House of Delegates

Consolidated Documents:

June 2024 ASHP House of Delegates

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House of Delegates

AGENDA

ASHP House of Delegates
Portland, Oregon

Presiding – Melanie A. Dodd
Chair, House of Delegates

FIRST MEETING

Oregon Convention Center
Sunday, June 9, 2024
1:00 – 5:00 p.m.

1. CALL TO ORDER
2. ROLL CALL OF DELEGATES
3. REPORT ON PREVIOUS SESSION
4. RATIFICATION OF PREVIOUS ACTIONS
5. REPORT OF THE COMMITTEE ON NOMINATIONS
6. REPORT OF THE COMMITTEE ON RESOLUTIONS
7. STATEMENTS OF CANDIDATES, HOUSE OF DELEGATES CHAIR
8. BOARD OF DIRECTORS REPORTS
   a. COUNCIL ON PHARMACY PRACTICE
      Jennifer Tryon, Board Liaison
   b. COUNCIL ON PUBLIC POLICY
      Vivian Bradley Johnson, Board Liaison
   c. COUNCIL ON THERAPEUTICS
      Vickie Powell, Board Liaison
   d. COUNCIL ON EDUCATION AND WORKFORCE DEVELOPMENT
      Kristi Gullickson, Board Liaison
   e. COUNCIL ON PHARMACY MANAGEMENT
      Kim Benner, Board Liaison
9. REPORT OF THE TREASURER
10. RECOMMENDATIONS OF DELEGATES
11. ANNOUNCEMENTS
12. ADJOURNMENT OF FIRST MEETING

SECOND MEETING

Oregon Convention Center
Tuesday, June 11, 2024
4:00 – 6:00 p.m.

1. CALL TO ORDER
2. QUORUM CALL
3. ELECTION OF THE CHAIR OF THE HOUSE OF DELEGATES
4. REPORT OF THE COMMITTEE ON RESOLUTIONS
5. UNFINISHED AND NEW BUSINESS
6. REPORT OF THE PRESIDENT AND THE CEO

   Nishaminy Kasbekar and Paul Abramowitz
7. RECOMMENDATIONS OF DELEGATES
8. INSTALLATION OF OFFICERS AND DIRECTORS
9. ANNOUNCEMENTS
10. ADJOURNMENT OF SECOND MEETING

ASHP HOUSE OF DELEGATES

Melanie A. Dodd, Chair
Paul C. Walker, Vice Chair

As of May 20, 2024

OFFICERS AND BOARD OF DIRECTORS
Nishaminy Kasbekar, President
Leigh A. Briscoe-Dwyer, President-Elect
Paul C. Walker, Immediate Past President
Christene M. Jolowsky, Treasurer
Paul W. Abramowitz, Chief Executive Officer
Kim W. Benner, Board Liaison, Council on Pharmacy Management
Melanie A. Dodd, Chair of the House
Kristine K. Gullickson, Board Liaison, Council on Education and Workforce Development
Vivian Bradley Johnson, Board Liaison, Council on Public Policy
Pamela K. Phelps, Board Liaison, Commission on Affiliate Relations
Vickie L. Powell, Board Liaison, Council on Therapeutics
Jennifer E. Tryon, Board Liaison, Council on Pharmacy Practice

PAST PRESIDENTS			
Roger Anderson	Rebecca Finley	Lynnae Mahaney	Thomas Thielke
John Armitstead	Lisa Gersema	Gerald Meyer	Linda Tyler
Daniel Ashby	Diane Ginsburg	John Murphy	Sara White
Paul Baumgartner	Harold Godwin	Cynthia Raehl	T. Mark Woods
Jill Martin Boone	Mick Hunt	Philip Schneider	David Zilz
Cynthia Brennan	Clifford Hynniman	Kathryn Schultz	
Bruce Canaday	Marianne Ivey	Bruce Scott	
Kevin Colgan	Thomas Johnson	Steven Sheaffer	
Debra Devereaux	Stan Kent	Janet Silvester	
Fred Eckel	Robert Lantos	Kelly Smith	

STATE	DELEGATES	ALTERNATES
Alabama (3)	Nancy Bailey Danna Nelson Megan Roberts	Nathan Pinner
Alaska (2)	Shawna King Laura Lampasone	
Arizona (3)	Melinda Burnworth Christopher Edwards Kelly Erdos	Janelle Duran Jake Schwarz Sarah Stevens
Arkansas (3)	Jama Huntley Phillip Jackson Brandy Hubbard	Josh Maloney

California (7)	Gary Besinque Katrina Derry Daniel Kudo Elaine Law Sarah McBane Caroline Sierra Steven Thompson	Kethen So
Colorado (3)	Clint Hinman Lance Ray Tara Vlasimsky	Bridger Singer
Connecticut (3)	Molly Leber Colleen Teevan	Christina Hatfield
Delaware (2)	Cheri Briggs Pooja Dogra	
Florida (6)	Jeffrey Bush Andrew Kaplan Dionis Malo Heather Petrie Farima Raof William Terneus	Margareth Larose Pierre
Georgia (3)	Davey Legendre Christy Norman Samantha Roberts	Matthew Hurd Kunal Patel
Hawaii (2)	Shelley Kikuchi Mark Mierzwa	Wesley Sumida
Idaho (2)	Paul Driver Victoria Wallace	Jessica Bowen
Illinois (5)	Andy Donnelly Bernice Mann Jennifer Phillips Radhika Polisetty Matthew Rim	Chris Crank Sharon Karina Nikola Markoski Samantha Rimas
Indiana (3)	Andrew Lodolo Christopher Scott Tate Trujillo	
Iowa (3)	John Hamiel Lisa Mascardo Jessica Nesheim	Emmeline Paintsil Jenna Rose Jennifer Williams
Kansas (3)	Christina Crowley Brian Gilbert Katie Wilson	Jeff Little Zahra Nasrazadani Megan Ohrlund
Kentucky (3)	Dale English Scott Hayes Thomas Platt	Kortney Brown Stephanie Justice Chelsea Maier
Louisiana (3)	Heather Maturin Tara Montgomery Heather Savage	Jason Lafitte

Maine (2)	Brian McCullough Megan Rusby	
Maryland (4)	John Hill Terri Jorgenson Marybeth Kazanas Janet Lee	Justin Hare Molly Wascher
Massachusetts (4)	Jason Lancaster Frankie Mernick Marla O'Shea-Bulman Russel Roberts	Monica Mahoney
Michigan (4)	Jesse Hogue Lama Hsaiky Jessica Jones Rebecca Maynard	Rox Gatia Ed Szandzik
Minnesota (3)	Lance Oyen John Pastor Rachel Root	Paul Morales Scott Nei Cassie Schmitt
Mississippi (2)	Caroline Bobinger Andrew Mays	Joshua Fleming
Missouri (3)	Joel Hennenfent Amy Sipe Mel Smith	Nathan Hanson Cassie Heffern Sayo Weihs
Montana (2)	Julie Neuman Logan Tinsen	JoEllen Maurer
Nebraska (3)	Tiffany Goeller Katie Reisbig David Schmidt	Jolyn Merry
Nevada (2)	Adam Porath Kate Ward	
New Hampshire (2)	Melanie McGuire Elizabeth Wade	Marilyn Hill
New Jersey (4)	Rich Artymowicz Julie Kalabalik-Hoganson Deb Sadowski Craig Sastic	Barbara Giacomelli Agnieszka Pasternak Jennifer Sternbach
New Mexico (2)	Lisa Anselmo Nick Crozier	
New York (5)	Travis Dick Paul Green Mark Sinnet Leila Tibi-Scherl Kimberly Zammit	Amisha Arya Brendan Begnoch Charrai Byrd Angela Cheng Carline Fevry Courtney Jarka Christine Nguyen

North Carolina (4)	Leslie Barefoot Angela Livingood Mary Parker Jeffrey Reichard	Mollie Scott Tyler Vest
North Dakota (2)	Maari Loy Katrina Rehak	Elizabeth Monson Saidee Oberlander
Ohio (5)	Ashley Duty Cynthia King Dan Lewis Kellie Musch Kembral Nelson	Ben Lopez Joshua Musch Jerry Siegel
Oklahoma (3)	Corey Guidry Jeremy Johnson Andrea Rai	
Oregon (3)	Ryan Gibbard Edward Saito Ryan Wargo	Michael Lanning
Pennsylvania (4)	Arpit Mehta Kimberly Mehta Cassandra Redmond Christine Roussel	Jennifer Belavic Scott Bolesta Larry Jones Joseph Stavish Evan Williams
Puerto Rico (2)	Carlos Méndez Bauza Idaliz Rodriguez Escudero	Mirza Martínez Giselle Rivera
Rhode Island (2)	Nelson Caetano Martha Roberts	Ray Iannuccillo Karen Nolan
South Carolina (3)	Thomas Achey Carolyn Bell Lisa Gibbs	Harrison Jozefczyk
South Dakota (2)	Betsy Karli Anne Morstad	Joseph Berendse Laura Stoebner
Tennessee (4)	Kelly Bobo Erin Neal Grayson Peek Jodi Taylor	Don Branam Jennifer Robertson
Texas (6)	Latresa Billings Joshua Blackwell Todd Canada Rodney Cox Binita Patel Jeffrey Wagner	Abimbola Farinde Jerry James
Utah (3)	Conor Hanrahan Elyse MacDonald Krystal Moorman-Bishir	Shannon Inglet Whitney Mortensen
Vermont (2)	Jeffrey Gonzalez Emily Piehl	Julie MacDougall Kevin Marvin

Virginia (4)	Kathy Koehl Amy Schultz Brian Spoelhof Rodney Stiltner	June Javier
Washington, D.C. (2)	Sue Carr Kelly Mullican	Joann Lee
Washington State (3)	Lauren Bristow Chris Greer Karen White	
West Virginia (2)	Chris Fitzpatrick Derek Grimm	
Wisconsin (4)	John Muchka Sarah Peppard William Peppard Kate Schaafsma	Monica Bogenschutz Edward Conlin Carmen Gust David Reeb
Wyoming (2)	Linda Gore Martin Jessica Papke	
SECTIONS AND FORUMS	**DELEGATES**	**ALTERNATES**
Ambulatory Care Practitioners	Brody Maack	Sara Panella
Clinical Specialists and Scientists	Nancy MacDonald	Megan Musselman
Community Pharmacy Practitioners	Ashley Storvick Boedecker	Courtney Isom
Digital and Telehealth Practitioners	Lisa Stump	
Inpatient Care Practitioners	Allison King	Lucas Schulz
Pharmacy Educators	Cher Enderby	Jennifer Arnoldi
Pharmacy Informatics and Technology	Hesham Mourad	Jeffrey Chalmers
Pharmacy Practice Leaders	Lindsey Kelley	Katherine Miller
Specialty Pharmacy Practitioners	Denise Scarpelli	Erica Diamantides
New Practitioners Forum	Justin Moore	Alfred Awuah
Pharmacy Student Forum	Heather Howell	Charbel Aoun
Pharmacy Technician Forum	Tyler Darcy	Daniel Nyakundi
FRATERNAL	**DELEGATES**	**ALTERNATES**
U.S. Air Force	Lt Col Rohin Kasudia	Maj. Elizabeth Tesch
U.S. Army	LTC Victoria O'Shea	MAJ Danielle Zsido
U.S. Navy	LT Staci Jones	LCDR Chirag Patel
U.S. Public Health Service	CDR Christopher McKnight	
Veterans Affairs	Heather Ourth	Tera Moore Anthony Morreale

House of Delegates Session—2023

June 11 and 13, 2023

Proceedings of the 75th annual session of the ASHP House of Delegates, June 11 and 13, 2023

Proceedings of the 75th annual session of the ASHP House of Delegates, June 11 and 13, 2023

Paul W. Abramowitz, Secretary

The 75th annual session of the ASHP House of Delegates was held at the Baltimore Convention Center, in Baltimore, Maryland, in conjunction with the 2023 Summer Meetings.

First meeting

The first meeting was convened at 1:00 p.m. Sunday, June 11, by Chair of the House of Delegates Melanie A. Dodd. Chair Dodd introduced the persons seated at the head table: Linda S. Tyler, Immediate Past President of ASHP and Vice Chair of the House of Delegates; Paul C. Walker, President of ASHP and Chair of the Board of Directors; Nishaminy (Nish) Kasbekar, President-elect of ASHP and Vice Chair of the Board of Directors; Paul W. Abramowitz, Chief Executive Officer of ASHP and Secretary of the House of Delegates; and Susan Eads Role, Parliamentarian.

Chair Dodd welcomed the delegates and described the purposes and functions of the House. She emphasized that the House has considerable responsibility for establishing policy related to ASHP professional pursuits and pharmacy practice in hospitals and health systems. She reviewed the general procedures and processes of the House of Delegates and acknowledged the historical significance of the House's 75 years of annual meetings.

The roll of official delegates was called. A quorum was present, including 208 delegates representing 49 states and the District of Columbia, as well as the federal services, chairs of ASHP sections and forums, ASHP officers, members of the Board of Directors, and ASHP past presidents (see Appendix I for a complete roster of delegates).

Chair Dodd reminded delegates that the report of the 74th annual session of the ASHP House of Delegates had been published on the ASHP website and had been distributed to all delegates. Delegates had been advised earlier to review this report. The proceedings of the 74th House of Delegates session were received without objection.

Ratification of Previous Actions. The House ratified its actions taken in March and May (Appendices II-III).

Report of the Committee on Nominations. Chair Dodd called on Donald Kishi, Chair of the Committee on Nominations, for the report of the Committee on Nominations (Appendix IV).[a] Nominees were presented as follows:

President 2023-2024
Leigh A. Briscoe-Dwyer, PharmD, BSPharm, BCPS, FASHP, System Director of Pharmacy, UHS Hospitals, Johnson City, NY

Kristina (Kristy) L. Butler, PharmD, BSPharm, BCACP, FASHP, FOSHP, Manager, Primary Care Clinical Pharmacy Services, Providence St. Joseph Health, Portland, OR

Board of Directors, 2023-2026
Jeffrey J. Cook, PharmD, MS, MBA, CHFP, Chief Pharmacy Officer and Assistant Dean for the College of Pharmacy, University of Arkansas for Medical Sciences, Little Rock, AR

Dawn M. Moore, PharmD, MS, CPEL, FACHE, Vice President and Chief Pharmacy Officer, Community Health Network, Indianapolis, IN

Douglas C. Slain, PharmD, BCPS, FASHP, Professor and Infectious Diseases Clinical Specialist and Clinical Pharmacy Chairman, West Virginia University, Morgantown, WV

Majid-Theodore Raja Tanas, PharmD, MS, MHA, FASHP, Vice President of Pharmacy and Chief Pharmacy Officer, Legacy Health, Portland, OR

Board of Directors, 2023-2025
Marie A. Chisholm-Burns, PharmD, PhD, MPH, MBA, FACHE, FASHP, FAST, Executive Vice President and Provost, Oregon Health & Science University, Portland, OR

Kristine K. Gullickson, PharmD, MBA, DPLA, FASHP, FMSHP, Director of Pharmacy, Abbott Northwestern Hospital, part of Allina Health, Minneapolis, MN

The Committee on Nominations consisted of Donald Kishi, Chair (CA); Thomas Johnson, Vice Chair (SD); Joshua Blackwell (TX); Maritza Lew (CA); Lisa Mascardo (IA); Milap Nahata (OH); and Tyler Vest (NC).

A "Meet the Candidates" session to be held on Monday, June 12, was announced. The candidates for the executive committees of the sections of ASHP were then presented to the House.

Policy committee reports. Chair Dodd outlined the process used to generate policy committee reports (Appendix V). She announced that the recommended policies from each council would be considered in the order presented in the committee reports.

Chair Dodd also announced that delegates could suggest minor wording changes (without introducing a formal amendment) that did not affect the substance of a policy proposal, and that the Board of Directors would consider these suggestions and report its decisions on them at the second meeting of the House. *(Note: The following reports on House action on policy committee recommendations give the language adopted at the first meeting of the House. The titles of policies amended by the House are preceded by an asterisk [*]. Amendments are noted as follows: underlined type indicates material added; ~~strikethrough~~ marks indicate material deleted. If no amendments are noted, the policy as proposed was adopted by the House. For purposes of this report, no distinction has been made between formal amendments and wording suggestions made by delegates.*

The ASHP Bylaws [Section 7.3.1.1] require the Board of Directors to reconsider an amended policy before it becomes final. The Board reported the results of its "due consideration" of amended policies during the second meeting of the House.)

Vivian Bradley Johnson, Board Liaison to the **Council on Pharmacy Practice**, presented the Council's Policy Recommendations 1 through 6.

***1. Emergency Medical Kits**
To recognize the importance of standardized and ~~immediate,~~ readily accessible emergency medical kits (EMKs) in locations ~~inaccessible to~~ with inconsistent emergency medical services; further,

To advocate for the inclusion of pharmacist expertise in policy and regulations for the interprofessional decisions related to ~~stocking and maintaining~~ the contents, storage, and maintenance of medications in EMKs; further,

To collaborate with other professions and stakeholders to ~~determine appropriate~~

standardize the contents of and locations for EMKs, and to develop guidelines and standardized training for proper use of EMK contents by designated personnel employed in those settings.

***2. Raising Awareness of the Risks Associated with the Misuse of Medications**
To ~~encourage~~ support the pharmacy workforce ~~pharmacists to engage~~ in ~~community~~ outreach efforts to provide education to authorities, patients, and the community on the risks associated with use of medications for nonmedical purposes or from nonmedical sources~~; further,~~

~~To encourage pharmacists to advise authorities, patients, and the community on the dangers of using medications for nonmedical purposes~~.

***3. Standardization of Medication Concentrations**
To support adoption of nationally standardized medication ~~drug~~ concentrations~~, and~~ dosing units, labeled units, and package sizes for medications administered to adult and pediatric patients, and to limit those standards~~ized concentrations and dosing units to one concentration and one dosing unit when~~ as much as possible; further,

To encourage interprofessional collaboration on the adoption and implementation of these standards~~ized drug concentrations and dosing units~~ across the continuum of care; further,

To encourage manufacturers and registered outsourcing facilities to provide medications in those standardized concentrations, labeled units, and package sizes ~~when it is clinically appropriate and feasible~~.

Note: This policy would supersede ASHP policy 1306.

***4. Pharmacoequity**
To ~~recognize~~ raise awareness that disparities in ~~standards of care~~ clinical practice negatively impact healthcare outcomes and compromise pharmacoequity ~~in marginalized and underserved populations~~; further,

To recognize the impact of social determinants of health on pharmacoequity and patient outcomes; further,

To advocate for drug availability, drug pricing structures, pricing transparency, and insurance coverage determinations that promote pharmacoequity; further, **[MOVED FROM BELOW]**

To advocate that the pharmacy workforce identify and address ~~threats~~ risks and ~~patient~~ vulnerabilities to pharmacoequity as part of comprehensive medication management services; further,

To advocate for resources, including technology, that improve access to care for marginalized and underserved populations where pharmacy access is limited; further,

To ~~raise awareness about implicit and unconscious~~ encourage the pharmacy workforce to identify and mitigate biases in healthcare decision-making that ~~may~~ compromise pharmacoequity~~; further,~~

~~To advocate for drug availability, drug pricing structures, and insurance coverage determinations that promote pharmacoequity~~ **[MOVED ABOVE]**.~~community~~ outreach efforts to provide education to authorities, patients, and the community on the risks associated with use of medications for nonmedical purposes or from nonmedical sources~~; further,~~

***5. Medication Administration by the Pharmacy Workforce**
To support the position that the administration of medications is ~~part of~~ within the ~~routine~~ scope of pharmacy practice; further,

~~To support the position that members of the pharmacy workforce who administer medications should be skilled to do so; further,~~

To advocate that states grant pharmacists and appropriately supervised student pharmacists and pharmacy technicians the authority to administer medications; further,

To support the position that pharmacists should be participants in establishing procedures in their own work settings with respect to the administration of medications (by anyone) and monitoring the safety and outcomes of medication administration.

Note: This policy would supersede ASHP policy 9820.

6. Reducing Healthcare Sector Carbon Emissions to Promote Public Health
To promote reducing carbon emissions from the healthcare sector through collaboration with other stakeholders; further,

To encourage members of the pharmacy workforce to seek out opportunities to engage in efforts to reduce carbon emissions in their workplaces and communities.

Pamela K. Phelps, Board Liaison to the **Council on Therapeutics**, presented the Council's Policy Recommendations 1 through 10.

***1. Availability and Use of Fentanyl Test Strips**
To affirm that fentanyl test strips (FTS) have a place in harm reduction strategies for people who use drugs; further,

To support legislation that declassifies FTS as drug paraphernalia; further,

To promote ~~continued widespread~~ public availability of and access to FTS at limited to no cost ~~to the public~~; further,

~~To foster research, education, training, and the development of resources to assist the pharmacy workforce, other healthcare workers, patients, and caregivers in the use and utility of FTS; further,~~

To support the pharmacy workforce in their roles as essential members of the healthcare team in educating the public and healthcare providers about the role of FTS in public health efforts.

2. Manipulation of Drug Products for Alternate Routes of Administration
To advocate that the Food and Drug Administration encourage drug product manufacturers to identify changes in pharmacokinetic and pharmacodynamic properties of drug products when manipulated for administration through an alternate delivery system or different route than originally studied, and to make this information available to healthcare providers; further,

To collaborate with stakeholders to increase research on clinically relevant changes to pharmacokinetic and pharmacodynamic properties of drug products when manipulated or administered through a different route and to enhance the aggregation and publication of and access to this data; further,

To research and promote best practices for manipulation and administration of drug products through alternate routes when necessary; further,

To foster pharmacist-led development of policies, procedures, and educational resources on the safety and efficacy of manipulating drug products for administration through alternate routes.

***3. DEA Scheduling of Controlled Substances**
To advocate that the Drug Enforcement Administration (DEA) establish clear,

measurable criteria and a transparent process for scheduling determinations; further,

To urge the DEA to use such a process to re-evaluate existing schedules for all substances regulated under the Controlled Substances Act to ensure consistency and incorporate current science-based evidence concerning scheduling criteria; further,

To advocate that the United States Congress, with input from stakeholders, enact clear definitions of ~~define~~ the terms *potential for abuse*, *currently accepted medical use*, and *accepted safety for use* in the Controlled Substances Act; further,

To advocate for monitoring **of** the ~~effect~~ impact of DEA scheduling of products under the Controlled Substances Act and other abuse-prevention efforts (e.g., prescription drug monitoring programs) ~~to assess the impact~~ on patient access to ~~these medications~~ therapy and on ~~the practice burden of~~ healthcare providers~~'~~ workload; further,

To advocate for the ~~alignment~~ elimination of federal and state laws ~~to eliminate~~ that create barriers to research on ~~and~~ therapeutic use of Schedule I substances.

Note: This policy would supersede ASHP policy 1315.

***4. Pharmacist Prescribing Authority for Antiretroviral Therapy for the Prevention of HIV/AIDS**

To affirm that drug products for pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for human immunodeficiency virus (HIV) infection prevention should be provided to individuals in a manner that ensures safe and appropriate use; further,

To oppose reclassification of currently available drugs used for PrEP and PEP to nonprescription status; further,

To advocate for legislation and regulation that expands pharmacist scope of practice to encompass initiation of PrEP and PEP therapy; further,

To advocate that the therapies and associated care for PrEP and PEP are available to patients with zero cost-sharing; further,

To support establishment of specific and structured criteria to guide comprehensive pharmacist interventions related to PrEP and PEP; further,

To support the research, education, and training of the pharmacy workforce on the therapeutic, psychosocial, and operationalization considerations of pharmacist-provided PrEP and PEP therapy; further,

To support educating the public regarding the public health benefits of PrEP and PEP**;**
further,

~~**and t**~~**T**o support the U.S. Department of Health and Human Services *Ending the HIV Epidemic in the U.S.* initiative that strives to end the HIV epidemic in the United States by 2030; further,

To advocate for reimbursement, pay parity, and financially sustainable models related to the above pharmacist patient care and cognitive services.

