American Pharmacists Association

For Every Pharmacist. For All of Pharmacy.

2022–2023 House of Delegates

Report of the Policy Committee

- Workplace Conditions
- Just Culture Approach to Patient Safety
- Site of Care Patient Steerage

Committee members

Loren Kirk, Chair
Nicholas Capote
Jennifer Courtney
Juanita Draime
Marsha Gilbreath
Kelly Kent
Lauren Lakdawala
Amanda Meeker
Julia Miller
Charlie Mollien
Lucy West

Ex officio members

Missy Skelton Duke, Speaker of the House
Brandi Hamilton, Speaker-elect of the House

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

2022–2023 APhA Policy Committee report

Workplace Conditions

The committee recommends that the American Pharmacists Association adopt the following statements:

1. APhA calls for employers to provide fair, realistic, and equitable workplace conditions for pharmacy personnel that promotes a safe, healthy, and sustainable working environment.
   [Refer to Summary of Discussion Items 1–9]

2. APhA urges all entities that impact pharmacy personnel workplace conditions to adopt the APhA/National Alliance of State Pharmacy Associations (NASPA) Pharmacists Fundamental Responsibilities and Rights.
   [Refer to Summary of Discussion Items 1–2, 10–12]

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 and facilitate improved focus.
   [Refer to Summary of Discussion Items 1–2, 13–22]

4. APhA advocates for employers to provide workplace onboarding and training for pharmacy personnel to promote optimal employee performance and satisfaction.
   [Refer to Summary of Discussion Items 1–2, 23–26]

5. APhA encourages pharmacy personnel, starting with leaders, to model and promote individualized healthy working behaviors that improve well-being and to encourage and empower colleagues to do the same.
   [Refer to Summary of Discussion Items 1–2, 26–30]

6. APhA opposes the sole use of productivity and fiscal measures for employee performance evaluations.
   [Refer to Summary of Discussion Items 1–2, 31–34]

7. APhA calls for employers to take an active role in the development and use of behavioral performance competencies in performance evaluations.
   [Refer to Summary of Discussion Items 31–34]

Summary of Discussion

1. The committee considered multiple titles such as "workplace expectations," "employment standards," or "workplace best practices" and agreed on the wording of "workplace conditions." "Conditions" fit best in the context of this topic, as APhA is not a standard-setting organization and there are many different sets of "best practices" for pharmacy depending on the practice setting or workplace. (1–6)
2. The committee reviewed the International Labour Organization's definition of "working conditions," recognizing that this concept could mean different things to different people. This definition describes that working conditions cover a broad range of topics and issues, from working time (e.g., hours of work, rest periods, and work schedules) to remuneration as well as the physical conditions and mental demands that exist in the workplace. (1)
3. The committee also noted that the word choice of "workplace conditions" represents the intent to convey policies related to the work environment as opposed to inadvertently suggesting these policies are adding expectations of individual employees. (1–6)
4. The committee discussed a need to not only advocate safe and healthy working environments in proposed policy, but to also advocate that these work environments are sustainable. The committee noted that this addition was important to maintain a realistic and optimal expectation for pharmacy personnel. (1)
5. The committee determined that "calls on" is the best and most appropriate verb choice to convey urgency and agency of the recommendation. Alternative options considered included demand, insist, expect, urge, etc. (1)
6. The committee discussed the expectation that workplace conditions be realistic and be considered from both the employer and employee perspectives. (1)
7. The committee recognized in their discussion that an ideal work environment differs from person to person but may broadly be defined as an environment in which one feels supported, engaged, and equipped with the tools necessary to best facilitate their work and career advancement. (1)
8. When thinking about working conditions, the committee considered demands, environment, and circumstances of a job that directly impact its employees' satisfaction and activity. (1)
9. The committee reviewed the following articles when discussing the use of the adjective "realistic" to describe recommended working conditions: (1)

a. *Journal of General Internal Medicine* article: Porter J, Boyd C, Skandari MR, et al. Revisiting the time needed to provide adult primary care. J Gen Intern Med. 2022; [Epub ahead of print]. doi: https://doi.org/10.1007/s11606-022-07707-x

b. *Forbes* article describing the journal study: Balasubramanian S. Physicians would need almost 27 hour a day to provide optimal patient care, per new study. Jersey City: Forbes Media. Available at: https://www.forbes.com/sites/saibala/2022/08/28/physicians-would-need-almost-27-hours-a-day-to-provide-optimal-patient-care-per-new-study/?sh=449de521582b. Accessed November 9, 2022.

