House of Delegates

Policy Manual

Revised 08/2016

Introduction

The House of Delegates establishes policy of the Illinois Pharmacists Association. As a representative body, it speaks for the membership of the Association and of the pharmacy profession in Illinois.

The lack of a concise statement of policies adopted by the House of Delegates previously hampered both the House of Delegates' proceedings as well as the execution of House policies by the Board of Directors. In October, 1979 the House directed that the policy manual which follows be developed and updated as frequently as necessary.

This manual has been organized on the basis of subject rather than chronologically. Policies have been classified in the following categories:

I. **Professional Issues**
   a. Legal Matters
   b. Pharmacy Practice
II. **Organizational Issues**
III. **Public Issues**
IV. **Educational Issues**
V. **Archived Policies**

In the case of the issues that have received attention by the House on more than one occasion, we have cited the most recent statement or policy.

Policies in Light Blue are considered to be under review by action of the House of Delegates. These policies remain active until further action by the House of Delegates to Retain, Revise, or Archive the policy.

Composition of the House of Delegates

The House of Delegates consists of Delegates appointed by Associations recognized by the House as provided in Article VIII and delegates of Sections of the Association as provided for in Article VII. Past presidents and current officers of the Association shall be Delegates, ex-officio with vote. In addition, each region of the Association is represented by eight (8) elected pharmacist delegates and one (1) technician delegate.

Duties of the House of Delegates

The House of Delegates is charged by the Bylaws of the Association with the responsibility of serving as a legislative body in the development of Association policy and philosophy.

Section I. **Professional Issues**

A. Legal Matters

1. Pharmacy Ownership – 1974

Concept I
The Act should establish that the ownership and professional direction of a licensed pharmacy be by an Illinois registered pharmacist, or if a partnership, all members of which are Illinois registered pharmacists, or if a corporation or association, the majority of stockholders and directors be Illinois registered pharmacists.

Concept II
The Act should not exempt any individual, groups of individuals, corporations or any other legal entity from the ownership requirements.

Concept III
The Act should provide a reasonable time frame during which time owners, who may not be eligible for ownership under the Act, may dispose of their property.

Concept IV
Units of government on the state and local level may operate a licensed pharmacy without meeting this requirement.

Concept V
All appropriate laws and regulations, including the Business Corporation Act, should be amended to ensure compliance with the above.

Concept VI
Grandfather Clause - A clause should be included which would exempt pharmacies in existence on the effective date of the Act from the requirements of the Act.

2. Repeal of Anti-Substitution – 1971 (*Archived)*

3. Percentage Lease Arrangements – 1979

The House adopted a policy supporting an end to percentage lease agreements between pharmacies and prescriber-owner medical center/office entities, and urged the use instead of lease agreements based on fair market value.

4. Procedure for Complaint – 1978

The House adopted the following procedure for complaints:

a. Institution of Proceedings

A charge is initiated by filing a written complaint with the Executive Director. The complaint must set out the following:

i. Factual allegations of conduct deemed to constitute a violation of the code of Ethics or Constitution or Bylaws.
ii. A citation of the particular paragraph, section or interpretation opinion upon which the charge is based.
iii. The signature of the complainant.
iv. An affirmative statement that the complainant is ready and willing to appear before the Ethics and Grievance Committee to support the allegations.

b. Preliminary Review

The Ethics and Grievance Committee shall examine all formal complaints and determine whether the facts alleged, if true, constitute a valid complaint. If so, the Committee may then:

i. Seek voluntary compliance with the Code of Ethics, Constitution or Bylaws.
ii. Schedule a formal hearing.
iii. Delay action pending further information.
iv. Dismiss the complaint.

c. Formal Hearing

In cases where the Ethics and Grievance Committee complaint state a prima facie case and where the charge is such that voluntary compliance is inappropriate, or where a member has refused to voluntarily comply, the Committee shall transmit a copy of the formal complain to the member along with notification of a hearing.

i. Hearing will be held within six (6) months from the date the formal complaint is filed, but not less than sixty (60) calendar days from date of filing.
ii. Notice will be sent by registered mail with return receipt.
iii. Notice will also be given to the following:
    1. Members of the Ethics and Grievance Committee
    2. Complainant
    3. Executive Director
    4. Association's Legal Counsel.
iv. The hearing date may be extended upon the request of either party for sufficient cause. A second notice, shall be sent to all parties given the first notice, in the event of any change in date, time or place of hearing.
v. A charged member has the following options upon receipt of notice for formal hearing:
    1. To answer within thirty (30) days by registered mail to the committee indicating that he will attend the hearing at the scheduled time.

2. To answer within thirty (30) days by registered mail to the committee requesting an extension setting forth the reasons for such request.
3. To answer the charges by registered letter in lieu of a formal hearing. Such letter must be received by the committee within sixty (60) days of receipt of this notice.

vi. Failure to appear or answer will result in a decision being rendered on the available facts.

vii. All hearings will be held in Executive session. Only committee members, the parties and their counsel and witnesses will be admitted.

viii. At least five (5) committee members must be in attendance for a formal hearing.

ix. A record of the proceedings shall be made, either by written or electronic means. Upon the request of either party or their counsel, and payment of a fee sufficient to cover the cost of duplication of the record, either party may obtain a copy of the record. The record of the hearing shall be retained until the time for appeal has expired.

x. The cost of the hearing will be assumed by the Association EXCEPT that the parties are responsible for their own expenses incurred for travel, lodging, meals and counsel, and any expenses of their witnesses.

d. Decision

There must be at least three (3) affirmative votes for action to be taken by the Committee on a complaint. A decision may be rendered orally at the end of the hearing. However, if rendered orally, it must be reduced to writing in a summary form and transmitted to each party, the Executive Director and the Board of Directors within twelve (12) months from the date the complaint was filed. All decisions are final and binding on all parties, UNLESS appealed.

e. Appeal

i. Either party may appeal a decision of the Ethics and Grievance Committee to the Committee to the Board of Directors.

ii. The Board of Directors shall have the power to grant a rehearing or discipline imposed. Where the appeal involves the dismissal of the complaint, the Board of Directors may reverse the Committee and grant formal hearing.

iii. Appeals are conducted upon the record of the hearing.

iv. An appeal may be limited to review of the discipline imposed. To perfect the right of appeal, written notice of appeal must be filed with the Executive Director of the Association within sixty (60) days from the date on which the Ethics and Grievance Committee rendered its decision. Such notice must be set forth with particularity, the objectives upon which it is based.

v. A decision of the Board of Directors is final and binding on all parties. A decision shall be rendered by the Board of Directors within twelve (12) months from the date of receipt of the notice of appeal by the Executive Director. A summary of the decision shall be reduced to writing and transmitted to the parties.

5. Procedure for Grievances – 1978

The House adopted the following procedure for grievances:
Any member who feels that he is or has been treated unfairly concerning his employment should do the following within a period of ten days from the time of the occurrence:

a. Discuss the matter with his immediate supervisor for an equitable solution to the problem. Most grievances will and should be resolved at this level.

b. If the member is not satisfied with the results received in Step 1, he should go to the pharmacy owner for a decision (because of the wide variety of economic structures which employ pharmacists, the Executive Director may be consulted on the mechanism of step 2).

c. If the member still feels the difficulty has not been resolved, he shall have fourteen (14) days within which to file his complaint with Executive Director. The member may have assistance in presenting complaint. The Executive Director shall render a decision within ten (10) days after reviewing the case.

d. The right to appeal the Executive Director's decision is granted and must be made in writing by either party, within ten (10) days to the Ethics and Grievance Committee. The Committee's decision shall be final.

e. Subjects for grievance shall be limited to working conditions, unfair application of rules or regulations, supervisor's disregard of pharmacy policy, inequitable treatment compared to their employees, or being required to violate the Code to Ethics.

6. Disciplinary Action – 1982

In 1978 the House adopted a policy supporting legislative change which would expand the disciplinary options available to the Board of Pharmacy by including probation and other penalties less severe than suspension. (Probation and Censure subsequently were added to the Pharmacy Practice Act by PA81-0939).

In 1982 the House supported the enactment of legislation which will clearly define the powers of the State Board of Pharmacy with regard to investigations and disciplinary proceedings and place these powers more directly under the supervision of the Board. The House also voted in support of the amendment of Section 13.2 (4037) of the Pharmacy Practice Act to give the Board of Pharmacy limited discretion in recommending the granting or denial of the restoration of a lapsed or expired license to practice pharmacy.

7. Physician Dispensing – 1976

The House adopted policy supporting legislation which would prohibit dispensing of prescription drugs by physicians and other prescribers.

8. Opposition to Discriminatory Pricing – 1975

The House, by discussing and commending the Supreme Court opinion rendered in Portland Retail Druggists Association vs. Abbott et al, established Association policy in opposition to discriminatory pricing policies of drug manufacturers.

9. Confidentiality of Prescription Files – 1975, 1982

In 1975 the House of Delegates adopted as policy a motion opposing the provisions of HB 102 which places upon the pharmacist the onus of determining whether a prescription proffered to and filled by the pharmacist is for a legitimate medical purpose; and to oppose the right of any peace officer to demand of a pharmacist the right to inspect his prescription records, or any other records connected with the dispensing of drugs and medicines. In 1982 the House addressed the issue again in the context of adopting Standards of Practice.
(See Standards of Practice 1982 House action, Page 12, Section I, B-7).

10. Prescription Drug Product Imprinting – 1981

The House adopted a policy in support of legislation requiring prescription drug product imprinting. The Association was directed not to cause such legislation to be introduced. If introduced by another party, however, the Association should support such legislation if upon review it is found that no substantial administrative burdens are placed upon the pharmacist by enactment of the legislation.

11. Triplicate Prescription Form – 1982 *(Archived)*

12. Prescription Drug Sampling – 1982 – POLICY UNDER REVIEW

The House of Delegates adopted as policy the resolution: to enhance the public health and control questionable distribution of prescription drugs, the Illinois Pharmacists Association urges the adoption of statutory provisions which will prohibit the "sampling" of prescription drugs by manufacturers and distributors in Illinois.

13. Pharmacist's License – 1982 *(Archived)*

14. **Wholesale Druggist Exemption – 1983**

The House supports the removal of the Wholesale Druggist's exemptions from the Pharmacy Practice Act, and encourages the establishment of licensing or registration criteria.