***5. Point-of-Care Testing and Treatment**

To advocate for laws, ~~and~~ regulations, and development of specific, structured criteria that ~~would~~ include performing diagnostic point-of-care testing (POCT) and interpreting test results ~~and associated diagnosis~~, leading to the referral, prescribing, dosing, and dispensing clinically indicated by POCT in pharmacists' scope of practice; further,

~~To support the development of specific and structured criteria for pharmacist diagnosis,~~

~~referral, prescribing, dosing, and dispensing based on POCT; further,~~

To support the ~~diagnosis and~~ tracking of reportable diseases through pharmacist-managed POCT and reporting to public health agencies when appropriate; further,

To promote training and education of the pharmacy workforce to competently engage in POCT and related patient care services; further, [MOVED FROM BELOW]

To foster research on patient access and public health improvements, cost savings, and revenue streams associated with pharmacist-managed POCT and related patient care services~~; further,~~

~~To promote training and education of the pharmacy workforce to competently engage in POCT and related patient care services~~ [MOVED ABOVE].

Note: This policy would supersede ASHP policy 2229.

***6. Nonprescription Availability of Self-Administered Influenza Antivirals ~~Oseltamivir~~**

To support a behind-the-counter practice model that expands access to self-administered influenza antivirals ~~oseltamivir; further,~~

~~To support interoperable documentation of oseltamivir dispensing and associated testing accessible by all members of the healthcare team in outpatient and inpatient settings; further,~~

~~To support diagnosis and tracking of influenza through pharmacist-driven influenza point-of-care testing and reporting to the appropriate public health agencies prior to oseltamivir dispensing; further,~~

~~To advocate that specific and structured criteria be established for prescribing, dosing, and dispensing of oseltamivir for treatment and prophylaxis by pharmacists; further,~~

~~To advocate that pharmacist-provided counseling for oseltamivir and patient education on influenza be required for dispensing; further,~~

~~To continue to promote influenza vaccination by pharmacists, despite oseltamivir availability; further,~~

~~To advocate that the proposed reclassification of oseltamivir be accompanied by coverage changes by third-party payers to ensure that patient access is not compromised and that pharmacists are reimbursed for the clinical services provided~~.

Note: This policy would supersede ASHP policy 2116.

***7. Over-the-Counter Availability of Hormonal ~~Oral~~ Contraceptives**

To advocate that ~~over-the-counter (OTC) oral~~ hormonal contraceptives be available over the counter (OTC) without age restriction only under conditions that ensure safe use, including the availability of pharmacist consultation to ensure appropriate self-screening and product selection; further,

~~To support the development, implementation, and use of clinical decision-making tools and education to facilitate pharmacist consultation; further,~~

To encourage the Food and Drug Administration to require manufacturers to include all patients of childbearing age, including adolescents, in studies to determine the safety and ~~efficacy~~ effectiveness of OTC ~~oral~~ hormonal contraceptives; further,

To advocate that ~~the proposed reclassification of these products be accompanied by coverage changes by third-party payers to ensure~~ all insurers and manufacturers maintain coverage and limits on out-of-pocket expenditure so that patient access and privacy are ~~is~~ not compromised.

Note: This policy would supersede ASHP policy 1410.

8. Responsible Medication-Related Clinical Testing and Monitoring
To recognize that overuse of clinical testing leads to unnecessary costs, waste, and patient harm; further,

To encourage the development of standardized measures of appropriate clinical testing to better allow for appropriate comparisons for benchmarking purposes and use in research; further,

To promote pharmacist accountability and engagement in interprofessional efforts to promote judicious use of clinical testing and monitoring, including multi-faceted, organization-level approaches and educational efforts; further,

To promote research that evaluates pharmacists' contributions and identifies opportunities for the appropriate ordering of medication-related procedures and tests; further,

To promote the use of interoperable health information technology services and health information exchanges to decrease unnecessary testing.

Note: This policy would supersede ASHP policy 1823.

***9. Therapeutic and Psychosocial Considerations of Patients Across the Gender Identity Spectrum**
To recognize the role of gender-affirming care in achieving health equity and reducing health disparities; further,

To advocate that gender identity ~~be considered in~~ is a critical component of medication and disease management of patients across the gender identity spectrum; further, **[MOVED FROM BELOW]**

To advocate for equitable access to ~~and broad insurance coverage of~~ gender-affirming care, including access to a pharmacist who ensures safe and effective medication use ~~medication, medical, and surgical therapies~~; further,

~~To advocate that patients across the gender identity spectrum have access to pharmacist care to ensure safe and effective medication use without discriminatory barriers; further,~~

~~To advocate that gender identity be considered in medication and disease management of patients across the gender identity spectrum; further,~~ **[MOVED ABOVE]**

To promote research, ~~on, education about, and~~ development, and implementation of therapeutic and biopsychosocial best practices in the care of patients across the gender identity spectrum; further,

To encourage the incorporation of specific education and training regarding patient gender identity into educational standards and competencies for the pharmacy workforce; further,

To encourage easily accessed, structured documentation of a patient's sex assigned at birth, self-identified gender, chosen name, personal pronouns, and relevant medical history in electronic health records; further,

To affirm that healthcare workers should be able to provide gender-affirming care per their clinical judgment and their conscience without fear of legal consequence, workplace sanctions, social stigmatization, harassment, or harm.

Note: This policy would supersede ASHP policy 1718.

***10. Removal of Injectable Promethazine from Hospital Formularies**
To advocate that injectable promethazine be removed from hospital formularies; further,

To encourage regulatory and safety bodies ~~the Food and Drug Administration~~ to review ~~the~~ patient safety data and ~~consider withdrawing~~ encourage research on adverse events related to administration of injectable promethazine ~~from the market~~; further,

To encourage manufacturers to produce injectable promethazine in package sizes and concentrations that reduce risk.

Note: This policy would supersede ASHP policy 1831.

Kim W. Benner, Board Liaison to the **Council on Education and Workforce Development**, presented the Council's Policy Recommendation.

***1. Well-Being and Resilience of the Pharmacy Workforce**

To affirm that occupational burnout adversely affects an individual's well-being and healthcare outcomes; further,

To acknowledge that the healthcare workforce encounters unique stressors throughout their education, training, and careers that contribute to occupational burnout; further,

To declare that healthcare workforce well-being and resilience requires shared responsibility among healthcare team members and between individuals and organizations; further,

To ~~encourage~~ empower individuals and institutions to embrace well-being and resilience as a ~~personal responsibility that should be~~ priority supported by organizational culture; further,

To promote that pharmacy leadership collaborate with their institutions to assess the well-being and resilience of the pharmacy workforce and identify effective prevention and intervention strategies; further,

To encourage hospitals and health systems to invest in the development and assessment of interprofessional programs ~~aimed at prevention, recognition, and treatment of~~ that prevent occupational burnout while supporting well-being, and to support nonpunitive participation in these programs~~; further,~~

~~To encourage education, research and dissemination of findings on stress, burnout, and well-being; further,~~

~~To collaborate with other professions and stakeholders to identify effective prevention and intervention strategies that support well-being at an individual, organizational, and system level~~.

Note: This policy would supersede ASHP policy 1825.

The meeting adjourned at 5:30 p.m.

Second meeting

The second and final meeting of the House of Delegates session convened on Tuesday, June 13, at 4:00 p.m. A quorum was present.

Report of Treasurer. Christene M. Jolowsky presented the report of the Treasurer. There was no discussion (Appendix VI).

Report of the President and the Chief Executive Officer. President Walker provided an update on numerous ASHP initiatives. There was no discussion, and the delegates voted to accept the report (Appendix VII).

Board of Directors duly considered matters. Pursuant to Bylaws section 7.3.1.1, the Board met on the morning of June 13 to "duly consider" the policies amended at the first meeting. Four policy recommendations were approved without amendment. Fourteen policy recommendations were amended or edited by the House of Delegates. The Board agreed with the House's amendments and editorial changes to 13 policy recommendations, with nonsubstantive editorial changes to seven of

those 13 policy recommendations. The Board did not accept House amendments to one policy recommendation, Council on Therapeutics 4, and offered revised language for that policy recommendation, as noted below (amendments made by the House are delineated as follows: words added are underlined; words deleted are ~~stricken~~. Text added by the Board is indicated in **bold double underline;** text deleted by the Board is indicated in ~~**bold double strikethrough**~~):

Council on Therapeutics 4. Pharmacist Prescribing Authority for Antiretroviral Therapy for the Prevention of HIV/AIDS
To affirm that drug products for pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for human immunodeficiency virus (HIV) infection prevention should be provided to individuals in a manner that ensures safe and appropriate use; further,

To oppose reclassification of currently available drugs used for PrEP and PEP to nonprescription status; further,
To advocate for legislation and regulation that expands pharmacist scope of practice to encompass initiation of PrEP and PEP therapy; further,

To advocate that the therapies and associated care for PrEP and PEP are available to patients with zero cost-sharing; further,

To support establishment of specific and structured criteria to guide comprehensive pharmacist interventions related to PrEP and PEP; further,

To support the research, education, and training of the pharmacy workforce on the therapeutic, psychosocial, and operationalization considerations of pharmacist-provided PrEP and PEP therapy; further,

To support educating the public regarding the public health benefits of PrEP and PEP~~ **and to support the U.S. Department of Health and Human Services *Ending the HIV Epidemic in the U.S.* initiative that strives to end the HIV epidemic in the United States by 2030; further,**~~

~~**To advocate for reimbursement, pay parity, and financially sustainable models related to the above pharmacist patient care and cognitive services**~~.

The House voted to accept the Board's revised policy language recommendation.

New Business. Chair Dodd announced that, in accordance with Article 7 of the Bylaws, there was three items of New Business to be considered. Chair Dodd called on Jodi Taylor (TN) to introduce the first item of New Business (Appendix VIII). The New Business read as follows:

Discontinuing ASHP policy "Nonprescription Availability of Self-Administered Influenza Antivirals"

Motion:
In light of the encompassing nature of the ASHP policy "Point-of-Care Testing and Treatment" approved by the House of Delegates on June 11, 2023, we move to discontinue the ASHP policy "Nonprescription Availability of Self-Administered Influenza Antivirals" approved the same day.

Background:
Given the availability and feasibility of point-of-care testing in pharmacies, influenza antiviral therapeutics are an excellent option for pharmacist-initiated treatment. We believe the ASHP policy "Point-of-Care Testing and Treatment" sufficiently covers self-administered influenza antivirals and that individual policies for specific therapeutics are not needed. Additionally, behind-the-counter

availability of self-administered influenza antivirals as described in the policy might lead to a reduction in the pharmacist's ability to advocate and screen for influenza and other indicated vaccinations, as purchase of behind-the-counter products can be transactional rather than involving the pharmacist's clinical involvement.

Suggested Outcomes:
House of Delegates to vote to discontinue the ASHP policy proposal "Nonprescription Availability of Self-Administered Influenza Antivirals" in light of the approval of the policy proposal "Point-of-Care Testing and Treatment."

Following discussion, the item was not approved for referral to the Board of Directors.

Chair Dodd then called on Jaclyn Boyle (SACP) to introduce the second item of New Business. (Appendix IX). The New Business read as follows:

Compensation for pharmacist cognitive services

Motion:
To adopt the following as a new ASHP policy:

To advocate for reimbursement, pay parity, and financially sustainable models related to cognitive services of pharmacist-accountable services, regardless of site of care; further,

To educate the pharmacy workforce and stakeholders about financially sustainable models of care; further,

To advocate that compensation for healthcare services be commensurate with the level of care provided, based on the needs of the patient; further,

To advocate for the development of consistent, transparent billing, reimbursement, and alternative payment model policies and practices by both government and commercial payers.

Background:
While the existing ASHP's Statement on the Pharmacist's Role in Primary Care describes the need for compensation and sustainability in primary care, this may not necessarily apply to pharmacists who are practicing in other areas such as acute care, Accountable Care Organizations, population health settings, specialty clinics, and other settings. While ASHP's active advocacy efforts including the ASHP's Model CMM Legislation (https://www.ashp.org/-/media/assets/advocacy-issues/docs/2023/CMM-Legislation-to-Reduce-Medication-Errors-and-Improve-Patient-Outcomes) are related to supporting reimbursement and other compensation practices, we believe that this issue is so integral to the future of the profession, and particularly the expansion of pharmacists as providers who conduct cognitive services in all practice settings, that ASHP establish a comprehensive permanent policy related to this topic as a standalone issue. This policy can also offer foundational policy language that guides ASHP work in an ever-evolving compensation/reimbursement healthcare system. ASHP Members could also utilize this policy in their own personal advocacy efforts within their individual institutions to collaborate with compliance and billing departments in expanding pharmacist-provided cognitive services.

Additional rationale from the ASHP Policy 2020, Care-Commensurate Reimbursement:
As a means to reduce costs for federal programs, the Centers for Medicare & Medicaid Services (CMS) has been aggressively expanding efforts to reduce reimbursement at certain sites of care. Specifically, CMS has cut reimbursement for care services provided at hospital outpatient departments to match the rate paid physicians' offices. CMS refers to this policy as "site-neutral payment." On the basis

of site neutrality, CMS also extended cuts to hospital reimbursement for drugs purchased under the 340B drug discount program to hospital outpatient departments. Private payers have also sought to impose site-neutral payment policies.

Reimbursement for services should reflect unique factors associated with a site of care. Hospital outpatient departments are held to higher quality standards with more oversight than what is often required for alternate sites of care. In addition to the Medicare Conditions of Participation, hospital outpatient departments must meet accreditation, United States Pharmacopeia (USP), and even Food and Drug Administration requirements. These standards result in high-quality patient care, but at a higher cost than what can be accomplished without the oversight.

Patients may also derive benefits from receiving care at a hospital outpatient department. Hospital care delivery models are crafted to ensure that patients receive the highest quality care possible. For hospitals that belong to an accountable care organization or are otherwise part of an integrated network, seeing patients at the outpatient department allows providers to better coordinate care, resulting in improved patient outcomes. Care provided in this setting is often highly complex and complementary to acute care that the patient receives from the hospital. Drastic cuts to hospital outpatient reimbursement could endanger the long-term viability of these care delivery models – if services are cut or outpatient departments are closed, patient access will suffer.

Additional rationale from the ASHP Statement on Primary Care:
Billing and reimbursement for primary care pharmacy services
The National Academy of Sciences recommends that payers, including Medicaid, Medicare, commercial insurers, and self-insured employers, should shift payments toward a hybrid model that includes fee-for-service and capitated payments, and that these models should pay prospectively for interprofessional, integrated, team-based care.6 Financial sustainability for services provided by primary care pharmacists may be achieved using a variety of models. Due to lack of federal provider status for pharmacists and subsequent inability to directly bill Medicare as primary care providers, organizations and practices have become creative in maintaining financial sustainability of primary care pharmacist services. Some settings utilize indirect funding, while others take advantage of some of the limited direct insurance billing opportunities to fund pharmacists in primary care settings. Direct billing opportunities will vary based on the setting, hospital-based versus physician-based practices, as well as state-specific laws and regulations. Medicare, Medicaid, and commercial health plans may reimburse pharmacists for certain services, while some will require direct contracting with the health plan. Several states have passed pharmacist state provider status laws and/or reimbursement parity laws allowing for reimbursement for direct patient care pharmacist services by state Medicaid and/or commercial plans.[4]

References:
1. ASHP Statement on the Role of Pharmacists in Primary Care.
2. Kraus T. Support Legislation to Reduce Medication Errors and Improve Patient Outcomes. https://www.ashp.org/-/media/assets/advocacy-issues/docs/2023/CMM-Legislation-to-Reduce-Medication-Errors-and-Improve-Patient-Outcomes
3. ASHP Policies 2020, 2134, 2232.

Following discussion, the item was approved for referral to the Board of Directors.

Chair Dodd then called on Kevin Marvin (VT) to introduce the third item of New Business.

(Appendix X). The New Business read as follows:

Barcodes with Lot and Expiration Date Needs and Impacts

Motion:
To adopt the following new policy for expedited, urgent approval by the ASHP Board of Directors:

To advocate that the Food and Drug Administration and organizations who develop barcode standards require barcodes contain lot number and expiration date on all immediate product packages to enable automated collection and validation of this information during medication preparation, dispensing, and administration processes; further,

To educate regulatory and safety organizations that barcode scanning versus manual logging of lot numbers and expirations is critical for patient safety and preparation sterility and improves data visibility for medication recalls; further,

To advocate that state boards of pharmacy, regulatory agencies, and accrediting bodies delay punitive action on rules requiring logging of lot number and expiration dates during sterile product preparation until this information is made available on immediate product barcodes.

Background:
The current Food and Drug Administration (FDA) barcode rule requires NDC, Lot Number and Expiration Date on all Saleable medication packages. FDA created an exception for immediate packages which include unit dose packages and individual vials sold as lots in boxes. More than 90% of products dispensed in a hospital are immediate packages. The exception requires that the barcodes on these immediate packages be linear (1D) barcodes. Due to the technology of 1D barcodes, it is difficult to fit the larger barcode containing additional characters needed to code lot number, expiration date and NDC on labels of inner packages. As a result, the 1D barcodes required on inner packages only contain the NDC number.

The current FDA proposed rule will allow but not require 2D barcodes and minimally encode only the NDC number in the barcode. The FDA reason for this is that the expansion of NDC to 12 digits will create issues for some manufacturers who code a 10-digit NDC number in the barcode and don't have the label space to expand the 1D barcode to 12 digits. 2D barcodes require less label space than 1D barcodes. This FDA proposed rule will not guarantee that barcodes on inner products contain lot number and expiration date. FDA representatives say that they are addressing the immediate package requirements in the revised rule but his is only true for the NDC 12 character expansion and not for the encoding of lot and expiration date.
Multiple State Boards of Pharmacy including California and Texas require hospitals to log the NDC, lot and expiration dates on all IV products compounded or repackaged. USP 797 is also adding the same requirements to be effective 11/01/2023.

The logging of lot and exp dates is not a second check but an attempt to track medications all the way to the patient in the case of recalls and event reporting. With IV workflow systems and barcodes with lot #/exp Dt, an IV can be prepared and documented with only 2 barcode scans. Current linear barcodes require scans of the ndc and multiple mouse clicks and 22 or more keystrokes on a keyboard to enter the data. Putting a keyboard into the sterile environment or pulling hands in and out of the sterile field threatens sterility. Dispersing this data entry work in the middle of a complicated IV workflow will not only create data entry or transcription errors but will increase the potential for computation errors as the preparer keys in or handwrites these

seemingly random numbers while computing, measuring, and verifying doses.

In 2011 the FDA made a change to the 2004 barcode rule when they allowed vaccine manufacturers to encode NDC, Lot and Exp date on 2D barcodes on inner packages in support of the National Childhood Vaccine Injury Act of 1986.* This change supports reporting of adverse events to the Vaccine Adverse Event Reporting System. This was an allowed exception and not a requirement. This recommendation has been discussed with several software vendors who have stated that the functionality is already in their systems to capture lot number and expiration dates, if available, when barcode scanning. This functionality has not only been added to IV preparation functions but also to dispensing and medication administration. They have validated the above statements that many keyboard keystrokes can be replaced by simple barcode scans. In addition, they noted that barcode scans can be initiated by foot switches without touching the scanners and therefore minimize potential for impact on sterility. A two component IV with base solution and 1 additive was reported to require 22 keystrokes and 2 mouse clicks at a minimum if lot and expiration date are not in the barcode. One vender reported that they are in the process of adding automatic checks for expired medications and recalled lot numbers during all medication barcode scanning functions throughout the medication process. Significant time savings can be realized through automated checking of expiration dates and recalls throughout the medication process including Automated Dispense cabinet restocking.

Current 2D scanners can read 1D and 2D barcodes. Past arguments 19 years ago that hospitals do not have the barcode readers to read 2D barcodes are no longer valid. Many products dispensed are saleable packages that only contain 2D barcodes. In addition, 2D barcode readers are significantly less expensive and more reliable than the 1D laser scanners used in the past.
GS1, the barcode standards organization that defines medication barcode standards has invited stakeholders to provide input on how GS1 can better support industry needs. This is a call-out to organizations such as ASHP to communicate the need for lot, expiration and on immediate products and to work with GS1 to assure the resulting barcodes meet the need in health systems. Such communication with GS1 should include the barcoding of repackaged products and investigational medications. This is the invite statement from GS1: "Manufacturers should be moving toward 2D to support forward movement in adoption and use. Downstream trading partners should focus on scanning and consuming - the time is now to move in this direction. As stakeholders across the healthcare supply chain begin to adopt scanning and consuming of data from GS1 DataMatrix barcodes further detail may be needed to support this industry.

GS1 US invites any organization to collaborate and share positive or negative learnings. Sharing lessons learned, what worked well and what needs more attention to fulfill the important possibilities that exist will need to continue if we are to achieve the benefits that sharing, scanning, and using advanced data about healthcare products can provide."

ASHP Policy 1003, FDA AUTHORITY ON RECALLS (Council on Public Policy) partially supports this recommendation as it contains the clause: "To urge the FDA to require drug manufacturers and the computer software industry to provide bar codes and data fields for lot number, expiration date, and other necessary and appropriate information on all medication packaging, including unit dose, unit-of-use, and injectable drug packaging, in order to facilitate compliance with recalls or withdrawals and to prevent the administration of recalled products to patients;" This policy is aimed more at human readable printing of data

fields for lot and expiration date rather than encoding of that information in a barcode.

Rules are being implemented and considered by State Boards of Pharmacy and USP to track medications to the patient and validate expiration dates. There is a general lack of understanding how these rules impact IV preparation workflows and corresponding medication safety and sterility of IV preparation. It is important to educate rule makers on this impact and work with the FDA to expedite a barcode rule change to **REQUIRE** and not just allow the lot and expiration date on immediate product bar codes.

Suggested Outcomes:

1) That ASHP adopt the proposed policy.

Following discussion, the item was approved for referral to the Board of Directors.

Recommendations. Chair Dodd called on members of the House of Delegates for Recommendations. (See Appendix XI for a complete listing of all Recommendations.)

Recognition. Chair Dodd recognized members of the Board who were continuing in office (Appendix XII). She also introduced members of the Board who were completing their terms of office.

As a token of appreciation on behalf of the Board of Directors and members of ASHP, Chair Dodd presented President Walker with an inscribed gavel commemorating his term of office.

Installation of Section Chairs. Chair Dodd then installed the chairs of ASHP's sections: Brody J. Maack, Section of Ambulatory Care Practitioners; Nancy MacDonald, Section of Clinical Specialists and Scientists; Allison King, Section of Inpatient Care Practitioners; Cher Enderby, Section of Pharmacy Educators; Hesham Mourad, Section of Pharmacy Informatics and Technology; Lindsey R. Kelley, Section of Pharmacy Practice Leaders; Denise Scarpelli, Section of Specialty Pharmacy Practitioners; William Moore, New Practitioner's Forum; and Tyler Darcy, Pharmacy Technician Forum. Chair Dodd then recognized the remaining members of the executive committees of sections and forums.