10. The committee reviewed the APhA and NASPA Pharmacists Fundamental Responsibilities and Rights as approved by both organizations in June 2021 with the intent that broader implementation of these principles are important for improvement of workplace expectations. (2)
11. The committee noted that, although the APhA and NASPA Pharmacists Fundamental Responsibilities and Rights is already supported by 57 entities at the time this report was created—including national associations, state associations, schools/colleges of pharmacy, and others—it would be especially powerful for the general APhA membership to demonstrate support through adoption of proposed policy for further implementation and support across the profession. (2)
12. The committee initially considered explicitly naming key stakeholders such as payers, employers, accrediting organizations, and other stakeholders in the policy statement related to the adoption of the APhA/NASPA Pharmacists Fundamental Responsibilities and Rights. However, the committee opted to keep the statement broadly applicable by using the language of "all entities" at the beginning of the statement to instead include anyone who places expectations on pharmacists. (2)
13. The committee noted the close connection between individual capability and availability to provide safe and effective patient care services. Therefore, the committee advocated for an explicit statement to emphasize a need for adequate staffing, thoughtful workflow design, and productivity analysis. (3)
14. The committee emphasized a need to not only call for optimized working environments and technology, but to also call for empowerment of the actual people involved. This is especially pertinent in situations in which frontline pharmacists do not feel permitted to act in their best interest during particularly challenging and intense work situations, even when technically they have support mechanisms available. The committee noted that this lacking sense of empowerment to act on personal judgment in pressing situations is a recurring point seen by results from the Pharmacy Workplace and Well-Being Reporting (PWWR) survey. (3)

15. The committee considered the word choice of "autonomy" to convey the agency of all personnel to utilize these models; however the committee noted that "autonomy" has varying implications across all levels of personnel and leadership (pharmacists, technicians, pharmacy managers, district leaders, etc.). As a result, the committee opted to frame this statement through the lens of empowerment. (3)
16. The committee discussed the word choice of "practice management models" to describe implementation of workplace procedures, noting that this phrase may have varying connotations with different readers. Alternative language considered included "staffing models," and "practice models." (3)
17. The committee noted limitations that APhA policy has in terms of describing workplace policies and procedures that may conflict with state legislative and regulatory scopes of authority. For example, the committee considered including pharmacy hours of operation in the list of considerations but recognized that some states regulate this at the state board of pharmacy level or department of health level. (3)
18. When discussing the issue of pharmacists' hesitation to exercise flexible practice management models, the committee reviewed a relevant example complaint from the state of Vermont, in which a pharmacy was reported for numerous offenses, including unanticipated store closures and unsafe pharmacy working conditions. Similarly, the committee reviewed another relevant example from Virginia of pharmacy personnel reporting risks to patient safety caused by understaffing. (3)
    a. Walgreens complaints from Vermont: State of Vermont Secretary of State. Walgreens Specification of Charges. Atlanta: Gray Television, Inc. Available at: https://webpubcontent.gray.tv/wcax/docs/Walgreens%20Specification%20of%20Charges.pdf. Accessed November 10, 2022.
    b. Understaffing at some CVS pharmacies in Virginia has put patients at risk, former employees say: Masters K. Understaffing at some CVS pharmacies in Virginia has put patients at risk, former employees say. N.p.: The Virginia Mercury. Available at: https://www.virginiamercury.com/2021/10/11/understaffing-at-some-cvs-pharmacies-in-virginia-has-put-patients-at-risk-former-employees-say/. Accessed November 10, 2022.
19. The committee discussed the importance of good-faith collaborative decision-making efforts among both pharmacy personnel and their employers/managers to adjust offered programs and services to patients and potential impact on hours of operation, with appropriate notification to regulatory agencies, based on availability of pharmacist and pharmacy personnel. (3)
20. The committee discussed "workload balancing tools" such as automated or centralized pharmacy services, in contexts where pharmacists have limited

personnel to help support pharmacy services. These examples were not included in the proposed statement to keep the statement broad and allow pharmacy personnel to consider multiple options for flexible working environments. (3)