15. **Student Pharmacist Designation – 1984** *(Archived)*

16. **Pharmacy Technician Designation – 1984** *(Archived)*

17. **Pharmacy-Only Category for Rx to OTC Switch Products – 1984 – POLICY UNDER REVIEW**

The House directed IPhA to seek Illinois legislation which would limit to pharmacies the sale of drug products switched from legend to over-the counter status; that this pharmacy-only requirement should apply for five (5) years from the date of the Rx-OTC change and that pharmacies be required to make pharmacist consultation readily available to patients concerning these products. Further, that such legislation should contain provisions requiring pharmacists to maintain records or profiles when requested by patients using these products which are similar to profiles maintained for Rx and OTC products used by patients.

18. **Pharmacist-Only Class of OTC Medications – 1990 – POLICY UNDER REVIEW**

The IPhA supports the concept of a third class or pharmacists' legend interim class of OTC medications sold only by or under the supervision of pharmacists and encourages the IPhA to support any and all national pharmacy associations to support such legislation or regulatory mechanisms that will allow this process.

19. **Removal of USP/NF in Favor of "Menu" of Approved References – 1985** *(Archived)*

20. **Non-Profit Institutions Act – 1985**

The House directed IPhA to support efforts seeking to repeal or modify the Non-profit Institutions Act exemption from the Robinson-Patman Act and such other legislative changes as are necessary to restore fair competition.

21. **Recovery of Disciplinary Costs – 1986**

The House directed IPhA to support efforts of the State Board of Pharmacy and Department of Professional Regulation to devise a means of recovering the costs incurred with respect to disciplinary proceedings against licensees that result in significant disciplinary actions for violations of law which pose a threat to the health and safety of the public.

22. Mail Order Pharmacies – 1988 – POLICY UNDER EEVIEW

The Illinois Pharmacists Association opposes mail order prescription services in which the patient either is forced to utilize such a service in order to obtain a prescription drug benefit or is subjected to financial disincentives to utilize a local community pharmacy. This policy does recognize however, that mail order pharmacy services may, at some times, be necessary.

Adopted in 1987: IPhA supports legislative or regulatory efforts to require out-of-state mail order pharmacies to 1) obtain a pharmacy license from the State Board of Pharmacy; 2) employ and designate as pharmacist-in-charge an Illinois licensed pharmacist; 3) comply with Illinois Triplicate Prescription Program; 4) comply with Illinois Drug Product Selection laws regarding patient authorization and notification of generic interchange.

23. Policy Statement of Veterinary Drugs – 1988

The Illinois Pharmacists Association opposes practices of manufacturers and wholesalers that directly or indirectly restrict or exclude pharmacists from the sale or distribution of veterinary drugs. IPhA believes that this practice runs contrary to the interest of public health and safety. The IPhA should work closely with the University of Illinois Colleges of Agriculture, Veterinary Medicine, and Pharmacy, as well as the American Pharmaceutical Association and other appropriate groups to explore mutual goals and interest with respect to the safe and effective use and distribution of veterinary pharmaceuticals. IPhA should address the need for pharmacists to become more knowledgeable about veterinary drugs and their use.

24. Veterinary Drug Recordkeeping – 1991 – POLICY UNDER REVIEW

The Illinois Pharmacists Association recommends that the Prescription Drug Marketing Act of 1987 be amended to require veterinary drug product distributors keep distribution records and that those records be made available to the appropriate state and federal regulatory officials.

25. Illinois Prescription Form – 1988 *(Archived)*

26. Illinois Formulary Content – 1988 *(Archived)*

27. Transfer of Controlled Substances Prescription – 1990 *(Archived)*

28. Controlled Substances Recordkeeping – 1991

BE IT RESOLVED that IPhA and in cooperation with national pharmacy organizations enter into a dialogue with the DEA to come to some reasonable policy in regard to pharmacy recordkeeping errors, and controlled substance counts, and BE IT FURTHER RESOLVED that IPhA as an interim measure determine what DEA is now doing and distribute this information to its members.

29. Pharmacy Dedicated Fund – 1992 – POLICY UNDER REVIEW

BE IT RESOLVED that the dedicated fund for the Board of Pharmacy of the State of Illinois that is generated from the collection of license fees from pharmacists, pharmacies, and related pharmacy activities (i.e. drug wholesaler licenses) be used for the purpose for which it was intended. That purpose is the financing of the activities of the Illinois State Board of Pharmacy: the issuing of pharmacy and pharmacist licenses, pharmacy inspections by the Board of Pharmacy investigators, and any and all activities that encompass the practice of pharmacy in the State of Illinois. Any use of these monies from the dedicated fund for the Board of Pharmacy for any expenses other than those generated by the Board of Pharmacy shall be considered an improper use of funds. Furthermore, any motion to increase license fees for pharmacists, pharmacies, and related pharmacy activities because of increased costs shall be considered unjustified when the cause of the increase is due to a shortage in funds resulting from a diversion of monies for expenses that are not generated by the Board of Pharmacy.

30. Dispense as Written – 1994 *(Archived)*

31. Depoting – 1995

The Illinois Pharmacists Association supports legislation to amend the Illinois Pharmacy Practice Act defining "Depoting" as follows: "Depoting means the assembling, collecting and/or forwarding of prescriptions that are to be filled at a location other than the dispensing pharmacy and/or the distributing or forwarding of filled prescriptions at or from a location other than the dispensing pharmacy, excepting nursing homes, hospices, or senior citizen complexes."

The Illinois Pharmacists Association supports legislation to amend the violations section of the Illinois Pharmacy Practice Act "establishing or participating in depoting as defined by the Act."

32. Professional Judgment Interference – 1995

The Illinois Pharmacists Association opposes any interference with the professional judgment of a pharmacist by any other pharmacist, employer, or their agents, or by other employees.

The Illinois Pharmacists Association supports legislation to amend the Illinois Pharmacy Practice Act to make such interference a violation of the Act.

33. OBRA 1990 Recognizing Pharmacists – 1995

The Illinois Pharmacists Association endorses the Omnibus Budget Reconciliation Act (OBRA) of 1990 as it relates to the practice of pharmacy, thus recognizing pharmacists as professionals whose expertise can be effectively utilized to detect potential problems with drug therapy and promote rational outcomes from drug therapy and pharmaceutical care. IPhA staff was directed to seek legislation to implement this policy.

34. Transfer of Prescriptions – 1995

The Illinois Pharmacists Association supports legislation to amend the Illinois Pharmacy Practice Act to require pharmacists to honor prescription transfer request "at the time of the request."

35. Prescription Files-Transfer-Conditions Upon Filling Prescriptions – 1995

The Illinois Pharmacists Association supports legislation to amend the Illinois Pharmacy Practice Act with the following language: "A licensed pharmacist in this State may transfer and dispense, compound, or fill a valid prescription that has been dispensed, compounded, or filled, which is on file in a pharmacy licensed in any state."

36. Pharmacy Practice Definition – 1995

The Illinois Pharmacists Association supports legislation to amend the Illinois Pharmacy Practice Act to define "Pharmacy Practice" as follows: " 'Practice of Pharmacy' means the provision of pharmaceutical care to patients which includes, but is not limited to..."

37. Pharmacy Benefit Manager License – 1995

The Illinois Pharmacist Association believes that the manipulation of electronically transferred prescription drug orders by pharmacy benefit managers (PBMs) and other third party entities constitutes the practice of pharmacy and requires the entity to hold a valid pharmacy license in the State of Illinois.

38. Taxation of Prescriptions – 1998

The Illinois Pharmacist Association works to affect the repeal of any tax upon the ingredients of a prescription or upon the prescription itself and actively opposes the imposition of any new taxes upon prescriptions once the repeal of current taxation has been achieved.

39. Mandatory Reporting of Dispensing Errors for the Illinois State Board of Pharmacy – 1999

IPhA is opposed to legislation and/or Rules that pharmacists and or pharmacies be mandated to report or document dispensing errors for review by the Board of Pharmacy and/or the State Pharmacy inspectors.

40. Pharmacist Conscience Clause – 1999, 2006

IPhA affirms pharmacists' status as health care professionals. Pharmacists, pharmacies, and pharmacy owners are involved in the direct provision of health care and are therefore protected by the Illinois Health Care Right of Conscience Act, 745 ILCS. IPhA supports pharmacists, pharmacies, and pharmacy owners' rights of conscientious refusal. Refusal based on conscience should be conducted in a confidential, professional, and compassionate manner. IPhA asserts that pharmacists, pharmacies, and pharmacy owners are not legally required to provide pharmaceutical services when those services are personally found to be conscientiously objectionable. This policy shall not be construed to imply that pharmacists, pharmacies, and pharmacy owners possess a right to obstruct or impede a patient's fulfillment of legally prescribed therapy.

41. Patient to Pharmacist Ratio – 2000

IPhA supports the use of the term "patient-pharmacist ratio" to replace the reference to workload.

42. Direct to Consumer Advertising – 2001

IPhA shall be opposed to direct to consumer (DTC) advertising by pharmaceutical manufacturers.

43. Pharmacists as Health Care Providers – 2001 – POICY UNDER REVIEW

IPhA shall initiate and pursue legislation to designate pharmacists as Health Care Professional.

IPhA shall support any U.S. Congress bills that recognize pharmacists as providers and allow payment for pharmacists' services.

44. Pharmacy Benefit Managers (PBMs) – 2003

IPhA shall initiate and pursue legislation to define and regulate Pharmacy Benefit Managers (PBMs).

45. Board of Pharmacy Autonomy – 2003, reaffirmed 2014 – POLICY UNDER REVIEW

IPhA supports autonomy of the Board of Pharmacy from the Department of Professional Regulation.

46. Healthcare Professional and Provider – 2003 – POLICY UNDER REVIEW

IPhA in coordination with the American Pharmacists Association and the National Community Pharmacists Association shall pursue the establishment of a National Task Force for Research and Development for States and Federal Legislation defining pharmacists as healthcare professionals and healthcare providers.

47. Board of Pharmacy – 2003 – POLICY UNDER REVIEW

IPhA shall investigate and pursue as reasonably practicable the establishment of an autonomous Board of Pharmacy supported by peer review licensing, investigation, enforcement and discipline.