ASHP-PAC Fundraising Competition. Chair Dodd then announced the results of the House of Delegates ASHP-PAC Fundraising Competition. Delegates from Idaho took first place, second place went to New Hampshire, and Kansas came in third. The competition raised $13,512 to advance ASHP advocacy priorities.

Announcement of Board Awards. President Walker then announced the recipients of various Board of Directors awards.

Installation of Directors. Chair Dodd then installed Vickie Powell as a Director of ASHP and announced that Jennifer Tryon would be installed as a Director at a later date (Appendix XII).

Installation of the President. Chair Dodd then installed Nishaminy Kasbekar as President of ASHP (Appendix XII). (See Appendix XIII for the Inaugural Address of the Incoming President.)

Adjournment. The 75th annual June meeting of the House of Delegates adjourned at 6:00 p.m.

Appendix I

ROSTER - HOUSE OF DELEGATES

Baltimore, Maryland
June 11-13, 2023

Presiding – Melanie A. Dodd, Chair
Linda S. Tyler, Vice Chair

First Meeting: Sunday, June 11, 2023
Second Meeting: Tuesday June 13, 2023

OFFICERS AND BOARD OF DIRECTORS
Paul C. Walker, President
Nishaminy Kasbekar, President-Elect
Linda S. Tyler, Immediate Past President
Christene M. Jolowsky, Treasurer
Paul W. Abramowitz, Chief Executive Officer
Kim W. Benner, Board Liaison, Council on Education and Workforce Development
Leigh A. Briscoe-Dwyer, Board Liaison, Council on Pharmacy Management
Samuel V. Calabrese, Board Liaison, Council on Public Policy
Vivian Bradley Johnson, Board Liaison, Council on Pharmacy Practice
Pamela K. Phelps, Board Liaison, Council on Therapeutics
Jamie S. Sinclair, Board Liaison, Commission on Affiliate Relations
Melanie A. Dodd, Chair of the House

PAST PRESIDENTS			
Roger Anderson	Diane Ginsburg	Lynnae Mahaney	Kelly Smith
Daniel Ashby	Harold Godwin	Philip Schneider	Thomas Thielke
Debra Devereaux	Marianne Ivey	Kathryn Schultz	Sara White
Rebecca Finley	Thomas Johnson	Steven Sheaffer	T. Mark Woods
Lisa Gersema	Stan Kent	Janet Silvester	

STATE	**DELEGATES**	**ALTERNATES**
Alabama (3)	Nancy Bailey Laura Matthews Megan Roberts	Joshua Settle
Alaska (2)		
Arizona (3)	Janelle Duran Christopher Edwards Danielle Kamm[1] Lindsey Kelley[2]	Melinda Burnworth
Arkansas (2)	Jeff Cook Jama Huntley	Josh Maloney

California (7)	Gary Besinque Daniel Kudo Elaine Law Sarah McBane Stacey Raff James D. Scott Steven Thompson	Kathy Ghomeshi
Colorado (3)	Clint Hinman Lance Ray Tara Vlasimsky	Sarah Anderson
Connecticut (3)	Christina Hatfield Colleen Teevan	David Goffman
Delaware (2)	Cheri Briggs Brittany Tschaen	
Florida (5)	Kathy Baldwin Jeffrey Bush Julie Groppi Andrew Kaplan Farima Fakheri Raof	Arti Bhavsar William Terneus, Jr.
Georgia (3)	Davey Legendre Scott McAuley Christy Norman	Anthony Scott
Hawaii (2)	Marcella Chock	Joy Matsuyama
Idaho (2)	Audra Sandoval Victoria Wallace	Paul Driver
Illinois (5)	Megan Corrigan Andy Donnelly Bernice Man Jennifer Phillips Radhika Polisetty	Chris Crank R. Jason Orr Matt Rim Trish Wegner
Indiana (3)	Chris Lowe Christopher Scott Tate Trujillo	
Iowa (3)	Alice Callahan John Hamiel[1] Jenna Rose Emmeline Paintsil[2]	Melanie Ryan Marisa Zweifel
Kansas (3)	Brian Gilbert Joanna Robinson[1] Katie Wilson[1] Jeff Little[2] Katherine Miller[2]	Chris Bell
Kentucky (3)	Dale English Scott Hayes Thomas Platt	Kortney Brown Maggie English Suzi Francis

Louisiana (3)	Monica Dziuba Heather Savage Myra Thomas	Lisa Boothby
Maine (2)	Brian McCullough Kathryn Sawicki	
Maryland (4)	Marybeth Kazanas Janet Lee Dorela Priftanji Molly Wascher	John Hill Terri Jorgenson
Massachusetts (4)	Jacqueline Gagnon Monica Mahoney Francesca Mernick Russel Roberts	Marla O'Shea-Bulman
Michigan (4)	Rox Gatia Jesse Hogue Jessica Jones Rebecca Maynard	Lama Hsaiky Stephen Stout Ed Szandzik
Minnesota (3)	Kristi Gullickson Lance Oyen John Pastor	Scott Nei Cassie Schmitt Garrett Schramm
Mississippi (3)	Christopher Ayers Joshua Fleming Andrew Mays	Caroline Bobinger
Missouri (3)	Laura Butkievich Joel Hennenfent Amy Sipe	Nathan Hanson Christina Stafford
Montana (2)	Julie Neuman	Logan Tinsen
Nebraska (3)	Tiffany Goeller Katie Reisbig Jerome Wohleb	John Mildenberger David Schmidt
Nevada (2)	Adam Porath Kate Ward	
New Hampshire (2)	Tonya Carlton Elizabeth Wade	Melanie McGuire
New Jersey (4)	Julie Kalabalik-Hoganson Deborah Sadowski Craig Sastic Nissy Varughese	Barbara Giacomelli William Herlihy Urshila Shah
New Mexico (2)	Joe Anderson Amy Buesing	Lisa Anselmo Nick Crozier
New York (5)	Travis Dick Robert DiGregorio Frank Sosnowski Lisa Voigt[1] Kim Zammit Charrai Byrd[2]	Lijian Cai Heide Christensen Russ Lazzaro Daryl Schiller Steven Tuckman

North Carolina (4)	Angela Livingood Stephen Eckel[2] Mollie Scott Michael Stepanovic[2] Tyler Vest[1]	
North Dakota (2)	Maari Loy Elizabeth Monson	
Ohio (5)	Rachel Chandra Ashley Duty Kellie Evans Musch Kembral Nelson Jacalyn Rogers	Robert Parsons Rebecca Taylor
Oklahoma (3)	Jeremy Johnson Andrea Rai	Corey Guidry Christopher Pack
Oregon (3)	Ryan Gibbard Michael Lanning Edward Saito	Ryan Wargo
Pennsylvania (4)	Paul Green Arpit Mehta Joseph Stavish[1]	Scott Bolesta Kim Mehta Christine Roussel
Puerto Rico (2)		
Rhode Island (2)	Shannon Baker Martha Roberts	Ray Iannuccillo Karen Nolan
South Carolina (3)	Thomas Achey Carolyn Bell Lisa Gibbs	Laura Holden
South Dakota (2)	Joseph Berendse Anne Morstad	Alyssa Howard Laura Stoebner
Tennessee (4)	Kelly Bobo Don Branam Erin Neal Jodi Taylor	Jennifer Robertson Mark Sullivan
Texas (6)	Latresa Billings Joshua Blackwell Jerry James Rodney Cox Randy Martin Binita Patel	Todd Connor Bradi Frei Todd Canada
Utah (3)	Elyse MacDonald Anthony Trovato Whitney Mortensen	Kavish Choudhary David Young Lonnie Smith
Vermont (2)	Jennifer Burrier Kevin Marvin	Julie MacDougall
Virginia (4)	Catherine Floroff Amy Schultz Brian Spoelhof Darren Stevens	Neha Naik

Washington, D.C. (2)	Carla Darling Sumit Dua[1] Sue Carr[2]	
Washington State (4)	Lauren Bristow Rena Gosser Chris Greer James Houpt	Karen White Roger Woolf
West Virginia (2)	Chris Fitzpatrick Derek Grimm	
Wisconsin (4)	Monica Bogenschutz John Muchka William Peppard Kate Schaafsma	Tom Dilworth Tara Feller Courtney Morris Tahmeena Siddiqui
Wyoming (2)	Jonathan Beattie	
SECTIONS AND FORUMS	**DELEGATES**	**ALTERNATES**
Ambulatory Care Practitioners	Jaclyn Boyle	Brody Maack
Clinical Specialists and Scientists	Christi Jen	Nancy MacDonald
Community Pharmacy Practitioners	Melissa Ortega	Ashley Storvick
Inpatient Care Practitioners	Sarah Stephens	Allison King
Pharmacy Educators	James Trovato	Cher Enderby
Pharmacy Informatics and Technology	Benjamin Anderson	Hesham Mourad
Pharmacy Practice Leaders	Lindsey Amerine	Lindsey Kelley
Specialty Pharmacy Practitioners	Scott Canfield	Denise Scarpelli
New Practitioners Forum	Charnae Ross	Justin Moore
Pharmacy Student Forum		
Pharmacy Technician Forum	Cindy Jeter	Tyler Darcy
FRATERNAL	**DELEGATES**	**ALTERNATES**
U.S. Air Force	Lt Col Rohin Kasudia	Lt Col Jin Kim
U.S. Army	LTC Joe Taylor	MAJ Ryan Constantino
U.S. Navy	LT Staci Jones	LT Chirag Patel
U.S. Public Health Service	LCDR Kali Autrey	LCDR Bryan "Russ" Gunter CDR Christopher McKnight (Coast Guard)
Veterans Affairs	Heather Ourth	Anthony Morreale Virginia "Ginny" Torrise

[1]Seated in Sunday meeting only.

[2]Seated in Tuesday meeting only.

Appendix II

House of Delegates

REPORT ON THE VIRTUAL HOUSE OF DELEGATES

March 17-24, 2023

RESULTS OF THE VOTING

Between March 17 and 24, the ASHP House of Delegates (roster attached as an Appendix) voted on 17 policy recommendations. Delegates approved 10 policy recommendations by 85% or more, the threshold for final approval. Seven policy recommendations did not receive 85% of the votes and will be sent to the June House of Delegates.

POLICY RECOMMENDATIONS APPROVED

The 10 policy recommendations **approved** are as follows (percentage of delegates voting to approve follows the policy title):

Education and Training in Digital Health (96%)
Source: Council on Education and Workforce Development
To acknowledge that digital health is a growing modality that supports the pharmacy workforce in providing patient care; further,

To support training and education for the pharmacy workforce in innovative models that support digital health services; further,

To advocate for involvement of the pharmacy workforce in research on digital health services and outcomes.

Education and Training in Telehealth (97%)
Source: Council on Education and Workforce Development
To discontinue ASHP policy 2117, Education and Training in Telehealth, which reads:

To acknowledge that telehealth is a growing modality that supports the pharmacy workforce

in providing direct patient care; further,

To support training and education for the pharmacy workforce in innovative models that support telehealth services; further,

To promote the incorporation of students and residents into virtual modalities of care and interdisciplinary collaboration; further,

To foster documentation and dissemination of best practices and outcomes achieved by the pharmacy workforce as a result of telehealth services.

Digital Therapeutics Products (94%)
Source: Council on Pharmacy Management
To affirm the essential role of the pharmacist in the team-based evaluation, implementation, use, and ongoing assessment of digital therapeutic products to ensure the safety, effectiveness, and efficiency of medication use; further,

To encourage the pharmacy workforce to promote broader and more equitable use of digital therapeutic products by identifying and addressing barriers to patient and healthcare worker access to those products; further,

To encourage clinicians and researchers to establish evidence-based frameworks to guide use of digital therapeutic products; further,

To advocate that insurance coverage and reimbursement decisions regarding digital therapeutic products be made on the basis of those evidence-based frameworks.

Interoperability of Patient-Care Technologies (98%)
Source: Council on Pharmacy Management
To encourage interdisciplinary development and implementation of standards that foster foundational, structural, semantic, and organizational interoperability of health information technology (HIT); further,

To encourage the integration, consolidation, and harmonization of medication-related databases used in patient-care technologies to reduce the risk that outdated, inaccurate, or conflicting data might be used and to minimize the resources required to maintain such databases; further,

To encourage healthcare organizations to adopt HIT that utilizes industry standards and can access, exchange, integrate, and cooperatively use data within and across organizational, regional, and national boundaries.

Note: This policy supersedes ASHP policy 1302.

Patient Medication Delivery Systems (98%)
Source: Council on Pharmacy Practice
To foster the clinical and technical expertise of the pharmacy workforce in the use of medication delivery systems; further,

To advocate for key decision-making roles for the pharmacy workforce in the selection, implementation, maintenance, and monitoring of medication delivery systems; further,

To urge hospitals and health systems to directly involve departments of pharmacy and interprofessional stakeholders in performing appropriate risk assessments before new medication delivery systems are implemented or existing systems are upgraded; further,

To advocate that medication delivery systems employ patient safety-enhancing capabilities and be interoperable with health information systems; further,

To encourage continuous innovation and improvement in medication delivery system technologies; further,

To foster development of tools and resources to assist the pharmacy workforce in designing and monitoring the use of medication delivery system.

Education About Performance-Enhancing Substances (86%)
Source: Council on Pharmacy Practice
To encourage pharmacists to engage in and advise community outreach efforts informing the public on the risks associated with the use of performance-enhancing substances, including but not limited to medications; further,

To educate patients on the importance of disclosing the use of performance-enhancing substances that may or may not be prescribed for legitimate medical indications; further,

To encourage pharmacists to advise athletic authorities, athletes, the community, and healthcare providers on the dangers of performance-enhancing substances and other products that are prohibited in competition; further,

To advocate for the role of the pharmacist in all aspects of performance-enhancing substances control.

Note: This policy supersedes ASHP policy 1305.

Support for FDA Expanded Access (Compassionate Use) Program (95%)
Source: Council on Public Policy
To advocate that the Food and Drug Administration (FDA) Expanded Access (Compassionate Use) Program be the primary mechanism for patient access to drugs for which an

investigational new drug application (IND) has been filed, in order to preserve the integrity of the drug approval process and assure patient safety; further,

To advocate for broader patient access to such drugs under the FDA Expanded Access Program; further,

To advocate that IND applicants expedite review and release of drugs for patients who qualify for the program; further,

To advocate that the drug therapy be recommended by a physician and reviewed and monitored by a pharmacist to assure safe patient care; further,

To advocate for the patient's right to be informed of the potential benefits and risks via an informed consent process, and the responsibility of an institutional review board to review and approve the informed consent and the drug therapy protocol; further,

To support the use of the Right-to-Try pathway in instances in which all other options have been exhausted, provided there is (1) a robust informed consent process, and (2) institutional and clinical oversight by a physician and a pharmacist.

Note: This policy supersedes ASHP policy 1508.

Biosimilar Medications (97%)
Source: Council on Public Policy
To encourage the development of safe and effective biosimilar medications in order to make such medications more affordable and accessible; further,

To encourage research on the safety, effectiveness, and interchangeability of biosimilar medications; further,

To support legislation and regulation to allow Food and Drug Administration (FDA) approval of biosimilar medications that are also determined by the FDA to be interchangeable and therefore supports substitution for the reference product without the intervention of the prescriber; further,

To oppose the implementation of any state laws restricting biosimilar interchangeability; further,

To oppose any state legislation that would require a pharmacist to notify a prescriber when a biosimilar deemed to be interchangeable by the FDA is dispensed; further,

To require postmarketing surveillance for all biosimilar medications to ensure their continued safety, effectiveness, purity, quality, identity, and strength; further,

To advocate for adequate reimbursement for biosimilar medications that are approved by the FDA; further,

To promote and develop education of pharmacists, providers, and patients about biosimilar medications and their appropriate use within hospitals and health systems; further,

To advocate for patient, prescriber, and pharmacist choice in selecting the most clinically appropriate and cost-effective therapy.

Note: This policy supersedes ASHP policy 1816.

Licensure of Pharmacy Graduates (85%)
Source: Council on Public Policy
To support state licensure eligibility of a pharmacist who has graduated from a foreign or domestic pharmacy program accredited by the Accreditation Council for Pharmacy Education (ACPE) or accredited by an ACPE-recognized accreditation program.

Note: This policy supersedes ASHP policy 0323.

Pharmacogenomics (95%)
Source: Council on Therapeutics
To advocate that pharmacists take a leadership role in pharmacogenomics-related patient testing, based on current or anticipated medication therapy; further,

To advocate for the inclusion of pharmacogenomic test results in medical and pharmacy records in a format that clearly states the implications of the results for drug therapy and facilitates availability of the genetic information throughout the continuum of care and over a patient's lifetime; further,

To encourage health systems to support an interprofessional, evidenced-based effort to implement appropriate pharmacogenomics services and to identify and determine appropriate dissemination of actionable information to appropriate healthcare providers for review; further,

To encourage pharmacists to educate prescribers and patients about the use of pharmacogenomic tests and their appropriate application to drug therapy management; further,

To advocate that all health insurance policies provide coverage for pharmacogenomic testing to optimize patient care; further,

To advocate that drug product manufacturers and researchers conduct and report outcomes of pharmacogenomic research to facilitate safe and effective use of medications; further,

To encourage research into the economic and clinical impact of preemptive pharmacogenomic testing; further,

To encourage pharmacy workforce education on the use of pharmacogenomics and its application to therapeutic decision-making.

Note: This policy supersedes ASHP policy 2113.

POLICY RECOMMENDATIONS NOT APPROVED

The House **voted to not approve** the following seven policy recommendations (percentage of delegates voting to approve follows the policy title):

Well-Being and Resilience of the Pharmacy Workforce (84%)
Source: Council on Education and Workforce Development
To affirm that occupational burnout adversely affects an individual's well-being and healthcare outcomes; further,

To acknowledge that the healthcare workforce encounters unique stressors throughout their education, training, and careers that contribute to occupational burnout; further,

To declare that healthcare workforce well-being and resilience requires shared responsibility among healthcare team members and between individuals and organizations; further,

To encourage individuals to embrace well-being and resilience as a personal responsibility that should be supported by organizational culture; further,

To promote that pharmacy leadership collaborate with their institutions to assess the well-being and resilience of the pharmacy workforce and identify effective prevention and intervention strategies; further,

To encourage hospitals and health systems to invest in the development and assessment of programs aimed at prevention, recognition, and treatment of occupational burnout, and to support participation in these programs; further,

To encourage education, research and dissemination of findings on stress, burnout, and well-being; further,

To collaborate with other professions and stakeholders to identify effective prevention and intervention strategies that support well-being at an individual, organizational, and system level.

Note: This policy supersedes ASHP policy 1825.

Emergency Medical Kits (74%)
Source: Council on Pharmacy Practice
To recognize the importance of immediate, readily accessible emergency medical kits (EMKs) in locations inaccessible to emergency medical services; further,

To advocate for the inclusion of pharmacist expertise in the interprofessional decisions related to stocking and maintaining medications in EMKs; further,

To collaborate with other professions and stakeholders to determine appropriate locations for EMKs.

Raising Awareness of the Risks Associated with the Misuse of Medications (67%)
Source: Council on Pharmacy Practice
To encourage pharmacists to engage in community outreach efforts to provide education on the risks associated with use of medications for nonmedical purposes or from nonmedical sources; further,

To encourage pharmacists to advise authorities, patients, and the community on the dangers of using medications for nonmedical purposes.

Standardization of Medication Concentrations (81%)
Source: Council on Pharmacy Practice
To support adoption of nationally standardized drug concentrations and dosing units for medications administered to adult and pediatric patients, and to limit those standardized concentrations and dosing units to one concentration and one dosing unit when possible; further,

To encourage interprofessional collaboration on the adoption and implementation of standardized drug concentrations and dosing units across the continuum of care; further,

To encourage manufacturers and outsourcing facilities to provide medications in those standardized concentrations when it is clinically appropriate and feasible.

Note: This policy supersedes ASHP policy 1306.

Availability and Use of Fentanyl Test Strips (77%)
Source: Council on Therapeutics
To affirm that fentanyl test strips (FTS) have a place in harm reduction strategies for people who use drugs; further,

To support legislation that declassifies FTS as drug paraphernalia; further,

To promote continued widespread availability of and access to FTS at limited to no cost to the public; further,

To foster research, education, training, and the development of resources to assist the pharmacy workforce, other healthcare workers, patients, and caregivers in the use and utility of FTS; further,

To support the pharmacy workforce in their roles as essential members of the healthcare team in educating the public and healthcare providers about the role of FTS in public health effort.

Manipulation of Drug Products for Alternate Routes of Administration (83%)
Source: Council on Therapeutics
To advocate that the Food and Drug Administration encourage drug product manufacturers to identify changes in pharmacokinetic and pharmacodynamic properties of drug products when manipulated for administration through an alternate delivery system or different route than originally studied, and to make this information available to healthcare providers; further,

To collaborate with stakeholders to increase research on clinically relevant changes to pharmacokinetic and pharmacodynamic properties of drug products when manipulated or administered through a different route and to enhance the aggregation and publication of and access to this data; further,

To research and promote best practices for manipulation and administration of drug products through alternate routes when necessary; further,

To foster pharmacist-led development of policies, procedures, and educational resources on the safety and efficacy of manipulating drug products for administration through alternate routes.

DEA Scheduling of Controlled Substances (72%)
Source: Council on Therapeutics
To advocate that the Drug Enforcement Administration (DEA) establish clear, measurable criteria and a transparent process for scheduling determinations; further,

To urge the DEA to use such a process to re-evaluate existing schedules for all substances regulated under the Controlled Substances Act to ensure consistency and incorporate current science-based evidence concerning scheduling criteria; further,

To advocate that the United States Congress define the terms *potential for abuse*, *currently accepted medical use*, and *accepted safety for use* in the Controlled Substances Act; further,

To monitor the effect of DEA scheduling of products under the Controlled Substances Act and other abuse-prevention efforts (e.g., prescription drug monitoring programs) to assess the impact on patient access to these medications and on the practice burden of healthcare providers; further,

To advocate for the alignment of federal and state laws to eliminate barriers to research on and therapeutic use of Schedule I substances.

Note: This policy supersedes ASHP policy 1315.

NOTES ON VOTING

Ninety-five percent (209) of delegates to the virtual House of Delegates participated in the voting, with 96% (157) of state delegates voting. Ninety-six percent of registered past presidents voted, and 88% of state delegations had 100% participation by their delegates.

