhA Academy of Pharmaceutical Sciences to be appended.

(JAPhA. NS12:280; June 1972)

1970

Drug Product Quality Statement (2004.arc)

The House of Delegates, at a special meeting on November 23-24, 1969, adopted the following amended preamble of the Drug Product Quality Statement of the APhA Academy of Pharmaceutical Sciences: "Prior to the initial distribution of a drug product or modification of an existing product, every manufacturer should be obligated to perform tests which are appropriate and sufficient to demonstrate the clinical safety and efficacy claimed for that manufacturer's product, and to make a summary of this information readily available to the medical and pharmaceutical professions. In particular, in the absence of such tests, it cannot be assumed that the product will exhibit clinical acceptability."

(JAPhA. NS10:90; February 1970)

1970

Reference Drug Products (2004.arc)

1. The committee recommends that APhA adopt a policy favoring the general concept of a reference product for drug dosage forms.
2. The committee further recommends that a careful examination of specifics be made before a particular system to achieve this goal is endorsed.

(JAPhA. NS10:347; June 1970)

1969

Disclosure of Testing Information (2004.arc)

The committee recommends that APhA supports action by Congress to require public disclosure of all testing information on the various products purchased by the federal government and other data collected in the procurement process relating to the qualifications of the manufacturer.

(JAPhA. NS9:365; July 1969)

1966

Drug Lists for Welfare Prescription Orders (2004.arc)

The committee reiterates its recommendation that state agencies utilizing a system of listing drugs by generic name, or by cost, or by a combination of these factors, include a printed statement on their prescription order blanks which, when signed by the prescriber, permits the pharmacist to dispense a comparable drug from the approved list. The committee further recommends that all state programs include some provision that would enable a physician to prescribe nonlisted drugs when required.

(JAPhA. NS6:313; June 1966)

DRUG RECALLS

1968

Clearinghouse Approach (2004.arc)

The committee reaffirms its endorsement of the "clearinghouse" approach to drug recalls and makes the following recommendations:

1. That a standard recall form and envelope be used, which would provide necessary information for easy identification of recalled drugs and precise information on the disposition of the drugs.
2. That a system of recordkeeping at all levels be developed that would ensure the chain of product identification from the manufacturer to the ultimate consumer. This would include a simpler identification of the lot number on the product label.
3. That a well-defined communications system be implemented to ensure that all pharmacists and wholesalers receive drug recalls.

4. That the seriousness of any recall be established so that appropriate promptness of action can be taken based on the depth and severity of the recall.
5. That an educational program be developed and implemented so that all segments of the industry and health professions are encouraged to comply fully.

(JAPhA. NS8:380; July 1968)

1967

Reimbursement for Nonprescription Recalls (2004.arc)

1. The committee recommends that the House of Delegates endorse the drug recall procedure preferred by APhA staff.
2. The committee recommends that APhA adopt a position that when a home remedy is recalled pharmacists should be reimbursed for any cost and expense involved in retrieving these products for the manufacturer.

(JAPhA. NS7:307; June 1967)

1967

Standard Recall Form (2004.arc)

1. The obvious implication of drug recalls in public health has prompted the committee to express its concern over the current practice of recalling drugs. Drug recall letters are often confusing and misleading, many times conveying little or no information regarding the recall. Weekly recall bulletins are also confusing. The committee recommends that
   a. A standard recall form be instituted for all recalls.
   b. The information contained on this form include the manufacturer and distributor of the drug, the full reason for recall, the control numbers of the lots being recalled, and a reproduction of the label of the product.
   c. All pharmacists receive a copy of the recall.
   d. Criteria be established for the depth of recall.

(JAPhA. NS7:323; June 1967)

EDUCATION, CURRICULUM AND COMPETENCE FOR PHARMACY

Competency and Training in Specific Areas

2016, 2003, 1987

Substance Use Disorder Education (2019.arc)

APhA supports comprehensive Substance Use Disorder education, prevention, treatment, and recovery programs.

(Am Pharm. NS27(6):424; June 1987) (JAPhA. NS43(5)(suppl 1):S58; September/October 2003) (Reviewed 2006) (Reviewed 2011) (JAPhA. 56(4):369; July/August 2016)

2003

Drug Addiction/Chemical Dependency Education (2019.arc)

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

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

1989

Pharmacy-Based Screening and Monitoring Services (2003.arc)

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

(Am Pharm. NS29(7):463; July 1989)

1986

Continuing Competence Assurance (2001.arc)

2. APhA should assist states in developing standards of practice, utilizing the 1979 Standards of Practice for the Profession of Pharmacy as the model.

(Am Pharm. NS26(6):419; June 1986)

1986

Continuing Competence Assurance (2006.arc)

1. APhA encourages initiatives that enable pharmacists to maintain competency.

(Am Pharm. NS26(6):419; June 1986)

2014

The Use and Sale of Electronic Cigarettes (e-cigarettes) (2019.arc)

1. APhA opposes the sale of e-cigarettes and other vaporized nicotine products in pharmacies until such time that scientific data support the health and environmental safety of these products.
2. APhA opposes the use of e-cigarettes and other vaporized nicotine products in areas subject to current clean air regulations for combustible tobacco products until such time that scientific data support the health and environmental safety of these products.
3. APhA urges pharmacists to become more knowledgeable about e-cigarettes and other vaporized nicotine products.
4. APhA urges FDA to require the full disclosure of all ingredients in e-cigarettes and other vaporized nicotine products in both the pre-use and vapor states.

(JAPhA. 54(4):358; July/August 2014) (Reviewed 2019)

1983

Post-graduate Programs in Distinctive Pharmacy Services (2003.arc)

APhA encourages the development of structured post-graduate continuing education programs, conducted over an extended period of time, to prepare pharmacists to provide distinctive pharmacy services.

(Am Pharm. NS23(6):52; June 1983)

1975

Measurement of Continuing Competence (2003.arc)

APhA supports a voluntary system to measure the competence of pharmacy practitioners on a continuing basis.

(JAPhA. NS15:336; June 1975)

1974

Continuing Education Standards (2003.arc)

The committee recommends that APhA works with practitioners, educators, and boards of pharmacy members to develop standards for continuing education in pharmacy.

(JAPhA. NS14:495; September 1974)

1974

Mandatory Continuing Education (2003.arc)

2. APhA feels the profession in each individual state should make its own decision whether to require continuing education consistent with nationally recognized standards, if and when such standards are available.
3. APhA should continue to seek better methods of evaluating the benefits of continuing education for pharmacists.

(JAPhA. NS14:494; September 1974)

1972

National Clearinghouse for Continuing Education (2003.arc)

1. The committee recommends that APhA function as a national clearinghouse for continuing education.
2. The committee recommends that APhA develop a continuing education accreditation program in cooperation with colleges of pharmacy, state boards of pharmacy, national affiliated organizations, and state pharmaceutical associations.
3. The committee recommends that APhA provide services to aid states in the administration of continuing education relicensure requirements and to facilitate the fulfillment of such requirements by pharmacists.

(JAPhA. NS12:298; June 1972)

Degree/Designation

1991

Doctor of Pharmacy: Equivalency Process (2003.arc)

APhA supports the assessment of the feasibility of a Doctor of Pharmacy equivalency process for current baccalaureate pharmacists. The assessment shall be conducted in cooperation with other national pharmacy associations and pharmacy academia.

(Am Pharm. NS31(6):28; June 1991)

1981

A Single Doctoral Degree as the Entry-Level Degree for Pharmacists (2003.arc)

APhA policy calling for a professional doctoral entry-level degree for pharmacists takes no position on the time period that should be required for awarding such degree.

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

1981

Doctor of Pharmacy Degree (2003.arc)

The House of Delegates urges the Board of Trustees to immediately work toward the establishment of a task force charged to devise a plan of action for the most expeditious implementation for the granting, by pharmacy schools, of a uniform Doctor o Pharmacy degree that is to be the sole entry-level degree for the profession.

(Am Pharm. NS21(5):41; May 1981)

1978

Doctor of Pharmacy Degree (2011.arc)

1. Supports the development of mechanisms other than full-time study that will enable current baccalaureates in pharmacy to attain a professional doctoral degree.
2. The development of mechanisms that will enable current baccalaureates in pharmacy to attain a professional doctoral degree should involve input from various segments of the profession.

(Am Pharm. NS18(8):42; July 1978) (Reviewed 2003) (Reviewed 2006)

1977

Degrees Offered (2001.arc)

1. APhA endorses a single professional degree in pharmacy.
2. The single degree in pharmacy should be a professional doctoral degree.
3. The educational program leading to a single professional doctoral degree in pharmacy should be pharmacy practice-oriented.
4. The educational program leading to a single professional doctoral degree in pharmacy should enable pharmacists to qualify for licensure examination upon graduation and to practice immediately upon successful completion of the licensure examination.
5. The development of standards for the curricula leading to the single professional doctoral degree in pharmacy should involve input from various segments of the profession.

(JAPhA. NS17:461; July 1977)

Internships/Externships and Residencies

2008

Experiential Education (2018.arc)

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 stakeholders to collaborate in the development of a blueprint that evaluates, streamlines, and consolidates all student pharmacists' experiential education requirements.

(JAPhA. NS48(4):470; July August 2008) (Reviewed 2013)

2006

Residency Programs (2013.arc)

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)

2006

Residency Programs (2013.arc)

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)

2005, 1990

Expansion and Recognition of Internship, Externship, and Clerkships (2018.arc)

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

(Am Pharm. NS30(6):45; June 1990) (Reviewed 2003)(JAPhA. NS45(5):560; September/October 2005) (Reviewed 2006) (Reviewed 2008) (Reviewed 2013)

1984

Residencies in Community Pharmacy (2013.arc)

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

(Am Pharm. NS24(7):60; July 1984) (Reviewed 2003) (Reviewed 2008)

1982

Credit for Nontraditional Practice Experience (2003.arc)

APhA supports the awarding of credit hours for structured, professionally related experiences gained outside the traditional dispensing pharmacy environment to partially fulfill the experiential requirements of state boards of pharmacy.

(Am Pharm. NS22(7):33; July1982)

Pharmacy School Curriculum

1992

Balanced Education for Pharmacists (2016.arc)

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

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

1991

Emerging Technologies (2013.arc)

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

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

EMPLOYER/EMPLOYEE RELATIONS

Other Employment Issues

2001

Employee Benefits (2019.arc)

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

(JAPhA. NS(5)(suppl 1):S10; September/October 2001) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2019)

1977

Employers' Use of Lie Detection Tests (2014.arc)

1. Polygraph tests should not be used as a means of preemployment screening in pharmacies.
2. Polygraph tests should not be used in pharmacies for routine "security" checking of employees.
3. Polygraph tests should not be used in pharmacies in the course of investigations for cause.

(JAPhA. NS17:450; July 1977) (Reviewed 2004) (Reviewed 2007) (Reviewed 2012)

1973

Employer/Employee Communications (2001.arc)

The committee recommends that APhA encourage members to utilize APhA in facilitating meaningful communication between employers and employee pharmacists regarding the application of the APhA Policy Statement on Employment Standards in specific employment situations.

(JAPhA. NS13:505; September 1973)

1967

State Associations' Participation in Employee/Employer Relations (2001.arc)

The committee commends state associations for their foresight in establishing committees on employer-employee relations. These committees are urged to provide an additional service to their members: that of establishing guidelines for providing fringe benefits, profit-sharing plans, and other related benefits to employee pharmacists. The committee further recommends that all state associations become active in this area and appoint such committees. State associations are urged to place this important subject in their annual meeting programs or seminars.

(JAPhA. NS7:321; June 1967)

Productivity Requirements

2001, 1969

Employer Requirement: Number of Prescriptions Pharmacist Dispenses (2007.arc)

APhA opposes workload requirements that stifle professional motivation and prerogatives.

(JAPhA. NS9:361; July 1969) (JAPhA. NS4(5)(suppl 1):S8; September/October 2001)

Salary, Wages, Benefits, and Retirement

1978

Retirement, Mandatory (2001.arc)

APhA supports the elimination of age-based mandatory retirement.

(Am Pharm. NS18(8):36; July 1978)

1974

Employees' Pension Plans: Employer Participation (2001.arc)

The committee recommends that APhA encourages employers to incorporate early vesting rights in pension plans provided as a part of their remuneration of employed pharmacists. Such provisions include a schedule assuring the pharmacist at least 50 percent vesting no later than 5 years and 100 percent not more than 10 years from the date of employment.

(JAPhA. NS14:489; September 1974)

1969

Payroll Deduction for Employees' Professional Dues (2001.arc)

The committee recommends that employers and employees investigate the possibility of using a payroll deduction system for paying employees' professional association dues.

(JAPhA. NS9:361; July 1969)

1967

Minimum Wage Law (2001.arc)

The committee recommends that APhA staff develop suitable guidance and informational materials on the application of the minimum wage law to pharmacies for the information and use of the membership.

(JAPhA. NS7:308; June 1967)

Unionization

1999, 1965

Unionization of Pharmacists: State Participation in Employee/Employer Relations (2001.arc)

1. The tempo of unionization efforts and interests has noticeably increased in the past year. The committee treated this problem in some detail in its last report and again urges state professional societies to create forums for effective communication between employer and employee pharmacists. We note and commend those few states that have or are now implementing the committee's recommendation that employer-employee relations committees be established to deal with personnel issues facing the practitioners in our profession.
2. The committee further recommends that APhA provides state professional societies and colleges of pharmacy with informational materials on developments in personnel relations and unionization. We further recommend that employer-employee relations be considered as a discussion topic in continuing education or management seminars for pharmacists so that employers and employees alike are encouraged to give more serious consideration to the respective expectations of each other.

(JAPhA. NS39(4):447; July/August 1999) (JAPhA. NS5:280; May 1965)

1999, 1971

Unionization of Pharmacists: State Participation in Employer/Employee Relations (2001.arc)

6. The committee recommends that employed pharmacists take active roles in state and local association activities and, when appointed, serve on policy-making committees.

(JAPhA. NS39(4):447; July/August 1999) (JAPhA. NS11:273; May 1971)

Working Conditions

2012, 2007, 2001, 1995

Impact of Pharmacists' Working Conditions on Public Safety (2019.arc)

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

(Am Pharm. NS35(6):36; June 1995) (JAPhA. NS4(5)(suppl 1):58; September/October 2001) (Reviewed 2001) (JAPhA. NS45(5):580; September/October 2007) (JAPhA. NS52(4): 459; July/August 2012) (Reviewed 2017)

2004, 1977

Pharmacy Practice: Professional Judgment (2023.arc)

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

(JAPhA. NS17:463; July 1977) (JAPhA NS44(5):551; September/October 2004) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2020)

1995

Imact of Pharmacists' Working Conditions on Public Safety (2001.arc)

4. APhA will convene a task force comprised of employers, pharmacists, technicians, the National Association of Boards of Pharmacy, and other appropriate groups to develop guidelines for working environments conducive to providing effective pharmaceutical care.

(Am Pharm. NS35(6):36; June 1995)

ENVIRONMENTAL CONCERNS

2014

The Use and Sale of Electronic Cigarettes (e-cigarettes) (2019.arc)

1. APhA opposes the sale of e-cigarettes and other vaporized nicotine products in pharmacies until such time that scientific data support the health and environmental safety of these products.
2. APhA opposes the use of e-cigarettes and other vaporized nicotine products in areas subject to current clean air regulations for combustible tobacco products until such time that scientific data support the health and environmental safety of these products.
3. APhA urges pharmacists to become more knowledgeable about e-cigarettes and other vaporized nicotine products.
4. APhA urges FDA to require the full disclosure of all ingredients in e-cigarettes and other vaporized nicotine products in both the pre-use and vapor states.

(JAPhA. 54(4):358; July/August 2014) (Reviewed 2019)

2004, 1977

Fluorinated Hydrocarbons: Utilization in Aerosol Products (2015.arc)

APhA supports legislative or regulatory actions banning the nonessential 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.

(JAPhA. NS17:446; July 1977) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010)

2004

Medication Disposal (2013.arc)

1. APhA encourages the Environmental Protection Agency and other appropriate entities to continue research exploring any connection between the disposal of discarded prescription or 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.