48. Generic Substitution Formulary in Illinois – 2004 – POLICY UNDER REVIEW

The Illinois Pharmacists Association supports the use of the FDA Orange Book as the sole reference for generic equivalence and drug product selection.

49. Return and Reuse of Medications – 2005 - POLICY UNDER REVIEW

IPhA shall investigate and initiate as appropriate regulatory changes to allow Division I and Division II pharmacies to accept for return and reuse medications dispensed to and stored at longterm care facilities that meet applicable standards of storage and control.

50. Illinois State Board of Pharmacy Budget – 2005

That the IPhA take an advocacy position on behalf of the Illinois Board of Pharmacy to obtain the authority to prepare, submit and administer a separate and distinct budget contained in the annual Budget of the State of Illinois.

51. Mid Level Practitioner Designation – 2010 – POLICY UNDER REVIEW

That IPhA seek the ability for properly trained and credentialed pharmacists to be designated as Mid Level Practitioners in Illinois.

52. Transfer Coupons – 2010

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

53. Recognition of a Pharmacist as a "Healthcare Provider" – 2013 – POLICY UNDER REVIEW

That the IPhA shall establish as an advocacy priority for the recognition and utilization of pharmacists as "Healthcare Providers" to aid in closing the gaps in health care.

That the IPhA supports changes to the Social Security Act and any relevant Illinois statutes to allow pharmacists to be recognized and paid as "healthcare providers" of patient care services, including but not limited to medication therapy management.

That the IPhA supports efforts from national and state pharmacy associations and stakeholders toward the recognition of pharmacists as healthcare providers.

B. Pharmacy Practice

1. Code of Ethics – 1982

In 1965, the House of Delegates adopted the Code of Ethics utilized by APhA. When APhA has, over the years, revised its Code, the Board of Directors, in keeping with the 1965 action, has revised IPhA's Code to keep it in conformance.

In 1982, the House of Delegates adopted the revised 1981 APhA Code of Ethics. The revised Code eliminates all gender references.

In 1995, the House of Delegates adopted the revised 1994 APhA Code of Ethics.
(See Attachment 3.)

2. Dosage Forms – 1979

The House adopted policy supporting the authorization of pharmacists to change dosage forms in accordance with sound therapeutic considerations.

3. Emergency Medication Refills – 1979

The House adopted policy supporting the authorization of pharmacists to provide emergency medication refills in accordance with sound therapeutic considerations when the prescriber cannot be reached.

4. Supportive Personnel – 1979 – POLICY UNDER REVIEW

a. The House of Delegates, on October 21, 1979, adopted as policy the following:

Section (a) A registered pharmacist, actively engaged in the practice of pharmacy, may utilize under his/her direct supervision, pharmacy aides who are at least 18 years of age, of good moral character and temperate habits with no history of drug abuse or conviction of a felony related to drugs to perform clerical or manipulative non-judgmental tasks in accordance with Section (b).

Section (b) Duties of Pharmacy Aides. A pharmacy aide may assist registered pharmacists by accepting a new written prescription order; receiving request for refilling prescription medication by prescription number; locating prescriptions orders in files for refilling; bringing empty prescription medication containers to the dispensing counter; recording information in the refill record, patient profile or family prescription order record; typing and affixing an identification label for institutionalized patient medication where such medication is administered by a health care practitioner, licensed to administer medication; typing and affixing a label for prescription medication, other than for an institutionalized patient, provided that a pharmacist shall initial the label in handwriting before the

prescription medication is dispensed; repackage and prepackage drugs (however, the pharmacist shall select the drug to be repackaged or prepackaged, decide the wording and the requirements on the label, and check the completed repackaging or prepackaging procedure and product. A repackaged or prepackaged drug is one packaged, ordinarily in frequently prescribed quantities, properly labeled for storage for subsequent dispensing by a pharmacist, or pharmacist intern under the direction of a pharmacist, who at that time sees that it is properly labeled for the patient); and filing prescription orders.

Section (c) Direct supervision as used in Section(a) means that the pharmacy aide shall be supervised by a registered pharmacist who is physically present with the pharmacy and who has the ability to control, and is responsible for the actions of the supportive personnel.

Section (d) Housekeeping and clerical duties such as bookkeeping, pricing and inventory control are not functions that require the direct supervision by a registered pharmacist.

b. Given the crucial role that support personnel will play in the implementation of pharmaceutical care, IPhA should develop and/or coordinate and distribute to members information regarding the availability of education and/or training standards for various types of support personnel. Care should be taken to allow adequate time for the development of training programs to ensure qualified people are available to fill these roles.-1995

5. National Drug Code (NDC) – 1975 – POLICY UNDER REVIEW

The House adopted a policy supporting the revisions of the existing NDC system to provide a uniform identification number for the drug entity, dosage form, strength and quantity, in addition to a manufacturer's identification number adopted from the APhA.

6. Development Principles for Standards of Practice – 1978

a. Each standard shall be reasonable and not impose a hardship on the average pharmacy practitioner.

b. Each standard shall allow the pharmacist the broadest exercise of individual professional prerogative that is consistent with the standard's objective and purpose.

7. Standards of Practice – 1982

The House adopted the following standards of practice:

The scope of pharmaceutical services offered shall be consistent with the health needs of the patients served and the promotion of rational drug use.

Pharmacists shall maintain a patient medication record system which provides a mechanism to monitor the therapeutic regimen as individual patient needs dictate.

Pharmacists shall evaluate the drug therapy of their patients and, when appropriate, make recommendations regarding a patient's drug therapy to other health practitioners involved in the care of the patient or to the patient directly.

Pharmacists shall consult with their patient or patient's representatives regarding their health care needs.

Pharmacists shall ensure the confidentiality of their patient's drug therapy and other information given in confidence.

Pharmacists shall maintain and expand their professional competence in order to meet the health care needs of their patients.

Pharmacists shall contribute to the advancement of the profession of pharmacy.

8. Standards for Enteral/Parenteral Product Compounding – 1988 – POLICY UNDER REVIEW

These standards of practice shall guide the pharmacist engaged in the preparation of enteral therapy, nasogastric feedings, the sterile preparation of parental therapy, parental nutrition, and/or cytotoxic or antineoplastic agents.

a. Pharmacy Environment: The compounding and dispensing of enteral/parenteral products shall be accomplished in a licensed pharmacy meeting all requirements of the Pharmacy Practice Act. The environment for this specialized practice shall be set apart, designed, and equipped to facilitate controlled aseptic conditions. The following specific standards shall apply:

    i. When utilizing laminar airflow equipment for the preparation of sterile products, the pharmacy shall have a designated area which is designated to avoid outside traffic and airflow, have cleanable work surfaces, floors and walls, be ventilated in a manner not interfering with laminar airflow hood conditions, and not be used for the bulk storage of supplies and materials.

    ii. The pharmacy shall compound and dispense all cytotoxic agents in an area utilizing a vertical laminar airflow hood type "A" or "B". Appropriate waste containers shall be available for the disposal of all cytotoxic wastes including disposable apparel. All cytotoxic agents dispensed shall carry bold caution labels indicating the hazardous nature of the product or, through documented employee/patient training, the hazardous nature of the cytotoxic materials shall be conveyed to employees and patients.

    iii. The following items of equipment and supplies shall be available: 1)Appropriate environmental control devices capable of maintaining at least Class 100 conditions in the workplace where sterile objects are exposed and sterile activities performed. All such equipment must be certified annually by a qualified contractor. In the event that the laminar equipment is moved from its site of certification, re-certification must occur.

Laminar airflow equipment must be certified according to Federal Standard 2098 (for horizontal laminar airflow equipment) or National Sanitation Foundation Standard 49 (for vertical laminar airflow equipment); and 2) Supplies shall include disposable needles, syringes and other items needed for aseptic admixture; disposable masks, caps, gowns, and sterile disposable gloves; appropriate filters and filtration equipment; suitable disinfectant cleaning solutions; and bactericidal hand washing agents.

iv. The following resource material and texts in their current version shall be maintained in the pharmacy: 1) OSHA Work Practice Guidelines for Persons Dealing with Cytotoxic/Hazardous Drugs; 2) At least one of the following compounding references: USP/NF, US Dispensatory, Remington's Pharmaceutical Sciences; 3) At least one of the following compatibility references: Handbook on Injectable Drugs (Trissel), Guide to Parenteral Admixtures (King), or other appropriate drug/drug compatibility reference; and 4) a file on stability data given to finished products, such data obtained either from published material or by accepted scientific method.

b. Dispensing and Distribution: An enteral/parenteral compounding pharmacy shall dispense its products with the following conditions in force:

i. Special handling and packaging of compounded enteral and parenteral preparations when delivering them from the pharmacy to the patient as required by the stability of preparations.

ii. The facility shall have 24 hour accessibility to its pharmacist(s) for its patients.

iii. At the time of delivery of the product, the dispensing container shall bear a non-removable label which must include: 1) Patient's name and room number (when applicable); 2) Prescriber's name (if not for on-site use); 3)Pharmacy name, address, phone number (if not for on-site use); 4) Identification number (if not for on-site use); 5) Name of base solution and amount used; 6) Name of additives including concentrations and dosage; 7) Expiration date and time (if applicable); 8) Directions for use and rate of administration (when applicable); 9) Initials of pharmacist and technician dispensing (if applicable dispensing); 10) Proper storage conditions; and 11) Required controlled substances transfer warning (when applicable).

iv. The pharmacy in coordination with other health care professionals, is responsible for providing written and verbal instructions, when necessary, for the proper preparation, distribution, storage, and use of all drugs or devices dispensed to the patient's home, with documentation.

v. A patient profile shall be maintained for each patient. The profile shall contain, but not be limited to the following information: 1) Patient's name, age, sex, weight, address, and home phone number; 2) Primary diagnosis related to the need for prescribed therapy, plus secondary diagnosis if necessary; 3) Product dispensed, drug content and quantity, date dispensed, directions for use, identifying number, initials of pharmacist dispensing;

4) Known drug sensitivities and allergies to drug and foods; and, 5) Other drugs patient is receiving.

vi. A Policy and Procedure Manual shall be prepared and maintained at each enteral/parenteral compounding pharmacy. The manual shall set forth in detail the objectives and operational guidelines of the pharmacy. It shall include policies and procedures which shall be consistent with recommended standards, and inclusive of all activities and functions of the pharmacy. The manual shall be maintained in a current status, with annual review of policies and procedures.