HOUSE OF DELEGATES

Melanie A. Dodd, Chair
Linda S. Tyler, Vice Chair

As of March 24, 2023

OFFICERS AND BOARD OF DIRECTORS
Paul C. Walker, President
Nishaminy Kasbekar, President-Elect
Linda S. Tyler, Immediate Past President
Christene M. Jolowsky, Treasurer
Paul W. Abramowitz, Chief Executive Officer
Kim W. Benner, Board Liaison, Council on Education and Workforce Development
Leigh A. Briscoe-Dwyer, Board Liaison, Council on Pharmacy Management
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Vivian Bradley Johnson, Board Liaison, Council on Pharmacy Practice
Pam Phelps, Board Liaison, Council on Therapeutics
Jamie S. Sinclair, Board Liaison, Commission on Affiliate Relations
Melanie A. Dodd, Chair of the House

PAST PRESIDENTS			
R. David Anderson	Debra Devereaux	Stan Kent	Janet Silvester
Roger Anderson	Fred Eckel	Robert Lantos	Kelly Smith
John Armitstead	Rebecca Finley	Herman Lazarus	Thomas Thielke
Daniel Ashby	Lisa Gersema	Gerald Meyer	Sara White
Paul Baumgartner	Diane Ginsburg	John Murphy	T. Mark Woods
Jill Martin Boone	Harold Godwin	Cynthia Raehl	David Zilz
Cynthia Brennan	Mick Hunt	Philip Schneider	
Bruce Canaday	Clifford Hynniman	Kathryn Schultz	
Jannet Carmichael	Marianne Ivey	Bruce Scott	
Kevin Colgan	Thomas Johnson	Steven Sheaffer	

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Alabama (3)	Nancy Bailey Laura Matthews Megan Roberts	Joshua Settle
Alaska (2)	Shawna King Laura Lampasone	
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Wisconsin (4)	Tom Dilworth John Muchka William Peppard Kate Schaafsma	Monica Bogenschutz Tara Feller Courtney Morris Tahmeena Siddiqui
Wyoming (2)	Jonathan Beattie Jaime Bobinmyer Hornecker	
SECTIONS AND FORUMS	**DELEGATES**	**ALTERNATES**
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Pharmacy Student Forum	Ma Emmanuelle (Ella) Domingo	Austen Werab
Pharmacy Technician Forum	Cindy Jeter	Tyler Darcy
FRATERNAL	**DELEGATES**	**ALTERNATES**
U.S. Air Force	Lt Col Rohin Kasudia	Lt Col Jin Kim
U.S. Army	LTC Joe Taylor	MAJ Ryan Constantino
U.S. Navy	LT Staci Jones	LT Chirag Patel
U.S. Public Health Service	LCDR Kali Autrey	LCDR Bryan "Russ" Gunter CDR Christopher McKnight (Coast Guard)
Veterans Affairs	Heather Ourth	Anthony Morreale Virginia "Ginny" Torrise

Appendix III

House of Delegates

REPORT ON THE VIRTUAL HOUSE OF DELEGATES

May 12-18, 2023

RESULTS OF THE VOTING

From May 12 to 18, the ASHP House of Delegates (roster attached as an Appendix) voted on seven policy recommendations. Delegates approved five policy recommendations statements by 85% or more, the threshold for final approval.

The five policy recommendations **approved** are as follows (percentage of delegates voting to approve follows the policy title):

Payer-Directed Drug Distribution Models (90.9%)
Source: Council on Pharmacy Management
To advocate that insurers and pharmacy benefit managers be prohibited from mandating drug distribution models that introduce patient safety and supply chain risks or limit patient choice.

Note: This policy supersedes ASHP policy 2248.

Use of Social Determinants of Health Data in Pharmacy Practice (88.1%)
Source: Council on Pharmacy Management
To encourage the use of patient and community social determinants of health (SDoH) data in pharmacy practice to optimize patient care services, reduce healthcare disparities, and improve healthcare access and equity; further,

To educate the pharmacy workforce and learners about SDoH domains, including their impact on patient care delivery and health outcomes; further,

To encourage research to identify methods, use, and evaluation of SDoH data to positively influence key quality measures and patient outcomes.

Note: This policy supersedes ASHP policy 2249.

Pharmacy Accreditations, Certifications, and Licenses (86.7%)
Source: Council on Pharmacy Management
To advocate that healthcare accreditation, certification, and licensing organizations adopt consistent standards for the medication-use process, based on established evidence-based principles of patient safety and quality of care; further,

To advocate that health-system administrators allocate the resources required to support medication-use compliance and regulatory demands.

Note: This policy supersedes ASHP policy 1810.

ASHP Statement on Leadership as a Professional Obligation (98.1%)
Source: Council on Pharmacy Management
To approve the ASHP Statement on Leadership as a Professional Obligation.

Note: This statement supersedes the ASHP Statement on Leadership as a Professional Obligation dated June 12, 2011.

ASHP Statement on Criteria for an Intermediate Category of Drugs (90.9%)
Source: Council on Therapeutics
To discontinue the ASHP Statement on Criteria for an Intermediate Category of Drugs.

The House **voted to not approve** the two following policy recommendations by the 85% supermajority and will be considered by the House of Delegates in June:

Reducing Healthcare Sector Carbon Emissions to Promote Public Health (81.9%)
Source: Council on Pharmacy Practice
To promote reducing carbon emissions from the healthcare sector through collaboration with other stakeholders; further,

To encourage members of the pharmacy workforce to seek out opportunities to engage in efforts to reduce carbon emissions in their workplaces and communities.

ASHP Statement on Precepting as a Professional Obligation (83.4%)
Source: Section of Pharmacy Educators
To approve the ASHP Statement on Precepting as a Professional Obligation.

NOTES ON VOTING

Over 95% (211) of delegates to the virtual House of Delegates participated in the voting, with 94% (154) of state delegates voting and 88% of state delegations having 100% participation by their delegates.

HOUSE OF DELEGATES

Melanie A. Dodd, Chair
Linda S. Tyler, Vice Chair
As of May 12, 2023

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Veterans Affairs	Heather Ourth	Anthony Morreale Virginia "Ginny" Torrise

Appendix IV

House of Delegates

HOUSE OF DELEGATES

REPORT OF THE

COMMITTEE ON NOMINATIONS

June 11, 2023

Baltimore, Maryland

Donald Kishi (Chair), California
Thomas Johnson (Vice Chair), South Dakota
Joshua Blackwell, Texas
Maritza Lew, California
Lisa Mascardo, Iowa
Milap Nahata, Ohio
Tyler Vest, North Carolina
Michael Nnadi (1st Alternate), Texas
Kuldip Patel (2nd Alternate), North Carolina
Brian Cohen (3rd Alternate), Texas

ASHP COMMITTEE ON NOMINATIONS

Madam Chair, Fellow Delegates:

The Committee on Nominations consists of seven members of ASHP who are appointed by the Immediate Past President. The Committee is charged with the task of presenting to you our best judgments about those persons who possess the tangible and intangible attributes of leadership that qualify them to serve as our officers and directors.

Selection of nominees for ASHP office involves a series of very challenging decisions on the part of the Committee. Ultimately, those decisions are intended to permit the membership to select leaders with the professional, intellectual, and personal qualities of leadership that will sustain the dynamism and pioneering spirit that have characterized both ASHP and its more than 60,000 members who provide patient care service across the entire spectrum of care.

First, the Committee must determine that a prospective nominee for office is an active member as required in the Charter. This is generally the easiest and most straightforward part of the Committee's work. The Committee must ascertain that each prospective nominee can perform the duties required of the office or offices to which he or she has been nominated. All nominees must be able to perform the duties of a Director, set forth in section 5.4 of the Bylaws. Presidential nominees must also be able to perform the duties of that office, set forth in article 4 of the Bylaws.

The more difficult part of the Committee's work is to assess those intangible qualities of emotional intelligence (empathy, self-awareness, self-regulation, social skills, and motivation), leadership, vision, engagement, and overall professional awareness that characterize the standout candidates – those truly able to provide leadership for ASHP and the profession. The Committee assesses the attributes of prospective candidates for office in areas such as:

- Professional experience, career path, and practice orientation.
- Leadership skills and leadership experience including but not limited to the extent of leadership involvement in ASHP and its affiliates.
- Knowledge of pharmacy practice and vision for practice and ASHP.
- Ability to represent ASHP’s diverse membership interests and perspectives.
- Communication and consensus building skills.

There are no right or wrong answers to these criteria. Certain qualities may be weighed differently at various points in the evolution of the profession.

The Committee’s year-long process of receiving nominations and screening candidates is designed to solicit extensive membership input and, ultimately, to permit the Committee to candidly and confidentially assess which candidates best fit ASHP’s needs. The Committee has met three times since the last session of the House of Delegates: in person on December 6, 2022, at the ASHP Midyear Clinical Meeting; via teleconference on March 15, 2023; and in person on April 19, 2023, at ASHP Headquarters. Review of nominees’ materials was conducted continuously between March and April 2023 solely via secure electronic transmissions. This process has been reviewed for quality improvement and will be repeated for the 2023–2024 nomination cycle.

As in the past, the Committee used various means to canvass ASHP members and state affiliates for candidates who they felt were most qualified to lead us. All members were invited via announcements in ASHP News and Daily Briefing, social media, online ASHP NewsLink bulletins, and the ASHP website to submit nominations for the Committee's consideration. Nominations from affiliated state societies were solicited through special mailings and the "state affiliate" edition of the online NewsLink service.

Based upon recommendations from membership, state affiliates, and ASHP staff, the Committee contacted over 830 individuals identified as possible candidates. Some individuals were invited to accept consideration for more than one office. Of the nominees who responded to the invitation to place themselves in nomination, the breakdown by office is as follows:

PRESIDENT-ELECT: 4 accepted
BOARD OF DIRECTORS: 17 accepted

A list of candidates that were slated was provided to delegates following the Committee's meeting on April 19, 2023.

The Committee is pleased to place in official nomination the following candidates for election to the indicated offices. Names, biographical data, and statements have been distributed to the House.

President-Elect

Leigh A. Briscoe-Dwyer, PharmD, BSPharm, BCPS, FASHP (Johnson City, NY)
Kristina (Kristy) L. Butler, PharmD, BSPharm, BCACP, FASHP, FOSHP (Portland, OR)

Board of Directors, 2024-2027

Jeffrey J. Cook, PharmD, MS, MBA, CHFP (Little Rock, AR)
Dawn M. Moore, PharmD, MS, CPEL, FACHE (Indianapolis, IN)
Douglas C. Slain, PharmD, BCPS, FASHP (Morgantown, WV)
Majid-Theodore R. Tanas, PharmD, MHA, MS, FASHP (Portland, OR)

Board of Directors, 2023-2025

Marie A. Chisholm-Burns, PharmD, PhD, MPH, MBA, FACHE, FASHP, FAST (Portland, OR)
Kristine (Kristi) K. Gullickson, PharmD, MBA, DPLA, FASHP, FMSHP (Minneapolis, MN)

Please note that current Board member Sam Calabrese will join ASHP as Vice President, Accreditation Services Office, effective June 2023. To fill his vacated seat on the ASHP Board of Directors, the Committee on Nominations has slated two candidates to serve the remaining two years of his term (2023-2025).

Madam Chair, this completes the presentation of candidates by the Committee on Nominations. Congratulations to all the candidates.

CANDIDATES FOR PRESIDENT 2024–2025

Leigh A. Briscoe-Dwyer, PharmD, BSPharm, BCPS, FASHP (leigh.briscoe-dwyer@nyuhs.org) is the system director of pharmacy for the UHS Hospitals System in Johnson City, NY. She received her Bachelor of Science in Pharmacy from Albany College of Pharmacy and her Doctor of Pharmacy degree from St. John's University. She began her career as a clinical specialist in HIV and infectious disease at SUNY Stony Brook and has worked in various areas of pharmacy practice, including the pharmaceutical industry, with the majority of the last 20 years in pharmacy leadership roles.

Her ASHP service includes Board of Directors (2020-2023), chair, Committee on Nominations, Council on Public Policy, the FASHP Recognition Committee, and New York State delegate to the ASHP House of Delegates for over ten years. She is a past president of the Long Island Society of Health-system Pharmacists and was very active in the New York State Council of Health-system Pharmacists as a board member and presidential officer. In addition, she served on the New York State Board of Pharmacy for ten years in several capacities, including as its chair.

She is a member of the Board of Trustees of Albany College of Pharmacy and Health Sciences and is chair of its Academic Affairs Committee. She has received numerous recognitions for her contributions to pharmacy, including the Distinguished Alumnus Award from St. John's University, the NYSCHP Board of Directors Award, and the NYSCHP Research and Education Foundation Bernard Mehl Leadership Award.

Statement:
The pharmacy profession has emerged in the last decade to be a driving force in the transformation of healthcare. As external disruptors enter the market, the profession needs to remain focused on its strengths while capitalizing on the opportunities this presents.

The public perception of pharmacy does not appear to be reflective of the work we do in health systems today. An appreciation for a reliable medication-use system that has a positive impact on every patient it touches must be a priority for our profession. We need to continue to strengthen the voice of pharmacy so we retain our current workforce and continue to attract the best and brightest as we move forward to the future of our practice. That practice will not focus on drug distribution but on efficiencies gained with technology, genomics, and digital health.

As we emerge from the pandemic into the future of healthcare, it is my wish that the profession of pharmacy will be recognized as:

- *Providers of life-saving patient care rather than of products*
- *Experts in active medication management rather than passive monitors of medication use*
- *True financial contributors who have earned a seat at the table rather than simply cost centers*
- *Leaders of healthcare organizations beyond management of pharmacy departments*
- *Members, once again, of the most trusted profession*

ASHP remains well-positioned to lead the profession into this future, and it would be an honor for me to serve as ASHP President.

Kristina (Kristy) L. Butler, PharmD, BSPharm, BCACP, FASHP, FOSHP (Kristina.Butler@providence.org) is the manager of Primary Care Clinical Pharmacy Services for the Oregon market of Providence St. Joseph Health. She leads a large team to provide robust clinical pharmacy services, population health management, quality and utilization initiatives, education, and support of operational priorities in ambulatory care. Additionally, she serves on several committees for Providence and collaborates with healthcare leaders across settings in Providence's multi-state, integrated health system.

Butler previously practiced as a clinical pharmacy specialist in Primary Care with Providence and at Oregon Health & Science University (OHSU). She received her BS in Pharmacy from Oregon State University (OSU) and her PharmD from OSU/OHSU. She completed a specialized pharmacy residency in primary care through Providence in Portland, OR and is board certified in ambulatory care. She is an author of several book chapters and invited speaker at numerous ASHP and regional conferences on establishing, managing, and advancing pharmacy practice; precepting; well-being and resilience; value-based care and population health; and continuous professional development.

Her ASHP service includes Board of Directors (2019-2022); chair, Section of Ambulatory Care Practitioners; chair, Council on Public Policy; member, Ambulatory Care Conference & Summit's Consensus Recommendations Panel; and delegate, ASHP House of Delegates. Butler has also served the Oregon Society of Health-System Pharmacists (OSHP) in several roles, including president. She has received recognition for her contributions to the profession as a Fellow of ASHP and OSHP, OSHP Pharmacy Practitioner of the Year, OSHP Pharmacist of the Year, and OSU College of Pharmacy's inaugural Outstanding Young Alumni Award recipient.

Statement:
Ideal team-based care allows each healthcare expert to practice at top of their education and training, collaborating for a common goal: helping the patient achieve optimal health. Pharmacists are essential members of the healthcare team, and we must ensure that every patient in every setting has equitable access to comprehensive pharmacy services and optimal, safe, and effective medication use.

As healthcare systems work to solve long-standing, new, and future challenges, it requires highly functional teams of leaders who each contribute their expertise to reach a common goal: optimal healthcare. To achieve this, we must advance population health, stabilize costs and reduce waste, enhance the patient care experience, improve healthcare workers' well-being, and ensure health equity… that is, we strive for the "Quintuple Aim." The pharmacy enterprise is uniquely qualified to lead and transform patient-centered care, technology and data science, and medication use and safety to support these aims.

I believe that pharmacists and the pharmacy workforce must embrace our position as medication experts and leaders, taking accountability for medication use, health equity, and high-value care with individual patients and in healthcare as a whole. This belief is foundational to my career as a clinician and leader and to my service to the profession with ASHP. I am grateful to have the opportunity to advance the role of pharmacists and the pharmacy workforce in patient care and leadership teams and to serve patients, our profession, and the members of ASHP. I am truly honored to be nominated as ASHP President.

CANDIDATES FOR BOARD OF DIRECTORS 2024–2027

Jeffrey J. Cook, PharmD, MS, MBA, CHFP (jcook@uams.edu) is the chief pharmacy officer and assistant dean for the College of Pharmacy at the University of Arkansas for Medical Sciences in Little Rock, Arkansas. Having served eight years in the U.S. Army and having practiced pharmacy in community hospitals, academic health systems, and integrated delivery networks, he has broad perspectives on unique leadership challenges across health-system pharmacy.

Committed to the profession through education, Jeffrey has been actively precepting learners for almost twenty years. He has been a key contributor to residency programs from HSPAL and postgraduate year 1 and has built confidence in the professionals responsible for the future. Jeffrey received his MBA from Stetson University, his MS in Pharmacy Economics from The University of Florida, and his PharmD from The Ohio State College of Pharmacy. He recently strengthened his understanding of the financing of healthcare through HFMA, by acquiring skills as a Certified Health Finance Professional. He is working toward a greater commitment to 340B preservation through the Apexus Certified Expert (340B ACE) certificate training.

Jeffrey is serving ASHP as one of two Arkansas delegates to the House of Delegates. He also serves on the ASHP Section of Pharmacy Educators Section Advisory Group for Collaboration between Health Systems and Academia. He is the former Chair of the Arkansas Association of Health-System Pharmacists Hospital Advisory Group. He is frequently invited to present on leadership and pharmacy topics within the state. Jeffrey was recently honored with the 2022 American Association of Colleges of Pharmacy (AACP) Master Preceptor Award.

Statement:
The healthcare industry is unique in structure and function but shares the common problem of limited resources. As the financing of healthcare moves to a value-based payment approach, pharmacy professionals get an opportunity to step up and help be part of the solutions needed to improve our healthcare in the U.S. Being a pharmacy professional today means working in uncertain times, but it also means being creative with solutions that solve problems we see on a daily basis.

If we continue to work toward raising standards in education, enabling the maximum potential for our clinicians (top-of-license activity), and diversifying our teams to enable better collaboration, we will see more solutions and fewer problems.

The financing of healthcare is complicated, but pharmacy professionals can intervene at points along the continuum of care that can result in better outcomes, cost-savings, increased coverage of care, and better use of limited resources overall.

This is a fight that can't just take place in the health systems across the country. This fight has to start with advocating for improvements at the local, state, and federal levels. When we see something, we say something and work to fix the problem in a manner that is beneficial overall. Some of the most pressing issues today include 340B protections, workforce shortages, and rising costs in healthcare.

ASHP has played a vital role in giving our profession the voice to make a difference. It would be an honor and a privilege to serve on its Board.

Dawn M. Moore, PharmD, MS, CPEL, FACHE (DMoore4@ecommunity.com) is the vice president and chief pharmacy officer at Community Health Network in Indianapolis, Indiana, and an affiliate assistant professor at Purdue University and Butler University. Moore earned her Doctor of Pharmacy degree from Florida A&M University and MS from University of Wisconsin.

In her current role, she oversees the strategic, administrative, and operational initiatives of the pharmacy enterprise's nine-hospital, 1,230-bed health system with over 200 sites of care, encompassing inpatient, retail, specialty, ambulatory care pharmacy, homecare, and infusion pharmacy services. With over 22 years of experience leading hospital and health-system pharmacies, she is skilled at driving quality and safety in patient care, optimizing medication revenue integrity, decreasing drug costs and inappropriate utilization, and expanding and implementing new practices.

She is a member of the ASHP Pharmacy Executive Leadership Alliance and has served as a member of the ASHP Task Force on Racial Diversity, Equity, and Inclusion; ASHP Multi-Hospital Health-System Pharmacy Executive Committee; ASHP Women in Pharmacy Leadership Steering Committee; ASHP Council on Pharmacy Management; and as adjunct faculty to the ASHP Foundation Pharmacy Leadership Academy. In addition to her leadership within ASHP, she leads in her community as a board member, Indianapolis Coalition for Patient Safety; member, Indiana Healthcare Executives Network, and served as president, Indiana Pharmacy Association. Her passion to address health disparities cultivated her interest as a board member and chair, The Martin Center for Sickle Cell Initiative. Nationally, she served as a member, Vizient Purchasing Council; and founding member, Advisory Board Pharmacy Executive Forum.

Statement:

"Not everything that is faced can be changed, but nothing can be changed until it is faced."
— James Baldwin

As healthcare practitioners, we are called to enhance the health and well-being of patients and the communities we serve. As the profession continues to recover from the pandemic, evolves, and modernizes, addressing future opportunities and challenges will require us to think boldly and act persistently.

Nationally, ASHP is well-positioned to lead our profession into tomorrow's pharmacy landscape. But it will also require each of us, at the state and local levels, to advocate for what I believe are critical initiatives:

- *Create a sustainable workforce to meet the future competency and quantity needs of the profession to serve our patients and communities.*
- *Ensure the safety of expanded care deliveries, in-home medical services, and virtual care through pharmacist-led partnerships with nontraditional providers.*
- *Integrate telemedicine and other innovative digital health strategies, such as artificial intelligence/machine learning, into pharmacy practice allowing for improved population health management and workflow efficiencies and supporting clinicians to practice at the top of their license.*

- *Mitigate business strategies threatening the access and distribution of medications (including 340B programs, site-of-care restrictions, and white bagging) and ensure safe medication use for all patients.*
- *Foster pharmacy workforce diversity to closely reflect the patient populations served.*

Together, through our bold and persistent actions, we can face and overcome these challenges!

It is an honor to be slated, and it would be a privilege to serve on the ASHP Board.

Douglas C. Slain, PharmD, BCPS, FASHP (dslain@hsc.wvu.edu) is a professor & infectious diseases clinical specialist at West Virginia University (WVU) School of Pharmacy and WVU Medicine's J.W. Ruby Memorial Hospital and Clinics. He also serves as the chairman of the Clinical Pharmacy Department. Slain received his pharmacy bachelor's degree and his Doctor of Pharmacy degree from Duquesne University in Pittsburgh. He then completed a residency and fellowship in infectious diseases pharmacotherapy at the Virginia Commonwealth University (VCU)-Medical College of Virginia (MCV) Hospitals in Richmond.

Slain has been extensively involved with ASHP. He has served as chair and director-at-large of the Section of Clinical Specialists & Scientists, as chair of the Council on Therapeutics, as a voting member of the historic Pharmacy Practice Model Initiative (PPMI) Summit, as a member of the 2012-2013 Task Force on Organizational Structure, as a delegate to the House of Delegates, and as vice president of the West Virginia Society of Health-System Pharmacists (WVSHP). Slain has also served as a postgraduate year 2 residency program director for over 20 years.

Statement:
Pharmacy is a noble profession that is strengthened by our collective efforts, which are shared, fostered, and enhanced through engagement with national associations like ASHP. When I look at our profession with a strategic lens of a SWOT (strengths, weaknesses, opportunities, and threats) analysis, I like our chances for continued success. During my career, I have witnessed a resiliency in our profession that has been able to address many challenges to our mission to provide optimal and safe medication use.

Healthcare needs remain top of mind for many people. As we emerge from a global pandemic, we are also in a time where the large "baby boom" generation has significant medication needs. These needs can be even greater during transitions of care. I would like to see pharmacists take on an even larger role in caring for patients across all care settings. A few other areas that ASHP should continue to address are:

- *Promoting pharmacy careers to ensure a healthy pipeline of talented future pharmacists.*
- *Developing a vibrant and well-trained technician workforce.*
- *Promoting an environment that values diversity and is inclusive for our members and patients.*
- *Advocating for a reliable medication supply chain.*
- *Promoting medication safety, effectiveness, and affordability.*

I am grateful for having the opportunity to serve ASHP and its members in a greater role. I am happy to provide my experience as a clinician, educator, and leader to help us to deliver the best opportunities for our membership, the profession, and the patients that we serve.

Majid-Theodore R. Tanas, PharmD, MHA, MS, FASHP (mtanas@lhs.org) is the chief pharmacy officer at Legacy Health, an eight-facility, 1,200-bed community health system ranging from a Level 1 trauma center to a critical access medical center, including pediatric and psychiatric specialty services. Tanas earned a BS in biochemistry from Whitworth University, an MS in biotechnology from Washington State University, a Doctor of Pharmacy from Washington State University, and a Master of Health Administration from the University of Washington during his two-year pharmacy administration residency at the University of Washington.