(JAPhA. NS44(5):551; September/October 2004) (Reviewed 2007) (Reviewed 2012)(Reviewed 2013)

ETHICAL ISSUES

1997

Physician-Assisted Suicide (2004.arc)

1. APhA reaffirms its 1977 policy that states:
    a. Each pharmacist, regardless of place or style of practice, must be free to exercise individual professional judgment and must have complete authority for those individual professional responsibilities assumed.
2. APhA reaffirms its 1977 policy that states: In cases where group decisions by pharmacists regarding professional matters are indicated, the decision-making process should ensure the opportunity for input by all pharmacists affected by the decisions.

(JAPhA. NS37(4):459; July/August 1997)

1995

Physician-Assisted Suicide (2004.arc)

The American Pharmaceutical Association shall appoint a special committee for the purpose of identifying and outlining the questions and concerns facing the profession of pharmacy within the issue of assisted suicide.

(Am Pharm. NS35(6):38; June 1995)

1963

Pharmacists' Misconduct (2010.arc)

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

(JAPhA. NS3:298; June 1963) (Reviewed 2004)

FEDERAL EMPLOYMENT OF PHARMACISTS INCLUDING THE ARMED FORCES

1986

Federal Pharmacy/Quality of Care (2004.arc)

APhA urges adoption of the U.S. Office of Personnel Management (USOPM) Tentative Standards for the Pharmacist Series, GS-660 revising the classification and qualification standards for federal civilian pharmacists.

(Am Pharm. NS26(6):419; June 1986)

1982

Employment Classification for Pharmacists in the Veterans Administration (VA) (2004.arc)

APhA supports VA reclassification of pharmacists from Title 5, United States Code, to Title 38, United States Code, personnel standards, and procedures.

(Am Pharm. NS22(7):32; July 1982)

1973

Pharmacists in the Armed Services: Rank as Officer (2004.arc)

APhA demands of the Department of Defense that pharmacists in the military service serving as pharmacists be elevated to officer status.

(JAPhA. NS13:489; September 1973)

1965

Pharmaceutical Service in the Armed Services (2004.arc)

1. APhA should place greater emphasis on its programs that seek to ensure that military and other governmental installations maintain the same legal and ethical standards in providing pharmaceutical services to governmental personnel and their dependents as those that are imposed to preserve the health, safety, and welfare of the civilian population.
2. APhA should establish a permanent staff position to provide concentrated and continuous attention to this objective.
3. APhA should seek to meet with the secretary of the Department of Defense to discuss procedures and policies for providing pharmaceutical services and assigning professional personnel.

(JAPhA. NS5:249; May 1965)

FEDERAL PROGRAMS AND POLICIES

1994

Small Business Set-Asides (2004.arc)

1. APhA shall work with the Small Business Administration (SBA) and Congress to guarantee that all contracts involving the expenditure of federal funds for prescription drugs and services comply in full with SBA guidelines as set out by Congress.

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

1978

Intrastate Commerce (2004.arc)

FDA should fully implement its current inspecting authority over manufacturing of drugs in intrastate commerce.

(Am Pharm. NS18(8):30; July 1978)

1970

Food, Drug, and Cosmetic Act: Delaney Clause (2004.arc)

The committee recommends that APhA supports revision of the Delaney Clause in a manner that would provide for suitable review of scientific data, evaluation by qualified experts, and exercise of judgment by a responsible governmental agency before a decision is made regarding the safety of a food additive.

(JAPhA. NS10:345; June 1970)

1970

National Formulary and United States Pharmacopoeia (2004.arc)

2. APhA recommends to its own members and to all U.S. pharmacists a renewed appreciation of the official compendia themselves, as well as the unique standards-setting mechanism which the compendia constitute.
3. APhA urges all American pharmacists to do everything in their power to support and defend the compendia as symbolic of the privilege which Congress, on behalf of the American public, has entrusted to them personally through the profession of pharmacy.

(JAPhA. NS10:363; June 1970)

1969

Office of Economic Opportunity (OEO) (2004.arc)

There is a wide spectrum of arrangements for pharmaceutical service that ranges from an "in-house" pharmacy to an exclusive "vendor" system. The possibility of establishing pharmaceutical services within the guidelines of OEO, Model Cities, or other governmental agencies is not excluded. The committee recommends that APhA develop guidelines for pharmacists and their associations for exploring, and perhaps utilizing, any or all varied possibilities.

(JAPhA. NS9:350; July 1969)

1968

Medicare Pharmaceutical Services (2005.arc)

1. The committee does not think it reasonable to deny those receiving Social Security benefits the essential item of pharmaceutical services so necessary to complete therapy and health care benefits in this modern-day society. In this regard, the committee reaffirms its support of the criteria set forth in the 1967 report of the committee on legislation and recommends that APhA continue its support of S.2936.
2. When a formulary is established, we recommend that APhA insists that the selection of drugs in the formulary be governed by appropriate and qualified health care practitioners guided by the medical needs of the recipients. We further urge that any such formulary provide appropriate procedures to accommodate the need for a nonformulary drug when medical necessity so requires.

(JAPhA. NS8:361; July 1968)

1968

Medicare Pharmaceutical Services (2005.arc)

1. S.2936 authorizes the formulary committee to publish and disseminate (at least annually) an alphabetical list of qualified drugs by established names and other representative names by which the drugs are commonly known, along with the benefits allowable, pharmacists, physicians, and other interested persons, including Social Security beneficiaries. The committee recommends that APhA seek revision of this provision to delete "beneficiaries" from the distribution.
2. In its 1967 report, the committee recommended guidelines for use by the APhA Board of Trustees in considering and acting upon proposals concerning drug costs. The committee believes that S.2936 meets these established criteria. We recommend that the House of Delegates continues its support of these guidelines and endorse S.2936 with the change recommended.

(JAPhA. NS8:369; July 1968)

1968

Medicare/Medicaid: Standards of Pharmaceutical Service (2005.arc)

1. The committee reaffirms its admonition that the profession must insist that high standards of pharmaceutical service be available under any government-funded, pharmaceutical service program.
2. The committee reiterates the standards established in 1967 as the proper guide for APhA in future legislative activity for Title XIX.

(JAPhA. NS8:361; July 1968)

1967

Medicaid: Objectives for State Legislation (2005.arc)

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

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

(JAPhA. NS7:313; June 1967)

1967

Medicare Formulary Committee (2005.arc)

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

(JAPhA. NS7:313; June 1967)

1967

Medicare Reimbursement Procedures (2005.arc)

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

(JAPhA. NS7:313; June 1967)

1967

State Association Relations with Welfare and Health Departments (2005.arc)

The committee recommends that APhA continue to help state associations improve their working relationships with their respective welfare or health departments so that adequate pharmaceutical service will be provided to eligible recipients and so that pharmacists will receive a reasonable reimbursement for their services.

(JAPhA. NS7:311; June 1967)

1966

Medicaid: State Legislation, Pharmacists' Participation, and Reimbursement (2005.arc)

1. The committee recommends that APhA assist state associations in establishing, preferably in the authorizing state legislation, pharmaceutical consultant and pharmaceutical advisory committee provision in state plans under Title XIX to assist the state in complying with the federal law in the area of pharmaceutical services.
2. The committee repeats its recommendations made in 1964 and again in 1965 that state pharmaceutical societies encourage their state agencies to adopt the professional fee system. The committee further recommends that APhA prepares a detailed explanation of the professional fee system for distribution to state public assistance agencies.

(JAPhA. NS6:312; June 1966)

1966

Office of Economic Opportunity (OEO) (2004.arc)

APhA should protest the unnecessary expenditure of federal funds by the OEO for facilities and personnel that duplicate existing community pharmacy resources.

(JAPhA. NS7:311; June 1967)

1965

Welfare Programs: Reimbursement for Pharmaceutical Service (2005.arc)

The committee recommends that continued emphasis be placed on the average professional fee as the method of choice for reimbursing pharmacists for professional services in state welfare programs and simplifying administration aspects of the programs.

(JAPhA. NS5:278; May 1965)

FREEDOM OF ACCESS (FREEDOM OF CHOICE)

1968

Veterans Administration Drug Program: Free Choice of Pharmacist/Mail Order Prescriptions (2004.arc)

The committee recommends that APhA supports a free-choice provision in the drug program for veterans comparable to that which now exists under Medicare, Medicaid, and CHAMPUS. The continued expansion of the scope of coverage of the VA programs as result of military conflicts involving the United States ensures that the action of the VA will continue to have a substantial drug program.

(JAPhA. NS8:366; July 1968)

1967

Veterans Administration Drug Program: Free Choice of Pharmacist/Mail Order Prescriptions (2004.arc)

The committee recommends that APhA continue its strong opposition to the Veterans Administration mail-order provisions so that veterans may exercise their freedom of choice and elect to have their prescriptions dispensed by their personal pharmacist.

(JAPhA. NS7:311; July 1967)

1966

Pharmaceutical Service Under Medicaid and Medicare (2004.arc)

The committee recommends that APhA seeks to assure that legislative proposals provide the elderly and medically indigent the same freedom and safeguards as are afforded to all the self-paying members of our society. Patients who must rely upon governmentally financed or administered programs are entitled to the same high quality of pharmaceutical services as provided to the population as a whole.

(JAPhA. NS6:312; June 1966)

1966

Veterans Administration Drug Program: Free Choice of Pharmacist/Mail Order Prescriptions (2004.arc)

APhA should seek legislation to require the Veterans Administration to utilize existing community pharmacy facilities in furnishing pharmaceutical service to veterans and guarantee veteran beneficiaries' freedom to choose their own pharmacist.

(JAPhA. NS6:293; June 1966)

1966

Veterans Administration Drug Program: Free Choice of Pharmacist/Mail Order Prescriptions (2004.arc)

1. The committee recommends that APhA advise state pharmaceutical associations of the importance of including a free choice of practitioner provision in such legislation and further recommends that APhA provide the states with supporting data and material for use in the legislative efforts.
2. The committee further recommends that APhA urge state pharmaceutical societies to obtain representation on the advisory and policy-making committees that advise state agencies responsible for administering government health and welfare programs. This can sometimes be accomplished in the legislative considerations and should be one objective sought in state legislation implementing the federal law.

(JAPhA. NS6:300; June 1966)

1964

Welfare Programs: Freedom of Choice Principle (2004.arc)

APhA shall lend its full assistance to the various states to ensure that programs of public welfare are so developed and administered that they preserve the rights and dignity of the individual and fully recognize the need for the principle of freedom of choice of health services based on a sound and equitable appreciation for the costs involved in making such services available.

(JAPhA. NS4:428; August 1964)

1963

The Principle of Free Choice (2004.arc)

APhA continues to support the principle of free choice of all professional health practitioners.
(JAPhA. NS3:298; June 1963)

INTERPROFESSIONAL RELATIONS

Family Planning

1973

Family Planning Organizations (2004.arc)

The committee recommends that APhA encourages the voluntary participation of pharmacists in individual or organized activities relating to family planning.
(JAPhA. NS13:510; September 1973)

General Health Care Organizations

1975

Other Health Care and Professional Organizations (2004.arc)

2. The committee recommends that active participation of pharmacists in the meetings of related health organizations can best be achieved by involving pharmacists in the programs of existing bodies rather than by establishing special sections on pharmacy.
3. The committee recommends that state pharmaceutical associations develop liaison commissions with their state counterparts of the health-related organizations.

(JAPhA. NS15:331-333; June 1975)

1975

Professional Standards Review Organizations (PSROs) (2004.arc)

1. APhA supports amendment of the Social Security Act to make pharmacists eligible for membership in Professional Standards Review Organizations (PSROs).
2. APhA advocates active involvement of pharmacists in the development of professional standards review procedures and the review process itself, since the success of such review in maintaining the quality and appropriateness of health care is dependent upon informed participation.
3. Pharmacists should work through their state and/or local pharmaceutical associations to participate in the activities of Professional Standards Review Organizations.
4. APhA should develop programs to assist state and local pharmaceutical associations in their participation with Professional Standards Review Organizations.

(JAPhA. NS15:331-333; June 1975)

1968

Health Professional Societies (2004.arc)

The committee recommends that APhA initiates discussions with the professional societies of other health professions such as nursing, optometry, osteopathy, and podiatry.
(JAPhA. NS8:379 July 1968)

Hospitals

1966

Hospitals: Pharmacist Consultants (2004.arc)

A number of smaller hospitals will require pharmaceutical consultants to serve on pharmacy and therapeutics committees and to provide and supervise their pharmaceutical service programs. The committee recommends that APhA continue to provide guidance materials to assist practitioners.
(JAPhA. NS6:312; June 1966)

Mental Health

2004, 1965

Mental Health Programs (2019.arc)

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.

(JAPhA. NS5:274; May 1965) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2011)

Mental Health

1965

Mental Health Programs (2004.arc)

2. APhA should investigate the feasibility of establishing a definite function within its staff to disseminate information and provide guidance to the various state associations with respect to the development of mental health programs.

(JAPhA. NS5:274; May 1965)

Nursing Homes

1963

Nursing Homes (2004.arc)

1. APhA urges pharmacists to familiarize themselves with the guidebook; Pharmaceutical Services in the Nursing Home, which was developed with the assistance of APhA, the American Nursing Home Association, the American Society of Hospital Pharmacists, and the U.S. Public Health Service so that pharmacists can more effectively work with nursing home personnel to institute the proper professional safeguards that are vital to good patient care.
2. APhA urges local and state pharmaceutical associations to consider joint seminars and conferences with nursing home associations.

(JAPhA. NS3:299; June 1963)

Other Public Health

1972

Prevention and Control of Venereal Disease (2005.arc)

1. The committee recommends that APhA support the repeal of state and local laws that act to prevent pharmacists from participating with maximum effectiveness in efforts to combat venereal disease by restricting the availability of the prophylactic devices and dissemination of information regarding their use within pharmacies.
2. The committee recommends that APhA support the principle that state and local laws controlling the distribution of prophylactic devices should require that open display and advertising of prophylactic devices be accompanied by the distribution of educational materials relating to venereal disease prevention and control.

(JAPhA. NS12:304; June 1972)

Pharmacy Specialties

1964

Specialty Organizations in Pharmacy (2004.arc)

APhA should continue its policy of meeting with any and all specialty organizations in pharmacy to seek mutual understanding and to develop programs in order to achieve the objectives and policies of APhA.

(JAPhA. NS:428; August 1964)

Physician Ownership of Pharmacies

1970

APhA Support of Legislation to Ban Physician Ownership (2004.arc)

1. The committee recommends not only that APhA continue to urge passage of the Hart Bill in its present form, but that APhA support any version of the Hart Bill that would effectively ban physician ownership even without a ban on physician dispensing, if the apparent choice is between such a bill or no bill at all.
2. The committee recommends that affirmative efforts be made both by pharmacy organizations and individual pharmacists to establish contact with consumer representative organizations at national, state, and local levels to assure that consumers are aware of their stake in this legislation and are persuaded to work actively in its support.

(JAPhA. NS10:340; June 1970)

1963

Physician/Pharmacist Code of Understanding (2004.ac)

State pharmaceutical associations are urged to foster the use of the Physician-Pharmacist Code of Understanding, developed by APhA, as a means of better serving the public through improved and closer relationships between physicians and pharmacists.
(JAPhA. NS3:298; June 1963)

Podiatry

1967

Podiatrist Organizations (2004.arc)

The committee recommends increased liaison with podiatrists on a national and state level.
(JAPhA. NS7:320; June 1967)

Public Health

1968

American Public Health Association (2004.arc)

The committee reviewed the pharmacy public health meeting which was sponsored jointly by APhA and the American Association of Colleges of Pharmacy at the annual meeting of the American Public Health Association. The committee recommends that APhA continue to support such meetings and urges that pharmacists, when possible, make an effort to participate in these meetings.
(JAPhA. NS8:382; July 1968)

1968

Voluntary Health Agencies (2004.arc)

The committee recommends that state and local pharmacy organizations make an effort to establish communications with state and local counterparts of the national voluntary health agencies.
(JAPhA. NS8:382; July 1968)

State Pharmacy Associations

1963

State Organizations of the Professions (2004.arc)

APhA should encourage state pharmaceutical associations to participate in the formation of state organizations of the profession.
(JAPhA. NS3:298; June 1963)

Veterinary Medicine

1988

Pharmacists' Relationship to Veterinarians (2004.arc)

1. APhA should reestablish a liaison with the American Veterinary Medical Association and other appropriate groups to explore mutual goals and interests.