c. Cytotoxic Product Preparation: When cytotoxic agents are prepared, the pharmacy shall provide protection from contamination for all its personnel involved in the handling of cytotoxic agents by utilizing proper equipment and protective wear.

i. Protective disposable apparel shall be provided and used when applicable.

ii. Proper aseptic procedures shall be used at all times to prevent bacterial contamination of the product as well as chemical contamination of the operator.

iii. All unused drug and material used in the preparation of the agents must be disposed of properly in accordance with accepted professional standards and applicable laws.

iv. "Spill Kits" shall be available in the work area, and a reference book of Material Safety Data Sheets on all cytotoxic agents used, shall be available to personnel at all times.

d. Quality Assurance: The enteral/parenteral compounding pharmacy shall have in place an ongoing quality assurance program to assure the quality of the products it produces, consistent with recognized standards in the marketplace. The program shall include, but not be limited to:

i. Documentation of training procedures of all staff, with periodic reassessment of competence.

ii. Logs assuring the proper maintenance of a clean working environment.

iii. Logs documenting the proper storage of produces and temperature verifications of storage facilities.

iv. Records assuring the proper maintenance of all mechanical equipment utilized. The record shall include all calibrations when appropriate, and any preventive maintenance performed.

v. Product logs allowing all products compounded and their components to be traced. Lot numbers are to be included when the compounded product is given more than a 24 hour stability.

vi. Documentation of patient training and competency in managing the therapy provided to the patient, with ongoing reassessments. A pharmacist shall be directly responsible for any training involving drug use control.

vii. Records of all laminar airflow device certifications and preventive maintenance.

viii. Documentation of an established methodology to assure the sterility of those products produced requiring sterility. This methodology shall be in the form of either direct sterility sampling and/or process validation.

9. Professional Standards Review Organization (PSRO) – 1975

The House adopted the following positions which are based upon APhA adopted policies:

IPhA supports amendment of the Social Security Act to make pharmacists eligible for membership in PSROs.

The Association advocates active involvement of registered 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 healthcare is dependent upon informed participation.

Registered pharmacists should work through their state and/or local pharmaceutical associations to participate in the activities of PSROs.

The Association should develop programs to assist state and local pharmaceutical associations in their participation with PSROs.

10. Third Party Participation – 1978

Pharmacists may choose not to participate in third party plans that do not reimburse for services on a timely and/or adequate basis.

11. Prescription Drug Benefit for Senior Citizens and the Disabled – 1984, 1985 *(1985 Archived)* – POLICY UNDER REVIEW

The Association supports a reasonable prescription drug benefit for those over 65 years of age or disabled, so long as such a benefit is fiscally prudent for the State and fairly compensates provider pharmacies.

12. Medicaid Reimbursement Methodology – 1985

The House directed IPhA to advocate changes in the Medicaid reimbursement methodology which clearly recognize that the professional dispensing fee should be adequate to cover all the costs of dispensing prescriptions, including a fair and reasonable profit and that drug product allowances be set at a level which, as accurately as possible, reflects acquisition costs readily available to pharmacists.

13. Sale of Tobacco Products – 1987, 2000

It shall be the policy of this House that there be no promotion of the sale of tobacco products in pharmacies. – 1987 - It shall be the policy of this House that there be no sale of tobacco products in pharmacies - 2000

14. Marketing of Pharmaceutical Services – 1987

The House of Delegates requested the Board of Directors to develop a mechanism to assist pharmacists in the marketing of pharmaceutical services and in promoting a positive image of pharmacists to consumers and other health care providers.

15. Position Statement on Therapeutic Interchange – 1988

The Illinois Pharmacists Association supports the concept of therapeutic interchange as defined below. IPhA believes that 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 to be fully consistent with currently accepted standards of pharmacy practice. IPhA is opposed to any legislation which seeks to interfere with this pharmacist-patient relationship.

Definition of Therapeutic Interchange
Therapeutic alternatives are drug products containing different therapeutic moieties but which are of the same pharmacological and/or therapeutic class that can be expected to have similar therapeutic effects when administered to patients in therapeutically equivalent doses. Therapeutic interchange is the process of dispensing a therapeutic alternate for the product prescribed using predefined protocols developed jointly by pharmacy and medical professionals. Therapeutic interchange occurs when willing pharmacists provide information and advice to willing prescribers, resulting in drug therapy decisions more appropriate to patient needs than decisions either could have made alone.

16. Policy Statement on Drug Use Control – 1988 – POLICY UNDER REVIEW

The Illinois Pharmacists Association supports the pharmacist's active participation in the drug use control process as defined below. IPhA endeavors to effect an evolution in the interrelated roles of pharmacists, physicians, and other members of the health care team, in a manner which effectively utilizes the pharmacists' clinical expertise in the drug control process. IPhA does not support medication prescribing authority as an independent function of pharmacists.

Definition of Drug Use Control
Drug use control is the sum total of knowledge, understanding, judgment, procedures, skills, and ethics that assures optimal safety in the distribution use of medication.

17. Manufacturers Price Increases – 1988 – POLICY UNDER REVIEW

The Illinois Pharmacists Association supports a policy of accepting only twice a year pharmaceutical manufacturer price increases for pharmaceuticals, so that they will coincide in ample time for inclusion for the Federal Catastrophic Health Care Act of 1988.

18. Policy Statement on Use and Disposal of Chemotherapeutic agents, Sharps, and Other Medical Wastes in the Ambulatory Environment-1989

a. The Illinois Pharmacists Association encourages pharmacists to provide patient education regarding handling chemotherapeutic agents, sharps, and other medical waste including but not limited to, breakage, accidental spills, and destruction of used and unused products.

b. IPhA must develop educational programs for pharmacists and pharmacy students which emphasize patient counseling information for patients receiving chemotherapeutic agents on an outpatient basis.

c. IPhA should work with other health care professional organizations and manufacturers to delineate proper disposal guidelines in the outpatient setting. These guidelines should be published and made available to all health care professionals and their patients.

19. Facsimile Technology – 1991

a. The Illinois Pharmacists Association supports the use of facsimile technology in pharmacy practice.

b. The Illinois Pharmacists Association believes that the integrity of faxed prescriptions must be ultimately left to the judgment of the filling pharmacist.

20. Position Statement on Patient Counseling – 1996

a. The Illinois Pharmacists Association believes that "patient counseling" means the communication (orally when practicable for the patient or the patient's caregiver) by a pharmacist of information to the patient or caregiver to improve therapeutic outcomes by optimizing proper use of prescription medication or devices;

b. IPhA supports the use of alternate forms of communications, other than oral, to supplement patient counseling, when appropriate;

c. IPhA believes that a pharmacist should not be required to provide patient counseling when a patient or caregiver refuses patient counseling;

d. IPhA supports the requirement of patient counseling for outpatients of hospitals and institutions, when medications are dispensed on discharge from the hospital or institution; and,

e. IPhA supports patient counseling to the patient or caregiver of the patient as determined by the pharmacist's professional judgment in the following areas and any other areas the pharmacist may determine is appropriate:

   i. name and description of the medication(s);
   ii. dosage form and dosage;
   iii. route of administration
   iv. duration of therapy;
   v. techniques for self-monitoring;
   vi. proper storage;
   vii. refill information
   viii. actions to be taken in cases of missed doses;
   ix. special directions and precautions for preparation, administration, and use;
   x. and, common severe side or adverse effects, or interactions and therapeutic contraindications that may be encountered including their avoidance, and the action required if they occur.

21. Pharmacists as Case Managers – 1992 – POLICY UNDER REVIEW

The House adopted the following policy: The Illinois Pharmacists Association works with the Illinois Department of Public Aid to:

a. recognize the need for pharmacists to act as 'case management experts' in certain areas of medication delivery; and,

b. devise a system of reimbursement for such services.

22. Compounding Practices – 1993

The House endorsed the NABP's "Good Compounding Practices Applicable to State Licensed Pharmacists" as standards of practice for those pharmacies which compound; and referred the NABP "Good Compounding Practices Applicable to State Licensed Pharmacies" to an appropriate committee for review and possible inclusion into the Pharmacy Practice Act.

Compounding Practices – 1995

a. The Illinois Pharmacists Association believes that compounding medication is an integral part of the practice of pharmacy and compounding is the right of every pharmacist.

b. The Illinois Pharmacists Association supports the Illinois State Board of Pharmacy in its sole responsibility for enforcing laws related to the practice of medication compounding in pharmacies in the State of Illinois.

c. The Illinois Pharmacists Association supports any legislation regarding compounding that clarifies language to prevent misinterpretation and unlawful intervention of the Food and Drug Administration.

23. Pharmaceutical Care-1993, 1998, 1999

a. The Illinois Pharmacists Association endorses the concept of pharmacists providing pharmaceutical care, as defined in the Pharmacy Practice Act of 1987 (as amended), and being compensated for their cognitive services. 1993

b. The Illinois Pharmacists Association recognizes the right of its members covered by collective bargaining to negotiate with their respective employers for working conditions that would foster compliance with the standards of the Pharmaceutical Care as established by the profession. 1998

c. The Illinois Pharmacists Association recognizes that maximizing patient outcomes is the paramount mission of Pharmaceutical Care. To endeavor such mission achievements, IPhA endorses utilization of technical support, including technicians and automated systems, providing that such support by coordinated, monitored and authorized by a pharmacist throughout all phases of an integrated Pharmaceutical Care System. 1998

d. IPhA supports the practice of pharmacy only in settings where workloads minimize medication errors and maximize pharmaceutical care to protect the public health and safety. 1999

24. Pharmaceutical Industry Relationships – 1994, 2015

IPhA will adhere to the current version of the Accreditation Council for Pharmacy Education – Accreditation Standards for Continuing Pharmacy Education in relation to all sponsored and co-sponsored continuing pharmacy education and continuing pharmacy development programming and activities.

25. Prescriptions Compounding – 1994

The House accepted that the Association adopts the following policies:

IPhA believes that compounding medications is an integral part of the practice of pharmacy and compounding is the right of the pharmacist.

IPhA supports the Illinois State Board of Pharmacy in its sole responsibility for enforcing laws related to the practice of medication compounding in pharmacies in the State of Illinois.