21. Related to workload balancing tools, the committee discussed the variation across state board of pharmacy regulations and how this variable significantly influences pharmacy workflow and provision of pharmacy services. (3)
22. The committee considered the role and influence a pharmacist in charge (PIC) should have in creating the optimal work environments outlined by the proposed policy statements, noting that the PIC should have the ability to determine what is best for that work environment in a manner that helps safely achieve its employer's strategy and goals. (3)
23. The committee reviewed existing APhA policy regarding onboarding and training program recommendations and determined a gap in policy was present. Additionally, members of the committee cited anecdotal examples of new pharmacists or technicians having had limited training or onboarding for new roles, which negatively impacted their performance and satisfaction and contributed to patient safety errors. (4)
24. The committee pointed out that existing policy also does not capture the element of employee satisfaction in their roles as it relates to training and onboarding facilitated by employers. The committee debated the addition of "in their roles" as it relates to employee satisfaction, and ultimately chose to strike this language. (4)
25. The committee considered how best to comprehensively describe workplace onboarding and training, and what the intended goals should be for such training. Considerations included descriptions such as "adequate" or "sufficient" and verbs such as "promote" or "facilitate." The committee agreed to use the word "promote," as it seemed most actionable. (4)
26. The committee reviewed the APhA 2019 Pharmacist and Pharmacy Personnel Safety and Well-Being; 2019 Pharmacists Role in Mental Health Emotional Well-Being; and 2012, 2007, 1970 Employment Standards adopted policy statements to identify potential gaps needing to be addressed in relevant policy regarding wellness and training. (4–5)
27. The committee discussed healthy working behaviors, and the modeling of such behaviors by those in leadership roles (such as pharmacists in charge, managers, preceptors, etc.) as positive examples for enforcement. "Healthy working behaviors" refers to a variety of components which may be individualized depending on a staff person's needs. For example, the committee acknowledged that this may include, but is not limited to, the practice of taking meal breaks, designated time and space for exercise, opportunities to engage with meditation apps, etc. (5)

28. The committee opted to avoid overgeneralizations by specifying that healthy working behaviors may be "individualized," acknowledging that different wellness practices work for different individuals. (5)

29. The committee referenced an October 22, 2022, *Wall Street Journal* article when considering how to promote healthy working environments. (5)

    a. *Wall Street Journal* article: Ellis L. Toxic workplaces are bad for mental and physical health, Surgeon General says. N.p.: The Wall Street Journal. Available at: https://www.wsj.com/articles/toxic-workplaces-are-bad-for-mental-and-physical-health-surgeon-general-says-11666230714. Accessed November 11, 2022.

30. The committee referenced multiple recommendations from the 2019 Enhancing Well-being and Resilience Among the Pharmacist Workforce: A National Consensus Conference, that outlined how leadership should prioritize and model well-being and resilience for their workforce. (5)

    a. 2019 Enhancing Well-being and Resilience Among the Pharmacist Workforce: A National Consensus Conference: APhA, Accreditation Council for Pharmacy Education, American Association of Colleges of Pharmacy, et al. Enhancing Well-being and Resilience Among the Pharmacist Workforce: A National Consensus Conference. Washington, DC: APhA. Available at: https://aphanet.pharmacist.com/sites/default/files/audience/APhA_Well_Being_Resilience_Report_%200719.pdf. Accessed November 11, 2022.

31. The committee discussed that in some settings, productivity/fiscal measures may be used as the only metrics for performance evaluations of pharmacy personnel; for example, if someone was working solely with prior authorizations, medication therapy management services, comprehensive medication reviews, immunizations, or number of prescriptions filled. (6)

32. The committee discussed implications of behavioral and quality performance metrics in pharmacy, emphasizing that productivity and fiscal measures should not be used as the only metrics for employee performance evaluation. (6–7)

33. The committee identified a need and value in separating the productivity/fiscal and behavioral outcomes for personnel performance competencies into two separate statements. (6–7)

34. The committee provided rationale for including "behavioral" performance metrics, where examples of behavioral competencies outlined by the committee include empathy, active listening, effective communication, and personal responsibility. (6–7)

2022–2023 APhA Policy Committee Report

Just Culture Approach to Patient Safety

The committee recommends that the American Pharmacists Association adopt the following statements:

1. APhA calls for employers to adopt and implement just culture principles to improve patient safety and support pharmacy personnel.
   [Refer to Summary of Discussion Items 1–3]

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.
   [Refer to Summary of Discussion Items 1–2, 4–6]

3. APhA urges the adoption of non-disciplinary and non-punitive mechanisms for use by boards of pharmacy to promote just culture when addressing people, systems, and processes involved in medication errors.
   [Refer to Summary of Discussion Items 1–2, 7–16]

4. APhA encourages national and state associations to advocate for legislation in all states to provide protections to individuals utilizing error reporting systems to promote just culture.
   [Refer to Summary of Discussion Items 1–2, 12, 17–18]