(Am Pharm. NS28(6):395; June 1988)

LABELING

Expiration Dating and Drug Storage Instructions

1970

Expiration Dating and Drug Storage (2004.arc)

1. The committee recommends that manufacturers of prescription and nonprescription drugs include on the package label adequate directions as to storage conditions and the date after which the products should not be used.
2. The foregoing applies only to products distributed by manufacturers in their container and does not consider prescription medication dispensed by pharmacists.

(JAPhA. NS10:360; June 1970)

1968

Expiration Date (2004.arc)

The committee recommends that pharmacists place the expiration date of all time-dated drugs on the prescription labels of those drugs.

(JAPhA. NS8:380 July; 1968)

Identification of Drug and Manufacturer

2004, 1971

Drug Name and Strength (2010.arc)

APhA supports the practice of placing the name and strength of the drug on the prescription label; however, APhA opposes any requirement that the name and strength of the drug be included on the prescription label in any case in which the prescriber objects to or waives the inclusion of such information on the prescription label.

(JAPhA. NS11:260; May 1971) (JAPhA. NS44(5):551; September/October 2004)

1981

NDA or ANDA Number on Drug Product Label (2004.arc)

APhA supports legislation to require that the labels of prescription drug products distributed to pharmacists include evidence that FDA has approved the marketing of the product or that FDA has exempted the drug from approval requirements.

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

1978

Labeling of Nonprescription Drug Products (2004.arc)

APhA urges the manufacturers of nonprescription drug products to help increase patient awareness of the role of the pharmacist as a health care professional and a readily available information source on drug actions and interactions by including an appropriate statement in the labeling and advertising of nonprescription drug products.

(Am Pharm. NS18(8):3-36; July 1978)

1970

Drug Labeling Information (2004.arc)

The committee recommends that the following guidelines be adopted for use by APhA on pending drug code legislation:

1. Legislation should provide that the name of the manufacturer of the final dosage form be made part of the approved labeling of all prescription drug products.
2. The code authorized by the legislation should be relevant to professional practice in identifying individual commercial packages and administered doses.
3. Drugs, when dispensed by prescription, generally should be exempt from the requirement that the prescription label bear the code.
4. Pharmacists, when performing professional duties in providing medication on prescription orders, should be exempt from the packager and labeler provisions.

(JAPhA. NS10:343; June 1970)

1970

Drug Labeling Information (2004.arc)

APhA no longer opposes the practice of placing the name and strength of the drug on the prescription label as a routine matter, unless otherwise indicated by the prescriber.

(JAPhA. NS10:343; June 1970)

1969

National Drug Code: Prescription Capsule and Tablet Codes (2004.arc)

Recognizing the benefit to the health of the public that would accrue if all tablets and capsules of prescription medications were so coded, the committee encourages all manufacturers to code their capsules and tablets in this fashion.

(JAPhA. NS9:361; July 1969)

1969

Prescription Drug Inventory: Selection by Pharmacist/Brand vs. Generic Names (2004.arc)

The committee urges pharmacists to exercise the same professional judgment and care in selecting their prescription drug inventory as they do in dispensing that inventory. Because of the importance of the identity of the actual manufacturer of the drug product in the purchasing process, the committee recommends that APhA seek appropriate legislation to require such information as part of the drug product label.

(JAPhA. NS9:363; July 1969)

Ingredients

1970

Disclosure of Active Ingredients (2004.arc)

1. The committee recommends that supports for APhA efforts to obtain full disclosure of the quantity of active ingredients in the labeling of all nonprescription drugs be sought from all concerned organizations, including government agencies, other health professionals, and lay consumer groups.
2. The committee also recommends that APhA undertake an education program directed at all segments of the health professions, as well as an education program directed to the public and Congress, on the need for full disclosure of the active ingredients of all nonprescription drugs.

(JAPhA. NS10:349; June 1970)

1969

Disclosure of Active Ingredients (2004.arc)

The committee reaffirms its statement made in its 1968 report that pharmacists choose nonprescription drug products for recommendation from among those drugs on which the quantitative amounts of active ingredients are known (either from the label or the Handbook of Nonprescription Drugs.)

(JAPhA. NS9:334 June; 1969)

LICENSURE, REGISTRATION AND REGULATION

Licensure and Registration of Personnel

2004

Pharmacy Technicians (2008.arc)

1. APhA supports certification of pharmacy technicians by the Pharmacy Technician Certification Board (PTCB) to advance the position as a career within pharmacy practice.
2. APhA urges pharmacists to provide guidance and training to pharmacy technicians. Pharmacists and employers are urged to provide ongoing training/support opportunities.
3. APhA supports state boards of pharmacy regulating all pharmacy technicians. Such regulations must require pharmacist oversight of personnel involved in pharmacy services.

(JAPhA. NS44(5):55; September/October 2004)

1991

Development of Internship/Preceptor Guidelines (2008.arc)

1. APhA encourages state boards of pharmacy to review existing internship program objectives and to update or develop quality assurance procedures regarding internship.
2. APhA supports efforts by NABP and national pharmacy associations to identify, review, update, and publish pharmacy internship guidelines as they pertain to all practice environments.

(Am Pharm. NS31(6):28; June 1991) (Reviewed 2003) (Reviewed 2005)

1977

Licensure Qualifications for Foreign Students (2002.arc)

APhA supports the adoption of a uniform system of evaluation that permits objective determination of the educational qualifications of graduates of foreign colleges of pharmacy who wish to qualify for state licensure examinations.

(JAPhA. NS17:459; July 1977)

1972

National Pharmacy Examination (2002.arc)

1. The committee recommends that APhA assist NABP in developing a streamlined procedure for direct licensure in any state. The procedure should provide for a national pharmacy examination and make it possible for a pharmacist who has passed the examination to apply only to the state in which they wish to be licensed.
2. The committee recommends that APhA develop techniques and methodologies that could be used in ensuring the continued competency of pharmacy practitioners.

(JAPhA. NS12:309; June 1972)

Licensure, Registration and Inspection of Facilities

2001

Regulatory Compliance/Regulatory Burden (2008.arc)

APhA, in conjunction with the Occupational Safety and Health Administration and other appropriate regulators, shall educate employers and employee groups and the public about applicable regulations.

(JAPhA. NS41(5)(suppl 1):S9 September/October 2001)

1971

National Pharmacy Examination (2002.arc)

1. The committee recommends that APhA endorse the use of a national pharmacy examination by all boards of pharmacy.
2. The committee recommends that a candidate who passes the national examination be eligible for licensure in any state after demonstrating to the satisfaction of that state's board of pharmacy that they meet the state's requirements for character qualifications and knowledge of state pharmacy and drug law.

(JAPhA. NS11:276; May 1971)

Pharmacy Law and Practice Acts

1970

Model State Pharmacy Law (2002.arc)

1. The committee recommends that APhA proceed as promptly as possible to develop a new model state pharmacy law.
2. The committee recommends that pharmacists contact their state legislators and urge postponement of legislation to consolidate existing narcotic and drug abuse control laws, pending enactment of a federal controlled drug law and completion of a state bill by the National Conference of Commissioners on Uniform State Laws.

(JAPhA. NS10:352; June 1970)

LICENSURE, REGISTRATION, AND REGULATION

Licensure and Registration of Personnel

2008

Pharmacy Technician Education and Training (2018.arc)

1. APhA reaffirms the 2005/2001/1996 Control of Distribution System policy, which states that APhA supports pharmacists' authority to control the distribution process, the personnel involved, and the responsibility for all completed medication orders, regardless of practice setting.
2. APhA supports nationally recognized standards and guidelines for the accreditation of pharmacy technician education and training programs.
3. APhA supports the continued growth of accredited education and training programs that develop qualified pharmacy technicians who will support pharmacists in ensuring patient safety and enhancing patient care.
4. APhA supports the following minimum requirements for all new pharmacy technicians by the year 2015:
   (a) successful completion of an accredited education and training program and
   (b) certification by the Pharmacy Technician Certification Board (PTCB).
5. APhA supports state board of pharmacy regulations that require pharmacy technicians to meet minimum standards of education, training, and certification. APhA also encourages state boards of pharmacy to develop a phase-in process for current pharmacy technicians.

(JAPhA. NS48(4):470; July/August 2008) (Reviewed 2013)

1993

Universal Unique Identifier Numbering System (2015.arc)

APhA supports the development and use of a universal unique identifier numbering system that identifies all health care professionals involved with medication use.

(Am Pharm. NS33(7):56; July 1993) (Reviewed 2004) (Reviewed 2010)

MEDICAL AND PHARMACEUTICAL EQUIPMENT AND PRODUCTS

1999

Sale of Sterile Syringes (2023.arc)

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.

(JAPhA. 39(4):447; July/August 1999) (Reviewed 2003) (Reviewed 2006) (Reviewed 2008) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019) (Reviewed 2020)

MISCELLANEOUS POLICIES

1993

Endorsement of Preferred Vendors by APhA (2004.arc)

APhA shall not endorse as a preferred vendor any corporation that mandates an exclusive contract for pharmaceutical services for that particular company's employees or retirees. This motion shall be understood to require freedom of choice for the beneficiaries of that vendor when it offers a prescription drug benefit program.

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

1990

A White Paper on the Pharmacist's Clinical Roles in Managed Health Care Programs (2004.arc)

APhA, by action of the Board of Trustees, should commission publication of "A White Paper on the Pharmacist's Clinical Roles in Managed Health Care Programs."

(Am Pharm. NS30(6):46; June 1990)

1986

Rationing of Expensive Health Care Services (2004.arc)

1. APhA shall be active in developing criteria with other health care associations regarding rationing of health care services in order to represent pharmacy's interest.

(Am Pharm. NS26(6):420; June 1986) (JAPhA. NS44(5):551; September/October 2004)

1984

Center for Human Organ Acquisition (2004.arc)

4. APhA urges the establishment of facilities for the identification and matching of donors and recipients, so that the benefits of organ transplantation techniques may be available to all persons.

(Am Pharm. NS24(7):61; July 1984)

1970

Industry-Sponsored APhA Projects (2004.arc)

1. The committee recommends a continuation of current APhA policies relating to industry-sponsored APhA programs and activities, including advertising and exhibit standards, sustaining funds, publications, and slide talks.
2. The committee recommends that responsible subdivisions of APhA and staff review objectives, guidelines, value, and effectiveness of all award programs sponsored by grants from industry, as well as clarify the responsibilities and obligations of award recipients, staff, and officers to the sponsors of the awards.

(JAPhA. NS10:335; June, 1970)

NEW DRUG APPLICATIONS AND INVESTIGATIONAL NEW DRUGS

Investigational New Drugs

2010

Pharmacogenomics/Personalized Medicine (2019.arc)

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.

(JAPhA. NS50(4):471; July/August 2010) (Reviewed 2015) (Reviewed 2019)

New Drug Applications

1982

Utilization of Institutional Review Boards for Expediting New Drug Approval (2004.arc)

APhA favors efforts to expedite the drug approval process, without changing the standards of human subject protection, by supporting the actions which would provide an option to move review responsibility for certain elements of drug investigation to properly constituted and certified Institutional Review Boards.

(Am Pharm. NS22(7):32; July 1982)

1984

Abbreviated New Drug Applications (ANDAs) for Post-1962 Drugs (2004.arc)

APhA supports legislation and/or regulations that would serve to permit the filing, consideration, and approval of ANDAs for products containing drug entities initially approved since 1962, when such drug entities have been demonstrated through post-marketing experience to be safe and effective for continued use. Such legislation and/or regulation is not to affect or infringe on the patent life that may relate to the drug.

(Am Pharm. NS24(7):61; July 1984)

1980

Therapeutic Orphans (2004.arc)

1. APhA supports the adoption of policies in the new drug application (NDA) process that would result in premarketing clinical testing of the applicant drug in those population groups and for the major indicated uses for which the drug could reasonably be expected to achieve a substantial degree of use.

(Am Pharm. NS20(7):73; July 1980)

1978

Drugs for Phase IV Experimental Uses (2004.arc)

1. APhA supports the concept of limited investigational marketing of new drugs as part of the drug approval process and supports legislation that would provide for such marketing under the Federal Food, Drug, and Cosmetic Act.
2. APhA supports conditions precedent to limited investigational marketing of new drugs to ensure patients know that a drug is in Phase IV and marketed with limitations, that a drug is a new drug or is being used for a new indication, and that FDA has found the drug safe for its intended use(s).
3. Limited investigational marketing of new drugs should not restrict professional practice of pharmacy or medicine and should not limit patient access to drugs generally. Such marketing should not impose any general restrictions as to who can prescribe and who can dispense drugs that are approved for marketing on a noninvestigational basis.

(Am Pharm. NS18(8):30; July 1978)

PATIENT/PHARMACIST RELATIONSHIPS

1989

Patient Education on Medication Storage (2015.arc)

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

(Am Pharm. NS29(7):464; July 1989) (Reviewed 2004) (Reviewed 2006) (Reviewed 2010)

1968

Patient (2004.arc)

The committee recommends that the individual recipient of pharmaceutical services be referred to as "the patient." The committee recognizes that pharmacists referring to "their patients" might initially cause confusion in the minds of the public and other health practitioners but the fact remains that the recipient of pharmaceutical services is the patient.

(JAPhA. NS8:379; July 1968)

1966

Privileged Communications (2004.arc)

The committee recommends that APhA not advocate enactment of patient-pharmacist privilege statutes.
The confidential obligations imposed upon pharmacists by ethics and civil legal remedies are adequate to protect the public.

(JAPhA. NS6:301; June 1966)

PHARMACEUTICAL CARE

2010

Pharmacogenomics/Personalized Medicine (2019.arc)

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.

(JAPhA. NS50(4):471; July/August 2010) (Reviewed 2015)

2003, 1992

The Pharmacist's Role in Therapeutic Outcomes (2023.arc)

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

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

PHARMACY CRIME AND SECURITY

1980

Pharmacy Robberies (2004.arc)

APhA supports legislation to provide for a specific federal income tax credit for the purchase and installation of security devices to meet each pharmacy's unique, individual needs for security against robberies and burglaries.

(Am Pharm. NS20(7):62; July 1980)

PHARMACY PRACTICE

2014

The Use and Sale of Electronic Cigarettes (e-cigarettes) (2019.arc)

4. APhA urges FDA to require the full disclosure of all ingredients in e-cigarettes and other vaporized nicotine products in both the pre-use and vapor states.

(JAPhA. 54(4):358; July/August 2014) (Reviewed 2019)

2013, 1978

Pharmacists Providing Health Care Services (2023.arc)

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

(Am Pharm. NS18(8):47; July 1978) (Reviewed 2007) (Reviewed 2008) (JAPhA. 53(4):366; July/August 2013) (Reviewed 2016) (Reviewed 2022)

2010

Pharmacogenomics/Personalized Medicine (2019.arc)

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.

(JAPhA. NS50(4):471; July/August 2010) (Reviewed 2015)

2007

Medication Reconciliation the Pharmacists' Responsibility (2010.arc)

1. APhA recognizes pharmacists as the health care team member responsible for the medication r econciliation process when patients move between practice settings within the continuum of care.

(JAPhA. NS45(5):580; September/October 2007)

2007

Pharmacist Primary Care (2013.arc)

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

(JAPhA. NS45(5):580; September/October 2007) (Reviewed 2008) (Reviewed 2009) (Reviewed 2011) (Reviewed 2012)

2005, 1987

Drug Regimen Review (DRR) (2009.arc)

APhA endorses appropriate compensation to pharmacists for performing drug regimen review.

(Am Pharm. NS27(6):422; June 1987) (JAPhA. NS45(5):557; September/October 2005)

2005, 2000

Pharmacogenomics (2019.arc)

1. Recognizing the benefits and risks of pharmacogenomics and applications of this technology, 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 in order 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.

