

Alabama Pharmacy Consensus Conference  
September 30, 2006

Summary of Consensus Statements

1. Compensation (fee for services) and reimbursement (payment for cost incurred) are not synonymous due to differences in perceived value associated with the pharmaceutical services provided.
2. Embed the continuous quality improvement (CQI) process into all pharmacist functions and report the results and their value to the profession and other stakeholders.
3. Develop mechanisms to capture pharmacist interventions and translate the value of these interventions to the payer.
4. Demonstrate the value associated with pharmacist services that are both measurable and evidence-based.
5. A unified voice is essential across the entire profession of pharmacy for the purpose of improving patient outcomes and demonstrating economic value.
6. Economic synergy can be achieved by pharmacists working collaboratively with other healthcare professionals.
7. In order to be equitably compensated for professional services, such as medication therapy management, it is important to change public awareness and perception of pharmacy.
8. To avoid compromising patient care outcomes, economic models in the future must focus on quality while addressing anticipated levels of productivity.
9. The profession of pharmacy should utilize the information on those service areas where improvements in patient outcomes have been achieved to expand public awareness of pharmacy services.
10. Medication therapy management (MTM) and other areas of cognitive services are opportunities for pharmacists to expand their economic base.
11. Pharmacists should remain sensitive to opportunities to develop alliances between payers and practitioners which can benefit both parties economically.
12. Analyze and address the increased economic pressures within the profession associated with the increasing shortage of pharmacists, the rising costs of education, and the need for more pharmacists to teach and mentor students.

13. The commitment to providing pharmaceutical services to underserved regions is paramount and the economic consequences to society of not doing so will be significant. Programs such as the Rural Health Scholarship Program should be pursued in pharmacy.
14. In order to allow pharmacists to become more engaged in direct patient care, it is paramount that technicians receive formal training and education related to their scope of responsibilities.
15. The profession needs to establish standards for technician training.
16. Alabama's technician training and education programs must be accredited.
17. PTCB certification needs to be required in Alabama within 18 months of employment as a registered pharmacy technician.
18. The profession of pharmacy should convene to evaluate and recommend changes to the Alabama Pharmacy Practice Act to expand the role of certified technicians (scope of practice, pharmacist supervision).
19. Pharmacists graduating from schools of pharmacy in Alabama should be trained and educated as "generalist" as defined by ACPE.
20. Develop a structured mentoring program to develop future pharmacy leaders.
21. Patient safety must be pharmacy's highest priority.
22. Identify and disseminate alternative models for staffing and patient care services to address the pharmacist shortage.
23. Facilitate re-entry/competency review for pharmacists who have been out of the workforce practice for a period of time.
24. Medication Therapy Management is the purview of the pharmacist in Alabama.
25. Appropriate credentials that document practice abilities will be a prerequisite for all pharmacists that provide patient care services.
26. Support collaborative efforts by professional organizations, academia, and health care systems to develop new models of patient-centered care.
27. Support the establishment of a multi-lingual referral network of pharmacy practitioners to facilitate the provision of pharmaceutical care and medication therapy management services to diverse populations.

28. Change the composition of the Alabama State Board of Pharmacy to reflect the demographics of practicing pharmacists. Ethnicity, gender, practice setting, and other demographic trends should be considered.
29. Commission a study to examine the demographic trends and work patterns of pharmacy practice in Alabama.
30. Expand the participation of pharmacists in practice based research.
31. Encourage pharmacists to work in partnership with departments of health and other groups to address public health issues related to medication use.
32. Pharmacists should have workload and scheduling structures which emphasize patient safety and respect the pharmacist's professional practice.
33. Address the impression of some employers and some pharmacists that they are in an occupation rather than a profession.
34. Adopt or develop and implement technologies for providing and maintaining access to centralized and standardized patient data for all providers involved in patient care.
35. Prepare students to use appropriate technology to enhance patient safety in the delivery of patient care and in the dispensing process.
36. Advocate for necessary changes in legislation, regulation, and funding to implement central access to patient care data.
37. Support the improvement of technology to provide the most practical, pertinent and useful information for pharmaceutical care including dispensing and clinical services.
38. Identify and overcome barriers to the use of technology to improve efficiency in the delivery of pharmacy services.
39. Utilize and encourage the development of technology to aid in optimizing and documenting patient outcomes.
40. Pharmacists should maintain oversight of the medication use process as technology is implemented.
41. We recognize that pharmacists in different practice settings have numerous issues in common. Therefore it is in our best interest to work together.
42. Develop the Alabama Pharmacists Coalition (APC) comprised of all pharmacist organizations in the state for the purpose of exploring issues of common interest and formulating plans of action.

43. Require that the APC organize and meet by February 1<sup>st</sup>, 2007.
44. The APC shall be *initially* comprised of 2 members of each state pharmacist association (APA, AIDA, AISHP), at least one of which is a member of their board of directors. The two schools of pharmacy shall each send 1 representative.
45. Charge the APC as its first order of business to determine the best long-term structure of pharmacist organizations within the state to ensure a unified voice.
46. More pharmacists should participate in state pharmacy associations to enhance the profession's representation in legislative and public arenas and to optimize patient care.
47. Schools of pharmacy should study pharmacists' professional needs and attitudes and the dynamics of the professional organizations to determine the factors that encourage or discourage participation of pharmacists in organizations.
48. All students should be members of and demonstrate active participation in at least one professional association throughout their student careers.
49. Agree upon a definition of collaborative practice and define the key players involved in the collaborative practice process.
50. Involve physicians, public health departments, and other players in the process of developing a definition of collaborative practice.
51. Explore how individual collaboration can be established between pharmacists and physicians, public health departments, or other key players.
52. Determine what physicians, public health departments, and other key players expect from pharmacists in collaborative practices.
53. Obtain and disseminate information from pharmacy practitioners currently involved in collaborative practice.
54. Educate physicians, public health departments, and other key players about the training and abilities of pharmacists through a grassroots educational effort aimed at primary care practitioners.
55. Educate physicians, public health departments, and other key players outside of the pharmacy profession about the benefits of collaborative practice with pharmacists of improving patient care without negatively impacting physicians and other key players.

56. Identify and disseminate technology and resources to pharmacists who want to participate in collaborative practices.
57. Competencies involved in collaborative practice must be in the curricula of schools of pharmacy.
58. Improve political consensus for expansion of pharmacy services.
59. Encourage pharmacists to start collaborating now with physicians and other key players.
60. Charge the Alabama Pharmacists Coalition to develop an action plan by early 2007 for the purpose of implementing the above-listed recommendations.
61. Expand residency training in Alabama (Identify 24 hospitals in Alabama for new residency program development; 36 community residency programs).
62. Explore opportunities under Medicare Part D for community-based residency training support.
63. Develop an organized structure for community-based training program.
64. Challenge colleges of pharmacy to become community pharmacy practice sponsors.
65. Both schools of pharmacy should develop programs to retain residency trained pharmacists within Alabama.
66. Both schools of pharmacy should organize a consultant group to serve as a resource for new residency program development and expansion and advertise this resource locally and nationally.
67. This consultant group should develop cost-benefit data and examples to demonstrate the value of community residency training to both independent and chain pharmacies.
68. Make information available about graduates of residency programs to employers of the state of Alabama.
69. Employ more community-based, residency trained pharmacists on faculty to support the culture of residency training in the community setting.
70. Develop a conference to demonstrate the values and research outcomes of community residency programs.
71. Develop a community residency web-based forum for communication among community pharmacy residencies.