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.
   [Refer to Summary of Discussion Items 1–2, 19]

6. APhA supports the development of just culture education and training in the curriculum of all schools and colleges of pharmacy, postgraduate training, and continuing professional development programs.
   [Refer to Summary of Discussion Items 1–2, 20]

Summary of Discussion

1. The committee broadly defined just culture as a system in which errors are not attributed to an individual's mistakes, but rather to the totality of a structured environment, system, and workflow. (1–6)
2. The committee recommended intentional ordering of these policy statements to follow a logical progression from outlined just culture principles to encouraged transparency to advocacy to education. (1–6)
3. The committee discussed what the best and most appropriate verb choice would be to convey urgency and agency of the recommendation. Options included "calls for," "demand," "insist," "expect," "urge," etc. The ultimate recommendation to strike this balance was "calls on." (1)
4. The committee discussed the importance of information-sharing between employees and employers following medication errors and near misses. In doing so, the committee recommended this information transfer be deidentified and intentionally included this word within the statement. (2)
5. The committee refers to "deidentified" medication error data as information which does not name the individual staff members involved in a case. This does not necessarily mean deidentified patient data. (2)
6. The committee advocated for explicit support for not only information-sharing of medication errors, but also of near-misses, as near-miss analyses lead to improvements in risk avoidance. (2)
7. The committee noted that implementation of medication error reports varies depending on pharmacy practice site. For example, health systems integrate medication error reporting and just culture approaches in a more centralized manner compared to other pharmacy settings. (3)
8. The committee defined the intent of medication reporting processes as achieving transparency, data-sharing, and overall accountability across pharmacy practice sites. (3,5)
9. The committee noted that, in addition to reporting medication errors, information must also be used to reflect on the root cause of an error and how to improve systems involved. (3, 5)
10. The committee considered combining the ideas of mandatory national reporting systems for deidentified medication errors and encouraged transparency across settings into one shared policy statement. However, they ultimately agreed these were two separate ideas that warrant their own statements within this proposed policy. (3, 5)

11. The committee expressed interest in an industrywide effort to engage in confidential and transparent sharing of learnings and root cause findings that are relevant to reducing risk of medication errors. (3)
12. The committee considered mandatory enforcement of a just culture approach in pharmacy and referenced the tremendous lessons and information that are lost without standardized medication reporting practices. However, the committee opted against making this mandatory, recognizing APhA's limited ability to implement such a mandate, and instead opted to recommend collaboration with other stakeholders such as Institute for Safe Medication Practices (ISMP). (3–5)
13. When considering whether to recommend mandatory reporting, the committee reviewed APhA's 2022, 2018 Proactive Immunization Assessment and Immunization Information Systems policy as an example, which calls for mandatory reporting by all immunization providers of pertinent immunization data into Immunization Information Systems (IIS). (3)
14. The committee noted potential hesitation or pushback against shared medication error information from certain employers, due to personal interests and preservation. (3)
15. The committee discussed the importance of a standardized national documentation and reporting process that is the same across all states, rather than varying from state to state, so that pharmacy personnel are not ultimately burdened with documenting the same error multiple times. (3)
16. The committee reviewed APhA's 2000 Medication Errors policy. In doing so, they noted that the 2000 policy focuses on error prevention, whereas the proposed 2023 policy is intended to address the handling of errors after they are made. (1–3)
17. When discussing the role that pharmacy associations play in advocating for legislation to promote just culture, the committee considered the question of whether boards of pharmacy have the authority to be included in this recommendation. However, it was ultimately determined that they were not in the best position to do so compared to other stakeholders. (4)
18. The committee considered whether legislation is the only advocacy goal that may be called for in their proposed statement, but determined that legislation is the only true method of regulating medication error reporting practices and the boards of pharmacy involved. (4)
19. The committee raised the need to provide additional protection for professionals who do report their medication errors. Specifically, addressing fear from many health care professionals that the information they include when reporting errors could be used against them. (5)

20. The committee referenced and closely modeled language used in previously adopted policy by the APhA House of Delegates (see 2018 Efforts to Reduce the Stigma Associated with Mental Health Disorders or Diseases) when advocating the development of just culture education and training. (6)

2022–2023 APhA Policy Committee Report

Site of Care Patient Steerage

The committee recommends that the American Pharmacists Association adopt the following statements:

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.
   [Refer to Summary of Discussion Items 1–10]

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.
   [Refer to Summary of Discussion Items 1–5, 9–17]