(JAPhA. NS40(5)(suppl 1):S8; September/October 2000) (JAPhA. NS45(5):555; September/October 2005) (Reviewed 2009) (Reviewed 2010) (Reviewed 2015)

2001

Regulatory Compliance/Regulatory Burden (2008.arc)

APhA, in conjunction with the Occupational Safety and Health Administration and other appropriate regulators, shall educate employers and employee groups and the public about applicable regulations.

(JAPhA. NS41(5)(suppl 1):S9 September/October 2001)

1993

Commitment to Pharmaceutical Care (2004.arc)

APhA believes that in order to reform the payment system, individual pharmacists must commit themselves to the provision of pharmaceutical care.

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

1993

Patient Compliance: Industry Programs (2015.arc)

1. APhA supports the development of patient compliance programs that adhere to the principles of pharmaceutical care and are intended to improve the patient's health.
2. APhA should exert a leadership position in a collaborative effort with industry, the medical profession, and other organizations to develop guidelines for patient compliance programs.
3. APhA opposes patient compliance programs that compromise a pharmacist's ability to provide pharmaceutical care to a patient.

(Am Pharm. NS33(7):56; July 1993) (Reviewed 2004) (Reviewed 2010)

1993

Patient Compliance: Pharmacists' Responsibilities (2015.arc)

1. APhA affirms that pharmacists are responsible for assisting patients in becomine active and, informed decision-makers regarding compliance with their prescribed therapeutic plans.
2. APhA will convey to the public, employee benefit managers, third-party payors, and other health care decision makers, the value and cost-effectiveness of the role of the pharmacist in comprehensive medication-use management.

(Am Pharm. NS33(7):55 July; 1993) (Reviewed 2004) (Reviewed 2010)

1992

Compounding Activities of Pharmacists (2008.arc)

APhA affirms that compounding pursuant to, or in anticipation of, a prescription or diagnostic preparation order is an essential part of health care that is the prerogative of the pharmacist.

(Am Pharm. NS32(6):515; June 1992) (Reviewed 2004)

1991

Biotechnology (2004.arc)

APhA reaffirms the pharmacist's traditional authority and responsibility for achieving optimal therapeutic outcomes by ensuring appropriate use of all medications, devices, and associated services, including the unique biotechnology-based products.

(Am Pharm. NS31(6):29; June 1991)

1979

Endorsement of Standards of Practice (2004.arc)

APhA endorses the recommended standards of practice resulting from the 1978 APhA/AACP A National Study of the Practice of Pharmacy and recommends that pharmacists voluntarily implement these standards in their professional practices.

(Am Pharm. NS19(7):67; June 1979)

1979

Proposal on Drug Regimen Review (DRR) by Pharmacists (2004.arc)

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

(Am Pharm. NS19(7):61; June 1979)

1978

Definition of Pharmacy Practice (2002.arc)

APhA advocates that pharmacy practice be defined as a patient-oriented health service that applies a scientific body of knowledge to improve and promote health through assurances of safety and efficacy in drug use and drug-related therapy.

(Am Pharm. NS18(8):42; July 1978)

PHARMACY TECHNICIANS

2008

Pharmacy Technician Education and Training (2018.arc)

1. APhA reaffirms the 2005/2001/1996 Control of Distribution System policy, which states that APhA supports pharmacists' authority to control the distribution process, the personnel involved, and the responsibility for all completed medication orders, regardless of practice setting.
2. APhA supports nationally recognized standards and guidelines for the accreditation of pharmacy technician education and training programs.
3. APhA supports the continued growth of accredited education and training programs that develop qualified pharmacy technicians who will support pharmacists in ensuring patient safety and enhancing patient care.
4. APhA supports the following minimum requirements for all new pharmacy technicians by the year 2015:

(a) successful completion of an accredited education and training program and

(b) certification by the Pharmacy Technician Certification Board (PTCB).

5. APhA supports state board of pharmacy regulations that require pharmacy technicians to meet minimum standards of education, training, and certification. APhA also encourages state boards of pharmacy to develop a phase-in process for current pharmacy technicians.

(JAPhA. NS48(4):470; July/August 2008) (Reviewed 2013)

2005, 2001, 1996

Control of Distribution System (2008.arc)

APhA supports the pharmacists' authority to control the distribution process and personnel involved and the responsibility for all completed medication orders regardless of practice setting.

(JAPhA. NS396; June 1996) (JAPhA. NS4(5)(suppl 1):58; September/October 2001) (JAPhA. NS45(5):560; September/October 2005)

2004

Pharmacy Technicians (2008.arc)

1. APhA supports certification of pharmacy technicians by the Pharmacy Technician Certification Board (PTCB) to advance the position as a career within pharmacy practice.
2. APhA urges pharmacists to provide guidance and training to pharmacy technicians. Pharmacists and employers are urged to provide ongoing training/support opportunities.
3. APhA supports state boards of pharmacy regulating all pharmacy technicians. Such regulations must require pharmacist oversight of personnel involved in pharmacy services.

(JAPhA. NS44(5):55; September/October 2004)

1997

Pharmacy Technician Membership (2008.arc)

APhA should establish a membership category and services for pharmacy technicians.

(JAPhA. NS37(4):460; July/August 1997) (Reviewed 2001) (Reviewed 2007)

1996

Technician Licensure and Registration (2004.arc)

2. APhA supports the role of the state boards of pharmacy in protecting the public in the boards' interaction with the profession, including the boards' oversight of pharmacy technicians, through their control of pharmacists and pharmacy licenses.
3. In states where the board of pharmacy chooses to exercise some direct oversight of technicians, APhA recommends a registration system.
4. APhA reaffirms its opposition to licensure of pharmacy technicians by statute or regulation.

(JAPhA. NS36(6):396; June 1996) (Reviewed 2001)

1988

Pharmacy Technicians (2001.arc)

1. The American Pharmaceutical Association supports the pharmacist's authority to control the distribution process and the responsibility for all completed medication orders regardless of practice setting.
2. APhA supports the voluntary certification of pharmacy technicians by pharmacy profession.
3. APhA supports the voluntary accreditation of pharmacy technician training programs by the pharmacy profession.

(Am Pharm. NS28(6):395; June 1988)

1988

Pharmacy Technicians (2001.arc)

1. APhA endorses the use of the term "pharmacy technicians" to describe those individuals who assist pharmacists in the performance of selected professional duties.
2. APhA endorses the appropriate use of pharmacy technicians in various types of pharmacy practices.
3. APhA advocates that pharmacists maintain supervisory control over pharmacy technicians.
4. APhA advocates the training of pharmacy technicians via programs developed and administered under the guidance of pharmacists.
5. APhA advocates that pharmacists develop written guidelines for pharmacy technicians that specify functions and supervisory controls.

(Am Pharm. NS28(6):395; June 1988)

1971

Subprofessionals: Functions, Standards, and Supervision (2001.arc)

2. The committee recommends that APhA endorse the report by the Task Force on Practitioners' and Subprofessional's Roles in Pharmacy as an initial guide to the profession regarding the functions that can be performed by supportive personnel and that continued study be directed toward functions, standards of performance, and supervision of supportive personnel.
3. The committee recommends that APhA ensure that criteria for interservice training programs for supportive personnel be developed and disseminated.

(JAPhA. NS11:277; May 1971)

1971

Subprofessionals: Functions, Standards, and Supervision (2004.arc)

The committee recommends that APhA endorse the use of properly supervised supportive personnel in pharmacy practice as a positive step toward improving the quality and quantity of pharmaceutical services provided by the profession.

(JAPhA. NS11:277 May; 1971) (Reviewed 2001)

POISON PREVENTION

1973

Poison Prevention Packaging Act (2004.arc)

The committee recommends that APhA endorse and support enactment of the National Drug Trade Conference Model State Poison Prevention Packaging Act.

(Am Pharm. NS13:511; September 1973)

1970

Safety Packaging (2004.arc)

1. The committee recommends that APhA continue to support in principle, the voluntary use of safety closures by pharmacists where feasible and urges the profession to exert every effort to educate patients on the proper storage and use of drug products.
2. The committee recommends that, at this time, APhA not endorse legislation that would require the routine use of safety closures for all medication because technological and other issues of concern to pharmacists are not yet resolved.

(JAPhA. NS10:341; June 1970)

1969

Syrup of Ipecac (2004.arc)

The committees recommend that pharmacists make distribution of syrup of ipecac, USP, part of their National Poison Prevention Week activities. The committees urge all wholesalers to make 1-ounce containers of properly labeled syrup of ipecac, USP, available as a service to the profession of pharmacy and the public.

(JAPhA. NS9:333; July 1969)

1968

Poison Control, Information, and Treatment: Pharmacists' Responsibility (2004.arc)

3. The committee also recommends that manufacturers label fluid extract of ipecac as a poison.
4. The committee recommends that APhA consult with poison prevention and treatment authorities and prepare an acceptable publication that pharmacists can use in their poison-prevention activities.
5. In view of the above, the committee recommends that any publication describing poisoning procedures distributed by pharmacists for home use should only provide first-aid instructions for accidental poisoning. The only antidotes listed in this publication should be syrup of ipecac and activated charcoal. In addition, the public should be informed in this publication that these antidotes should be used only after consultation with proper authorities.

(JAPhA. NS8:383; July 1968)

1967

Insecticides: State Laws (2004.arc)

The committee recognizes a danger and inequality in many state laws regulating poisons and insecticides.
In many areas, an individual must obtain certain poisons only from a pharmacist after registering for the poison, while other, more powerful poisons may be obtained from unsupervised sources. The committee recommends that pharmacists urge the various state agencies to review their poison laws which in many cases are antiquated.

(JAPhA. NS7: 321; June 1967)

1966

Aspirin Packaging (2004.arc)

The committee endorses in principle the suggestion that children's aspirin (1.25g) be packaged in containers of no more than 25 tablets. A legislative review of pending bills that would effect this change is needed. The committee recommends that the Pharmaceutical Manufacturers Association and the Proprietary Association consider voluntary compliance before legislation is encouraged. Limiting the package size of children's aspirin would markedly reduce the number of accidental deaths from self-poisoning.

(JAPhA. NS6:333; June 1966)

1966

Syrup of Ipecac (2004.arc)

Pharmacists who supply ipecac syrup as an emergency emetic should take special precautions to avoid the possibility of confusion with fluid extract of ipecac. Although some have recommended the removal of fluid extract of ipecac from commerce, distinctive labeling that would serve as a means of clear differentiation between the syrup and the fluid extract seems a better alternative. The fluid extract is a convenience for those pharmacists who prepare the syrup in quantity for distribution in their community. Manufacturers are urged to consider new labeling for the fluid extract.

(JAPhA. NS6:32 June; 1966)

POST-MARKETING SURVEILLANCE

2010

Pharmacogenomics/Personalized Medicine (2019.arc)

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.

(JAPhA. NS50(4):471; July/August 2010) (Reviewed 2015)

2004, 1967

Adverse Drug Reactions: Pharmacists' Responsibilities (2009.arc)

APhA urges pharmacists to take an active role in reporting adverse drug reactions.

(JAPhA. NS7:324; June 1967) (JAPhA. NS44(5):551; September/October 2004)

1986, 1982

Post-marketing Surveillance (2004.arc)

1. APhA supports the concept of post-marketing drug surveillance.
2. APhA recognizes the spontaneous adverse drug reaction reporting system as the basic foundation of post-marketing drug surveillance; as such, APhA believes that this spontaneous reporting system should be maintained and strengthened.
3. APhA recommends the use of definitive post-marketing drug surveillance methods as indicated by a priori information or data gathered through spontaneous reporting.
4. APhA believes that by virtue of their skills and practice settings, pharmacists are well-suited to participate in and to advance post-marketing drug surveillance;hence, APhA fosters the utilization of pharmacists in these activities.

(Am Pharm. NS26(6):420; June 1986) (Am Pharm. NS22 (7):32; July 1982)

PRESCRIBING AUTHORITY

2013, 1980

Medication Selection by Pharmacists (2023.arc)

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

(Am Pharm. NS20(7):62; July 1980) (Reviewed 2003) (Reviewed 2007) (Reviewed 2008) (Reviewed 2009)(Reviewed 2011) (Reviewed 2012) (JAPhA. 53(4):366; July/August 2013) (Reviewed 2018)

2012, 1987

Pharmacists' Authority to Select Medications (2018.arc)

APhA supports authority for pharmacists to select nonprescription and prescription medications as part of pharmacists' responsibilities to design, implement, and monitor drug regimens for patients, in consultation with practitioners when appropriate.

(Am Pharm. NS27(6):422; June 1987) (Reviewed 2003) (Reviewed 2007) (Reviewed 2008) (Reviewed 2009) (Reviewed 2011) (JAPhA. NS52(4): 460; July/August 2012) (JAPhA. 53(4):366; July/August 2013)

2003, 1992

The Pharmacist's Role in Therapeutic Outcomes (2023.arc)

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

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

PRESCRIPTIONS AND PRESCRIPTION ORDERS

1997

Red "C" Stamp Regulations (2011.arc)

APhA supports the repeal of laws and rules requiring the red "C" stamp on all hardcopy schedule prescriptions.

(JAPhA. NS37(4):460; July/August 1997) (Reviewed 2006)

1993

Access to Patient Information (2010.arc)

1. APhA supports the right of pharmacists, in all practice environments, to have access to patient-specific information necessary to achieve optimal therapeutic outcomes.
2. APhA encourages the prescriber's assessment of the patient's disease state and desired or intended therapeutic outcome to accompany the prescription order.

(Am Pharm. NS33(7):54; July 1993) (Reviewed 2001) (Reviewed 2007)

1990

Facsimile (Fax) Transmission of Prescription Orders (2007.arc)

APhA encourages state boards of pharmacy and DEA to develop regulations governing the use of facsimile devices in pharmacy practice settings, with regard to such issues as verification of source of order, quality of facsimile transmission, and appropriate use with prescription orders for controlled substances.

(Am Pharm. NS30(6):46 June; 1990) (Reviewed 2001)

1979, 1978

Prescription Transfer Authorization (2006.arc)

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

(Am Pharm. NS19(7):56; June 1979) (Am Pharm. NS18(8):30; July 1978)

1976

Prescription: Identification of Prescriber (2001.arc)

Agencies that regulate the prescribing and dispensing of prescription drugs must ensure that all prescription orders contain sufficient legible information to permit the pharmacist to identify and communicate with the prescriber.

(JAPhA. NS16:340; June 1976)

1974

Diagnosis on Prescription Orders and Labels (2001.arc)

The committee recommends that APhA initiate discussions with organizations representing prescribers in the interest of including information regarding intended use or intended effect of medication or diagnosis on prescription orders and labels.

(JAPhA. NS14:499; September 1974)

1973

Prescription Order Forms: Guidelines (2001.arc)

1. The committee recommends that APhA not endorse the multiline prescription order form concept at this time.
2. The committee recommends that APhA have its Academy of General Practice of Pharmacy work with representatives of the prescribing professions to develop several prototype designs of medication orders and patient record systems for use in various health care environments.

(JAPhA. NS13:512; September 1973)

1969

Uniform Prescription Order Forms (2001.arc)

The committee recommends that APhA call a meeting of representatives from all professions licensed to prescribe, for the purposes of discussing the hazards involved with current prescription writing and detailing those steps that might result in a uniform prescription order form that could be used by all prescribing professions.

(Am Pharm. NS9:361; July 1969)

1967

Authority for Prescription Order Renewals (2001.arc)

The committee wishes to emphasize the fact that only a physician may authorize a renewal of a prescription; they may do this personally or authorize another to convey their authorization to the pharmacist. This is an area of intense interest and misinformation on the part of physicians and pharmacists. The committee recommends increased activity by local pharmaceutical groups to foster more discussion of this problem with physicians. Physicians and pharmacists should jointly review applicable laws and professional ethics so that a common understanding can be achieved.

(JAPhA. NS7:320; June 1967)

1963

Confidentiality of Prescription Orders (2001.arc)

APhA, recognizing the confidentiality of prescription order information from a legal and ethical standpoint, should develop procedures for making prescription order information available consistent with a proper pharmacist patient prescriber relationship when the disclosure of such information is for the purpose of serving the patient's interest.