IPhA believes that the compounding of medications has been of considerable benefit to patients, physicians and the healthcare system of the State of Illinois and has allowed a physician to prescribe the medication that he or she believes is appropriate in the best interest of the patient.

IPhA supports public policy that allows pharmacists to compound medications pursuant to or in anticipation of a prescription and believes that compounding of medications in anticipation of a prescription based on past physician prescribing habits is the pharmacist's prerogative as long as the physician-patient-pharmacist relationship exist.

26. Healthcare Reform Task Force – 1994

The House accepted this motion on healthcare reform:

Principle 1. Access to pharmaceuticals and pharmaceutical care as a core benefit. All citizens must have access to pharmaceuticals and pharmaceutical care as a core benefit under a reformed healthcare system.

Principle 2. Pharmacists create significant savings when empowered to act on behalf of patients in a reformed healthcare system, pharmacists will generate significant savings.

Principle 3. Quality assurance programs administered by pharmacists can significantly improve the effectiveness of medications in achieving positive patient outcomes.

Principle 4. Purchasing Pharmaceutical Products on Equal Terms. - All pharmacy providers must have access to purchase pharmaceutical products from manufacturers or distributors on equal terms.

Principle 5. Integrated Information Systems. - Integrated information systems that include pharmacists offer the potential for cost savings and better patient outcomes.

27. Establish IPhA Policy for Adoption of the Metric Measurement System as the Standard for Pharmacy and Other Healthcare Entities – 1994

The Illinois Pharmacists Association supports the adoption of the Metric Measurement System as the standard for all healthcare entities and pharmaceutical products in the United States, and urges the USP, FDA, manufacturers, and other healthcare entities to adopt this standard.

28. Standardization of Third Party Card Format – 1994, 1997

a. The IPhA should participate in a nationwide campaign to establish regulations to standardize the format for information supplied on the front of all third party cards. -1994

b. The IPhA actively supports the development of a standardized prescription card format or template to be utilized by all third party entities who offer prescription card programs in Illinois and the United States. - 1997

29. OBRA Moratorium on Fee Decreases – 1994 (*Archived)*

30. Merck/Medco/Coordinated Care Network – 1994 *(Archived)*

31. Pharmaceutical Incentive Programs – 1994

The Illinois Pharmacists Association opposes prescription drug manufacturers paying incentives to pharmacists, pharmacists' employees, HMO's mail order firms, physicians, or any other entity to promote the manufacturer's drugs or to switch patients from another drug to the manufacturer's drug.

32. Exclusive On-Line Networks – 1995

a. The Illinois Pharmacists Association supports the use of on-line data transmission systems to facilitate the conveyance of prescription information.

b. All such systems shall allow equal access to all users.

c. Safeguards must be incorporated into the system to only allow access to the system by authorized personnel.

33. Error Reporting – 1996, 1997

The House directed the Board of Directors to direct the Chain Pharmacy Practitioner Section to develop a policy statement regarding the issue of requiring pharmacies to include error reports in a pharmacy's daily records. – 1996

That the IPhA have available, for its members, an education program dealing with the development of a comprehensive quality control / risk management program for pharmacy practices. - 1997

34. Competency Examinations for Pharmacists – 1997

That the IPhA is at this time against any form of mandatory competency exams for pharmacists. The Association does, however, still support the use of voluntary competency examinations in specific areas of practice.

35. Technician Training – 1998 – POLICY UNDER REVIEW

The Illinois Pharmacists Association supports the following regarding pharmacy technician training:

a. Within three months of employment or changes in duties and responsibilities, a pharmacy technician shall receive training on the following topics:

   i. understanding of the duties and responsibilities of the technician and pharmacist;

   ii. knowledge of the task and technical skills;

   iii. knowledge of compounding, packaging, labeling, and storage;

   iv. knowledge of pharmaceutical and medical terminology;

   v. knowledge of record keeping requirements; and

   vi. ability to perform and apply arithmetic calculations.

b. All divisions of pharmacies will maintain an up-to-date training manual on the duties and responsibilities of pharmacy technicians.

c. All divisions of pharmacies will maintain retrievable records of training.

36. Practitioner-Pharmacist-Patient Relationship – 2000

The IPhA strongly believes when filling or refilling prescription orders, the pharmacist shall not be required to deal with parties, including, but not limited to, managed care companies and insurance providers, outside the Practitioner-Pharmacist-Patient relationship.

37. Affiliation with Local Associations – 2001

An IPhA member in good standing will be recognized as having membership into an IPhA affiliated local State Association (of the member's choice). The finance committee of the IPhA and local Association shall be directed to structure line item reimbursement of dues to the local association. This will be a pilot program.

38. Services to Local Associations – 2001

IPhA will form an alliance with local associations by offering services on a tier payment basis. The cost of services offered by IPhA will be established by the Executive Director in conjunction with the finance committee and approval by the Board of Directors.

39. Selective and Limited Medication Distribution Systems – 2002

IPhA opposes selective and limited medication distribution systems that inhibit patient care and have a significant impact on the competitive business practices of pharmacies; such as Novartis / Geneva's limited sale and distribution of generic Augmentin in July 2002.

40. Tablet Splitting – 2002

IPhA opposes the practice by third party payers that require pharmacies and patients' to split tablets (pills) to obtain the prescribed dosage to save the payer money without assessment of the patient by the pharmacist to determine if they have the ability to split the medication accurately and also to determine if by splitting the splitting the tablet the integrity is maintained. The pharmacist should be reimbursed for the assessment.

41. Unit of Use Packaging – 2002

IPhA encourages pharmaceutical manufacturers to supply medications, as appropriate, in standard unit of use packaging with bar coding that identifies product, package, lot number, and expiration date to facilitate the prescription process.

42. Safe Electronic Communication of Medication Orders – 2003

IPhA supports the guidelines of the Institute for Safe Medication Practice on Electronic Communication of Medication Orders.

43. Distractions occurring in Pharmacy Practice – 2003

IPhA supports that pharmacists use professional judgement and strive to involve themselves exclusively in those activities relevant to rational medication use and that pharmacists not be required to engage in activities that can lead to disruptions in pharmaceutical care provisions or risk commission of errors.

44. Telepharmacy and Remote Pharmacy Services – 2004 – POLICY UNDER REVIEW

IPhA opposes Telepharmacy or other remote pharmacy services except in narrowly defined and unusual, compelling circumstances.

45. Pharmacist Staffing in Hospitals – 2004

IPhA supports the principle that all hospitals shall have a pharmacist onsite 24 hours a day to provide patient care; and IPhA supports the use of technology that improves patient outcomes and patient safety.

46. Pharmacists Prescribing Class – 2005

IPhA supports the creation of a pharmacists prescribing class of medications, which allow pharmacists to prescribe certain classified medications to patients and monitor their disease and therapy outcomes.

47. Patient Safety and Prescription Error Reduction – 2005

IPhA supports ensuring the patients safety and reducing all errors throughout all components of: the pharmacy environment, pharmacist-patient services, and dispensing process.

IPhA encourages all pharmacies in the State of Illinois to continually create and review all patient safety programs to reduce all errors.

IPhA recognizes as an excellent foundation to ensuring patient safety: the works of the Institute for Safe Medication Practices, Pharmacy Associations (National, State, and Local), and the efforts of all State Boards of the Pharmacy, including North Carolina with their work on Item 935.

48. Pharmacists Professional Conduct Standards – 2005

The position of the Association is for Pharmacists to:

1. Cooperate with all responsible agencies and departments of the Federal and state government,

2. Provide leadership and guidance for the profession of Pharmacy by properly assuming its role with other health professional associations at the State and National level,

3. Assist and cooperate with all national specialty organizations to provide assistance and coordination in office of emergency management matters relative to their areas of concern,

4. Encourage and assist the local pharmacy associations in their efforts to cooperate with the state and local health profession organization in order that the pharmacist may assume their proper place in civil defense operations,

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.

49. Emergency Contraception Therapy – 2005 *(Archived)*

50. Ethics and Professional Training for Pharmacy Technicians – 2006

Ethics and professionalism should be a component of pharmacy technician training.

51. Pharmacy-Based Immunization Practice – 2009

IPhA encourages pharmacists to become immunization providers through recognized certificate programs.

IPhA encourages colleges and schools of pharmacy to provide immunization training as part of the required curriculum.

IPhA encourages pharmacists and pharmacies to collaborate with pharmacy, medical, and/or other interest organizations and/or health care providers to build and promote the public health.

IPhA supports the development of appropriate payment methods and reimbursement from third party insurance providers and other managed care organizations for vaccine product and vaccine administration.

52. MTM – Medication Therapy Management – 2009

IPhA encourages pharmacists and pharmacies to develop medication therapy management services appropriate for providing positive therapeutic outcomes and interventions.

IPhA encourages colleges and schools of pharmacy to prepare student pharmacists for development and participation in medication therapy management programs and initiatives.

IPhA encourages pharmacists and pharmacies to collaborate with pharmacy and medical providers to develop and promote proper collaborative practice agreements.

IPhA supports the development of appropriate fees for services and reimbursement from third party insurance providers and other managed care organizations for medication therapy management outcomes and interventions.

53. Integrity of the Pharmacist's Judgment – 2010

I move that the IPhA develop a policy to address mandates from outside the profession which inhibits the pharmacist from using their professional judgment in issues such as but not limited to: freedom to dispense or refuse to dispense a product, mandatory substitution, and no choice of manufacturer for multi-source products.

54. Continuous Professional Development – 2011

IPhA supports the concept of continuous professional development (CPD) as defined by ACPE - "the lifelong process of active participation in learning activities that assists individuals in developing and maintaining continuing competence, enhancing their professional practice, and supporting achievement of their career goals."

IPhA is committed to fostering continuous professional development (CPD) into all continuing pharmacy education (CPE) and association education endeavors.

IPhA supports the efforts of other recognized pharmacy organizations with the development and implementation of continuous professional development (CPD) standards.

55. Pharmacy Practice Accreditation – 2012

IPhA supports only those pharmacy accreditation processes that are voluntary, transparent, consensus-based, reasonably executable, affordable, and avoids duplication and barriers to delivery of patient care.

IPhA supports pharmacy practice accreditation processes that utilize pharmacy profession-developed accreditation standards and methods of evaluation to optimize the quality and safety of patient care and promote best practices.