Tanas has been an active member of ASHP over the past 20 years, beginning as a student in 2003. Since graduating from pharmacy school, he has served in the following appointments:

- New Practitioner Forum Communications and Public Affairs Advisory Group – Member (2007)
- New Practitioner Forum Leadership and Career Development Advisory Group – Member (2008)
- New Practitioners Forum Executive Committee (2009)
    - Pharmacy Practice Advisory Group – Executive Liaison
    - Science and Research Advisory Group – Executive Liaison
- Council of Pharmacy Practice (2010, 2011, 2012)
- House of Delegates: alternate (2014), delegate (elected in 2015)
- Board of Canvassers (2019-2022)
- Pharmacy Practice Leaders - Section of Multi-Hospital Pharmacy Executive: Member (2021), Vice-Chair (2022), Chair (2022-2023)

He serves as a faculty member for the Practical Training in Compounding Sterile Preparations Certificate (2022-2023). He has presented at numerous ASHP conferences, represented ASHP at an international conference as a delegate, and was recognized as a Fellow of ASHP in June 2022.

Statement:
The challenge ahead of pharmacy is evolving from an auditor of prescriptions to an initiator of care. Our charge is to improve an organization's financial viability, elevate clinical care at the bedside/clinic/counter, and improve medication safety.

With nearly 3 million nurses and 1 million physicians, the 300,000 pharmacists that make up our profession may be few in comparison, but our voice and impact in healthcare are far-reaching. Health systems must rapidly adapt from established business practices due to dwindling resources. The members of ASHP stand at the crossroads to advance health-system pharmacy, and we must forge ahead instead of looking to return to a pre-COVID era.

Health systems are essential for our communities and must enhance the care model, expanding the continuum of services across phases of care. Breaking down the silos between inpatient clinical care, ambulatory care, and outpatient pharmacy requires working together to move care to patients in new and creative ways. We must create integrative networks that meet patient care at every level to carry out our sacred responsibility of returning patients to their loved ones.

Let's not wait for an operational plan to be delivered. Instead, we must preemptively identify how the health-system pharmacy provides stability in uncertain times, how we can provide readily accessible services to our patients, and how pharmacy can create a safe and healing environment.

We are better together.

CANDIDATES FOR BOARD OF DIRECTORS 2023–2025

Marie A. Chisholm-Burns, PharmD, PhD, MPH, MBA, FACHE, FASHP, FAST (chishmar@ohsu.edu) is the executive vice president and provost of Oregon Health & Science University (OHSU) and the J.S. Reinschmidt Endowed Professor in the OHSU School of Medicine. She is also founder and director of the Medication Access Program, which has helped over 1100 solid-organ transplant recipients receive more than $112 million in prescription medications.

Chisholm-Burns received her BS in Pharmacy and Doctor of Pharmacy degrees from the University of Georgia, a Master of Public Health degree from Emory University, a Master of Business Administration degree from the University of Memphis, and a Doctor of Philosophy degree (emphasis: Health Sciences) from the University of South Dakota. She completed her residency at Piedmont Hospital and Mercer University Southern School of Pharmacy in Atlanta, Georgia.

Chisholm-Burns has been an active member of ASHP for 30 years. She served as the inaugural chair of the ASHP Section of Pharmacy Educators Executive Committee and is currently the immediate past chair. She is a member of the Pharmacy Forecast Advisory Committee and contributed to several Forecasts over the years, including 2023 (focused on health disparities) and 2021 (focused on healthcare access). She previously served in several ASHP leadership positions; for example, she served as director-at-large of the ASHP Section of Clinical Specialists and Scientists Executive Committee, as a member of the Center for Health-System Pharmacy Leadership Advisory Panel, and as a member of the *AJHP* editorial board. Additionally, Chisholm-Burns has received several awards from ASHP, including the 2022 Distinguished Leadership Award.

Statement:
The health of our communities is paramount but cannot be achieved without equitable healthcare access and delivery. My vision for pharmacy practice is to promote access and success – specifically, access to healthcare and success in eliminating health disparities and optimizing patient outcomes. Throughout my career, I have highlighted the value of pharmacists in advancing access and success in patient care. With support from others, including ASHP and its members, I documented extensive evidence of the beneficial effects of pharmacist-provided direct patient care. Such evidence supports inclusion of pharmacists in interprofessional healthcare delivery models as a strategy to increase access, improve outcomes, and reduce healthcare costs (this research has been published, presented nationally, and received multiple awards).

To ultimately achieve this vision of access and success, however, we should be cognizant of challenges facing healthcare professionals, including pharmacists, particularly issues related to stress/burnout. We must work together to facilitate well-being and supportive work environments. Further, we should enhance diversity, equity, and inclusion, not only for patients and communities we serve but also for members of our profession. And we should strive to promote access and success by:

- *Advocating for pharmacists to practice at the top of their license*
- *Supporting patients, pharmacy students, and pharmacists*
- *Expanding practice and care delivery, including greater participation on interprofessional healthcare teams*
- *Focusing greater attention on outreach in underserved and marginalized populations*

I am greatly honored to be nominated for the ASHP Board of Directors. It would be my privilege to serve the esteemed membership of ASHP.

Kristine (Kristi) K. Gullickson, PharmD, MBA, DPLA, FASHP, FMSHP (kristi.gullickson@allina.com) is director of pharmacy at Abbott Northwestern Hospital, part of Allina Health in Minneapolis, Minnesota. She is responsible for inpatient, infusion, and ambulatory pharmacy services with additional system-level responsibility for Allina Health pharmacy operations and oncology. She is the residency program director for the hospital's health-system pharmacy administration & leadership (HSPAL) postgraduate year 2 residency program and has precepted residents and leadership students for over 25 years.

Kristi received her Bachelor of Science in pharmacy and Doctor of Pharmacy from North Dakota State University. She completed a pharmacy practice residency at Abbott Northwestern Hospital and earned a diploma from the ASHP Pharmacy Leadership Academy. She received her MBA in healthcare administration from New England College.

Kristi currently serves ASHP as faculty, Manager Boot Camp and delegate, House of Delegates. She previously served as chair, Section of Pharmacy Practice Leaders (SPPL) Executive Committee; chair, Council on Pharmacy Practice; member, SPPL section advisory groups; member, multi-year House of Delegates; contributor, ASHP Leadership Basics Certificate; ASHP expert panel member for the ASHP Guidelines on Preventing Diversion of Controlled Substances and the ASHP/APhA Medication Management in Care Transitions project. Kristi is a past president of the Minnesota Society of Health-System Pharmacists (MSHP) and currently represents MSHP on the Minnesota Pharmacy Alliance practice advocacy group. Kristi is a Fellow of ASHP and MSHP and was awarded the MSHP Hallie Bruce Memorial Lecture Award, Minnesota's highest honor, in 2020.

Statement:
Health systems are facing significant volatility with negative operating margins, workforce shortages, payer mandates, legislative threats, and disruptors. There is no better time to differentiate our profession's unique contribution to improving health outcomes and driving value recognized by patients, payers, and policymakers. My vision for pharmacy practice is to leverage evolving care delivery models to improve access to pharmacists and pharmacy team services, transform pharmacist scope of practice, and advance the professionalization of our technician workforce. We will inspire compassion, service, and inclusion in our profession through connection and service to our community. We will collaborate through team-based care models and integrate into population health and payer contracts to improve health outcomes and reduce total cost of care.

ASHP has been my external compass for over 30 years, serving as my professional home. ASHP continues to lead with innovative best practices and policy guidance, advocacy and public policy, and incredible peer networking support that is truly second to none. It is critical that ASHP continues to collaborate with its members to advance priorities, including pharmacist provider status, improving access to equitable care and medications, supply chain integrity, 340B preservation, diversity, inclusion, and resilience and partner to revitalize efforts to recruit and retain our salient workforce for the future. Thank you for the honor of receiving this nomination. I would be grateful for the opportunity to serve on the ASHP Board.

Appendix V

House of Delegates

Board of Directors Report: Policy Recommendations for the June 2023 House of Delegates

Page

COUNCIL ON PHARMACY PRACTICE POLICY RECOMMENDATIONS

The Council on Pharmacy Practice is concerned with ASHP professional policies related to the responsibilities of pharmacy practitioners. Within the Council's purview are (1) practitioner care for individual patients, (2) practitioner activities in public health, (3) pharmacy practice standards and quality, (4) professional ethics, (5) interprofessional and public relations, and (6) related matters.

1. Emergency Medical Kits

To recognize the importance of immediate, readily accessible emergency medical kits (EMKs) in locations inaccessible to emergency medical services; further,

To advocate for the inclusion of pharmacist expertise in the interprofessional decisions related to stocking and maintaining medications in EMKs; further,

To collaborate with other professions and stakeholders to determine appropriate locations for EMKs.

Rationale

A social media movement called attention to the lack of standardization in emergency medical kits (EMKs) during an in-flight medical emergency. U.S. CFR 121.803 – Emergency Medical Equipment – requires certain medications and supplies for flights in case of medical emergencies but does not require the stocking of naloxone for reversing opioid overdoses or epinephrine auto-injectors for ease of administration, among many other medications and supplies. Many locations that are not accessible to emergency medical services (EMS), such as airplanes, contain a stock of emergency supplies and medications that are not standardized and may not be adequate to

manage some emergencies. In 2019, the Aerospace Medical Association Air Transport Medicine Committee sent recommendations to the Federal Aviation Administration regarding the contents of emergency medical kits, including recommendations to add naloxone and an epinephrine auto-injector (EpiPen).

The World Health Organization (WHO) has developed standardized health kits of medicines and medical supplies to meet different health needs in humanitarian emergencies and disasters. These kits are developed to provide reliable and affordable medicines and supplies quickly to those in need. The kits are used by United Nations agencies, nongovernmental organizations, and national governments. The contents of these kits are based primarily on the WHO's Essential Medicines list and guidelines on treatment of specific medial conditions. The contents of the kits are frequently reviewed and updated to adapt to changing needs based on experience in emergency situations. However, the WHO List of Essential Medicines does not specify an auto-injector for use in anaphylaxis.

There is growing concern regarding the need to standardize requirements set by a governing body to ensure that EMKs contain appropriate medications and supplies that are easy to use in an emergency, have been audited to ensure they contain the required items, have been stored appropriately, and do not contain expired products. Standardization of EMK contents would simplify flight crew and staff training requirements, which would include what products are contained within the EMKs, how to use them (when appropriate), and when to provide the kits in the case of an emergency. Finally, it is critical to collect and track incident and outcomes data to promote improvement in emergency response, and pharmacist involvement in the interprofessional evaluation of that data is essential.

Background

The Council examined this topic in response to suggestions from ASHP members. The recommendation came after a physician shared her experience assisting a passenger with a medical emergency on a flight to Europe. In an online article, the physician stated that if she and the crew had really needed to do something emergently to help a patient in distress, she would have been unprepared. The EMK she was provided included a disposable stethoscope and a disassembled blood pressure cuff and lacked a pulse oximeter, glucometer, and EpiPen. As the Council discussed this situation, they agreed that ASHP policy regarding stocking and maintaining EMKs is needed.

2. Raising Awareness of the Risks Associated with the Misuse of Medications

To encourage pharmacists to engage in community outreach efforts to provide education on the risks associated with use of medications for nonmedical purposes or from nonmedical sources; further,

To encourage pharmacists to advise authorities, patients, and the community on the dangers of using medications for nonmedical purposes.

Rationale

Misuse of medications involves the use of prescription and over-the-counter medications in ways that are not prescribed or directed. The use of medications for nonmedical purposes is also a category of misuse. Misuse may lead to serious consequences, such as emergency department visits, hospitalization, and death. While most of the evidence regarding medication misuse is related to opioids, central nervous system depressants, and stimulants, misuse of any medication may result in patient harm. As such, efforts to raise awareness of the risks of misusing any medication needs to prioritized, in addition to specific medications and medication classes. Pharmacists, as medication experts, can identify red flags and patterns of medication misuse and support community outreach efforts to help patients understand the risks associated with the misuse of medications.

Background

While the Council reviewed ASHP policy 1305, Education about Performance-Enhancing Substances, during sunset review, they noted a gap in ASHP policy related to the misuse of medications broadly. The Council felt that this proposed new policy would fill a gap between existing policies related to abuse and misuse of performance-enhancing and controlled substances.

3. Standardization of Medication Concentrations

To support adoption of nationally standardized drug concentrations and dosing units for medications administered to adult and pediatric patients, and to limit those standardized concentrations and dosing units to one concentration and one dosing unit when possible; further,

To encourage interprofessional collaboration on the adoption and implementation of standardized drug concentrations and dosing units across the continuum of care; further,

To encourage manufacturers and outsourcing facilities to provide medications in those standardized concentrations when it is clinically appropriate and feasible.

Note: This policy would supersede ASHP policy 1306.

Rationale

Standardization and simplification are widely accepted methods for reducing variability in processes and risk for error. With increased adoption of intelligent infusion devices, use of standard concentrations has enhanced infusion safety by eliminating most dosing and rate calculations. Standardizing concentrations reduces the potential for errors, particularly during transitions of care; simplifies ordering by providing fewer choices, which decreases provider

uncertainty; reduces operational variations, which enhances provider efficiency; and streamlines manufacturing, which accelerates production and allows for the formulation of premixed medications. In addition, broader use of standard concentrations might stimulate industry to offer a broader array of ready-to-administer infusions and facilitate the development of drug libraries.

In 2015, ASHP launched the Standardize 4 Safety (S4S) initiative. Funded by the U.S. Food and Drug Administration (FDA) and helmed by ASHP, S4S is the first national, interprofessional effort to standardize medication concentrations to reduce errors resulting from confusion over nonstandardized drug concentrations and errors that result from concentration differences when patients transition their care from one setting to another. To date, the expert committees have developed four lists—standardized concentrations for adult continuous infusions, pediatric continuous infusions, compounded oral liquids, and PCA/epidural infusion—and the S4S Initiative offers the pharmacy workforce other resources to help implement standardized concentrations.

Background

The Council reviewed ASHP policy 1306, Standardization of Intravenous Drug Concentrations, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To ~~develop~~ support adoption of nationally standardized drug concentrations and dosing units for ~~commonly used high-risk drugs that are given as continuous infusions~~ medications administered to adult and pediatric patients, and to limit those standardized concentrations and dosing units to one concentration and one dosing unit when possible; further,
>
> ~~To encourage all hospitals and health systems to use infusion devices that interface with their information systems and include standardized drug libraries with dosing limits, clinical advisories, and other patient-safety-enhancing capabilities; further,~~
>
> To encourage interprofessional collaboration on the adoption and implementation of standardized drug concentrations and dosing units ~~in hospitals and health systems~~ across the continuum of care; further,
>
> To encourage manufacturers and outsourcing facilities to provide medications in those standardized concentrations when it is clinically appropriate and feasible.

The Council suggested these amendments to broaden the scope of the policy beyond commonly used high-risk drugs to include a wider range of medications, to encourage limiting the standardized concentrations and dosing units to one where feasible, and to encourage manufacturers and outsourcing facilities to provide medications in those concentrations when appropriate and feasible.

4. Pharmacoequity

To recognize that disparities in standards of care negatively impact healthcare outcomes and compromise pharmacoequity in marginalized and underserved populations; further,

To recognize the impact of social determinants of health on pharmacoequity and patient outcomes; further,

To advocate that the pharmacy workforce identify and address threats and patient vulnerabilities to pharmacoequity as part of comprehensive medication management services; further,

To advocate for resources, including technology, that improve access to care for underserved populations where pharmacy access is limited; further,

To raise awareness about implicit and unconscious bias in healthcare decision-making that may compromise pharmacoequity; further,

To advocate for drug availability, drug pricing structures, and insurance coverage determinations that promote pharmacoequity.

Rationale

Pharmacoequity aims to ensure that all individuals regardless of race and ethnicity, socioeconomic status, or availability of resources, have access to the highest quality medications required to manage their health needs.[1] Barriers contributing to the lack of pharmacoequity include decreased access to care, increased costs of care, and differences in care based on provider bias (Essien UR, Dusetzina SB, Gellad WF. A policy prescription for reducing health disparities—achieving Pharmacoequity. *JAMA*. 2021;326(18):1793. doi:10.1001/jama.2021.17764). These barriers have helped raise awareness of the ABCs of solutions for promoting pharmacoequity: access, bias, and costs.

Decreased access to care may be due to insufficient prescription drug coverage or residing in a pharmacy desert. The current trends in the price of prescription drugs, combined with lack of insurance or underinsurance, results in lower use of prescribed medication and non-adherence. Pharmacists can help build culturally competent structures to reduce racial and ethnic disparities in healthcare through various means including promoting a more diverse work force, increasing awareness of disparities, promoting culturally competent care and services, researching and implementing best practices for providing culturally competent care, and ensuring effective communication with patients and among providers (ASHP Statement on Racial and Ethnic Disparities in Health Care, *Am J Health-Syst Pharm.* 2008; 65:728–33, doi.org/10.2146/ajhp070398).

Ensuring that all individuals regardless of race and ethnicity, socioeconomic status, or

availability of resources have access to the highest quality medications required to meet their needs will require a multifaceted approach. Promotion of culturally competent structures through increased awareness of disparities and diversification of the workforce, in addition to improving medication affordability and pharmacy access, are all steps needed to attain pharmacoequity.

Background

The Council examined this topic in response to suggestions from ASHP members. The Council considered existing ASHP policies, such as 2029, Preserving Patient Access to Pharmacy Services by Medically Underserved Populations, and 2231, Cultural Competency, and felt there was still a need to address pharmacoequity in a separate policy.

5. Medication Administration by the Pharmacy Workforce

To support the position that the administration of medications is part of the routine scope of pharmacy practice; further,

To support the position that members of the pharmacy workforce who administer medications should be skilled to do so; further,

To advocate that states grant pharmacists and appropriately supervised student pharmacists and pharmacy technicians the authority to administer medications; further,

To support the position that pharmacists should be participants in establishing procedures in their own work settings with respect to the administration of medications (by anyone) and monitoring the safety and outcomes of medication administration.

Note: This policy would supersede ASHP policy 9820.

Rationale

Laws, regulations, and local policies on medication administration vary greatly. Medications are routinely administered by many different practitioners, including nurses, physicians, radiology and nuclear medicine technologists, nurses aides, laboratory technologists, dental hygienists, respiratory therapists, and physical therapists. ASHP believes that administration of medications is part of the routine scope of pharmacy practice and supports laws, regulations, and local policies that allow for it and for medication administration by appropriately trained and supervised student pharmacists and pharmacy technicians. Decisions about pharmacists' involvement in medication administration should be made by individual healthcare organizations, which have an awareness of their resources and the adequacy of their medication administration processes. Patient need should be the primary factor in deciding who administers medications in any institution. In any case, all persons who administer medications, including pharmacists, student pharmacists, and pharmacy technicians, should be

appropriately trained to do so. Those who administer medications should be knowledgeable and skilled in the use of all medication administration and monitoring devices they use (e.g., syringes, infusion pumps, and blood glucose monitors). Finally, pharmacists should be involved in the institution's decision-making process regarding procedures used to administer medications.

Background

The Council reviewed ASHP policy 9820, Medication Administration by Pharmacists, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To support the position that the administration of medications ~~medicines~~ is part of the routine scope of pharmacy practice; further,
>
> To support the position that ~~pharmacists~~ members of the pharmacy workforce who administer medications ~~medicines~~ should be skilled to do so; further,
>
> To advocate that states grant pharmacists and appropriately supervised student pharmacists and pharmacy technicians the authority to administer medications; further,
>
> To support the position that pharmacists should be participants in establishing procedures in their own work settings with respect to the administration of ~~medicines~~ medications (by anyone) and monitoring the safety and outcomes of medication administration.

The Council suggested the amendments to acknowledge the medication administration roles of other members of the pharmacy workforce (student pharmacists, pharmacy technicians) and to add language advocating for recognition of those roles in state laws and regulations. Prior to this sunset review, policy 9820 did not have rationale. It has been added to these minutes and will move forward to be included in the next update of ASHP policies.

6. Reducing Healthcare Sector Carbon Emissions to Promote Public Health

To promote reducing carbon emissions from the healthcare sector through collaboration with other stakeholders; further,

To encourage members of the pharmacy workforce to seek out opportunities to engage in efforts to reduce carbon emissions in their workplaces and communities.

Rationale

ASHP acknowledges the scientific consensus on the adverse impact of carbon emissions on human health and the environment and recognizes the need to reduce carbon emissions, including from the healthcare sector. Climate change negatively impacts human health and

increases strain on the healthcare system. Health-related consequences of climate change that lead to increased morbidity and mortality include but are not limited to heat-related illnesses, respiratory illnesses, and vector-borne diseases. The 2015 Lancet Commission on Health and Climate Change concluded that addressing climate change is the greatest public health opportunity of the 21st century and that failure to adequately address climate change could undo most of the past century's progress in global health.

Carbon emissions are a target for addressing climate change. It has been estimated that the healthcare sector is responsible for 8.5% of carbon emissions in the U.S. Sources of healthcare carbon emissions rank as follows: healthcare facility operations (estimated to account for 7% of healthcare sector emissions); purchased sources of energy, heating, and cooling (11%); and healthcare sector procurements or supply chain for services and goods (>80%).

Healthcare organizations have been called upon to reduce their carbon footprint ("decarbonize") as a measure to promote patient and public health. The federal government has goals to decrease carbon emissions by 50% by 2030 and to achieve net-zero levels by 2050. Many healthcare-related organizations have made climate change and decarbonization pledges, including the members of the Medical Society Consortium on Climate & Health and organizations engaged in the National Academy of Medicine (NAM) Action Collaborative on Climate Change and as. In the fall of 2021, NAM launched the Action Collaborative on Decarbonizing the U.S. Health Sector (the "Climate Collaborative"), mobilizing four work groups: healthcare supply chain and infrastructure; healthcare delivery; health professional education and communication; and policy, financing, and metrics.

The pharmacy workforce has an important role in reducing carbon emissions from healthcare-related sources (Beechinor RJ et al. Climate change is here: what will the profession of pharmacy do about it? *Am J Health-Syst Pharm.* 2022; 79:1393-6). ASHP encourages collaboration with stakeholders that share a commitment to reducing carbon emissions from the healthcare sector and encourages members of the pharmacy workforce to seek out opportunities to engage in efforts to reduce carbon emissions in their workplaces and communities. To fill their roles in reducing carbon emissions, the pharmacy workforce will require education, training, and resources on emissions-reduction strategies. The development of evidence-based strategies will require research and dissemination of information on ways to reduce carbon emissions.

Background

The Council examined this topic in response to suggestions from ASHP members and staff. The Biden-Harris Administration and the Health and Human Services have called on healthcare stakeholders to (1) reduce their organization's emissions by 50 percent by 2030 and achieve net zero by 2050; (2) publicly report on their progress; (3) complete an inventory of Scope 3 (value chain) emissions; and (4) develop climate resilience plans for their facilities and communities. Since then, over 650 hospitals, health systems, suppliers, pharmaceutical and medical device companies, and other industry stakeholders submitted pledges to the White House with their commitments. Providence Health, Kaiser Permanente, The Joint Commission, the American College of Physicians, and NAM are among those organizations.