(JAPhA. NS3:298; June 1963)

PUBLIC HEALTH

Alcohol and Tobacco

2014

The Use and Sale of Electronic Cigarettes (e-cigarettes) (2019.arc)

1. APhA opposes the sale of e-cigarettes and other vaporized nicotine products in pharmacies until such time that scientific data support the health and environmental safety of these products.
2. APhA opposes the use of e-cigarettes and other vaporized nicotine products in areas subject to current clean air regulations for combustible tobacco products until such time that scientific data support the health and environmental safety of these products.
3. APhA urges pharmacists to become more knowledgeable about e-cigarettes and other vaporized nicotine products.
4. APhA urges FDA to require the full disclosure of all ingredients in e-cigarettes and other vaporized nicotine products in both the pre-use and vapor states.

(JAPhA. 54(4):358; July/August 2014) (Reviewed 2019)

2005, 1968

Cigarette Sales in Pharmacies. (2019.arc)

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

(JAPhA. NS8:382; July 1968) (JAPhA. NS45(5):555-556; September/October 2005) (Reviewed 2009) (Reviewed 2014)

1987

AIDS (2005.arc)

1. APhA encourages pharmacists to become more knowledgeable about AIDS.
3. APhA supports the development of educational programs for pharmacists that would enable them to assume a service role in the prevention and treatment of 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.

(Am Pharm. NS27(6):422; June 1987)

1973

Smoking in APhA's Public Meetings (2009.arc)

Many persons, including many of our colleagues, object to being subjected to the smoking of others. Those in attendance should not smoke in public meetings of APhA.

(JAPhA. NS13:489; September 1973) (Reviewed 2005)

1970

Cigarette Sales in Pharmacies (2005.arc)

1. The committee commends those pharmacists who have ceased selling cigarettes in their pharmacies and urges other pharmacists to initiate similar action. The main issue concerning smoking and health is not whether pharmacists discontinue selling cigarettes, but whether the public discontinues smoking them. The key, therefore, is public education and the committee urges pharmacists to take active roles in smoking and health education programs.
2. The committee is concerned over the developing trend of tobacco companies to compensate pharmacists who provide space for self-service cigarette racks in their pharmacies. In the committee's view, mass display of cigarettes in pharmacies is in direct contradiction to the role of the pharmacy as a public health facility.

(JAPhA. NS10:357; June 1970)

1969

Cigarette Sales in Pharmacies (2005.arc)

Since the sale of cigarettes in pharmacies can be considered as inconsistent with their functions as health institutions, the committee recommends that pharmacists examine what effect the sale of tobacco products in pharmacies has on public health.

(JAPhA. NS9:334; June 1969)

1968

Cigarette Sales in Pharmacies (2005.arc)

1. The committee recommends that, if feasible, APhA prepares a sign for use by pharmacies that do not sell cigarettes stating this fact.
2. The committee also recommends that APhA distribute to its members a list containing the tar and nicotine content of various brands of cigarettes.
3. The committee urges pharmacists to display this list in their pharmacies.

(JAPhA. NS8:382; June 1968)

1964

Dangers in Smoking: Public Education (2005.arc)

APhA encourages pharmacists to educate young adults on the medical evidence implicating cigarette smoking as a causative factor in certain diseases and illnesses.

(JAPhA. NS4:429; August 1964)

Community Awareness and Education

2014, 2005, 1986

Pharmacists' Responsibilities in Community Medication Awareness Programs (2019.arc)

1. APhA supports the development of comprehensive educational programs on the proper use and the safe and environmentally responsible disposal of prescription and nonprescription medication.
2. Pharmacists should take a major educational responsibility in proactive programs that optimize therapeutic outcomes and minimize risks from inappropriate medication use.

(Am Pharm. NS26(6):419; June 1986) (Reviewed 2005) (Reviewed 2009) (JAPhA. 54(4):358; July/August 2014)

2005, 1986

Pharmacists' Responsibilities in Community Medication Awareness Programs (2014.arc)

1. APhA supports the development of a comprehensive educational program on the proper use of prescription and nonprescription medication.

(Am Pharm. NS26(6):419; June 1986) (Reviewed 2005) (Reviewed 2009)

1972

Public Health Education: Proper Drug Use (2005.arc)

1. The committee recommends that APhA seek to establish, with the cooperation and support of the drug industry, a public education fund to produce educational materials, particularly for broadcast use, that would develop public awareness of proper drug use and the dangers inherent in improper drug use and that would emphasize the necessity for professional consultation for a supervision of drug therapy.
2. The committee recommends that APhA work to ensure that labeling and promotional materials for proprietary drug products direct attention to instructions regarding precautions and proper use of such products and identify the pharmacist as a source of information and advice regarding self-medication.

(JAPhA. NS12:304; June 1972)

1970

Public Health Education (2005.arc)

1. The committee recommends the following priorities for APhA in developing educational programs using all vehicles and mechanisms available:
    a. A respect for drugs (including drug abuse education) program
    b. A venereal disease education program
    c. A poison prevention program.

(JAPhA. NS10:350; June 1970)

HIV/AIDS

2005, 1993

HIV/AIDS Education (2019.arc)

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.

(Am Pharm. NS33(7):54; July 1993) (JAPhA. NS45(5):556; September/October 2005) (Reviewed 2009) (Reviewed 2014)

2005, 1990

Needle/Syringe Exchange Programs in the Prevention of Blood-Borne Infectious Diseases (2019.arc)

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.

(Am Pharm. NS30(6):45; June 1990) (JAPhA. NS45(5):556; September/October 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

2005, 1990

Needle/Syringe Exchange Programs in the Prevention of the Spread of Human Immunodeficiency Virus (HIV) and Other Infections Diseases (2020.arc)

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.
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.

(Am Pharm. NS30(6):45; June 1990) (JAPhA. NS45(5):556; September/October 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

1999

Sale of Sterile Syringes (2023.arc)

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.

(JAPhA. 39(4):447; July/August 1999) (Reviewed 2003) (Reviewed 2006) (Reviewed 2008) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019) (Reviewed 2020)

2016, 2003, 1987

Substance Use Disorder Education (2019.arc)

APhA supports comprehensive Substance Use Disorder education, prevention, treatment, and recovery programs.

(Am Pharm. NS27(6):424; June 1987) (JAPhA. NS43(5)(suppl 1):S58; September/October 2003) (Reviewed 2006) (Reviewed 2011) (JAPhA. 56(4):369; July/August 2016)

2006

Conversion of Nonprescription Products Into Drugs of Abuse (2016.arc)

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 (2016.arc)

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

(JAPhA. NS45(5):555; September/October 2005)(Reviewed 2006) (Reviewed 2011)

2005, 2002

Emergency Preparedness (2019.arc)

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.

(JAPhA. NS42(5)(suppl 1):S61; September/October 2002) (JAPhA NS45(5):559; September/October 2005) (Reviewed 2006) (Reviewed 2009) (Reviewed 2014)

1986

Reye Syndrome (2006.arc)

2. APhA supports the voluntary inclusion of Reye Syndrome warnings in the labeling of oral and rectal salicylate-containing products.

(Am Pharm. NS26(6):419; June 1986)

PUBLIC RELATIONS

1987

Future of Pharmacy (2019.arc)

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

(Am Pharm. NS27(6):422; June 1987) (Reviewed 2002) (Reviewed 2007) (Reviewed 2012) (Reviewed 2014)

1971

Promotion of Pharmacists' Value (2002.arc)

The committee recommends the following specific activities:

a. That APhA develop informational materials designed to provide the public factual information concerning pharmacy practice and charges for pharmaceutical services, and that such materials be distributed by APhA, state associations, and individual pharmacists.
b. That APhA hold a national meeting for consumer groups, government officials, the press, and others for the purpose of airing the needs for cost information and problems involved in providing it. Such a meeting should also seek to inform attendees of the nature and scope of pharmaceutical services.

(JAPhA. NS11:264; May 1971)

1969

APhA and Pharmacists' Role (2002.arc)

The committee recommends that APhA continue the public relations and public information programs and projects it now conducts and that, as time, staff, funds, and opportunities permit, it build upon this program foundation to better inform the public about APhA and the profession. The committee continues to believe that all public relations begin with the individual pharmacist on the community level and that APhA should continue to provide pharmacists and their associations with public-relations tools for local and personal implementation.

(JAPhA. NS9:357; July 1969)

QUALITY ASSURANCE

2012, 1995

Assuring Pharmacists' Continuing Competence in Contemporary Practice (2017.arc)

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

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

2000

Quality Assessment (2015.arc)

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

(JAPhA. NS40(5)(suppl 1):S8 September/October 2000)

1995

Measuring the Quality of Pharmaceutical Care (2006.arc)

1. APhA should appoint a task force charged with the development of quality assessment measures used for the evaluation and continuous improvement of the quality of pharmaceutical care services. The foundation for developing these measures should be the 1994 APhA House of Delegates adopted guidelines for Pharmacist's Responsibilities in Appropriate Drug Use and other relevant documents.

(Am Pharm. NS35(6):37; June 1995)

1994

Preventing Dispensing-Related Problems (2019.arc)

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, interpretation of the aggregate data regarding dispensing-related problems, and the dissemination of the results, which will enable pharmacists to further improve medication distribution.

(Am Pharm. NS34(6):56; June 1994) (Reviewed 2001) (Reviewed 2007) (Reviewed 2009) (Reviewed 2014)

RECLASSIFICATIONS OF DRUGS

2005, 1970, 1969, 1968, 1967, 1964

Four Classes of Drugs (2006.arc)

1. APhA supports continuing efforts to classify drugs into the following 4 classes:
    a. Drugs to be dispensed on prescription order and renewable at the prescriber's discretion only;
    b. Drugs to be dispensed initially on prescription order, but renewable at the pharmacist's discretion;
    c. Drugs to be dispensed personally by the pharmacist without prescription at the patient's request; and
    d. Drugs to be directly available to the public without professional supervision or control.

(JAPhA. NS4(9); September 1964) (JAPhA. NS7(6); June 1967) (JAPhA. NS8(7); July 1968) (JAPhA. NS9(7); July 1969) (JAPhA. NS10:358; June 1970) (JAPhA. NS45(5):557; September/October 2005)

2005, 1987

Transition Class of Drugs/Prescription to Nonprescription Switch (2006.arc)

1. APhA supports federal and state legislation that would establish a "transition class of drugs" and a process to facilitate the transition of suitable legend drug products to nonprescription status by, among other things
    (a) Authorizing FDA to designate that such drug products be dispensed without prescription orders
    (b) Requiring that such drug products be dispensed by pharmacists
    (c) Requiring that drug products remain in this transitional category until FDA determines, within a specified time period (e.g., 5 years) that the drug product can be moved into nonprescription status
    (d) Requiring that during this time period, studies be conducted to assess the appropriateness of such drug products for nonprescription drug use
2. APhA recognizes the need for the identification of those drugs or classes of drugs that might be candidates for a transition class of drugs and shall initiate a process to identify such drugs in cooperation with other organizations.
3. APhA recognizes the necessity for pharmacists to play an active role in consultation, monitoring, and reporting problems associated with the use of drugs included in a transition class of drugs.

(Am Pharm. NS27(6):423; June 1987) (JAPhA NS45(5):557; September/October 2005)

1984

Prescription to Nonprescription Switch (2005.arc)

1. APhA supports federal and state legislation that would establish a category of drug products and a process to facilitate the transition of suitable, legend, drug products to nonprescription status by, among other things
    (a) Authorizing FDA to designate that such drug products be dispensed without prescription orders;
    (b) Requiring that such drug products be dispensed by pharmacists;
    (c) Requiring that drug products remain in this transitional category until FDA determines, within a specified time period (e.g., 5 years) that the drug product can be moved into nonprescription status; and
    (d) Requiring that during this time period, studies be conducted to assess the appropriateness of such drug products for nonprescription use.

(Am Pharm. NS24(7):60; July 1984)

1968

Nitroglycerin: Patient Information if Reclassified (2005.arc)

The committee recommends that, should nitroglycerin be made available without prescription, APhA provides pharmacists with an appropriate pamphlet outlining the information patients should receive about pharmacology, toxicology, dosage, stability, and storage requirements.

(JAPhA. NS8:382; July 1968)

1968

Nitroglycerin: Proposed Reclassification as Nonprescription Drug (2005.arc)

The committee recommends that APhA staff seek active support for its position on nitroglycerin from the National Association of Retail Druggists (NARD) and the state associations.

(JAPhA. NS8:372; July 1968)

1968

Nitroglycerin: Reclassified as Nonprescription Drug (2005.arc)

1. The committee also endorses and commends the positive action of APhA in supporting the proposed reclassification of nitroglycerin sublingual tablets, published by FDA. We concur that the wide use of nitroglycerin tablets coupled with the inherent dangers and other factors outlined in the statement submitted to FDA by APhA, requires that pharmacists personally accept responsibility for the distribution of this drug when it is removed from the prescription legend category of the Federal Food, Drug and Cosmetic Act.
2. The committee reaffirms its belief that the public health and safety will be best served by a classification of drugs that are available at the request of a patient, but personally dispensed by a pharmacist. We urge APhA to continue to seek a unified position of support for its proposal from state and local professional societies of pharmacists and national pharmaceutical organizations.

(JAPhA. NS8:362; July 1968)

1967

Third Class of Drugs, Dispensed by Pharmacist (2005.arc)

The committee recommends that state pharmaceutical societies discuss and be prepared to vote on a direct proposition that they and their members will support an all-out effort on the principle that this third class of drugs be dispensed personally by a pharmacist.

(JAPhA. NS7:308; June 1967)

1966

Proposal and Promotion of Reclassification (2005.arc)

The committee reviewed the progress of the APhA reclassification of drugs proposal. We urge APhA to continue its discussions with legislators, governmental officials, and other national health organizations to promote an understanding of what the proposal is and why it is needed. The committee reiterates its view that the profession of pharmacy has the manpower and resources to provide professional guidance on products for self-medication.

(JAPhA. NS6:314; June 1966)

RECORD SYSTEMS

1996

Confidentiality of Patient Data (2015.arc)

1. 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, as well as 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) Distinguish between the clinical information required for communication among health care professionals, and the administrative or financial information required by others (e.g., claims processors and payers).

(JAPhA. NS36(6):396; June 1996) (Reviewed 2005) (Reviewed 2009) (Reviewed 2010) (Reviewed 2015)

1993

Professional Association-Driven Unique Identification System (2008.arc)

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

(Am Pharm. NS33(7):56; July 1993) (Reviewed 2005)

1981

Access to Medical Records (2009.arc)

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

(Am Pharm. NS21(5):40; May 1981) (Reviewed 2005)

1979, 1965

Proposal on Application of Privacy Concepts to Health Care Records (2005.arc)

1. APhA opposes any survey or audit of confidential patient information which results in disclosure of the name of the patient and/or the prescribing physician, without the express authorization of the patient or physician, or both, if both are to be identified.
2. APhA does not oppose pharmacists providing information on the prescribing of a particular drug product if the patient and/or the prescriber is not identified.
3. APhA believes that providing patient or prescriber identity and prescription order details to third party payors for the purpose of submitting a third-party payment program service claim is in the patient's best interest.
4. APhA opposes allowing unauthorized personnel to extract information from confidential patient records.

(JAPhA. NS5:273; June 1965) (Am Pharm. NS19(7):68; June 1979)

1976

Computerization in Pharmacy Practice (2001.arc)

APhA supports regulatory changes at the national and state levels that would provide for computerized patient and prescription records as an alternative to manually prepared record systems.

(JAPhA. NS16:344; June 1976)

1974

Patient Medication Profiles (2001.arc)

1. The committee recommends that APhA not endorse mandating by state law or board regulation, that pharmacists keep patient medication profiles.
2. The committee recommends that APhA continue to urge pharmacists to utilize patient medication profiles in providing a positive contribution to total patient care.
3. The committee recommends that APhA continue to publicize the significant contributions to public health that pharmacists provide by using patient medication profiles to the public, fiscal intermediaries, and the health professions.
4. The committee recommends that APhA develop programs that encourage more practitioners to utilize patient medication profiles.
5. The committee recommends that APhA initiate and encourage studies of the effectiveness of patient medication profiles in improving patient care.