IPhA opposes any mandatory pharmacy practice accreditation.

IPhA advocates that accreditation providers must make proactive efforts to harmonize accreditation standards and methods of evaluation to remain consistent, provide efficiency, establish best practices, and reduce barriers to patient care.

56. Settings of Quotas – 2012

IPhA opposes the setting of quotas, minimum numbers of prescriptions to fill per shift, number of immunizations per shift, or any other services provided by a pharmacist. A pharmacist should be able to use their professional judgment and take as much time as needed in order to perform their job in a safe and effective manner for their patients.

57. Restrictions of Pharmacy Operations by Third Party Payers – 2012

IPhA opposes any and all restrictions that are imposed upon pharmacies by a third party payer that will negatively affect patient care by setting standards or regulating policies, procedures and operations of the pharmacy including but not limited to: hours of operations, percentage of prescription dispensed and/or delivered, and the preparation of prescriptions.

58. Inclusion of Pharmacists in the Transitions of Care Model – 2013

IPhA supports the participation of the pharmacist in the Transition of Care Model. The role of the Pharmacist will include but is not limited to, providing a medication review, therapy overview, and other services for a recently hospital discharged patient to reduce the risk of readmission from a preventable complication.

IPhA supports and encourages the pharmacist be included as a "provider" in the interdisciplinary team responsible for the Transition of Care and general patient care.

Section II. **Organizational Issues**

1. Student Involvement – 1976 ***(Archived)***

2. Publication of Exam Filing Deadlines – 1986 (Archived)

3. Smoking at IPhA Functions – 1987

IPhA prohibits smoking, except in designated areas, located outside the rooms where the following IPhA meetings are being held: 1) meetings of the House of Delegates, 2) general sessions held at the IPhA Annual Meeting, 3) continuing education sessions, 4) Executive Committee meetings, 5) Board meetings, and 6) committee meetings.

4. Use of the Word "Patient" – 1991

From this moment on, the IPhA and its membership no longer refer to the consumers that we serve as customers. From this point on they shall be referred to as our "patients". Further, the term "patient" shall replace "customer" in all official correspondence and publications.

5. Communication Guidelines for Representatives and Staff of IPhA – 1994

The House adopted the following guidelines regarding IPhA communications:

a. Speeches and Official Presentations:
As an official IPhA representative, you may be asked to accept a speaking engagement or make some other appearance. In the case of speaking engagements, you may be assigned a specific topic to address, or you may undoubtedly have some degree of latitudes as to the content of your presentation. The Association, as part of its overall communications strategy, would like to assure that such opportunities are used to their maximum advantage in getting IPhA's message across to our members, the rest of the profession and the public. Coordination of your presentation through IPhA can help determine how it can best be used to convey messages important to the Association at that time.

Whenever possible, speeches and other presentations made by IPhA representatives on behalf of the Association should be presented from a prepared text or outline. The Association requests that such texts or outlines be submitted to the IPhA in advance of the presentation to allow time for legal and policy review as desired. Not only does this procedure help to assure that the information presented is accurate and in keeping with official IPhA policy, but it also permits the Association's public relations staff to respond appropriately to inquiries from media that may be stimulated by your presentation. It further allows for distribution of printed copies of your text to other parties who may have an interest or would benefit from the presentation, and it permits preparation of news report of your presentation.

This procedure relates primarily to presentations dealing with IPhA policies and activities. If you are presenting a continuing education program for IPhA, or making some other kind of

nonpolitical and/or nonpolicy presentation, it does not apply. Nevertheless, it would be appreciated if you would submit a copy of your presentation to IPhA for information and reference.

If speaking or making official an appearance in some non-IPhA capacity, make clear in both pre-presentation publicity and in your introduction the exact capacity in which you are speaking or appearing and that you are not representing IPhA.

b. Dealing with the Media:
Any individual serving in an official IPhA capacity may be approached by the media. By following certain procedures, assurance that interaction with the media generates the most positive results possible for the Association, and the speaker. If unable to accurately respond to a media query, do not hesitate to say so and to refer the media source to a more knowledgeable source. If such a source does not come immediately to mind, the media source should be referred to the Association's staff, who will put the media representative in touch with appropriate Association information sources.

Do not feel obligated to answer questions about the Association which go beyond your actual area of expertise. Refer the media to the Association's staff. Even if a question does not fall into your area of activity, do not feel obligated to respond on the spot if you are not comfortable with the answer. Offer to get back to the reporter in a reasonable length of time, allowing sufficient time to research the answer. It is best not to make statements "off the record" for in spite of any assurance you may receive to the contrary, there can be no guarantee that the information you provide will not show up in print, or be characterized as IPhA position.

c. Media Relations as a Two-Way Process:
In all cases, it is important to inform IPhA staff of any contact by the media, even if no response is made. The Association maintains a complete record of all such contacts. Report the name of the media representative making the contact, the publication or organization represented, the nature of the information being sought, and the telephone number to contact the representative.

d. Dealing with Government:
It is important that the Association's communication efforts be carefully coordinated. In the case of formal interaction with government (i.e., submission of official written statements, oral presentation of comments at hearings, or official letters of comment to legislative or regulatory bodies), a clearance process assures that all such materials receive a thorough policy, professional and legal review.

In the course of your IPhA duties, you may have occasion to interact informally with government officials. Because the Association believes that government officials should be educated about the profession on every possible occasion, these kinds of interactions are encouraged. However, it is important toobserve the same kind of cautions that pertain to public addresses or dealing with the media (i.e., accurately reflect IPhA policies and note when you are speaking as an individual and not as an IPhA representative). Association staff can brief you on the issues before speaking with the legislator or government agency representative. If time

constraints preclude such discussions, and you feel unqualified to address a particular issue to provide specific information requested, refer to a knowledgeable source of information with IPhA. 5. Conflicts of Interest:

In situations where policy making of representation poses a conflict of interest (or be perceived to exist) as a result or your rendering advice or assistance in an area in which you may have personal or business interest, you should immediately bring this perceived conflict to the attention of IPhA staff so a determination can be made as to how the matter can be best resolved to the satisfaction of all parties.

All elected officials of the Association will be asked to complete a disclosure statement to help avoid an awkward position or possibly having a conflict of interest.

6. Practice Sections – 1996 *(Archived)*

7. Promotion of Future IPhA Annual Meetings – 2000

IPhA shall institute the Annual Phun run once again as part of an overall package, to make the Annual State convention the most important part of an IPhA member's year.

8. Endorsement of political candidates – 2002

IPhA shall not by action of its Board of Directors, Officers or Executive Director endorse any political candidate for elected public office.

9. Political Policy – 2002

The Board of Directors is to develop a political policy to help guide the organization through the changing political scene. The House of Delegates also asks the Board of Directors to review and define IPhA's association with the IPPAC.

10. House of Delegates Policy Review Committee – 2006

The committee moves that the House of Delegates shall establish the House of Delegates Policy Review Committee as a standing committee of the House.

11. Archived Policies: Section of IPhA Policy Manual – 2006

The committee moves that the House of Delegates establish the "Archived Policies" – (Section V) in the Policy Manual - IPhA House of Delegates. The Archive Section shall be defined as and include any policy that has been:

a. Completed and/or archived

b. Obsolete and/or no longer pertinent.

12. House of Delegates Policy Review Committee: Policy Review Procedures – 2006

The committee moves that the House of Delegates adopt the following procedures for this committee to be utilized in reviewing policy.

- Any proposed actions of the policy review committee must be submitted at the next meeting of the House of Delegates for consideration
- The committee shall be appointed by the Speaker of the House
- Any issue(s) may be referred to the committee by any IPhA member in good standing
- The committee actions shall be as follows:
    i. Recommend to move policy to Archived Policies – Section V of policy manual
    ii. Refer to specific IPhA committee(s)
    iii. Refer to an ad-hoc committee.

13. Publication of actions of the IPhA Board of Directors – 2006

The actions of the IPhA Board be summarized in the next IPhA Journal printed and published on the website.

14. Mission and Vision Statement – 2007

Be it resolved that the IPhA House of Delegates has reviewed its mission and vision statements and reaffirms the mission and vision statements as currently written.

15. Interval for Reviewing Mission and Vision Statements – 2007 – POLICY UNDER REVIEW

The House of Delegates develops a committee for the ongoing review of the vision and mission statements of the IPhA minimally every two years.

16. Student House of Delegates – 2009

That IPhA establish a Student House of Delegates.

17. Public Affairs Committee Name Change – 2009

That IPhA change the name of the Public Affairs Committee to the Legislative/Regulatory Affairs Committee and refer to the Bylaws Committee to submit to the voting membership.

18. Committee Membership – 2009

The IPhA House of Delegates requests a review of Committee membership requirements in the Bylaws and include language that all members who represent IPhA on committees must be a current member in good standing of a recognized membership category defined by the Bylaws.

19. Executive Committee Meetings – 2011 *(Archived)*

20. IPhA PSMP/IPN – 2011

IPhA is committed to the support and the continuing success of the IPhA Patient Self-Management Program/Illinois Pharmacist Network initiatives and programs.

IPhA recognizes that the Clinical Pharmacy Coordinator must demonstrate commitment, skill, and leadership that is required for the administration of the IPhA PSMP/IPN.

21. IPhA Fellow – 2013

That the IPhA establish the designation of the title of IPhA Fellow (or FIPhA).

Further that the Awards Committee be instructed to develop the awardee qualifications and benefits of the FIPhA program and that the final report be presented to the IPhA Board of Directors for consideration.

22. Policy on Alliances – 2013, 2014

That the House of Delegates of IPhA supports the Board of Directors to cultivate alliances with other entities when the action results in a stronger association that will better serve the pharmacists in Illinois.

23. Pharmacy Technician involvement and representation – 2014

IPhA shall adopt necessary policy and bylaws changes to establish representation, with vote, for pharmacy technicians on the Board of Directors and in the House of Delegates.

IPhA urges the inclusion of pharmacy technician on standing committees of the Association.

24. House of Delegates Policy and Action Tracking – 2015

The Board of Directors shall create an action plan on the resolutions passed by the House of Delegates at their most recent meeting. The BOD chairperson or chairperson's designee shall report to the members of the HOD the Board's action plans regarding these motions. The report will be included in the reports for the next House of Delegates meeting.