The Council noted that although many healthcare-related organizations have made

climate change and decarbonization pledges, there is a notable absence of pharmacy organizations, which offers ASHP an opportunity provide leadership in these important efforts. The Council suggested that ASHP express support for the NAM initiative as well as other collaborative efforts to reduce the healthcare sector's carbon footprint and pledge to foster education, training, and the development and dissemination of resources to support the pharmacy workforce in reducing carbon emissions. Further, the Council suggested that the Board of Directors consider developing an ASHP commitment statement on reducing healthcare carbon emissions, similar to the ASHP Commitment Statement on Diversity, Equity, and Inclusion.

COUNCIL ON THERAPEUTICS
POLICY RECOMMENDATIONS

The Council on Therapeutics is concerned with ASHP professional policies related to medication therapy. Within the Council's purview are (1) the benefits and risks of drug products, (2) evidence-based use of medicines, (3) the application of drug information in practice, and (4) related matters.

Pamela K. Phelps, *Board Liaison*

1. Availability and Use of Fentanyl Test Strips

To affirm that fentanyl test strips (FTS) have a place in harm reduction strategies for people who use drugs; further,

To support legislation that declassifies FTS as drug paraphernalia; further,

To promote continued widespread availability of and access to FTS at limited to no cost to the public; further,

To foster research, education, training, and the development of resources to assist the pharmacy workforce, other healthcare workers, patients, and caregivers in the use and utility of FTS; further,

To support the pharmacy workforce in their roles as essential members of the healthcare team in educating the public and healthcare providers about the role of FTS in public health efforts.

Rationale

In April 2021 the National Center for Health Statistics reported that in the past 12-month period there were over 100,000 drug overdose deaths in the United States, with fentanyl responsible

for over two thirds of those deaths. Fentanyl, a synthetic opioid, is 50 to 100 times more potent than morphine, and therefore the risk of overdose is higher than with other opioids, particularly when the person consuming the fentanyl is not aware of its presence or has not developed a tolerance to it.

Studies have shown that fentanyl test strips (FTS) are used by people who use drugs (PWUD) to check their drugs for the presence of fentanyl and mitigate overdose risk by making informed decisions about their safety when consuming. The findings of a 2018 study suggest that the distribution and use of rapid fentanyl test strips are a feasible and PWUD-accepted harm reduction tool to detect the presence of fentanyl in illicit drugs. As a result, as part of the effort to reduce overdoses and promote harm reduction, state and county health departments and community organizations across the United States have started to distribute FTS as a low-barrier, inexpensive drug-checking strategy. Through the SUPPORT Act, the Centers for Disease Control and Prevention, the U.S. Department of Health and Human Services, and the Substance Abuse and Mental Health Services Administration are permitted to provide funding to be used to purchase FTS as a part of harm reduction efforts.

Currently, a little more than half the states in the U.S. have laws that declassify FTS as drug paraphernalia. Laws in the remaining states that designate FTS as drug paraphernalia may prevent states and organizations from applying for those grants or using their own funds to purchase FTS. Although many states have legislation in the works to remove this barrier, some states are reluctant to make this change, due to the perception that the use of FTS as quality control devices could encourage PWUD to seek out a stronger high rather than reduce the use of fentanyl, reinforcing risky behavior.

Further research is needed to test the effectiveness of FTS use in combination with behavioral interventions to increase use of established harm reduction practices and risk-reduction behaviors, prevent or reduce the risk of opioid overdose, and to better understand how social and drug-using networks could be leveraged for dissemination of novel strategies such as fentanyl testing interventions into existing overdose education and naloxone distribution programs.

The pharmacy workforce is well equipped meet the needs of PWUD and the use of FTS. For example, in June of 2022, the Illinois General Assembly passed H.B. 4556, which expands the ability of pharmacists and other healthcare professionals to distribute FTS. The Ohio State University School of Pharmacy offers a naloxone and FTS training and distribution event as an effort to reduce harm, to meet patients where they are, and to provide services along a continuum of care. Legislation and programs like these demonstrate the value of the pharmacy workforce and should be expanded throughout the United States.

Background

The Council discussed the role fentanyl has played in exacerbating the overdose and death toll in the opioid epidemic. The Council reviewed the Office of National Drug Control Policy's harm reduction strategy, which focuses on syringe exchange services, naloxone distribution, and FTS; the availability federal funding for organizations to purchase FTS; and the research supporting their use. The Council noted that although the American Medical Association has brief statements on FTS, there are no other pharmacy organizations that support the use of FTS and that the public health benefits of a policy on FTS would be advantageous for ASHP.

2. Manipulation of Drug Products for Alternate Routes of Administration

To advocate that the Food and Drug Administration encourage drug product manufacturers to identify changes in pharmacokinetic and pharmacodynamic properties of drug products when manipulated for administration through an alternate delivery system or different route than originally studied, and to make this information available to healthcare providers; further,

To collaborate with stakeholders to increase research on clinically relevant changes to pharmacokinetic and pharmacodynamic properties of drug products when manipulated or administered through a different route and to enhance the aggregation and publication of and access to this data; further,

To research and promote best practices for manipulation and administration of drug products through alternate routes when necessary; further,

To foster pharmacist-led development of policies, procedures, and educational resources on the safety and efficacy of manipulating drug products for administration through alternate routes.

Rationale

Manipulation of a drug product can include crushing, splitting, or suspending it in a solvent, which can alter the pharmaceutical properties of the original dosage form. These manipulations are often performed because a patient requires the medication administered enterally but is unable to take the medication by mouth, requires a dose that is not readily available and so can only be delivered through manipulation, or is unable to swallow or has a feeding tube placed necessitating manipulation. For patients who lose the ability to swallow easily (e.g., due to stroke or cancer), it is sometimes quite difficult to provide all their drug products via liquid formulations or those that can be crushed, due to lack of such products.

Complicating the clinical picture is that in many studies of oral drug products the dose passes through the stomach, exposing it to a specific set of pH conditions. The stomach may be bypassed when drug products are administered via feeding tube to organ systems in the body that may have a different pH, affecting the adsorption, metabolism, or distribution of the drug. Some drug products cannot be administered because they are insoluble in aqueous solutions. In addition, the physical properties of the manipulated formulation may also cause obstruction and clogging of enteral tubes used for feeding and medication administration, leading to undesirable outcomes, including supra- or subtherapeutic concentrations in the body, which could lead for example to organ rejection in transplant patients, loss of viral suppression in HIV-positive patients, or toxicities when manipulating an extended-release tablet. There are also exposure risks to caregivers preparing or administering manipulated drug products that are carcinogenic or teratogenic.

Additionally, there are too few resources that provide guidance on how manipulation

may affect the bioavailability of the drug product or whether the manipulated drug product remains bioequivalent with the original dosage form. There is even less research or publicly available information on the clinical effects of manipulated drug products. ASHP encourages manufacturers and independent clinical and practice-based researchers to conduct studies on these subjects and to disseminate this information via journal articles and other easily accessible resources. ASHP also encourages education of the pharmacy workforce and other healthcare providers regarding the basic principles of and drug dosing for manipulated drug products.

Background

The Council discussed current challenges in treating patients who may be unable to take drug products in their original form by mouth due to issues with swallowing, dose titration, and the presence of feeding tubes. Members shared experiences in which the only way to find out whether a drug product can be crushed or crushed and dissolved/suspended is to call the manufacturer, who may or may not have information on a particular drug product. Members also noted that the increasing sophistication of manufacturing has included the use of binders that may not permit manipulation at all. The Council stated that information is not easy to find or does not exist and that questions about manipulation go far beyond inquiries on whether or not an extended-release tablet can be cut. Council members agreed that the FDA could incentivize manufacturers to perform studies on manipulation of original dosage forms, but they recognized that such incentives may lead to unintended negative consequences, including recommendations that drug products not be manipulated, which could lead to loss of therapy options. The Council also noted that an incentive may not be enough for manufacturers to pursue such studies. Therefore, the Council also recommended that ASHP pursue partnerships with other stakeholders in an approach similar to the Standardize for Safety Initiative to set standards and recommendations for manipulation and administration of drug products.

3. DEA Scheduling of Controlled Substances

To advocate that the Drug Enforcement Administration (DEA) establish clear, measurable criteria and a transparent process for scheduling determinations; further,

To urge the DEA to use such a process to re-evaluate existing schedules for all substances regulated under the Controlled Substances Act to ensure consistency and incorporate current science-based evidence concerning scheduling criteria; further,

To advocate that the United States Congress define the terms *potential for abuse*, *currently accepted medical use*, and *accepted safety for use* in the Controlled Substances Act; further,

To monitor the effect of DEA scheduling of products under the Controlled Substances Act and other abuse-prevention efforts (e.g., prescription drug monitoring programs) to

assess the impact on patient access to these medications and on the practice burden of healthcare providers; further,

To advocate for the alignment of federal and state laws to eliminate barriers to research on and therapeutic use of Schedule I substances.

Note: This policy would supersede ASHP policy 1315.

Rationale

Since its passage in 1970, the Controlled Substances Act (CSA) has served as the foundation of modern drug control policy by regulating the manufacture, importation, possession, use, and distribution of certain substances. The CSA lists eight factors to be considered by the Drug Enforcement Administration (DEA) when deciding if a molecular entity should be scheduled: (1) the potential for abuse; (2) scientific evidence of its pharmacological effect; (3) state of current scientific knowledge regarding the substance; (4) history and current pattern of abuse; (5) scope, duration, and significance of abuse; (6) risk to public health; (7) its psychic or physiological dependence liability; and (8) whether the substance is an immediate precursor of a substance already controlled. The CSA then specifies that the three criteria used to determine the schedule of a substance include (1) its potential for abuse; (2) whether it has a medical use; and (3) its safety and risk of dependence. Several limitations of the aforementioned factors and criteria are worth noting. First, the eight factors are redundant and lack clarity. Second, the CSA does not specify the relationship between the eight factors and the three criteria for scheduling, and the DEA has not yet clarified this matter.

Additionally, the CSA does not explicitly define the terms *potential for abuse* or *accepted medical use,* giving the DEA much discretion to apply the scheduling criteria. The DEA has maintained broad discretion when scheduling substances according to their abuse potential, through court rulings that have upheld the DEA's comparison of the substance in question to already-scheduled substances. The DEA has formally defined the term *currently accepted medical use* in response to repeated litigation regarding the classification of Schedule I substances. The criteria under this definition include: (1) the drug's chemistry must be known and reproducible; (2) adequate safety studies; (3) adequate and well-controlled studies proving efficacy; (4) the drug must be accepted by qualified experts; and (5) the scientific evidence must be widely available.

The lack of regulatory clarity of the CSA has led to a complicated process and inconsistent scheduling of substances. The language of the CSA implies that for a substance to be placed into a particular schedule, it must fulfill all three criteria. It is entirely possible, however, for one substance to fail to meet all three criteria of one schedule. Nonetheless, the DEA maintains that all scheduled substances without an accepted medical use must be classified as Schedule I, illustrating the conflicting scheduling practices used.

Furthermore, the existing schedules do not take into account evolving evidence about the abuse potential of these drugs. For example, gabapentin and pregabalin are structural analogues of gamma-aminobutyric acid, with pregabalin being classified as Schedule V under the CSA. Gabapentin, however, remains federally uncontrolled. An increase in its abuse has led some states to classify this medication as a Schedule V substance and/or mandate prescription

reporting.

Finally, the CSA also places many restrictions on medical research into Schedule I substances, creating barriers that hinder the discovery of their potential therapeutic uses. Therefore, ASHP first recommends that the United States Congress use their legislative authority to define the aforementioned terms in the CSA to simply the scheduling process. ASHP also advocates that the DEA establish clear, measurable criteria, to the extent possible for this complex subject, and a transparent process for scheduling determinations. Further, the DEA is encouraged to use those criteria to re-evaluate current schedule assignments for all controlled substances based on recent evidence. Finally, the DEA is urged to ease the burden on applicants for research on Schedule I substances.

Background

The Council reviewed ASHP policy 1315, DEA Scheduling of Controlled Substances, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

To advocate that the Drug Enforcement Administration (DEA) establish clear, measurable criteria and a transparent process for scheduling determinations; further,

To urge the DEA to use such a process to re-evaluate existing schedules for all substances regulated under the Controlled Substances Act to ensure consistency and incorporate current science-based evidence concerning scheduling criteria ~~the abuse potential of these therapies~~; further,

To advocate that the United States Congress define the terms *potential for abuse, currently accepted medical use,* and *accepted safety for use* in the Controlled Substances Act; further,

To monitor the effect of DEA scheduling of products under the Controlled Substances Act and other abuse-prevention efforts (e.g., prescription drug monitoring programs) to assess the impact on patient access to these medications and on the practice burden of healthcare providers; further,

To advocate for the alignment of federal and state laws to eliminate barriers to research on and therapeutic use of Schedule I substances.

4. Pharmacist Prescribing Authority for Antiretroviral Therapy for the Prevention of HIV/AIDS

To affirm that drug products for pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for human immunodeficiency virus (HIV) infection prevention should be provided to individuals in a manner that ensures safe and appropriate use; further,

To oppose reclassification of currently available drugs used for PrEP and PEP to nonprescription status; further,

To advocate for legislation and regulation that expands pharmacist scope of practice to encompass initiation of PrEP and PEP therapy; further,

To advocate that the therapies and associated care for PrEP and PEP are available to patients with zero cost-sharing; further,

To support establishment of specific and structured criteria to guide comprehensive pharmacist interventions related to PrEP and PEP; further,

To support the research, education, and training of the pharmacy workforce on the therapeutic, psychosocial, and operationalization considerations of pharmacist-provided PrEP and PEP therapy; further,

To support educating the public regarding the public health benefits of PrEP and PEP.

Rationale

Increasing access to pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for human immunodeficiency virus (HIV) infection prevention is a public health priority. Despite the increase in the availability of antiretroviral therapies for such prophylaxis, much of the patient population that would benefit from access, particularly those in the black, indigenous, and people of color communities, has been limited by stigma and other barriers, including a requirement for a prescription in many parts of the U.S. One of those barriers to access is that many states do not provide pharmacists independent authority to order and initiate PrEP and PEP therapy. Given the time-sensitive nature of these therapies, patients and their partners would benefit from being able to access them at community pharmacies. Those forced to seek medications through a physician's office or other site of care may struggle to find a timely appointment, especially if they do not have an established primary care provider. In contrast to physicians, community pharmacists are often available without an appointment and pose a potential solution to expanding access to therapy. Through policy, education, and infrastructure changes, pharmacists can be an alternate source for PrEP, expanding availability and further reducing HIV transmission.

ASHP advocates expanding pharmacists' scope of practice to include initiation of PrEP and PEP therapy, including associated screening, testing, monitoring, referrals, product selection, and counseling, as well as the establishment of specific and structured criteria for prescribing, dosing, and dispensing of PrEP and PEP by pharmacists. As one example, California Bill 159, approved in October 2019, authorizes pharmacists who undergo a board-approved training program to supply PrEP and PEP every two years, with a 60-day supply cap and certain conditions under which the therapies can be prescribed. In addition, insurance companies are not allowed to require prior authorization for these drug products. The goal of this law is to get patients on PrEP and then direct them to a prescriber for further care management. Other

states, including New York, Colorado, Missouri, and New Hampshire, are exploring similar programs. As these practices and programs vary from state to state, ASHP also recommends structured criteria be set that optimizes patient care and access to these drug products.

Expanding collaborative practice, in which pharmacists are permitted under an agreement with a prescriber to prescribe a defined list of medications along with associated monitoring, provides an effective way to advance the scope of pharmacy practice nationwide. A Seattle pharmacy operationalized such a program by forming a clinic in which pharmacists perform a history, risk assessment, lab testing, and education before dispensing PrEP. Implementation of a standing order for pharmacists to furnish PrEP for their patients may provide longitudinal benefit, and infrastructure for pharmacists to bill for these services, as well as the facilities to see patients, must accompany such policy changes. To ensure that patients who present for HIV prophylaxis receive comprehensive care, pharmacists should be allowed to order tests for other sexually transmitted infections at the patient's request when possible, as some community pharmacies and other sites of care may not have the ability to provide certain tests onsite.

ASHP opposes reclassification of currently available drugs used for PrEP and PEP (tenofovir and emtricitabine) to nonprescription status, because existing models for nonprescription dispensing do not provide the safeguards required to ensure safe and effective use.

Other barriers to access include a lack of insurance coverage and high out-of-pocket costs, insurers' refusal to cover brand medications when necessary, and insurers failing to cover all formulations, including pediatric formulations. Modifications to national, regional, and local drug coverage decisions are needed to ensure that payer policies do not unintentionally restrict or prevent access. To promote the broadest possible access, ASHP advocates that PrEP and PEP be available to patients with zero cost-sharing, regardless of income or insurance coverage.

Pharmacist initiation of PrEP and PEP therapies will likely result in an increased workload and potential liability associated with provision of this care, which includes patient screening (including point-of-care testing, if applicable), patient education, dosing, counseling, and documentation of the care provided in the pharmacy and medical record. ASHP policy 2020, Care-Commensurate Reimbursement, states that pharmacists should be compensated for these kinds of clinical and patient care services.

A survey of community pharmacists revealed that education and training are needed to advance pharmacy practice in PrEP and PEP therapy. Training in necessary laboratory testing, trauma-informed care, destigmatizaton, and appropriate follow-up should be done to ensure an adequate knowledge base for pharmacists unfamiliar with the procedures. Finally, ASHP supports public education regarding the public health benefits of PrEP and PEP therapy.

Background

The Council reviewed the combined policy recommendations from the Council on Public Policy and the Council on Therapeutics from the 2021 Policy Week meetings. The Council also discussed the complex considerations for patients, including the following: presenting for treatment of other infectious diseases that may warrant screening as they may be ideal candidates for PreP; comorbidities that may affect therapy; state reportable illnesses requirements; harm reduction strategies; gender-affirming care; safeguarding for

administration, as some new therapies are injectables; and special populations, including pregnant women and children. The Council also discussed the logistical barriers for training pharmacists for PReP and PEP prescribing, as Council members shared that most states where such prescribing is permitted may only require a little as 90 minutes of training, frequently only on the drugs themselves and not on other aspects such as screening, trauma-informed care, safe spaces, and other psychosocial aspects in caring for patient populations who may seek out PrEP or PEP. This level of training seems inadequate; in comparison, immunization programs often require more than 20 hours of training to certify pharmacists as an immunizer. The Council also discussed the role of the hospital and health system when considering initialing PrEP or PEP, particularly when dispensing from hospital supply to cover the transition of care from hospital to home. In many smaller institutions or in underserved areas, these drugs may need to be ordered or pharmacies may not be open when the patient is discharged. In addition, many hospitals and health systems only dispense a 3-day supply of medications upon discharge. The Council also recognized that much of what should be considered for standards of care would be too much for an ASHP policy and recommended that the ASHP Guidelines on Pharmacist Involvement in HIV Care be updated to reflect the changes in practice and therapies since its publication in 2016.

5. Point-of-Care Testing and Treatment

To advocate for laws and regulations that would include performing point-of-care testing (POCT) and associated diagnosis, referral, prescribing, dosing, and dispensing clinically indicated by POCT in pharmacists' scope of practice; further,

To support the development of specific and structured criteria for pharmacist diagnosis, referral, prescribing, dosing, and dispensing based on POCT; further,

To support the diagnosis and tracking of reportable diseases through pharmacist-managed POCT and reporting to public health agencies when appropriate; further,

To foster research on patient access and public health improvements, cost savings, and revenue streams associated with pharmacist-managed POCT and related patient care services; further,

To promote training and education of the pharmacy workforce to competently engage in POCT and related patient care services.

Note: This policy would supersede ASHP policy 2229.

Rationale

Point-of-care testing (POCT) is laboratory testing that takes place at or near the site where the patient is located. These tests are quality-assured pathology services using analytical tools such as blood gas; critical care analyzers; and meters for glucose, urinalysis, and other metabolites.

They can be used for both communicable and noncommunicable disease states, including influenza A and B, strep throat, diabetes mellitus, hypertension, anticoagulation, congestive heart failure, and stroke. POCT can be performed by patients in their home, using for example a device that monitors international normalized ratio (INR) for warfarin management, or in the field by healthcare providers, such as rapid strep testing in community pharmacies. POCT devices fall under the Federal Food, Drug, and Cosmetic Act and therefore are also subject to pre- and post-marketing surveillance and review.

As the shortage of primary care providers continues and POTC technology improves, there is ample opportunity to expand the pharmacy workforce's roles in disease screening, diagnosis, and management. POCT provides fast results, which can reduce the time to therapeutic intervention through test-to-treat services, often at a lower cost to patients than an office visit. Pharmacists are well positioned to conduct risk assessments, provide appropriate treatment and referrals when necessary, provide disease state monitoring services, and in turn, improve adherence and identify unnecessary or inappropriate medications. For example, the availability of rapid influenza tests allows pharmacists to quickly diagnose and recommend treatment for influenza A and B, which has been found to reduce the time to first dose of antiviral drugs among individuals with influenza-like illness, compared to those referred to prescribers. The combined benefits of telehealth and test-to-treat services should not be discounted. Newer technology that patients can use in the home, including smart scales that monitor changes in weight for congestive heart failure patients, home blood glucose monitoring systems for diabetic patients, and INR monitoring have already demonstrated improved patient outcomes in conjunction with pharmacist care. Numerous studies demonstrate that home POCT can be implemented to streamline healthcare services to patients with chronic and acute disease states and also limit hospital admissions, readmissions, and delays in care and can ultimately lead to better outcomes as well as cost savings for patients and providers.

State legislation concerning pharmacist-managed POCT varies widely. For example, in California, pharmacists are able to perform routine patient assessment procedures through POCT that includes testing for HIV antibodies, total cholesterol, glucose and hemoglobin A1c levels, opiates, blood ketones, thyroid-stimulating hormone, hematocrit, and prothrombin time. Most common is legislation that permits pharmacists in collaborative practice agreements to perform rapid testing to diagnose group A streptococcal pharyngitis and prescribe antimicrobial therapy when a test is positive. This practice model has been shown to decrease the cost of diagnosis and treatment for children and adults and has demonstrated increased patient satisfaction.

ASHP advocates development of specific and structured criteria for pharmacist prescribing, dosing, and dispensing of antimicrobials for this purpose, under a variety of models (e.g., autonomous prescribing authority for pharmacists, delegation protocols, or collaborative practice agreements). A 2018 study found that 69% of pharmacists are willing to perform POCT in a community pharmacy setting, and 86% either strongly agreed or agreed to be willing to recommend appropriate treatment for influenza and group A streptococcal pharyngitis. With collaborative practice agreements in place, patients can bypass visiting a primary care provider, empowering pharmacists to assume an active role not only in treating patients but also in promoting public health by reporting positive cases to local health departments, should rapid

testing and reporting be a requirement of dispensing. A Washington State University study demonstrated that after a POCT training module, student pharmacists were not only able to proficiently perform POCT for group A streptococcal pharyngitis, influenza, and human immunodeficiency virus, but also showed an increased willingness to perform and recommend the tests, which could expand access.

Background

The Council reviewed ASHP policy 2229, Pharmacist's Role in Respiratory Pathogen Testing and Treatment, with the goal of broadening it to more generally address the pharmacy workforce's role in POCT and recommending amending it as follows:

To advocate for laws and regulations that would include in pharmacists' scope of practice for performing point-of-care testing (POCT) and associated diagnosis, referral, prescribing, dosing, and dispensing that as clinically indicated by POCT ~~that state board of pharmacy regulations include respiratory pathogen testing and associated prescribing or dispensing under pharmacists' scope of practice~~; further,

To support the development of specific and structured criteria for pharmacist diagnosis, referral, prescribing, dosing, and dispensing based on POCT ~~of antimicrobials for treatment of respiratory infections~~; further,

~~To advocate for laws and regulations that would allow pharmacists to dispense antimicrobials when clinically indicated or refer patients, as appropriate, based on point-of-care testing; further,~~

To support the diagnosis and tracking of reportable diseases through pharmacist-managed POCT ~~driven testing~~ and reporting to ~~appropriate~~ public health agencies when appropriate ~~prior to dispensing of antimicrobials~~; further,

~~To advocate for reimbursement for pharmacists' patient care services involved in respiratory pathogen testing and treatment; further,~~

To foster research on patient access and public health improvements, cost savings, and revenue streams associated with pharmacist-managed POCT and related patient care services; further,

To promote training and education of the pharmacy workforce to competently engage in POCT and related patient care services ~~respiratory pathogen testing and treatment when clinically indicated~~.