(JAPhA. NS14:496; September 1974)

1970

Patient Medication Profiles (2001.arc)

1. The committee urges pharmacists to make use of a profile system in their practices because patient medication profile systems are an indispensable element of pharmaceutical services in total health care.
2. The committee recommends that APhA prepare guidelines to assist pharmacists in developing efficient patient medication profile systems for their practices.
3. The committee recommends that APhA initiate a comprehensive study to make available to pharmacists information on drug interactions. Attention should be given to organizing and making this information available in a concise form which will include an explanation of the mechanism and clinical significance of specific drug interactions.

(JAPhA. NS10:361; June 1970)

1965

Patient Record Systems: Pharmacists' Responsibilities (2001.arc)

The committee recommends that pharmacists implement a patient record system to facilitate retrieval of the information needed to fill out claim forms for patients. Every pharmacist is familiar with the task of searching their prescription files over a period of several months to assist patients in compliance with the insurer's claim requirements. Such a system would minimize this burden on pharmacists and be a valuable assistance in properly serving their patients in other professional areas as well.
(JAPhA. NS5:273; May 1965)

REIMBURSEMENT AND COMPENSATION

Claim Forms and Procedures

1971

Universal Claim Form (2001.arc)

The committee recommends that APhA endorse the concept of the universal claim for use in all third-party payment prescription programs.
(JAPhA. NS11:278; May 1971)

1969

Metric System and Third-party Payment (2001.arc)

Recognizing that APhA has gone on record as supporting routine use of the metric system, the committee recommends that pharmacists use the metric system in their practice and when submitting claims for third-party payment.
(JAPhA. NS9:362; July 1969)

Federal Programs

2005, 1969

Medicare and Pharmaceutical Service (2012.arc)

APhA believes that the current Medicare (a federal program of hospital and medical insurance for nearly all people 65 and older) is grossly deficient in that it fails to provide a drug benefit to noninstitutionalized patients. The committee, therefore, strongly recommends that APhA continues to support federal legislation to eliminate this deficiency.
(JAPhA. NS9:363; July 1969) (JAPhA. NS45(5):558; September/October 2005) (Reviewed 2009)

2005, 1978

Medicare Prescription Drug Benefits (2013.arc)

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 to 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.

(Am Pharm. NS18(8):30; July 1978) (JAPhA. NS45(5):558; September/October 2005) (Reviewed 2009)

National Health Insurance

1963

National Health Insurance (NHI): APhA Opposition (2005.arc)

1. The basic position of APhA opposing compulsory national health insurance was adopted by this House of Delegates in 1949. In keeping with this position, officers of APhA have testified on numerous occasions before congressional committees. In the 87th Congress, APhA strongly opposed the King-Anderson legislation because of its compulsory characteristics and inadequacies.
2. It is the recommendation of this committee, however, that APhA now reviews its basic position. While considerable progress has been made since 1949 through voluntary programs, the profession must satisfy itself that all is being done that can be done to serve the public. In some instances, for example, remedial legislation could accelerate voluntary programs.

(JAPhA. NS3:324; June 1963)

Professional Fees

1975

Professional Fees in Federal Program: Maximum Allowable Cost (MAC) (2005.arc)

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

1966

Professional Fee System (2005.arc)

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

Third Party and Prepaid Programs

1994

Third-party Prescription Drug Programs (2001.arc)

1. APhA shall establish, publish, and promote criteria that any pharmacy benefits administrator must meet in order to secure the endorsement of this association.
2. APhA shall define the scope of those endorsements it is to provide.

(Am Pharm. NS29(7):464; July 1994)

1989

Pharmacists' Participation in Influencing Third-party Program Policies (2001.arc)

1. APhA believes that pharmacists must participate in the legislative and regulatory processes and in the development of policies related to third-party programs.
2. APhA supports the development of programs and materials for the pharmacist to educate legislators, third-party payors, and benefits managers about the value of comprehensive pharmaceutical services.
3. APhA supports the development of programs and materials to assist pharmacists in educating patients about pharmaceutical benefits included in their health insurance programs.

(Am Pharm. NS23(6):52; June 1989)

1983

Third-party Differentials (2001.arc)

APhA opposes third-party payment differentials for drugs based on their therapeutic use.
(Am Pharm. NS23(6):52; June 1983)

1971

Third-party Negotiations (2001.arc)

1. The committee recommends that APhA pursues all lawful means to obtain authorization for pharmacists to negotiate through their state associations regarding to reimbursement for pharmaceutical services from all third-party prescription benefit programs.
2. The committee recommends that such efforts be undertaken on a cooperative basis by all national organizations representing practicing pharmacists.

(JAPhA. NS11:268; May 1971)

1968

Prepaid Programs (2001.arc)

The committee reiterates APhA policy that it is not the function of APhA to underwrite or necessarily to endorse, any particular prepayment or pharmaceutical insurance plan.

(JAPhA. NS8:362; July 1968)

1967

Prepaid Programs (2001.arc)

The committee urges that the following points be considered as indispensable to a working prepayment program:

1. Free choice of pharmacists
2. That standard forms be used for all programs
3. That the professional fee be used as a means of reimbursement
4. That proof of eligibility of the recipient be readily established.

(JAPhA. NS7:321; June 1967)

1967

Prepaid Programs: Guidelines for Reimbursement (2001.arc)

1. The committee recommends that the House of Delegates reaffirm the policy that the APhA should not assume the role of underwriter in any such program. The committee further recommends that the House establishes the following guidelines for use in APhA work on prepayment programs:
    a. Patients must be given free choice of pharmacy.
    b. Pharmacists should be paid for their professional services on the basis of an equitable professional fee in addition to the cost of the drug dispensed.
    c. Programs should be a service type benefit program rather than a reimbursement type insurance program in its practical applications and administration.

(JAPhA. NS7:306 June; 1967)

1966

Prepaid Pharmaceutical Service (2001.arc)

The committee recommends that APhA continue to study alternative methods of financing and administering a plan to provide prepaid pharmaceutical services and that it continues to make its findings and assistance available upon request to state associations.

(JAPhA. NS6:314; June 1966)

1964

Insurance to Cover Catastrophic Illness (2005.arc)

APhA recognizes and is most concerned with the problems that can occur with the unfortunate advent of catastrophic illness and, therefore, encourages the health insurance industry to provide coverage that would specifically meet the costs associated with such catastrophic illnesses.

(JAPhA. NS4:429; August 1964)

2005, 1987

Drug Regimen Review (DRR) (2009.arc)

APhA endorses appropriate compensation to pharmacists for performing drug regimen review.

(Am Pharm. NS27(6):422; June 1987) (JAPhA. NS45(5):557; September/October 2005)

2004, 1979

Proposal on Drug Regimen Review (DRR) by Pharmacists (2005.arc)

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

(Am Pharm. NS19(7):65; June 1979) (JAPhA. NS44(5):551; September/October 2004)

RESEARCH

1986

Therapeutic Drug Testing in Children (2005.arc)

1. APhA supports the inclusion of children in clinical investigations of drug products when appropriate safeguards are instituted to ensure the safety of children, when the use of the drug has significant indications (need for use) in children, and when there is prior experience with the drug in the adult population.

(Am Pharm. NS26(6):420; June 1986)

1985

Genetic Research and its Application (2010.arc)

1. APhA recommends the establishment of a privately funded, voluntary body representing the public and private sectors to review genetic research and, in cooperation with existing public agencies, to develop uniform standards for all laboratories involved in such studies.
2. APhA recognizes the need for maintaining high levels of scientific and corporate social responsibility to assure public health and safety regarding to the consequences of genetic research.

(Am Pharm. NS25(5):51; May 1985) (Reviewed 2005)

1985

Testing Drugs in Elderly Patients (2005.arc)

1. APhA recommends that, for drugs intended for use in both elderly and nonelderly populations, age per se be eliminated as an exclusion criterion in clinical investigations.
2. APhA supports the inclusion of elderly populations in clinical investigations of drug products.
3. APhA favors development of research techniques which would identify possible problems not readily detected in clinical investigations to aid in the more effective use of drugs in the elderly.

(Am Pharm. NS25(5):51; May 1985)

1975

Prisoners in Human Experimentation (2005.arc)

1. APhA fully supports all reasonable procedures, including use of institutional review committees; informed consent; and other procedures as described in HEW's 1971 guide and the May 30, 1974, regulations on this subject, for the protection of all classes of human subjects; who are to be used for any form of human experimentation.
2. Future regulations which are promulgated should permit the continued effective use of prisoners in experimentation in a manner that is not substantially different from noninstitutionalized human subjects.

(JAPhA. NS15:319; June 1975)

1966

APhA Study Proposal (2019.arc)

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.

(JAPhA. NS6:293; June 1966) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014)

SAMPLING

1970

Manufacturers' Sampling Programs (2002.arc)

1. The committee recommends that APhA commends Roche Laboratories for its initiative in phasing out its system of traditional physician sampling.
2. The committee recommends further that APhA offers Roche Laboratories assistance in evaluating the results of their decision.
3. The committee recommends that those pharmacists who serve on pharmacy advisory panels of other pharmaceutical manufacturers familiarize themselves with the Roche program and recommend that these other companies take similar steps to phase out their sampling programs.

(JAPhA. NS10:354; June 1970)

1969

Manufacturers' Sampling Programs (2002.arc)

1. The committee offers the following guidelines to pharmacists and manufacturers for consideration in developing sampling programs involving pharmacists:
    a. Control of medication should be maintained by those who are authorized by law to control and possess prescription medication.
    b. Confidentiality of the prescription should be preserved.
    c. Administrative paperwork by pharmacists should be kept to a minimum.
    d. Pharmacists should be reimbursed a monetary fee that is commensurate with their professional services.
    e. The amounts of drug involved should be sufficient for starter doses only.
    f. Any programs involving starter dosage sampling that will involve pharmacists should be as extensive in terms of variety and quantity as in any comparable physician sampling program.

(JAPhA. NS9:362; June 1969)

1968

Mailing of Prescription Drug Samples (2002.arc)

The committee concludes that the mailing of prescription drug samples is not in the best interests of public health and recommends that the committee on legislation consider appropriate action.

(JAPhA. NS8:383; July 1968)

1966

Mailing of Prescription Drug Samples (2002.arc)

1. APhA shall lend its support and assistance to enactment of legislation that would prohibit the mailing of unsolicited drug samples.
2. Unsolicited mailings of samples of legend drugs continues to be a serious problem and public health hazard. Manufacturers are asked to review their current policies and pharmacists are reminded that they should promptly report any evidence of the abuse of sampling to the state boards of pharmacy, FDA, and APhA for appropriate action.

(JAPhA. NS6:293; July 1966)

1964

Professional Samples (2002.arc)

APhA should enlist the cooperation of the American Medical Association and the Pharmaceutical Manufacturers Association in developing a code of understanding to serve as a guide in the distribution and dispensing of professional samples.

(JAPhA. NS4:428; August 1964)

SPECIALTIES IN PHARMACY

1997

Criteria for the Recognition of a Specialized Area of Pharmacy Practice (2007.arc)

APhA strikes in its entirety the 1975 Criteria for the Recognition of a Specialized Area of Pharmacy Practice, replacing it with the following:

The following criteria should be utilized by the Board of Pharmaceutical Specialties in the determination of whether to afford official recognition to an area of specialization in pharmacy:

CRITERION A. The area of specialization shall be one for which specifically trained practitioners are needed to fulfill the responsibilities of the profession of pharmacy in improving the health and welfare of the public, responsibilities that may not otherwise be effectively fulfilled;

CRITERION B. The area of specialization in the practice of pharmacy shall be one in which there exists a significant and clear health demand to provide the necessary public reason for certification;

CRITERION C. The area of specialization shall include a reasonable number of individuals who devote most of the time of their practice to the specialty area;

CRITERION D. The area of specialization shall be based on specialized knowledge of one or more of the pharmaceutical sciences and the biological, physical, and behavioral sciences which underlie them. Administrative, managerial, procedural, or technical services and the environment in which pharmacy is practiced, are not applicable to this criterion;

CRITERION E. The area of specialization shall represent an identifiable field of pharmacy practice that requires specialized functioning by the practitioner and that is distinct from other recognized pharmacy specialties;

CRITERION F. The area of specialization shall be one in which schools and colleges of pharmacy and/or other organizations offer recognized education and training programs to those seeking advanced knowledge and skills in the area of specialty practice so that they may perform more competently;

CRITERION G. The area of specialization shall be one in which there is an adequate transmission of specialized knowledge through professional, scientific, and technical literature immediately related to the specialty.

(JAPhA. NS37(4):459-60; July/August 1997) (Reviewed 2001)

1973

Clinical Pharmacy and Pharmacy Practice (2001.arc)

1. The committee recommends that APhA endorses the Report of the Task Force on the Pharmacist's Clinical Role (Drug-Related Studies Program, National Center for Health Services, Research and Development, DHEW, September 1971) as containing worthwhile goals toward which all pharmacists should strive in rendering patient-oriented pharmaceutical service.
2. The committee recommends that the APhA recognizes that there are pharmacy practitioners who have additional clinical education, training, or experience and who are primarily involved in practicing expanded clinical functions described in the Task Force Report.

While these pharmacists are most often referred to as clinical pharmacists, they do not constitute an officially recognized specialty at this time.

3. The committee recommends that the House of Delegates rescinds its action taken in 1972 adopting the Report of the Task Force on the Definition of Clinical Pharmacy, Institutional Pharmacy, and Group Practice and the statement on pharmacy practice.
4. The committee recommends that APhA adopts the following definition of pharmacy practice:

"Pharmacy practice is defined as that personal health service that assures safety and efficacy in the procuring, storing, prescribing, compounding, dispensing, delivering, administering, and use of drugs and related articles."

(JAPhA. NS13:517; September 1973)

TITLES/DESIGNATIONS

Non-Pharmacists

1988

Pharmacy Technicians (2001.arc)

1. APhA endorses the use of the term "pharmacy technicians" to describe those individuals who assist pharmacists in the performance of selected professional duties.
2. APhA endorses the appropriate use of pharmacy technicians in various types of pharmacy practices.
3. APhA advocates that pharmacists maintain supervisory control over pharmacy technicians.
4. APhA advocates the training of pharmacy technicians via programs developed and administered under the guidance of pharmacists.
5. APhA advocates that pharmacists develop written guidelines for pharmacy technicians that specify functions and supervisory controls.

(Am Pharm. NS28(6):395; June 1988)

VACCINES

1981

Vaccine Liability Programs (2014.arc)

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.

(Am Pharm. NS21(5):41; May 1981) (Reviewed 2005) (Reviewed 2009)

WOMEN IN PHARMACY

1984

Female Health Professional Draft Registration (2009.arc)

APhA supports the enactment of legislation to amend the Military Selective Service Act to provide for the specific registration and induction of members of the pharmacy profession, both male and female, in times of national need for their professional services provided, however, that such support is limited to legislation which would grant commissions to pharmacists inducted by the authority of such legislation.

(AmPharm. NS24(7):60; July 1984) (Reviewed 2005)

1977

Equal Employment Opportunities (2005.arc)

APhA shall take positive action to make women equally visible as members of this esteemed profession including but not limited to advertising and recruiting material that depicting pharmacists.

(JAPhA. NS17:463; July 1977)

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Historical APhA Policies: Rescinded Statements 1963-2024

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DRUG ABUSE, CONTROL AND EDUCATION

Marijuana

1974

Marijuana Law Reform (2003.res)

The committee recommends that APhA support removal of marijuana from the federal Controlled Substances Act and related state and local laws and support the establishment of uniform controls for marijuana which more appropriately balance the potential public health hazards of marijuana with its current, social use.

(JAPhA. NS14:492; September 1974)

DRUG PRODUCT SELECTION

1986

"Quack" Therapy (2002.res)

1. APhA encourages FDA and FTC to increase their efforts to eliminate "quack products."
2. APhA encourages pharmacists not to stock any "quack products."

(Am Pharm. NS26(6):420; June 1986)

1974

Anti-substitution Laws: Elimination of Brand Names (2004.res)

The committee recommends that APhA undertake efforts, including support of legislation, to eliminate the use of brand names for prescription, legend drug products.