1. Drug Consumer Protection and Information Act-1974

The House adopts as policy the Drug Consumer Protection and Information Act as follows: Except as hereinafter provided, it shall be unlawful for any person to advertise, post, solicit or otherwise promote the sale of prescribed drugs.

a. Direct mail, handbill, newspaper, radio, television, sign or other forms of advertisement, including posted consumer information, shall not include:

   i. The name of a drug unless the non-proprietary name and potency of the active ingredient(s) along with a brief summary, as defined in the Federal Food, Drug and Cosmetic Act, of the indications, contraindications, side effects and dosage is included in type size identical to the name of the drug.

   ii. Controlled substances under Illinois and under Federal law or any other drug designated by the Board of Pharmacy, the Department of Public Health or the Therapeutics Committee of the Illinois State Medical Society as proper for advertising to the public.

   iii. Statements related to professional superiority such as "prescriptions dispensed exactly as the doctor ordered," "we stock only fresh drugs," "prescriptions accurately compounded," "quality drugs," "quality prescription service," "reliable prescription service," "dependable prescriptions," or any other such statements.

   iv. Statements related to prescription prices such as "low," "very low," or "lowest," discounts," "selective discounts," "price discriminations," without numerous, authenticated price comparisons to demonstrate the truthfulness of the statements.

   v. Statements such as "free drugs," or "free prescriptions."

b. All advertising as defined above shall include the following list of pharmaceutical services, with an indication as to which are provided, with or without cost, and which are not provided.

   i. Patient medications profiles along with a detailed survey at the time of dispensing to determine potential drug interactions.

   ii. Patient consultation.

   iii. Twenty-four hour emergency service.

   iv. Registered pharmacist on duty in prescription departments and available to fill prescriptions at all times.

   v. Dispense all prescriptions presented including those which require extemporaneous compounding.

   vi. Physician consultation.

   vii. Patient medication records for insurance, tax reports, and/or prescription renewal.

viii. Delivery service.

ix. Charge service.

2. Patient Package Inserts (PPIs) – 1979 – POLICY UNDER REVIEW

The House adopts as policy a continued opposition to the proposed mandatory PPI regulations.

3. Clean Air – 1977

In keeping with proposals in the State legislature and the City Council of Chicago, the House endorsed the "clean air" concept which prohibits smoking in public places, except in specially designated areas.

4. Pharmacy Crime – 1982, 2002

The House, in recognition of the particularly dangerous circumstances which arise from storing drugs which are often the target of armed robberies, proposed that the penalties for armed robberies involving prescription drugs be increased and made mandatory, *and to promote alternative dosage forms that have no abuse potential, but maintain drug efficacy*

5. AIDS in the Workplace – 1988

a. People with AIDS or HIV (Human Immunodeficiency Virus) infection are entitled to the same rights and opportunities as people with other serious or life threatening illnesses.

b. Employment policies must, at minimum, comply with federal, state, and local laws and regulations.

c. Employment policies should be based on the scientific and epidemiological evidence that people with AIDS or HIV infection do not pose a risk of transmission of the virus to coworkers through ordinary workplace contact.

d. The highest levels of management and union leadership should unequivocally endorse nondiscriminatory employment policies and educational programs about AIDS.

e. Employers and unions should communicate their support of these policies to workers in simple, clear and unambiguous terms.

f. Employers should provide employees with sensitive, accurate, and up-to-date education about risk reduction in their personal lives.

g. Employers have a duty to protect the confidentiality of employees' medical information.

h. To prevent work disruption and rejection by coworkers of an employee with AIDS or HIV infection, employers and unions should undertake education for all employees before such an incident occurs and as needed thereafter.

i. Employers should not require HIV screening as part of preemployment or general workplace physical examinations.

j. In those special occupational settings where there may be a potential risk of exposure to HIV (for example, in healthcare, where workers may be exposed to blood or blood products), employers should provide specific on going education and training , as well as the necessary equipment, to reinforce appropriate infection control procedures and ensure that they are implemented.

6. <u>Drug Testing in the Workplace – 1988</u>

a. A pharmacy workplace drug testing policy and procedure should be developed using he IPhA/ICHP Committee on Impaired Pharmacists Guidelines for Development of Pharmacy Employee Drug Testing Policies and Procedures.

b. A pharmacy employer's policy with respect to drug testing in the workplace should be presented in a job performance and public safety context. (i.e., Inadequate job performance affects public safety. Drug testing will help ensure that pharmaceutical services are provided in a safe manner.)

c. All pharmacy employees and job applicants must be informed of the employer's policy regarding drug testing. A written copy of the drug testing policy should be made available to all pharmacy employees.

d. Drug testing should be conducted only when the employer reasonably suspects impairment due to the employees' inability to adequately perform their assigned job duties.

7. <u>Policy Statement on Chemical Dependency – 1989</u>

a. The Illinois Pharmacists Association believes that pharmacists should not practice pharmacy while subject to physical or mental impairment due the influence of drugs - including alcohol or other causes that might adversely affect their ability to function properly in their professional capacities.

b. The Illinois Pharmacists Association recognizes that chemical dependency is a disease that affects all of society.

c. The Illinois Pharmacists Association is committed to assist the chemical dependent member of the pharmacy profession toward recovery from the disease by education, information, and peer support. Maintenance of the Illinois Pharmacists Rehabilitation Program is essential to this effort.

d. The Illinois Pharmacists Association encourages those institutions responsible for pharmacy education to allocate adequate curricular attention to substance use, misuse, and addictions.

8. Use of Tobacco-related Products – 1990 – POLICY UNDER REVIEW

a. The Illinois Pharmacists Association opposes the use of tobacco-related products because of their apparent detrimental effects on public health. Furthermore, IPhA supports involvement of pharmacists in public education programs regarding the health hazards of smoking. Particular attention should be given to educating young people on the health hazards of smoking.

b. It is the goal of the Illinois Pharmacists Association that no pharmacy in the State of Illinois offer tobacco products for sale by the year 2000.

9. Traceable Prescription Program – 1991 – POLICY UNDER REVIEW

a. The Illinois Pharmacists Association opposes a federally mandated Traceable Prescription Program.

b. The Illinois Pharmacists Association believes that each State should decide the breadth of any Traceable Prescription Program.

10. Insurance Competitive Pricing Act – 1991 – POLICY UNDER REVIEW

The Illinois Pharmacists Association supports the intentions of the 'Insurance Competitive Pricing Act' and other similar legislation that attempts to repeal the anti-trust exemption of the insurance industry due to the McCarran-Ferguson Act, and supports the legislative efforts of the national pharmacy associations in obtaining effective legislation, and lobby the Illinois congressional delegation to support our efforts.

11. Medicaid Financing – 1992 – POLICY UNDER REVIEW

LET IT BE RESOLVED that the Governor of the State of Illinois call an emergency session of the General Assembly at the earliest date, no later than November 15, 1992, to consider new methods of financing the Illinois Medicaid Program, and therefore, let it be resolved that the State of Illinois institute a dedicated ½% increase in the Illinois Income Tax Law or an appropriate reduction in benefits for a period of up to two years to resolve this deficiency in the Illinois Medicaid funding for the State of Illinois.

12. Pharmacy Patient Bill of Rights – 1993

The House adopted the Pharmacy Patient Bill of Rights. (See attachment 2).

13. State's Financial Condition – 1993

The House accepted the following statement about the State's financial condition:

The IPhA should urge the State of Illinois to cut current programs, hold taxes, and freeze implementation of any new programs until the State of Illinois has restored its financial stability and responsibility.

14. Hypodermic Needle/Syringe Exchange Programs – 1994, 1997 – POLICY UNDER REVIEW

The House accepted that the Association adopt the following policies:

a. The definition of a Needle Exchange Program (NEP)/(added 1997):

   i. that the program (NEP) contain provisions for the return and destruction of used needles;

   ii. that participation in the NEP must be voluntary;

   iii. that participants must be issued some form of identification to avoid law enforcement issues, in terms of needle exchange.

b. IPhA supports the concept of Hypodermic needle/syringe exchange programs.

c. IPhA should develop a list of requirements needed to be met by pharmacists/pharmacies wishing to participate in needle/syringe exchange programs.

d. IPhA should issue a statement encouraging manufacturers of hypodermic needles/syringes to follow the lead of Cerenex, and provide programs to ensure the proper disposal of their products.

15. DEA Registration of Mid-level Practitioners – 1994

The House accepted adoption for the Association regarding the following policies:

a. IPhA should seek the development of managed care supplied computer programs which will verify medications authorized to be prescribed by their mid-level practitioners.

b. IPhA should seek the inclusion of pharmacists in the DEA definition of mid-level practitioners.

16. Pharmacy Benefit Company Ownership – 1994

The House accepted that the Association adopt the following policy:

IPhA should continue to monitor the ownership of Pharmacy Benefit Management Companies (PBM's) and advocate the development and implementation of pharmacy reimbursable patient care programs.

17. Confidentiality of Computer Generated Patient Records – 1994

The House accepted adoption of the following policy for the Association:
IPhA encourages the development of uniform prescription computer software standards on a national level to prevent the unauthorized access of confidential patient records.

18. Over the Counter Drug Use – 1994

The House adopted for the Association the following policies:

a. IPhA encourages its membership and all pharmacists to include OTC drug use on all patient profiles.

b. IPhA should work with the Illinois Pharmacy Foundation to develop a consumer education campaign on the proper use and hazards of OTC drug use.

19. Poison Control Centers – 1994

a. The IPhA believes that educating the public regarding poison prevention and treatment is a valuable public health service.

b. The IPhA recognizes the invaluable public service provided by "Poison Control Centers" regarding poison prevention and treatment.

c. IPhA encourages the federal government, State of Illinois, and the medical benefit companies servicing Illinois to adequately fund continued operation of poison control centers to appropriately serve the needs of the public.

20. Patient-Pharmacist Privilege – 1995

a. The Illinois Pharmacists Association believes that current statutes, both federal and state, should be reviewed for the existence of a pharmacist-patient privilege.

b. The Illinois Pharmacists Association believes that if a pharmacist-patient privilege does not currently exist in law, the Association should support legislation, on a state level, establishing such a relationship.