The Council discussed the depth and breadth of the availability of POCT and the various ways these tests can be leveraged by pharmacists to provide patient-centered care across multiple sites of care. The Council also discussed the need for interoperable reports, standardized education and training, and successful reimbursement models. They also discussed how ASHP could provide education and training in the myriad of devices and further steps needed to integrate POCT into practice.

6. Nonprescription Availability of Oseltamivir

To support a behind-the-counter practice model that expands access to oseltamivir; further,

To support interoperable documentation of oseltamivir dispensing and associated testing accessible by all members of the healthcare team in outpatient and inpatient settings; further,

To support diagnosis and tracking of influenza through pharmacist-driven influenza point-of-care testing and reporting to the appropriate public health agencies prior to oseltamivir dispensing; further,

To advocate that specific and structured criteria be established for prescribing, dosing, and dispensing of oseltamivir for treatment and prophylaxis by pharmacists; further,

To advocate that pharmacist-provided counseling for oseltamivir and patient education on influenza be required for dispensing; further,

To continue to promote influenza vaccination by pharmacists, despite oseltamivir availability; further,

To advocate that the proposed reclassification of oseltamivir be accompanied by coverage changes by third-party payers to ensure that patient access is not compromised and that pharmacists are reimbursed for the clinical services provided.

Note: This policy would supersede ASHP policy 2116.

Rationale

Oseltamivir (Tamiflu) is a neuraminidase inhibitor used for the treatment and chemoprophylaxis of influenza. In July 2019, manufacturer Sanofi signed a deal with Roche Pharmaceuticals to obtain exclusive nonprescription rights to Tamiflu. ASHP supports the availability of oseltamivir via a behind-the-counter practice model. Use of this practice model, which has already been adopted for medications such as pseudoephedrine and emergency contraception, would facilitate appropriate use of oseltamivir and provide the pharmacist with an opportunity to provide patient assessment and professional consultation.

There are several perceived advantages and disadvantages of the nonprescription designation for oseltamivir. Potential benefits include quicker and improved oseltamivir access for patients, public health value by reducing exposure of sick individuals at provider visits, unlikely development of oseltamivir resistance based on currently available data, and experience with oseltamivir as a nonprescription medication in New Zealand since 2007. Potential concerns include stockpiling, shortages, questionable efficacy (an approximate

reduction in symptom duration of one day), adverse effects (e.g., nausea, vomiting, headache, neuropsychiatric effects), reduction of influenza vaccination rates because of oseltamivir availability, dosing considerations (e.g., renal function, pediatric weight-based dosing), costs, reimbursement for clinical services provided by pharmacists (e.g., point-of-care influenza testing, questionnaire screening tool for oseltamivir dispensing), blunting of other more severe underlying conditions without a provider visit, and overextension of pharmacist responsibilities and duties. Furthermore, public health considerations must also be a part of this expanded access. With availability over or behind the counter, patients may bypass visiting their primary care providers to obtain oseltamivir, and pharmacists will therefore need to assume an active role in promoting public health by reporting positive cases to local health departments, should rapid testing and reporting be a requirement of dispensing.

Given the intent to expand patient access to oseltamivir, ASHP advocates that the proposed reclassification should not result in increased costs to patients and pharmacies. Modifications to national, regional, and local drug coverage decisions are needed to ensure that payer policies do not unintentionally restrict or prevent access. In addition, the reclassification will likely result in an increased workload and potential liability associated with pharmacist provision of this care, which includes patient screening (and point-of-care testing, if applicable), patient education, oseltamivir dosing, counseling, and documentation of the care provided in the pharmacy and medical record. ASHP policy 2020, Care-Commensurate Reimbursement, states that pharmacists should be compensated for these kinds of clinical and patient care services.

Background

The Council reviewed ASHP policy 2116, Nonprescription Availability of Oseltamivir, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> ~~To support expanded access to oseltamivir through a proposed intermediate category of drug products, as described by ASHP policy, that would be available from all pharmacists and licensed healthcare professionals (including pharmacists) who are authorized to prescribe medications, rather than nonprescription designation; further,~~
>
> To support a behind-the-counter practice model that expands access to oseltamivir; further,
>
> To support interoperable documentation of oseltamivir dispensing and associated testing accessible by all members of the healthcare team in outpatient and inpatient settings; further, [MOVED FROM BELOW]
>
> To support diagnosis and tracking of influenza through pharmacist-driven influenza point-of-care testing and reporting to the appropriate public health agencies prior to oseltamivir dispensing; further,
>
> ~~To support interoperable documentation of oseltamivir dispensing and associated testing accessible by all members of the healthcare team in outpatient and inpatient~~

~~settings; further,~~ [MOVED ABOVE]

To advocate that specific and structured criteria be established for prescribing, dosing, and dispensing of oseltamivir for treatment and prophylaxis by pharmacists; further,

To advocate that pharmacist-provided counseling for oseltamivir and patient education on influenza be required for dispensing; further,

To continue to promote influenza vaccination by pharmacists, despite oseltamivir availability; further,

To advocate that the proposed reclassification of oseltamivir be accompanied by coverage changes by third-party payers to ensure that patient access is not compromised and that pharmacists are reimbursed for the clinical services provided.

7. Over-the-Counter Availability of Oral Contraceptives

To advocate that over-the-counter (OTC) oral contraceptives be available without age restriction only under conditions that ensure safe use, including the availability of pharmacist consultation to ensure appropriate self-screening and product selection; further,

To support the development, implementation, and use of clinical decision-making tools and education to facilitate pharmacist consultation; further,

To encourage the Food and Drug Administration to require manufacturers to include all patients of childbearing age, including adolescents, in studies to determine the safety and efficacy of OTC oral contraceptives; further,

To advocate that the proposed reclassification of these products be accompanied by coverage changes by third-party payers to ensure that patient access is not compromised.

Note: This policy would supersede ASHP policy 1410.

Rationale

There have been repeated calls to make oral contraceptive products more widely available, with the intent of expanding access to women's reproductive health therapies and reducing unintended pregnancies. The American College of Obstetricians and Gynecologists (ACOG), American Medical Association (AMA), and American Academy of Family Physicians (AAFP) have positions statements in support of over-the-counter (OTC) access to oral contraceptives to reduce unintended pregnancies, regardless of the age of the patient. ASHP agrees that there is no clinical justification to restrict access to oral contraceptives by adolescents past menarche.

As with other OTC medications, there is recognition that both progestin-only and combined oral contraceptive use carries a very small amount of risk of adverse events and should be determined to be safe and effective for self-use. OTC oral contraceptives should therefore be available where a patient has access to a pharmacist. Patient self-screening and product selection would be improved through pharmacist-provided consultation that assists patients in identifying absolute and relative contraindications (e.g., hypertension, heart or kidney disease), assessing other patient-specific factors (e.g., adherence practices), and determining when to recommend a referral to seek a higher level of care through the use of counseling and clinical decision-making tools. This process would guide the determination of whether a progestin-only or combination oral contraceptive product would be more safe and effective for an individual patient. ASHP does not believe that the current model for behind-the-counter access to some drug products (e.g., pseudoephedrine, emergency contraception) is appropriate for oral contraceptives because it would place the pharmacist in a gatekeeping rather than the clinical role that is necessary to ensure safe and effective use of these therapies.

Manufacturers will need to submit a supplemental new drug application for conversion from prescription to OTC status, including post-marketing surveillance reports and studies of consumer behaviors. It is critical that adolescents be included in these studies to assess their label comprehension, aptitude to self-select, and ability to effectively use the OTC oral contraceptives.

Given the intent to expand access to these therapies, ASHP advocates that the proposed reclassification to OTC should not result in increased costs to patients and should include full insurance coverage without cost sharing. Modifications to national, regional, and local drug coverage decisions may be needed to ensure that payer policies do not unintentionally restrict or prevent access to OTC oral contraceptives.

Background

The Council reviewed ASHP policy 1410, Access to Oral Contraceptives Through an Intermediate Category of Drug Products, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To advocate that over-the-counter (OTC) oral contraceptives be ~~provided~~ available without age restriction only under conditions that ensure safe use, including the availability of ~~counseling~~ pharmacist consultation to ensure appropriate self-screening and product selection; further,
>
> To support the development, implementation, and use of clinical decision-making tools and education to facilitate pharmacist consultation; further,
>
> To encourage the Food and Drug Administration to require manufacturers to include all patients of childbearing age, including adolescents, in studies to determine the safety and efficacy of OTC oral contraceptives; further,
>
> ~~To support expanded access to these products through a proposed intermediate category of drug products, as described by ASHP policy, that would be available from all~~

~~pharmacists and licensed health care professionals (including pharmacists) who are authorized to prescribe medications; further,~~

To advocate that the proposed reclassification of these products be accompanied by coverage changes by third-party payers to ensure that patient access is not compromised ~~and that pharmacists are reimbursed for the clinical services provided~~.

8. Responsible Medication-Related Clinical Testing and Monitoring

To recognize that overuse of clinical testing leads to unnecessary costs, waste, and patient harm; further,

To encourage the development of standardized measures of appropriate clinical testing to better allow for appropriate comparisons for benchmarking purposes and use in research; further,

To promote pharmacist accountability and engagement in interprofessional efforts to promote judicious use of clinical testing and monitoring, including multi-faceted, organization-level approaches and educational efforts; further,

To promote research that evaluates pharmacists' contributions and identifies opportunities for the appropriate ordering of medication-related procedures and tests; further,

To promote the use of interoperable health information technology services and health information exchanges to decrease unnecessary testing.

Note: This policy would supersede ASHP policy 1823.

Rationale

As the prevalence of collaborative practice grows and as pharmacist care expands into direct patient care services, so too do the responsibilities held by these practitioners. In many institutions, pharmacists' responsibilities now include ordering blood draws as a part of initiating a medication regimen, assessing drug levels, monitoring for adverse effects, or ordering imaging such as ultrasound for evaluating a deep vein thrombosis or an electrocardiogram to evaluate a QTc interval.

Overuse of medical care is a long-recognized problem in clinical medicine, and more spending and treatment do not translate into better patient outcomes and health. The number of articles on overuse nearly doubled from 2014 to 2015, indicating that awareness of overuse is increasing, despite little evidence of improved practice, which may mean that the overuse of diagnostic tests and lab monitoring is leading to patient harm and could outweigh benefits. Healthcare continues to be enthralled by high-technology innovation, including both therapies and tests. Once practice norms are established, clinicians are slow

to de-implement services, even those that are found to be potentially dangerous. Reasons for excessive ordering of tests by healthcare providers include defensive behavior, fear, uncertainty, lack of experience, the use of protocols and guidelines, routine clinical practice, inadequate educational feedback, and clinician's lack of awareness about the cost of examinations. Inappropriate testing causes unnecessary patient discomfort, may lead to iatrogenic anemia from over-testing, entails the risk of generating false-positive results and unnecessary treatment, leads to overloading of diagnostic services, wastes valuable healthcare resources, and is associated with other inefficiencies in healthcare delivery, thus undermining the quality of health services. Furthermore, ordering unnecessary tests may also disproportionately affect vulnerable populations, including pediatric patients; trigger unnecessary therapies, such as for asymptomatic bacteriuria; and introduce bias, such as when screening for illicit drugs is performed but not as part of a differential diagnosis. A multi-faceted approach is recommended to reduce waste and support the judicious use of clinical testing. Key strategies include use of interoperable health information technology services and health information exchanges; optimization of test ordering through use of clinical decision support systems; provider and pharmacist education; benchmarking; and organization-level guidance, such as through establishment of a laboratory formulary committee that includes formulary control. Additionally, a key limitation of current literature surrounding appropriateness of clinical testing is a lack of standardized definitions of "appropriateness." Guideline and professional organization-endorsed standards may be used to benchmark clinical testing, although variations by country or institutional practices may confound these definitions.

Choosing Wisely is a national program designed to help raise provider and public awareness and garner support for appropriate test utilization, with the goal of promoting conversations between providers and patients about choosing appropriate care in order to reduce both harm and waste. In 2016, ASHP announced its partnership with the ABIM Foundation on the Choosing Wisely campaign, and in 2017 became the first pharmacy organization to contribute recommendations to the campaign. ASHP has continued to support this partnership through regular review and updates of its recommendations.

Background

The Council reviewed ASHP policy 1823, Responsible Medication-Related Clinical Testing and Monitoring, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To recognize that overuse of clinical testing leads to unnecessary costs, waste, and patient harm; further,
>
> To encourage the development of standardized measures of appropriate clinical testing to better allow for appropriate comparisons for benchmarking purposes and use in research; further,
>
> To promote ~~encourage~~ pharmacist accountability and engagement in interprofessional efforts to promote judicious use of clinical testing and monitoring, including multi-faceted, organization-level approaches and educational efforts; further,

To promote research that evaluates pharmacists' contributions and identifies opportunities for the appropriate ordering of medication-related procedures and tests; further,

To promote the use of interoperable health information technology services and health information exchanges to decrease unnecessary testing.

9. Therapeutic and Psychosocial Considerations of Patients Across the Gender Identity Spectrum

To advocate for access to and broad insurance coverage of gender-affirming care, including medication, medical, and surgical therapies; further,

To advocate that patients across the gender identity spectrum have access to pharmacist care to ensure safe and effective medication use without discriminatory barriers; further,

To advocate that gender identity be considered in medication and disease management of patients across the gender identity spectrum; further,

To promote research on, education about, and development and implementation of therapeutic and biopsychosocial best practices in the care of patients across the gender identity spectrum; further,

To encourage the incorporation of specific education and training regarding patient gender identity into educational standards and competencies for the pharmacy workforce; further,

To encourage easily accessed, structured documentation of a patient's sex assigned at birth, self-identified gender, and relevant medical history in electronic health records.

Note: This policy would supersede ASHP policy 1718.

Rationale

Transgender people are at risk for health and access inequities as a direct result of biases and stigma. Insurance coverage for medication therapies, corrective surgeries, and associated medical needs such as mental health and endocrine services may be limited or nonexistent due to these discriminatory barriers.

In its National Survey on LGBTQ Youth Mental Health 2020, which surveyed over 40,000 lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) young people, the Trevor Project found that 29% of those who responded experienced housing instability; 40% seriously

considered attempting suicide in the past 12 months, with more than half of transgender and nonbinary youth having seriously considered suicide; 68% reported symptoms of generalized anxiety disorder in the past 2 weeks, including more than 75% of transgender and nonbinary youth; and 48% reported engaging in self-harm in the past 12 months, including over 60% of transgender and nonbinary youth. The authors also reported that 60% of respondents identified that the ability to afford care was the strongest barrier to receiving mental health care, and that nearly half of transgender and nonbinary youth did not receive wanted mental healthcare due to concerns related to the LGBTQ competence of providers. Further, they found that when transgender and nonbinary youth had access to binders, shapewear, and gender-affirming clothing, they reported lower rates of suicide attempts compared to transgender and nonbinary youth without access. These findings are echoed by Safer and colleagues, who also identify a lack of providers who are sufficiently knowledgeable on the topic, financial barriers, discrimination, lack of cultural competence by providers, health-system barriers, and socioeconomic barriers to this patient population.

There are guidelines to help practitioners identify the health and biopsychosocial needs of transgender and gender-nonbinary people as well as inclusive language guidelines for all practitioners to incorporate into their lexicon.

Patients electing to transition from their sex assigned at birth to their self-identified gender may have surgeries and take higher doses of hormones to change their physical appearance to reflect their self-identified sex. These patients have significant requirements for therapeutic drug monitoring, as certain lab values may to appear out of normal limits but are clinically appropriate for the transgender patient, and the risk of drug-drug interactions may be higher because medications may be taken at a higher than normal doses. These patients may be more at risk for adverse effects, including thyroid disorders, and may more frequently require anticoagulation and management of diabetes as a result of medication therapy. Other unique needs of these patients include cardiovascular and thrombotic risk assessment, screening for certain types of cancers should they elect to keep their gonadal organs, and other associated primary care screenings associated with their birth sex. Considerations for transgender patients who wish to have children will add the complexity of fertility as well as attention to use of teratogenic medications to their needs. Because of the unique and complex healthcare needs of transgender patients, it is essential that they have adequate access to appropriate care, including pharmacist care. To help ensure appropriate patient identification, assessment, and treatment, a patients' sex assigned at birth, self-identified gender, and (if applicable) gender-confirming therapies or procedures should be documented in a structured way in electronic health records. This documentation also helps healthcare providers address another of the unique biopsychosocial needs of transgender patients; like other healthcare providers, pharmacists should address transgender patients by their self-identified gender.

Those caring for these patients should be knowledgeable regarding the clinical, social, and access needs of this patient population. Student pharmacists, pharmacy residents, pharmacists, and pharmacy technicians therefore should all be trained to appropriately care for this patient population. The Affordable Care Act prohibits pharmacists from making their own decisions about the suitability of a prescribed medication in situations that would constitute discrimination against patients. Although ASHP policy 0610, Pharmacist's Right of Conscience and Patient's Right of Access to Therapy, recognizes the pharmacist's right of conscience, the

policy also recognizes "the patient's right to obtain legally prescribed and medically indicated treatments" and states that "a pharmacist exercising the right of conscience must be respectful of, and serve the legitimate healthcare needs and desires of, the patient, and shall provide a referral without any actions to persuade, coerce, or otherwise impose on the patient the pharmacist's values, beliefs, or objections."

Background

The Council reviewed ASHP policy 1718, Therapeutic and Psychosocial Considerations of Transgender Patients, as part of sunset review and recommended amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> ~~To support medication and disease management of transgender patients as a part of care unique to this population; further,~~
>
> To advocate for access to and broad insurance coverage of gender-affirming care, including medication, medical, and surgical therapies; further,
>
> To advocate that ~~transgender~~ patients across the gender identity spectrum have access to pharmacist care to ensure safe and effective medication use without discriminatory barriers; further,
>
> To advocate that gender identity be considered in medication and disease management of patients across the gender identity spectrum; further,
>
> To promote research on, education about, and development and implementation of therapeutic and biopsychosocial best practices in the care of ~~transgender~~ patients across the gender identity spectrum; further,
>
> To encourage the incorporation of specific education and training regarding patient gender identity into educational standards and competencies for the pharmacy workforce; further,
>
> To encourage easily accessed, structured documentation of ~~both~~ a patient's ~~birth~~ sex assigned at birth, ~~and~~ self-identified gender, and relevant medical history in electronic health records.

The amended policy consolidates policy recommendations from the Council on Therapeutics, Council on Public Policy, and members of the ASHP House of Delegates to reflect more modern and appropriate terminology and current events that impact this patient population.

10. Removal of Injectable Promethazine from Hospital Formularies

1 To advocate that injectable promethazine be removed from hospital formularies; further,

To encourage the Food and Drug Administration to review the patient safety data and consider withdrawing injectable promethazine from the market.

Note: This policy would supersede ASHP policy 1831.

Rationale

In its 2020-2021 Targeted Medication Best Practices for Hospitals, the Institute for Safe Medication Practices (ISMP) included a recommendation to eliminate injectable promethazine from hospitals. This recommendation includes removal of injectable promethazine from all areas of the hospital, including the pharmacy; classification of injectable promethazine as a nonstocked, nonformulary medication; implementation of a medical staff-approved automatic therapeutic substitution policy; conversion of all injectable promethazine orders to another antiemetic; and removal of injectable promethazine from all computerized medication order screens and from all order sets and protocols. In 2018, only 56% of ISMP Survey respondents believed promethazine to be a high-alert medication, which was a *decrease* from 59% in 2014. The 2018 survey also found that 54% of respondents also thought that "IV promethazine" should be changed to "injectable promethazine," also underscoring the need for broader protections from intravenous administration use. This recommendation reiterated the identical 2018-2019 ISMP Best Practice recommendation, which was a change from previous ones in which ISMP promoted safe use by raising awareness about risks associated with intravenous (IV) promethazine administration. Despite the efforts to improve the safety of injectable promethazine use, sporadic and significant patient harm continues to occur.

Promethazine is a known vesicant that can cause tissue damage and necrosis when extravasation occurs during IV administration, and it has negative effects on cardiac conduction. Although therapeutic alternatives are available for most indications, the alternative therapies are also not without risk and may not be as effective in some clinical situations. Processes to limit the potential for patient harm when IV administration of promethazine is indicated include but are not limited to use of therapeutic alternatives (e.g., 5-HT_3 receptor antagonists, antipsychotic agents, antihistamines); use of alternate routes and modalities of administration (e.g., oral, rectal); and restrictions on use (e.g., nonformulary, nonstocked status and removal from order sets and protocols). While prior guidance provided practice recommendations to mitigate the risk of injectable promethazine use (e.g., minimum drug dilution, continuous nurse monitoring of infusion, administration through a running IV line), a 2006 ISMP survey of hospitals revealed poor adherence to these recommendations, despite the well-documented risks of circumventing them. Although medication regimens for some specific patient populations may include injectable promethazine, many guidelines for management of disease states in which promethazine may have a role do not recommend injectable promethazine as an agent of initial choice, indicating it should be used as last line/salvage therapy. Often, these guidelines do not include injectable promethazine as a therapeutic option at all; given the number and variety of suitable alternatives, the risks of using this medication outweigh the benefits. Finally, since ISMP has recommended injectable promethazine's removal from formularies, there is not much data on its safety and efficacy, as implementation of the recommendation has varied across the U.S., and what data is available has been mostly

anecdotal or case-based reports. ASHP encourages the Food and Drug Administration to aggregate this information and evaluate injectable promethazine's patient safety data to re-evaluate its market status.

Background

At its June 2022 meeting, the Council reviewed ASHP policy 1831, Safe and Effective Use of IV Promethazine, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethough~~ indicates deletion):

> To advocate that injectable ~~intravenous~~ promethazine be removed from hospital formularies ~~used only when medically necessary~~; further,
>
> To encourage the Food and Drug Administration to review the patient safety data and consider withdrawing injectable promethazine from the market.

The Council recommended revising policy 1831 to align with ISMP standards because risks to patient harm outweigh any therapeutic advantage injectable promethazine may have against refractory therapies. Since this policy originated in 2017, there has been a proliferation of more cost-effective therapeutic alternatives for most indications for which injectable promethazine is used. The Council also discussed the role the Food and Drug Administration should have in removing this formulation from the market, given the significant harm to patients when administered incorrectly and the decrease in awareness of injectable promethazine as a high-alert medication.

After the Board approved the amended policy recommendation at its September 2022 meeting, the House of Delegates considered it at the November virtual House and did not approve the amended policy by the necessary 85%. In addition, the proposed revised policy generated a great deal of discussion on the House of Delegates Connect community, prompting the Council to reconsider the proposed amendments. After review, the Council revised the amended policy recommendation again to ensure alignment with ISMP and address considerations for patient populations for which injectable promethazine is medically necessary. The amendments the Council made at its January 31 meeting to the revised policy language it proposed in June are as follows (underscore indicates new text; ~~strikethough~~ indicates deletion):

> To advocate that injectable promethazine be removed from hospital and health-system formularies; further,
>
> To recommend that hospitals and health systems that continue to use injectable promethazine develop policies that strictly limit use to specific patient populations and utilize administration techniques that minimize risk of preventable harm; further,
>
> To encourage the Food and Drug Administration to review the most current patient safety data and ~~consider withdrawing injectable promethazine from the market~~ re-evaluate injectable promethazine's market status.