(JAPhA. NS14:492; September 1974)

EDUCATION, CURRICULUM AND COMPETENCE FOR PHARMACY

Continuing Education

1975

Standards for Continuing Competence (2003.res)

APhA supports programs designed to established valid standards of competence for pharmacy practice and reliable means of measuring and evaluating such competence.

(JAPhA.NS15:336; June 1975)

EMPLOYER/EMPLOYEE RELATIONS

Unionization

1999, 1971

Unionization of Pharmacists: State Participation in Employer/Employee Relations (2001.res)

5. The committee recommends that APhA reiterate its condemnation of local and state association membership requirements and privileges based on employer or employee status.

(JAPhA. NS39(4):447; July/August 1999) (JAPhA. NS11:273; May 1971)

1969

Employee Participation in Continuing Education: Employer Responsibility (2001.res)

The committee is concerned about the increasing number of complaints from the more recent graduates about the lack of interest by their employers in providing time and financial assistance to attend continuing education meetings. In some instances, the newer practitioners are being penalized, and, in other instances, the opportunity is being denied. The committee recognizes that there are many enlightened employers who contribute to the development of the profession and their practices by encouraging and assisting the pharmacists they employ in participating in educational and professional meetings. The committee recommends that APhA encourage consideration of this subject in articles and conferences on the subject of employer/employee relations.

(JAPhA. NS9:336; July 1969)

FEDERAL PROGRAMS AND POLICIES

1970

National Formulary and United States Pharmacopoeia (2004.res)

1. APhA exhorts all state pharmacy board officials to actively support requirements pertaining to the maintaining of the current official NF and USP in each pharmacy in the United States as a condition of licensure.

(JAPhA. NS10:363; June 1970)

LICENSURE, REGISTRATION AND REGULATION

Licensure, Registration and Inspection of Facilities

1967

Institutional Pharmacy: State Law Requirements (2002.res)

The committee recommends that APhA consider the possibility and effect of special institutional pharmacy permits that would allow an institution to establish a pharmacy under applicable state law but yet not meet all of the requirements of the state Pharmacy Practice Act with the limitation that the pharmaceutical services rendered would be limited to institutionalized patients.

(JAPhA. NS7:305; June 1967)

MAIL ORDER PRESCRIPTIONS

1991, 1977

Pharmacist/Patient Communication (2001.res)

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.

(JAPhA. NS17:464; July 1977) (AmPharm. NS31(6):28; June 1991)

1970

APhA Opposition (2001.res)

1. The committee recommends that APhA continue in its opposition to plans that offer prescription services by mail order on the grounds that such practice by its very nature constitutes a threat to public health and welfare, because it eliminates or interferes with the physician-patient-pharmacist relationship and also because such practice violates pharmacy laws and regulations of many states.
2. The committee recommends further that APhA continue its efforts to assist pharmacy groups in litigation against mail order operations offering prescription services.

(JAPhA. NS10:354; June 1970)

1965

APhA Opposition (2001.res)

1. APhA unequivocally opposes the circumvention of state pharmacy laws, the destruction of the physician-patient-pharmacist relationship, and the obvious opportunity for diversion of drugs to illegitimate uses presented by all prescription mail order schemes.
2. APhA shall provide guidance to several state societies to assist them in protecting the welfare of the public from such mail order operations.
3. APhA shall again encourage Congress to review the problems associated with the improper distribution and use of drugs obtained by mail order.

(JAPhA. NS5:273; May 1965)

PATIENT/PHARMACIST RELATIONSHIPS

1991, 1977

Pharmacist/Patient Communication (2001.res)

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.

(JAPhA. NS17:464; July 1977) (AmPharm. NS31(6):28; June 1991)

PHARMACY TECHNICIANS

1991, 1988

Pharmacy Technicians (2001.res)

1. APhA reaffirms its policy, adopted in 1988, which opposes the licensure, registration, or certification of pharmacy technicians by statue or regulation.

(Am Pharm. NS(6):28; June 1988) (Am Pharm. NS(6):28; June 1991)

1971

Supportive Personnel: Functions, Standards and Supervision (2001.res)

4. The committee recommends that supportive personnel not be licensed, certified, or registered by statute or regulation.

(JAPhA. NS11:277; May 1971)

1968

Subprofessionals: Training for Pharmacy Technicians (2001.res)

It seems obvious that, unless need can be demonstrated and the duties of technicians clearly defined, no training for technicians should be instituted. It is imperative, therefore, that pharmacists throughout the country discourage the establishment of such programs in junior and community colleges for the present. The committee recommends that state pharmaceutical associations—and, through them, their county associations—be advised of this problem and that they be asked to be on the alert against any misguided steps to initiate such programs. The executive director of APhA should be notified should any institution in the country announce plans to train such personnel.

(JAPhA. NS8:388; July 1968)

1966

Subprofessionals (2001.res)

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

(JAPhA. NS6:332; June 1966)

PRESCRIBING AUTHORITY

1976

Prescribing Drugs — Authority (2009.res)

APhA opposes granting independent drug prescribing authority to physician assistants and nurse practitioners.

(JAPhA. NS16:341; June 1976) (Reviewed 2007)

REIMBURSEMENT AND COMPENSATION

Federal Programs

1970

Medicare, Medicaid, and Other Third-Party Payment Programs (2005.res)

1. The committee recommends that no changes be made in APhA policy that favors out-of-hospital, prescription benefits under Medicare.

(JAPhA. NS10:346; June 1970)

1969

Veterans Administration Hometown Prescription Program (2005.res)

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

Professional Fees

1967

Fee for Service Guidelines (2005.res)

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

1967

Pharmaceutical Service Cost Information (2005.res)

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

TITLES/DESIGNATIONS

Non-Pharmacists

1988

Pharmacy Technicians (2001.res)

6. APhA opposes the licensure, registration, or certification of pharmacy technicians by statute or regulation.

(Am Pharm. NS28(6):395; June 1988)

1976

Pharmacy Aide (2001.res)

1. APhA endorses the term "pharmacy aide" as the accepted term to designate that category of supportive personnel most frequently utilized in pharmacy practice who are trained to perform routine, non-judgmental functions under the supervision of a pharmacist.
2. APhA advocates the training of pharmacy aides via in-service or on-the-job training programs.
3. APhA advocates that pharmacy aides function under written procedures that specify functions and supervisory controls and that ensure the efficiency of pharmacy practice, while not compromising the quality of pharmaceutical service, and further, that no more than one non- pharmacist (excluding registered intern pharmacist) be involved in the non-judgmental, prescription dispensing functions under the direct supervision of a pharmacist at any given time.

(JAPhA. NS16:343; June 1976)

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American Pharmacists Association Bylaws as amended through May 13, 2019

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 shall provide such other membership benefits and services as may be established 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. Membership. Any pharmacist, researcher, student, technician, or any other individual who shares the ASSOCIATION's mission and vision may become a member of the ASSOCIATION.

A. Any member shall be able to:
   i. Serve as a member and vote as part of ASSOCIATION committees.
   ii. Serve as a delegate and vote in the ASSOCIATION's House of Delegates.
   iii. Hold office, as allowed by the individual office, in this ASSOCIATION.
   iv. Vote in ASSOCIATION elections as allowed by the individual office.

Section 2. Categories of Membership. Members of this ASSOCIATION shall be divided into membership categories as may be established by the Board of Trustees. At a minimum, the ASSOCIATION shall have a pharmacist, researcher, new practitioner pharmacist, student pharmacist, and pharmacy technician membership category.

Section 3. Membership Groups. This ASSOCIATION shall organize membership groups and develop necessary processes and procedures to reflect the diverse professional needs of the membership, as established by the Board of Trustees. Each membership group shall have a leadership structure and leadership election processes as established by the Board of Trustees.

Section 4. 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 groups unless entitled to do so under another category of membership.

Section 5. Admission to Membership. Any individual shall be admitted to membership in the appropriate category 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 6. Membership Benefits and Services. Membership benefits and services for each category of membership shall be those established 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 7. 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 8. Dues. Each member shall pay such dues as may be required by the Board of Trustees for each category or group of membership. The Board of Trustees may establish 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 special or complimentary dues within established categories or groups 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 one of the ASSOCIATION's Member categories 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 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 one of the ASSOCIATION's Member categories 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 one of the ASSOCIATION's Member categories 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 pharmacist 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 5. 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. Nine (9) Elected Trustees, the Officers, and the Speaker of the House of Delegates shall constitute the Board of Trustees.

A. Elected Trustee composition.
   i. Pharmacist Member – one (1)
   ii. Researcher Member – one (1)
   iii. New Practitioner Pharmacist Member - one (1)
   iv. Student Pharmacist Member - one (1)
   v. Pharmacy Technician Member - one (1)
   vi. At-Large Member (from the pharmacist, researcher, or new practitioner pharmacist membership categories) - four (4)

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 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 serve until their successors have been duly elected and installed for a term as established by the Board of Trustees with a minimum of one (1) year and not to exceed three (3) years in length. No individual shall serve more than two (2) successive full terms in the same position. 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 an individual of the appropriate Membership 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 Board of Trustees plus one shall constitute a quorum for the transaction of business.

Section 8. Removal. An Elected Trustee or the Speaker of the House 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 Affiliated State Organizations (See Article VII), ASSOCIATION membership categories, Recognized National Organizations (See Article VII), Delegates Ex Officio, and Speaker-appointed delegates. Each delegate and Delegate Ex Officio must be a member of this ASSOCIATION.

Section 2. Apportionment of Delegates.

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

i. If either an affiliated state organization delegation has been inactivated via procedures outlined in Article VII, Section 2.G of these Bylaws or no delegates have been appointed by the affiliated state organization by the deadline established in the House Rules of Procedure, the Speaker may appoint one delegate who, at the time of appointment, resides or is employed in the state or region they are chosen to represent.

B. ASSOCIATION membership categories shall have a total of 100 delegates. The House Rules of Procedure shall establish a mechanism for appointment of these seats corresponding to APhA's current membership and ensuring that each membership category has no fewer than 5 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. The Speaker shall appoint up to 20 delegates from House committee members not appointed as delegates from other delegations.

F. Each appointing delegation shall have the right to appoint alternate delegates.

G. Delegations that have one or more seats unfilled during both House sessions for 3 consecutive years may have those seats inactivated from their delegate allocation. Delegations shall be notified 60 days prior to the inactivation of delegate seats and may petition the Secretary of the House for reappointment of those seats.

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 and Recognized National Organizations will appoint the delegates and alternate delegates to which they are entitled according to Article VII, Section 2 of these Bylaws and the APhA House Rules of Procedure. All delegates and alternate delegates other than Delegates Ex Officio shall serve until May 31st of each year. 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 adopted by the House of Delegates. The House may, at the discretion of the Speaker, convene using electronic means prior to the regular meeting outlined herein provided that the Secretary of the House notifies the delegates at least 30 days prior to convening such session. All House of Delegates Rules of Procedure and these Bylaws apply to all House sessions, whether held electronically or in person. 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 or electronic petition of a majority of authorized delegates provided that the Secretary of the House notifies the delegates at least 10 days prior to convening such session. Special meetings of the House of Delegates may occur electronically or be scheduled in person at a time and location to 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:

A. House Committee on Nominations

B. House Committee of Canvassers

C. 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 l. 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. Any organization, representing pharmacy, from a State, Territory, or the District of Columbia may be designated as an Affiliated State Organization by the Board of Trustees at its discretion.

Section 3. Affiliated Student Pharmacist Chapters. Any ACPE-accredited school or college of pharmacy may be designated as an Affiliated Student Pharmacist Chapter by the Board of Trustees at its discretion.

ARTICLE VIII. MEETINGS

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. 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.

ARTICLE IX. ELECTIONS

Section 1. Nominating Committee. The Board of Trustees Committee on Nominations shall nominate all candidates for President-elect and Elected Trustees and may accept recommendations from other membership category specific nominating committees following processes as defined by the APhA Board of Trustees. The Board of Trustees Committee on Nominations shall consist of the most recent nonincumbent Former President, the immediate former Speaker of the House of Delegates, and one (1) member from each of the membership categories appointed by the President. No individual shall serve on the Committee on Nominations in more than three (3) consecutive calendar years.

Section 2. Election Procedure. Except as may otherwise be provided in these Bylaws, the names of candidates for election and a ballot shall be provided to all members entitled to vote. Executed ballots must be received by the date published on the ballot.

The Committee of Canvassers, as appointed by the President, 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 names of candidates elected shall be made public following certification of the election by the Committee of Canvassers. Once certified, the results of any election shall not be subject to challenge.

Section 3. Time of Election. Except as may otherwise be provided in these Bylaws, the ASSOCIATION nomination and election process shall be conducted pursuant to a schedule established by the Executive Vice President with the approval of the Board of Trustees, which will permit candidates elected to assume office as provided in these Bylaws.

Section 4. Installation. Except as may otherwise be provided in these Bylaws, Officers and Elected Trustees of the ASSOCIATION and the elected officers of the membership groups shall assume office at the conclusion of business on the last day of the Annual Meeting of the ASSOCIATION following the year in which they are elected.

Section 5. Honorary President. When nominated by the Board of Trustees, an Honorary President of the ASSOCIATION shall be elected pursuant to the election procedures established in these Bylaws. The Honorary President shall be a member of the ASSOCIATION, shall have made significant contributions to the ASSOCIATION, and shall serve for a one-year term commencing on the first day of the Annual Meeting following the year in which elected.

ARTICLE X. FINANCES

Section 1. Financial and Investment Policy. The financial and investment policy of this ASSOCIATION shall be as established by the Board of Trustees with the advice of the Treasurer, Executive Vice President, and such other financial advisors as the Board of Trustees may deem necessary or desirable. Investments shall not be restricted to those approved by law by the District of Columbia or any other jurisdiction.

Section 2. Financial Administration. The Executive Vice President, with the approval of the Treasurer, shall be responsible for the continuing management of the financial affairs of this ASSOCIATION. The Board of Trustees shall approve any bank intended to serve as a repository of ASSOCIATION assets and a public accounting firm that shall be retained to conduct an annual audit of ASSOCIATION accounts. All disbursements of ASSOCIATION funds shall be pursuant to such policies and procedures as may be established by the Board of Trustees and are to be monitored and reviewed on a regular basis by the Treasurer and the Executive Vice President or by the Executive Vice President alone.

Section 3. Bonds. The Treasurer, the Executive Vice President, and such other members, employees, or agents of this ASSOCIATION as the Board of Trustees may direct shall be bonded for proper care and disposition of ASSOCIATION property in their possession or custody. Such bonds shall be in amounts and subject to such conditions as the Board of Trustees shall direct. The expense of such bonds shall be borne by the ASSOCIATION.

Section 4. Financial Report. The Treasurer shall make an annual financial report to the membership that includes an audited financial statement for the preceding fiscal year.

ARTICLE XI. 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 XII. 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 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 XIII. 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 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. Once certified, the results of any vote on a proposed Bylaw amendment shall not be subject to challenge.

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 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 XIV. 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.

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.

Principle VII: The Pharmaceutical Care Benefit facilitates exchange of patient information.

(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.

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Guidelines for Pharmacy-based Immunization Advocacy and Administration

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

APhA has invested many resources in the development of education, advocacy, practice support, and scientific programs related to the role of pharmacists in increasing the rate of immunizations. These activities have assisted the profession to develop collaborative relationships with other health 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 as a New Business Item to the APhA House of Delegates at the 1997 Annual Meeting held in Los Angeles, California. 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 following guidelines. The guidelines are a dynamic document and will be periodically reviewed as the health care arena changes.

The guidelines were reviewed in 2012 and reviewed and revised through the APhA–APPM Immunizing Pharmacists SIG and public comment period in 2018. Final approval of the revised document was made by the APhA Board of Trustees on January 26, 2019.

For additional information, contact Mitchel Rothholz, RPh, MBA, at 202-429-7549 or at mrothholz@aphanet.org.

Guidelines for Pharmacy-based Immunization Advocacy and Administration American Pharmacists Association

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

(a) Pharmacists should adopt at least one of three levels of involvement in vaccine advocacy:
  (1.) Pharmacist as educator (educate patients, caregivers, and other health care professionals about vaccines, and both serious communicable and preventable diseases; serve as immunization champions);
  (2.) Pharmacist as facilitator (host others who immunize);
  (3.) Pharmacist as immunizer (protect vulnerable patients, consistent with state law).