21. Limits on Sale of Non-Controlled Legend Drugs – 1996 – POLICY UNDER REVIEW

The House supports amending the Illinois Wholesale Drug Distribution Licensing Act to define to whom a drug distributor may sell non-controlled legend drug.

22. Use of DEET in Children – 1996

The House adopted the following policy statement: "The Illinois Pharmacists Association believes that products containing DEET should not be used on children less than two years old because of the possibility of central nervous system toxicity."

23. Prescription Monitoring Program – 2004

IPhA supports the establishment of a prescription monitoring program for controlled substance schedules two through five. Additionally, the prescription monitoring program would allow health care practitioners, including pharmacists, access to the information when appropriated for evaluating patient care and proper medication management.

24. Emergency Contraception—Pharmacist Participation – 2004

IPhA supports initiatives and legislation to allow pharmacists to provide emergency contraception services.

25. Importation of Medications – 2003

IPhA opposes any business or volunteer activity that promotes or advocates the provision of foreign sourced medications that have not been tested and approved by the FDA for Illinois residents.

26. Limiting Sale of Methamphetamine Precursors – 2005

IPhA supports the protection of the citizens of Illinois from the illicit production, creation, and expansion of illegal methamphetamines (i.e. crystal meth) in the State of Illinois, through the conversion of methamphetamine precursors.

IPhA also supports reclassification of pseudoephedrine containing products in tablet and caplet form as a Class V controlled substance.

27. Unwanted Medication Disposal – 2008

A motion is hereby made to the House of Delegates of the Illinois Pharmacists Association that the said association supports initiatives to create and administer a funded program whereby designated pharmacies in Illinois enrolled in the program would serve as vehicles for disposal of unused, unwanted and discarded medication for Illinois.

(Note: Reference policy is listed as follows)
I-B-18: Policy Statement on Use and Disposal of Chemotherapeutic agents, Sharps, and Other Medical Wastes in the Ambulatory Environment-1989

28. Medical Marijuana – 2011

IPhA 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.

IPhA urges the DEA to change marijuana's status as a federal Schedule I controlled substance to Schedule II; with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods.

IPhA supports that when such evidence exists, pharmacists be the only mechanism in which this medication can be distributed to patients in the same legislative manner that they currently distribute controlled medications.

IPhA supports pharmacists' involvement in dispensing standardized medical marijuana if provided within the context of appropriately structured clinical trials or protocols and that medical marijuana should be regulated by good manufacturing practices to ensure quality, safety and standardizations of the drug.

This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.

29. Pharmacists Involvement in Declared Emergencies – 2012

IPhA supports the involvement and participation of pharmacists in providing patient care in declared emergencies.

IPhA supports working with all stakeholders to provide information, establish practice guidelines, and advocate for legislative/regulatory changes to allow for efficient distribution, dispensing, and administration of medications and providing patient care in declared emergencies.

30. Student Pharmacist Inclusion in Prescription Drug Monitoring Programs – 2013

IPhA encourages the Illinois Prescription Monitoring Program to allow access to pharmacy students, under the direct supervision of a pharmacist, so as to further the ultimate goal of appropriate utilization of medications and to raise awareness among other healthcare professionals that such programs exist.

Section IV. **Educational Issues**

1. Continuing Education (CE)-1984

The House adopted a policy supporting mandatory continuing education for pharmacist relicensure.

The House recommended that the Association seek legislation to enact this policy by requiring 3.0 CE Units of ACPE-approved continuing education credit biennially for pharmacist relicensure. (Successful legislation was enacted effective 7/1/86).

Note (2014): Continuing Education (CE) is now called Continuing Pharmacy Education (CPE)

2. Pharmacy Education-1977 (Reaffirmed 1991)

The House adopted a policy supporting the Doctor of Pharmacy Degree (Pharm.D.) and a mechanism for pharmacists with a Bachelor of Science Degree to obtain a Pharm.D. Degree without full-time enrollment.

3. Graduates of Foreign Colleges of Pharmacy-1980

The House of Delegates endorsed development of a uniform system of evaluation which would permit objective determination of the educational qualifications of graduates of foreign colleges of pharmacy who wish to gain entry to the Illinois pharmacy licensure exam. The system should be developed along the following lines:

a. Language proficiency shall be demonstrated by successful completion of an examination with both written and oral components and which is designated to evaluate the level of communication skills required in professional practice.

b. Evaluation of an applicant's educational background include determination of equivalency in the general curricular areas described in the ACPE accreditation standards:

   i. Equivalency in the preclinical sciences shall be demonstrated by successful completion of a diagnostic test in the physical and biological sciences.

   ii. Equivalency in professional studies and training shall be demonstrated by successful completion of structured experiential program which meets predetermined educational goals and objectives.

c. This system will proceed in a step-wise fashion so that a candidate has demonstrated language and preclinical proficiency prior to undertaking the experiential program. An applicant who fails to pass the preclinical sciences diagnostic test will be required to complete an appropriate course of study prior to re-examination and prior to proceeding to the experiential program.

Section V. **Archived Policies**

1. I-A-2: Repeal of Anti-Substitution-1971

Following action taken by APhA in 1970, the House adopted a policy directing the Association to enlist the support of the Illinois State Medical Society in an effort to amend or to repeal the Illinois anti-substitution statute in order to provide an opportunity for pharmacists to exercise professional judgment in brand selection.

2. I-A-11: Triplicate Prescription Form-1982

The House of Delegates adopted as policy a motion supporting the Triplicate Prescription Form requirement for all Schedule II Controlled Substances. Further, the Association supports the efforts of the Illinois Dangerous Drugs Commission (now the Department of Alcoholism and Substance Abuse) to develop a meaningful system for collecting and disseminating, in a timely manner, relevant data produced by the triplicate drug program.

3. I-A-13: Pharmacist's License – 1982

The House supports the increase of license fees from $5.00 per year to as much as $25.00 per year with funds being deposited in a designated Pharmacy Fund and being expended only for Pharmacy functions.

4. I-A-15: Student Pharmacist Designation-1984

The House directed IPhA to seek an amendment to the Pharmacy Practice Act which creates a new licensing or registration category for pharmacy students enrolled in a recognized college of pharmacy. The amendment would allow such individuals to be officially recognized as Student Pharmacists. (Accomplished via HB 986, Effective 1/1/86)

5. I-A-16: Pharmacy Technician Designation-1984

The House directed IPhA to seek amendment to the Pharmacy Practice Act which removes remaining references to "apprentice pharmacist." Further, that the Act also be amended to specifically allow pharmacists to utilize the services of individuals to assist them in the practice of pharmacy and that such individuals be required to register with the Department of Professional Regulation as "Pharmacy Technicians." The amendatory language should make clear the Department's authority to remove (permanently or temporarily) Pharmacy Technician status from an individual found to have abused the privilege of authorized access to pharmaceuticals.
(Accomplished via HB 986, Effective 1/1/86).

6. I-A-19: Removal of USP/NF in Favor of "Menu" of Approved References-1985

The House directed IPhA to seek amendment of Chapter III, Section 4027 (Illinois Pharmacy Practice Act), removing the USP/NF requirement in favor of a requirement that appropriate reference texts be selected by the pharmacist from a "menu" of approved compendia and references. (Accomplished via HB 347, effective 1/1/87)

7. I-A-25: Illinois Prescription Form – 1988 ***(Archived)***

BE IT RESOLVED that IPhA initiate efforts to amend the Pharmacy Practice Act to change the signature format to a "one-line - no box" format whereby the prescriber personally writes a phase, each time he/she writes a prescription, such as "brand medically necessary" in order to require dispensing of a prescribed brand name product.

8. I-A-26: Illinois Formulary Content-1988

BE IT RESOLVED that IPhA support efforts to expand the Illinois Formulary for the Drug Product Selection Program beyond the current set of criteria for product inclusion.

9. I-A-27: Transfer of Controlled Substances Prescription-1990

The House directed IPhA to work with the Board of Pharmacy of the State of Illinois to amend the Rules for the Administration of the Pharmacy Practice Act of 1987 to allow the transfer of controlled substance prescriptions.

10. I-A-30: Dispense as Written – 1994

The House adopted for the IPhA the following policy statement regarding dispense as written: IPhA supports legislation that amends the Illinois Department of Public Health Drug Product Selection Program that would require the words "Dispense As Written", "DAW", or a statement substantially to this effect to be written on the face of each prescription in the prescriber's own handwriting as the mechanism to prohibit generic substitution.

11. I-B-11: OBRA Moratorium on Fee Decreases-1994

In 1985, the House directed IPhA to seek expansion of the state of Illinois Pharmaceutical Assistance to the Aged and Disabled program under conditions as favorable or more favorable than current conditions. (Accomplished via HB 2917 and SB2042 with provisions effective 8/11/86 [relating to pharmacist's professional fee] and 1/1/87 regarding additional categories of covered drugs.)

12. I-B-29: OBRA Moratorium on Fee Decreases-1994

IPhA should seek an extension on the OBRA 90 moratorium on fee decreases.

13. I-B-30: Merck/Medco/Coordinated Care Network-1994

The Illinois Pharmacists Association hereby denounces the action of Merck/Medco in their maneuvering to undermine community pharmacy as it exists today.

14. I-B-49: Emergency Contraception Therapy – 2005

To seek legislative action that will provide licensed Pharmacists the right to dispense emergency contraceptive therapy, under collaborative practice standards, to women seeking to access such therapy.

15. II-1: Student Involvement – 1976

The House adopted policy urging inclusion of pharmacy students on standing committees of the Association.

16. II-2: Publication of Exam Filing Deadlines – 1986

The House directed that IPhA seek through the Illinois legislative process legislation that establishes guidelines for proper notification to applicants of examination date(s) and site(s) and for proper resultant notification after the exam in a timely manner. (Accomplished in part via passage of the Pharmacy Practice Act of 1987).

17. II-6: Practice Sections-1996

The House directed the Bylaws Committee to review the issue of affording practice sections a vote on IPhA's Board of Directors.

18. II-19: Executive Committee Meetings – 2011

The IPhA House of Delegates requests a review of the Executive Committee language in the Bylaws and address the following:

a. Clarify who may call for an Executive Committee meeting,
b. Notification process to all Executive Committee of a meeting,
c. Board of Directors approval of Executive Committee actions at meeting following the Executive Committee meeting.