Summary of Discussion

1. The committee reflected on the existing APhA 2022 Procurement Strategies and Patient Steerage policy and the additional gaps that were unable to be addressed by the House of Delegates during the March 2022 House of Delegates meeting. The following items were identified as key areas discussed by the Committee: (1–2)
    a. The 2022 policy ultimately addresses medication choice, chain of custody considerations, and the integrity of drug.
    b. The 2022 policy addresses mandated procurement strategies which restrict patients' and providers' ability to choose treatment options and that compromise patient safety or quality of care.
    c. The 2022 policy calls for procurement strategies and care models that lower total costs, ensure continuity care, and do not restrict or delay care.
    d. The 2022 policy does not explicitly contemplate the effect that payer-driven mandates have on the specific site where care is delivered and administered. This may be regarded as another strategy to lower costs without clinical benefit.
2. The committee emphasized that while these proposed policy statements have an origin connecting back to the 2022 Procurement Strategies and Patient Steerage policies, the issues around site of care steerage are broader and can stand alone as a separate policy topic within the APhA policy manual. (1–2)
3. The committee discussed to whom and where this policy topic is intended to apply and agreed this referred to specific patient care sites, such as medication administration sites, in addition to the currently uncompensated coordination and business model that must exist to ensure safe, effective, and affordable medication use in these settings. (1–2)
4. The committee outlined that this policy topic overall centers around two ideas: firstly, the elimination of payer-driven mandates for patients to certain sites of care and, secondly, addressing a current gap in the involved business models. (1–2)
5. The committee reviewed the following existing APhA adopted policy in connection to site of care patient steerage: (1–2)
    a. 2020 Coordination of the Pharmacy and Medical Benefit
    b. 2004,1990 Freedom to Choose
6. The committee noted that, while language of APhA's 2020 Coordination of the Pharmacy and Medical Benefit policy addresses compensation of pharmacists for patient care services, there is an opportunity to outline additional members of the pharmacy team in the 2023 policy, such as technicians and other staff involved in billing and care coordination activities (patient financial assistance, prior authorization, appeals, etc.). (1)
7. The committee discussed the role that payers, pharmacy benefit managers (PBMs), and vertical integration play in the implementation of site of care mandates and considered this in the drafting of their policy. (1)
8. The committee discussed the word choice of "shared decision making" versus "provider-informed patient choice" and ultimately opted for "shared provider-patient decision making" to capture both patient agency and health care professionals' exercise of professional judgement. (1)

9. The committee outlined that one of the issues intended to be addressed in this policy topic is that payer-driven site of care patient mandates are often not made with medication safety or quality of care as a priority for the mandates. (1–2)
10. The committee discussed the connection between patients having informed choice in their site of care to the minimization of delays in care coordination. (1–2)
11. In addition to calling for the elimination of payer-driven medication administration policies/provisions restricting access points, the committee discussed a need for specific mention of payment mechanisms to support more functions than simply the medication administration. (2)
12. The committee reviewed the Home Infusion Per Diem HCPCS Code (S9338), which could serve as a model of comprehensive compensation models that covers and creates clarity around services provided and paid for outside of the medication procurement. (2)
    a. "HCPCS code S9338 for Home infusion therapy, immunotherapy, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem as maintained by CMS falls under Home Infusion Therapy"
13. The committee considered potential pushback or questions of timelessness of this proposed policy. The committee noted the potential to sunset or modify this policy in the future as-needed if one day payer-driven provisions no longer restrict patient access to care or lead to other negative implications. (2)
14. The committee noted that part of what this policy advocates for is the pharmacists' ability to bill for all clinical, administrative, and care coordination services. The committee noted there is a magnitude of resources and personnel involved in this work that are not currently compensated and especially not directly compensated. (2)
15. The committee deliberated on how to best capture the payment and billing mechanisms involved and agreed care coordination services for provider-administered medications, often driven or led by pharmacy personnel, are essential to safe and effective medication use. Furthermore, the committee desired to call for payment mechanisms that would include, but not be limited to, only pharmacy providers for these services and as such selected the language of "provider-administered." (2)
16. The committee outlined that, when incorporating payment mechanisms in this policy, the term "comprehensive" covers all health care professionals, including pharmacy personnel. (2)
17. The committee contemplated word choice of "payment mechanisms" versus "compensation mechanisms" in an effort to best capture the need for a billing infrastructure for related tasks. They ultimately opted for "applicable compensation mechanisms" in an effort to be most inclusive. (2)