(b) Pharmacists should focus their immunization efforts to meet the immunization and disease prevention needs of the patient and protect the public from vaccine-preventable diseases.

(c) Pharmacists should utilize the Joint Commission of Pharmacy Practitioners (JCPP) Pharmacist's Patient Care Process, NVAC, and CDC established standards, and available immunization history to routinely determine the immunization status of patients, make appropriate recommendations, administer the indicated immunization or refer patients to an appropriate provider for immunization, and document the vaccination.

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

Guideline 2 – Partnership – Pharmacists will be a member of the immunization neighborhood by collaborating, coordinating, and communicating with immunization stakeholders to protect the community from vaccine-preventable diseases.

(a) Pharmacists should support the immunization advocacy goals and other educational programs of health departments in their city, county, and state, in addition to the nation's vaccine plan.

(b) Pharmacists should collaborate with prescribers and health departments within their communities.

(c) Pharmacists should assist their patients in maintaining a medical home, including care such as immunization administration. Pharmacists should identify gaps in immunization history, administer indicated immunizations when appropriate, and communicate vaccinations to identified medical homes.

(d) Pharmacists should consult with and report immunization delivery, as appropriate, to primary care providers; local, state, and/or multijurisdictional immunization information systems (IIS); and other relevant parties.

(e) Pharmacists should identify high-risk patients in hospitals and other institutions and ensure that appropriate vaccinations are administered before discharge. If administration is not appropriate before discharge, the pharmacist should develop and implement a plan for vaccination post-discharge.

(f) Pharmacists should identify high-risk patients in nursing homes and other facilities and ensure that needed vaccinations are administered either upon admission or in drug regimen reviews.

(g) Pharmacists should collaborate with local health departments, universities, faith-based organizations, and businesses to identify patients traveling to destinations where administration of vaccines are recommended (e.g., yellow fever vaccine) and facilitate the administration of needed vaccines and other services.

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 response to and reporting of adverse events and should provide this service only in settings equipped with epinephrine and related supplies.

(c) Before immunization, pharmacists should review the vaccine screening questionnaire with patients and/or their families/caregivers about contraindications and inform them about the vaccine, and its risks and benefits.

(d) Pharmacists should maintain ongoing processes and receive continuing education and training on current immunization recommendations, schedules, and techniques at least annually, and meet all state regulations for licensure.

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 send the immunization record information to the proper immunization information system (IIS) and assess patient's immunization status from IIS and other appropriate resources.
(c) Pharmacists should report adverse events following immunization to appropriate primary care providers and to the Vaccine Adverse Event Reporting System (VAERS).
(d) Pharmacists should report vaccine administration errors using the Institute for Safe Medication Practices (ISMP) National Vaccine Errors Reporting Program (VERP).

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

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

(b) Pharmacists should respect individual patient autonomy and beliefs, as well as educate patients and their caregivers about the benefits of, and risks from, vaccines in language that is culturally sensitive and at an appropriate educational level.

(c) Pharmacists should act as an immunization resource in an effort to clarify misinformation related to immunizations.

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

References

Orenstein, W. A., Gellin, B. G., Beigi, R. H., Despres, S., LaRussa, P. S., Lynfield, R., National Vaccine Advisory Committee. (2014). Recommendations from the national vaccine advisory committee: Standards for adult immunization practice. Public Health Reports (1974-), 129(2).

CDC. Standards for pediatric immunization practices. MMWR. 1993;42 (RR-5): 1-13.

National Coalition for Adult Immunization. Bethesda, MD: NCAI 1995.

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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:

Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment;

Submission to or rejection of such conduct by an individual is used as the basis of employment decisions affecting such individual; and/or

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:

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.

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 within (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 within (30) days of the receipt of the written document from the employee making the complaint.

The investigator will:

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.

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"?

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).

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.
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 1912–2023

Year	Chairman/Speaker	Vice Chairman/Vice Speaker-Elect	Secretary
1912-1913	William C. Anderson	C.M Snow	C. Roehr
1913-1914	C.M. Snow	W.S. Richardson	R.A. Kuever
1914-1915	W.S. Richardson	C.B. Jordan	J. Weinstein
1915-1916	Henry P. Hynson	F.W. Nitardy	J. Hostmann
1916-1917	James H. Beal	S.C. Henry	J. Hostmann
1917-1918	S.C. Henry	O.F. Claus	J. Hostmann
1918-1919	O.F. Claus	Samuel Hilton	J. Hostmann
1919-1920	Samuel L. Hilton	E.F. Kelly	J. Hostmann
1920-1921	Evander F. Kelly	J.G. Beard	J. Hostmann
1921-1922	Evander F. Kelly	E.L. Newcomb	J. Hostmann
1922-1923	Evander F. Kelly	E.L. Newcomb	William Day
1923-1924	L.L. Walton	W. Bruce Philip	William Day
1924-1925	W. Bruce Philip	W.D. Jones	William Day
1925-1926	W.D. Jones	Jacob Diner	E.F. Kelly
1926-1927	Jacob Diner	L.A. Seltzer	E.F. Kelly
1927-1928	Leonard A. Seltzer	A. Hunsberger	E.F. Kelly
1928-1929	Ambroise Hunsberger	R.L. Swain	E.F. Kelly
1929-1930	Robert L. Swain	C.B. Jordan	E.F. Kelly
1930-1931	C.B. Jordan	Thomas Roach	E.F Kelly
1931-1932	Thomas Roach	J.W. Slocum	E.F. Kelly
1932-1933	J.W. Slocum	P.H. Costello	E.F. Kelly
1933-1934	Patrick H. Costello	S.A. Williams	E.F. Kelly
1934-1935	Rowland Jones, Jr.	S.A. Williams	E.F. Kelly
1935-1936	Roy Bird Cook	C.T. Gilbert	E.F. Kelly
1936-1937	Robert C. Wilson	A.F. Ludwig	E.F. Kelly
1937-1938	A.L.I. Winne	Ernest Little	E.F. Kelly
1938-1939	C.H. Rogers	R.A. Kuever	E.F. Kelly
1939-1940	M.N. Ford	E.C. Severin	E.F. Kelly
1940-1941	Hugo H. Schaefer	C.L. Guthrie	E.F. Kelly
1941-1942	Henry H. Gregg	C.L. O'Connell	E.F. Kelly
1942-1943	J.K. Atwood	Glenn Jenkins	E.F. Kelly
1943-1944	Glenn L. Jenkins	S.H. Dretzka	E.F. Kelly
1944-1945	Sylvester H. Dretzka	E.L. Hammond	E.F. Kelly
1945-1946	Sylvester H. Dretzka	E.L. Hammond	R.P. Fischelis
1946-1947	Hugh C. Muldoon	E.M. Josey	R.P. Fischelis
1947-1948	Charles H. Evans	Emil C. Horn	R.P. Fischelis
1948-1949	Bert Mull	Louis Fischl	R.P. Fischelis
1949-1950	R.Q. Richards	Newell Stewart	R.P. Fischelis
1950-1951	Newell W. Stewart	Thomas Wyatt	R.P. Fischelis
1951-1952	Louis J. Fischl	Mearl Pritchard	R.P. Fischelis
1952-1953	E.M. Josey	Paul Wilcox	R.P. Fischelis
1953-1954	Leib L. Riggs	Louis Zopf	R.P. Fischelis
1954-1955	Thomas D. Wyatt	James Lynch	R.P. Fischelis
1955-1956	James L. Lynch	W.B. Shangraw	R.P. Fischelis
1956-1957	Troy C. Daniels	John Butts	R.P. Fischelis
1957-1958	Nicholas Gesoalde	E.A. Swinyard	R.P. Fischelis
1958-1959	J. Warren Lansdowne	Calvin Berger	R.P. Fischelis
1959-1960	J. Warren Lansdowne	Wilbur Powers	Wm. S. Apple
1960-1961	Grover C. Bowles	John G. Adams	Wm. S. Apple
1961-1962	Grover C. Bowles	Donald Brodie	Wm. S. Apple
1962-1963	H.C. McAllister	David Stewart	Wm. S. Apple
1963-1964	Calvin Berger	Robert Johnson	Wm. S. Apple

1964-1965	Linwood F. Tice	Robert G. Gibbs	Wm. S. Apple
1965-1966	William R. Whitten	Jack Karlin	Wm. S. Apple
1966-1967	Charles A. Schreiber	W.B. Rumford	Wm. S. Apple
1967-1968	W. Byron Rumford	W.J. Smith	Wm. S. Apple
1968-1969	Mary Louise Andersen	Merritt Skinner	Wm. S. Apple
1969-1970	Mary Louise Andersen	Merritt Skinner	Wm. S. Apple
1970-1971	Clifton J. Latiolais	Philip Sacks	Wm. S. Apple
1971-1972	Philip Sacks	George Inman	Wm. S. Apple
1972-1973	Jacob W. Miller	Joseph McSoley	Wm. S. Apple
1973-1974	Jacob W. Miller	James Wagner	Wm. S. Apple
1974-1975	David J. Krigstein	Louis Jeffrey	Wm. S. Apple
1975-1976	David J. Krigstein	Mark Sullivan	Wm. S. Apple
1976-1977	Merritt L. Skinner	Herbert Carlin	Wm. S. Apple
1977-1978	Mary Munson Runge	Herbert Carlin	Wm. S. Apple
1978-1979	Ralph S. Levi	Earl Giacolini	Wm. S. Apple
1979-1980	William J. Edwards	Earl Giacolini	Wm. S. Apple
1980-1981	William J. Edwards	D.S. Crawford	Wm. S. Apple
1981-1982	D. Stephen Crawford	S. Schondelmeyer	Wm. S. Apple
1982-1983	D. Stephen Crawford	E.M. Valentine	Wm. S. Apple
1983-1984	Lowell J. Anderson	Joseph Fink, III	M.Q. Bectel
1984-1985	Lowell J. Anderson	Shirley McKee	J. Schlegel
1985-1986	Raymond W. Roberts	Lucinda L. Maine	J. Schlegel
1986-1987	Shirley P. McKee	Lucinda L. Maine	J. Schlegel
1987-1988	Shirley P. McKee	------	J. Schlegel
1988-1989	Lucinda L. Maine	------	G. Griffenhagen
1989-1990	Lucinda L. Maine	------	John A. Gans
1990-1991	E. Michelle Valentine	------	John A. Gans
1991-1992	Hazel M. Pipken	------	John A. Gans
1992-1993	Hazel M. Pipken	------	John A. Gans
1993-1994	Leonard “Red” Camp	------	John A. Gans
1994-1995	Wilma K. Wong	------	John A. Gans
1995-1996	Wilma K. Wong	------	John A. Gans
1996-1997	Susan E. Bartlemay	------	John A. Gans
1997-1998	Timothy L. Tucker	------	John A. Gans
1998-1999	Betty Jean Harris	------	John A. Gans
1999-2000	Pamela Tribble	------	John A. Gans
2000-2001	Bethany Boyd	------	John A. Gans
2001-2002	Michael A. Moné	------	John A. Gans
2002-2003	Timothy L. Tucker	------	John A. Gans
2003-2004	Craig A. Pedersen	------	John A. Gans
2004-2005	Lawrence “LB” Brown	------	John A. Gans
2005-2006	Adele Pietrantoni	------	John A. Gans
2006-2007	Adele Pietrantoni	Michael Ira Smith	John A. Gans
2007-2008	Michael Ira Smith	------	John A. Gans
2008-2009	Michael Ira Smith	Valerie T. Prince	John A. Gans
2009-2010	Valerie T. Prince	------	T.E. Menighan
2010-2011	Valerie T. Prince	Bradley P. Tice	T.E. Menighan
2011-2012	Bradley P. Tice	------	T.E. Menighan
2012-2013	Bradley P. Tice	William H. Riffee	T.E. Menighan
2013-2014	William H. Riffee	------	T.E. Menighan
2014-2015	William H. Riffee	Theresa Wells-Tolle	T.E. Menighan
2015-2016	Theresa Wells-Tolle	-------	T.E. Menighan
2016-2017	Theresa Wells-Tolle	Michael D. Hogue	T.E. Menighan
2017-2018	Michael D. Hogue	-------	T.E. Menighan
2018-2019	Michael D. Hogue	Joey Mattingly	T.E. Menighan
2019-2020	Joey Mattingly	———-	T. E. Menighan
2020-2021	Joey Mattingly	Melissa Skelton Duke	Scott Knoer
2021-2022	Melissa Skelton Duke	-------	Scott Knoer
2022-2023	Melissa Skelton Duke	Brandi Hamilton	Ilisa Bernstein
2023-2024	Brandi Hamilton	-------	Michael Hogue
2024-2025	Brandi Hamilton	Mary S. Klein	Michael Hogue

Glossary of the APhA House of Delegates

AACP: American Association of Colleges of Pharmacy

AAPS: American Association of Pharmaceutical Scientists

ACA: American College of Apothecaries

ACCP: American College of Clinical Pharmacy

ACPE: Accreditation Council for Pharmacy Education

AIDS: Acquired Immunodeficiency Syndrome

AIHP: American Institute of the History of Pharmacy

AMA: American Medical Association

AMCP: Academy of Managed Care Pharmacy

AMVA: American Medical Veterinary Association

ANDA: Abbreviated New Drug Approval

APHA: American Public Health Association

APhA: American Pharmacists Association

APhA-APPM: American Pharmacists Association Academy of Pharmacy Practice and Management

APhA-APRS: American Pharmacists Association Academy of Pharmaceutical Research and Science

APhA-ASP: American Pharmacists Association Academy of Student Pharmacists

APPE: Advanced Pharmacy Practice Experiences

ASCP: American Society of Consultant Pharmacists

ASHP: American Society of Health Systems Pharmacists

ASPL: American Society for Pharmacy Law

ASPR: Office of the Assistant Secretary for Preparedness and Response

BPS: Board of Pharmacy Specialties

CCP: Council on Credentialing in Pharmacy

CDC: Centers for Disease Control and Prevention

CE: Continuing Education

CMS: Centers for Medicare and Medicaid Services

CPOE: Computerized Prescriber Order Entry

CPT: Current Procedural Terminology

DEA: Drug Enforcement Agency

DRR: Drug Regimen Review

DUE: Drug Use Evaluation

DUR: Drug Utilization Review

DSHEA: Dietary Supplement Health and Education Act

EHR: Electronic Health Record

EPA: Environmental Protection Agency

ERISA: Employee Retirement Income Security Act

FDA: U.S. Food and Drug Administration

FDCA: Food Drug and Cosmetic Act

FTC: U.S. Federal Trade Commission

GMP: Good Manufacturing Practices

HIPAA: Health Insurance Portability and Accountability Act

HIV: Human Immunodeficiency Virus

IACP: International Academy of Compounding Pharmacists

IND: Investigational New Drug

IPPE: Introductory Pharmacy Practice Experiences

IRB: Institutional Review Board

JCPP: Joint Commission of Pharmacy Practitioners

MAC: Maximum Allowable Cost

MTM: Medication Therapy Management

NABP: National Association of Boards of Pharmacy
NAPLEX: North American Pharmacist Licensure Examination

NARD: National Association of Retail Druggists

NCPA: National Community Pharmacists Association

NCPDP: National Council of Prescription Drug Programs

NDA: New Drug Application

NDC: National Drug Code

NF: National Formulary

NIH: National Institutes of Health

NPhA: National Pharmaceutical Association National Pharmacists Association

OEO: Office of Economic Opportunity

OPEO: Office of Preparedness and Emergency Operations

OPM: U.S. Office of Personnel Management

ORDUR: On-line Realtime Drug Utilization Review

OSHA: Occupational Safety and Health Administration

OTC: Over-the-counter

PBRN: Practice Based Research Networks

PCAB: Pharmacy Compounding Accreditation Board

PhRMA: Pharmaceutical Research and Manufacturers of America

PSRO: Professional Standards Review Organizations

PSTAC: Pharmacist Services Technical Advisory Coalition

PTCB: Pharmacy Technician Certification Board

SBA: Small Business Administration

USP: United States Pharmacopeia

USPHS: U.S. Public Health Services

VA: Veterans Administration

WHO: World Health Organization

APhA
American Pharmacists Association