At its April 13 meeting, the Board of Directors voted to not approve the Council's amended recommendation from its January 31 meeting. The Board noted that at the November 2022 virtual House a majority of delegates voted to approve the Council's June 22 proposed amendments, just not the 85% supermajority necessary for approval at a virtual House. The Board further noted the contradictory messages in policy language that would simultaneously advocate removal of injectable promethazine from hospital and health-system formularies and an FDA safety review while recommending that hospitals and health systems develop policies to ensure its safe use. The Board expressed its unanimous opinion that the Council's earlier language from its June 2022 meeting, advocating for removal of injectable promethazine from hospital formularies, more closely aligns with ASHP's medication safety mission and would more clearly serve its advocacy agenda.

COUNCIL ON EDUCATION AND WORKFORCE DEVELOPMENT POLICY RECOMMENDATION

The Council on Education and Workforce Development is concerned with ASHP professional policies, related to the quality and quantity of pharmacy practitioners. Within the Council's purview are (1) student education, (2) postgraduate education and training, (3) specialization, (4) assessment and maintenance of competence, (5) credentialing, (6) balance between workforce supply and demand, (7) development of technicians, and (8) related matters.

Kim Benner, *Board Liaison*

Council Members
Angela Bingham, *Chair* (Pennsylvania)
Joshua Blackwell, *Vice Chair* (Texas)
Stacy Dalpoas (North Carolina)
Johnnie Early II (Florida)
Michelle Estevez (Wyoming)
Glen Gard (Illinois)
Jacob Jarboe, *Student* (Alabama)
Tera Moore (Colorado)
Joshua Raub (Michigan)
Jennifer Robertson (Tennessee)
Caroline Sierra (California)
Ted Walton (Georgia)
David Zimmerman (Pennsylvania)
Sophia Chhay and Erika Thomas, *Secretaries*

1. Well-Being and Resilience of the Pharmacy Workforce

To affirm that occupational burnout adversely affects an individual's well-being and healthcare outcomes; further,

To acknowledge that the healthcare workforce encounters unique stressors throughout their education, training, and careers that contribute to occupational burnout; further,

To declare that healthcare workforce well-being and resilience requires shared responsibility among healthcare team members and between individuals and organizations; further,

To encourage individuals to embrace well-being and resilience as a personal responsibility that should be supported by organizational culture; further,

To promote that pharmacy leadership collaborate with their institutions to assess the well-being and resilience of the pharmacy workforce and identify effective prevention and intervention strategies; further,

To encourage hospitals and health systems to invest in the development and assessment of programs aimed at prevention, recognition, and treatment of occupational burnout, and to support participation in these programs; further,

To encourage education, research and dissemination of findings on stress, burnout, and well-being; further,

To collaborate with other professions and stakeholders to identify effective prevention and intervention strategies that support well-being at an individual, organizational, and system level.

Note: This policy would supersede ASHP policy 1825.

Rationale

Clinician burnout can have serious, wide-ranging consequences on individual clinicians and learners, health care organizations, and patient care. Occupational burnout is a syndrome characterized by a high degree of emotional exhaustion, high depersonalization (e.g., cynicism), and a low sense of personal accomplishment from work due to both internal and external factors. The results follow a 2018 study in the *American Journal of Health-System Pharmacy* (AJHP) that found 53 percent of health-system pharmacists self-reported a high degree of burnout caused by increasing stresses and demands. Occupational burnout affects today's pharmacy workforce at unprecedented rates. At the individual level, pharmacy staff burnout can result in medication errors and increased patient harm. At the hospital or healthcare system level, the consequences of occupational burnout include disengagement, loss of productivity, and employee turnover, which can lead to inefficiency and financial problems for healthcare organizations. Stress in our clinical learning environment can affect all healthcare learners, with negative outcomes ranging from poor well-being to substance abuse to depression, even suicide. A 2017 AJHP article reported that pharmacy residents working more than 60 hours per week reported high levels of stress, depression, and hostility.

ASHP joined the National Academy of Medicine (NAM) Action Collaborative on Clinician Well-Being and Resilience in 2017. The goals of the Collaborative are to 1. Raise the visibility of clinician anxiety, burnout, depression, stress, and suicide, 2. Improve baseline understanding of challenges to clinician well-being, and 3. Advance evidence-based, multidisciplinary solutions to improve patient care by caring for the caregiver. The NAM Action Collaborative Conceptual Model depicts both individual and external factors affecting well-being and resilience and indicates that it requires a combined effort from the individual and the system to address and prevent occupational burnout.

Studies suggest that burnout is a problem of the entire healthcare organization as well as individual clinicians, so maintaining clinician well-being and resilience requires a combined effort by the individuals and their employers. To be successful, interventional programs must promote prevention, recognition, and treatment of burnout, and healthcare organizations must foster a culture that supports not just participation in these programs but a sense of personal

responsibility for developing and maintaining resilience. A healthcare organization with a resilient workforce will provide the best healthcare outcomes.

Supporting the well-being of the pharmacy workforce requires sustained attention and action at organizational, state, and national levels, as well as investment in research and information sharing to advance evidence-based solutions. A pharmacy workforce with the ability to thrive during adversity—a resilient workforce—is essential to combat burnout and support higher-quality care, increased patient safety, and improved patient satisfaction.

Background

The Council reviewed ASHP policy 1825, Clinician Well-Being and Resilience, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

To affirm that occupational burnout adversely affects an individual's well-being and healthcare outcomes; further,

To acknowledge that the healthcare workforce encounters unique stressors throughout their education, training, and careers that contribute to occupational burnout; further,

To declare that healthcare workforce well-being and resilience requires shared responsibility among healthcare team members and between individuals and organizations; further,

To encourage individuals to embrace well-being and resilience as a personal responsibility that should be supported by organizational culture; further,

To promote that pharmacy leadership collaborate with their institutions to assess the well-being and resilience of the pharmacy workforce and identify effective prevention and intervention strategies; further,

To encourage hospitals and health systems to invest in the development and assessment of programs aimed at prevention, recognition, and treatment of occupational burnout, and to support participation in these programs; further,

To encourage education, ~~and~~ research, and dissemination of findings on stress, occupational burnout, and well-being; further,

To collaborate with other professions and stakeholders to identify effective ~~preventive and treatment~~ prevention and intervention strategies at an individual, organizational, and system level.

SECTION OF PHARMACY EDUCATORS POLICY RECOMMENDATION

The mission of the ASHP Section of Pharmacy Educators is to support pharmacy educators in preparing, engaging, and advancing the pharmacy workforce to optimize health.

Melanie A. Dodd, *Board Liaison*

1. ASHP Statement on Precepting as a Professional Obligation

1 To approve the ASHP Statement on Precepting as a Professional Obligation (Appendix).

Appendix:

ASHP Statement on Precepting as a Professional Obligation

Position

The American Society of Health-System Pharmacists (ASHP) believes that all pharmacists have a professional obligation to give back to the profession through involvement in the precepting process of students and postgraduate trainees. ASHP encourages pharmacy practice leaders, practitioners, postgraduate trainees, and faculty members to embrace the responsibility to be involved in the precepting process in an effort to advance pharmacy practice and improve patient care. To this end, ASHP urges all pharmacists and healthcare institutions to accept this responsibility and commit time and resources to the precepting process and the development of precepting skills.

ASHP encourages pharmacy practice leaders to create a culture of teaching and learning, integrate precepting as a practice philosophy, support an organizational commitment to well-being, and facilitate the integration of learners into patient care services and scholarly work. Pharmacy leaders and administrators, colleges of pharmacy, faculty, and current preceptors have a responsibility to foster and support the evidence-based development of the precepting skills of all pharmacy practitioners and postgraduate trainees, facilitate the development of practice models that provide regular opportunities to precept learners, encourage all pharmacists to be involved in the precepting process, and support the assessment of training programs' outcomes.

Background

Upon graduation, all pharmacists pledge to use their knowledge, skills, experiences, and values to train the next generation by taking the Oath of a Pharmacist.[1] The apprenticeship model of "see one, do one, teach one" is grounded in centuries of tradition across many healthcare disciplines. Current apprenticeship models, such as the Cognitive Apprenticeship Model, encourage the development of observable skills and critical thinking skills that are fundamental to contemporary practice.[2] The evolution of the current pharmacy education system and apprenticeship models requires preceptor supervision during experiential learning and postgraduate training.

Precepting consists of providing a learner with practical experiences in a practice setting in which they can develop and apply principles of pharmacy practice. The precepting process begins within the college of pharmacy curricula and co-curricula and extends through advanced pharmacy practice experiences (APPEs) and postgraduate trainee experiences. Throughout this prolonged process, preceptors serve vital roles by providing instruction, mentorship, coaching, facilitation, assessment, and feedback to learners. The precepting process teaches more than clinical skills by promoting skill development in professionalism, communication, teamwork, interprofessional collaboration, leadership, time management, and professional values as well as facilitating professional identity formation (PIF).[3] Involvement in the precepting process and experiential learning consists of more than serving as the primary preceptor on rotations and may extend to opportunities such as team precepting, shadowing experiences, speaking engagements, providing feedback to learners, facilitating topic discussions, learner mentoring, learner supervision, and more.

Experiential learning is fundamental to the application of knowledge and skills gained during didactic curricula.[3,4] To determine if students are practice ready, colleges of pharmacy utilize entrustable professional activities (EPAs), which are workplace tasks or responsibilities students are entrusted to perform in the experiential setting with direct or distant supervision.[5] Evaluation of entrustability levels of EPAs requires input from preceptors to assign a degree of trust in student competence. While mastery of EPAs requires the learner to gain foundational knowledge, skills, and attitudes in didactic curricula, these activities cannot be adequately replicated in the classroom; therefore, they should be fully elucidated and evaluated in the experiential setting.[4] Likewise, postgraduate programs require qualified preceptors to provide appropriate training, supervision, and guidance to all postgraduate trainees as they progress toward competence using the postgraduate trainee program's defined assessment scale.[6]

Preceptors are necessary to ensure learners attain the desired level of competency for practice; however, a dearth of preceptors has been a long-standing problem. Experiential site and preceptor capacity are frequent concerns of experiential education directors.[7] There are several contributing factors to this persistent preceptor shortage. First, colleges of pharmacy must adhere to the Accreditation Council for Pharmacy Education (ACPE) accreditation standards, which require enough preceptors to deliver and evaluate students in the experiential setting.[8] Between 2000 to 2020, there was a greater than 70% increase in the number of colleges of pharmacy, and since 2013, there has been a 65% increase in postgraduate training programs.[9] Furthermore, preceptors of postgraduate trainees require advanced training and/or experience to meet postgraduate training standards.[6] These requirements and expansion of programs may limit the number of experiential sites or individuals available to precept at any given time, which may worsen if all pharmacists do not accept precepting as a professional responsibility.

Another contributing factor to these shortages may be pharmacist burnout. Burnout is increasingly associated with work-related stressors, resulting in decreased clinician job satisfaction, productivity, interprofessional teamwork, and mental health. Increasing concerns about the personal ability to effectively balance patient care, administrative, teaching, and other roles may negatively influence pharmacists' interest in precepting. The consequences of burnout to patient care reinforce the need of colleges of pharmacy and healthcare institutions to systematically commit to the well-being of all pharmacy practitioners, pharmacy technicians, and learners.

Within the challenges of our ever-evolving healthcare and educational systems, high-quality preceptors are needed now more than ever. Their contributions continue the rich tradition of pharmacists as one of the most trusted healthcare professionals and bring value to healthcare institutions, learners, and patients.

Value of precepting

The amount of literature demonstrating mutual benefit for learners, preceptors, healthcare institutions, and patients is vast.[3,10] Ultimately, a synergistic relationship among stakeholders can improve patient care by aligning the goals of colleges of pharmacy, learners, preceptors, and healthcare institutions and embracing precepting as a practice philosophy.[11] Additionally, when learners are used as pharmacist extenders, clinical productivity increases, personal and

professional growth ensues, and institutional metrics improve.[3,10]

Value to learners. Preceptors are often one of the most influential teachers learners encounter as part of their training. They significantly influence learners' PIF through instructing, modeling, coaching, and facilitating as learners internalize and demonstrate the values and behaviors of pharmacists in practice. Preceptors' provision of feedback on learners' performance and their intraprofessional and interprofessional interactions are instrumental in learners' professional socialization and identity development. Preceptors also significantly impact learners' career choices and trajectories, personal and professional development, involvement in professional advocacy, and participation in scholarly activities.[3] Learners also benefit from collaborating with various professionals in their interprofessional practice experiences.

Value to preceptors. There is tangible value for preceptors who incorporate students and postgraduate trainees into experiential learning opportunities. Incorporation of learners as pharmacist extenders helps preceptors expand their clinical services to patients and allows them to accommodate more learners, particularly when the Layered Learning Practice Model (LLPM) is used. The LLPM is the teaching approach in which seasoned clinical preceptors supervise learners' clinical and precepting experience and train postgraduate trainees to precept students.[12] Learners may also serve as productive members of the LLPM. In addition to gaining supervised autonomy, learners develop foundational precepting skills by participating in near-peer teaching as appropriate for their development. This model utilizes a team approach so that pharmacists, postgraduate trainees, students, and technicians within larger healthcare teams maximize and extend the reach of pharmacy services.

Incorporating learners also allows preceptors to increase scholarly activities. Preceptors have ample opportunities to collaborate with learners for presenting and publishing abstracts, posters, and manuscripts.[3] These partnerships can help advance preceptors' research goals while developing learners' scholarly skills. Preceptors can leverage journal clubs or presentations on upcoming literature or clinical topics to maintain an updated knowledge base. Precepting is a professionally rewarding opportunity to influence future pharmacy clinicians and leave an enduring legacy on the future of the profession.[3]

Value to healthcare institutions and patients. Abundant literature documents the benefits of learners to healthcare institutions. Utilization of learners at healthcare institutions improves institutional metrics by expanding pharmacy services and advancing research agendas and dissemination rates.[10,13] For example, literature has shown tangible benefits of learners when they participate in taking medication histories, optimizing transitions of care, performing discharge counseling, practicing medication therapy management, and administering vaccinations.[10] Involvement of learners in these activities has been associated with the prevention of errors, decreases in medication costs, increased patient interventions and encounters, and decreased pharmacist-to-patient ratios.[10,14] Finally, trainees often apply for positions within their training institution, creating a pipeline of future employees.

Responsibilities of stakeholders

Positively impacting patient care is the shared vision of learners, preceptors, healthcare institutions, colleges of pharmacy, and professional organizations, and preceptors are necessary

to achieve that vision.[11] Preceptors provide an invaluable aspect of pharmacy education as they empower learners to independently apply their knowledge and skills in real-world situations. Colleges of pharmacy uphold the responsibility to prepare APPE-ready students by adhering to ACPE standards regarding experiential learning, and postgraduate training programs uphold the responsibility to ensure postgraduate trainees are practice or advanced practice ready. Practitioners involved in the precepting process play an integral role in determining these outcomes for learners. When experiential learning is thoughtfully designed, students, postgraduate trainees, preceptors, healthcare institutions, and ultimately patients benefit.[3,15]

Preceptors have diverse learning needs and preferences, and healthcare institutions vary in development resources available to preceptors. Preceptor development is instrumental in supporting the design of experiential learning and preparing preceptors for teaching and mentoring within the precepting process. To improve preceptor efficiency and maximize learning, development regarding in-the-moment experiential teaching is crucial, and additional training and sharing best practices in leveraging learners to help meet institutional goals should be a priority. It is imperative that professional organizations, colleges of pharmacy, and healthcare institutions collaborate to provide evidence-based preceptor development resources in a variety of media and formats and promote an inclusive and equitable culture of teaching and learning. As such, the continual professional development of preceptors is a shared responsibility among these entities.

Responsibilities of professional organizations

Professional organizations play a pivotal role in the development of precepting standards and preceptor development resources. ASHP and ACPE provide guidance on the standards and requirements for preceptor training and development.[6,8] Professional organizations should collaborate with preceptors, healthcare institutions, and colleges of pharmacy to provide practical and contemporary preceptor development resources and programming to meet the standards. These organizations are equipped to spotlight best teaching practices and practice models of their diverse members.[16] Professional organizations are also positioned to advocate for the importance of precepting and preceptor development to pharmacists and healthcare institutions.

Responsibilities of colleges of pharmacy and postgraduate training programs

In addition to providing preceptor development resources to meet individual and group preceptor development needs, colleges of pharmacy and postgraduate training programs can assist in the creation, research, and dissemination of best practices in precepting and innovative practice models to spur the development of others.[11] Colleges of pharmacy and postgraduate training programs also aid in the development of preceptors and healthcare institutions through sharing de-identified aggregate feedback from learners, quality assurance programs, and in the acknowledgement of quality precepting through recognition programs.[16]

Responsibilities of healthcare institutions

It is critical to the training of the next generation of pharmacists that healthcare institutions embrace the responsibility to support preceptor development and to develop precepting as a

practice philosophy within their institutions. Practice and research models that integrate learners and leverage them to extend pharmacy services should be encouraged and highlighted. Particular importance should be placed on the well-being of busy preceptors who are balancing clinical, professional, and precepting responsibilities. While preceptors continue to adapt to newer educational models that discourage long didactic sessions, preceptors need time for the precepting process. Protected time may be necessary for planning practice experiences, orienting learners, reviewing expectations, discussing learner background and goals, completing and delivering feedback and evaluations, reviewing learner's work, and providing teaching pearls from learning activities. Although this time may vary based on the specific site and infrastructure in place, leadership discussions with precepting teams can help determine what type of support is needed and foster collaborative solutions.

Additionally, this responsibility includes providing financial support to attend preceptor development offerings, protected time to be involved in the precepting process and attend training and development programs, access to development resources, and an organizational commitment to employee well-being. The expectation of precepting as a practice philosophy should be included in role descriptions, performance appraisals, and career ladders to encourage and recognize effective precepting. Examples of competency areas on performance appraisals include commitment to precepting, advocacy for the profession, communication and collaboration, qualities of the learning environment, use of teaching and learning strategies that develop clinical reasoning and other skills, feedback and assessment practices of learners, content expertise, contribution in the area precepted, and ongoing professional engagement.[6,17,18] These competencies may also serve as a framework for self- and peer assessment that are essential to professional development as well as guide preceptor development plans.[17,18, 19,20]

Responsibilities of preceptors

Preceptors should approach precepting with a commitment to lifelong learning and continual personal and professional growth. Strategies to implement this philosophy include continuing professional development (CPD) and the self-directed assessment seeking (SDAS) approaches. In CPD, learning needs are identified through self-assessment and reflection; specific, measurable, achievable, relevant, time-bound (SMART) goals are developed to meet learning needs; the effectiveness of the plan is assessed; and learning is applied to teaching practices.[19,20] Recognizing the limitations of self-assessment alone, the SDAS performance improvement process involves seeking feedback and assessment from external sources such as peers and learners, self-reflecting to identify areas of strength and growth, and developing a plan for improvement.[21] Development plans may include preceptor development offered through written, online, on-demand, live, and other resources. The Habits of Preceptors Rubric is an example of a criterion-referenced tool to support preceptors engaged in self-directed assessment to guide CPD.[22] Preceptors may also create a teaching or precepting philosophy to guide their work. Postgraduate trainees and students also have important roles in preceptor development through provision of constructive and professional feedback on learning experiences and precepting practices. Preceptors should create an environment and foster dialogue that encourages and welcomes feedback from learners throughout a rotation. In

addition, colleges of pharmacy and postgraduate trainee programs should train learners to provide constructive, meaningful feedback for learning experiences and preceptors.

Incorporating precepting into practice

Serving as a liaison between classroom education and practical application, preceptors are role models for the practice of pharmacy and share the art of the profession with learners. Preceptors are vital to modeling professionalism, communication, and application of skills and knowledge when they advise, mentor, and provide feedback during thoughtfully designed experiential learning. Additionally, throughout postgraduate training, it is imperative that trainees not only learn to precept effectively, but also to employ those skills by becoming preceptors themselves following completion of postgraduate training. All pharmacists with practice experience, including those with and without postgraduate training, have a responsibility to be involved in the precepting process.

Preceptors have a responsibility to be involved not only in training learners, but also in the continuous quality improvement process of the training. Both colleges of pharmacy and postgraduate trainee programs have set standards for continuous quality improvement. ACPE 2016 Standard 20 requires that colleges of pharmacy solicit preceptors for continuous quality improvement of educational programs, especially in experiential learning, and ASHP standards require that preceptors provide input related to continuous improvement and formal postgraduate trainee program evaluation.[6,8] These efforts ensure that experiential learning for both students and postgraduate trainees remain parallel with contemporary practice. Preceptors and learners are vital to these quality improvement processes to ensure patient care and outcomes and institutional metrics are optimized.

Finally, preceptors are encouraged to publish examples of the value of precepting as a practice philosophy, the value of learners as pharmacist extenders, and the impact of learners on patient outcomes through scholarly work. As precepting is incorporated into daily practice, this scholarly work reflects contemporary practice, documents value to other healthcare institutions, provides a framework for the development of effective precepting, and encourages other healthcare institutions to embrace precepting as a professional responsibility. Disseminating both positive and negative outcomes as scholarly work is vital to optimizing outcomes for all stakeholders, most importantly patients.

Conclusion

ASHP believes involvement in the precepting process of learners is the professional responsibility of all pharmacy practice leaders, pharmacists, postgraduate trainees, and faculty to advance pharmacy practice and improve patient outcomes. All pharmacy stakeholders play a vital role in embracing precepting as a practice philosophy and supporting a culture of teaching and learning in the experiential setting. Professional organizations, pharmacy leaders and administrators, colleges of pharmacy, and healthcare institutions should support pharmacists, postgraduate trainees, and pharmacy technicians in developing and utilizing precepting skills, provide resources for formal precepting training and development, and promote learner and preceptor well-being.

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Additional Information

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2023 Report of the ASHP Treasurer

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ASHP is the largest and most influential professional pharmacy organization in the United States and maintains a steadfast commitment to meeting the evolving and unique needs of our members throughout every stage of their professional journeys.

The Treasurer has the responsibility to report annually on ASHP's financial condition to the membership. ASHP's fiscal year is from June 1 through May 31, coinciding with our policy development process and timetable. This report describes ASHP's actual financial performance for fiscal year (FY) 2022, projected financial performance for FY2023, and an FY2024 budget status update.

Fiscal Year 2022 Ending May 31, 2022—Actual

ASHP's FY2022 financial statement audit for the year ending May 31, 2022, was performed by Aronson LLC. The audit resulted in ASHP receiving the best opinion available, an unmodified opinion.

ASHP's core operations[1] were impacted by the lingering effects of COVID-19. Core gross revenue was $43.8 million (Figure 1), down by $7.1 million compared to FY2021. The gross revenue decrease was primarily attributable to the Midyear Clinical Meeting & Exhibition (MCM) being held as a virtual meeting with significantly reduced registration pricing and a decrease in paid registration. This was favorably offset by successes in other areas. ASHP achieved a record number of members at 60,315 on December 31, 2021, with a related increase in membership revenue. We also showed record revenue from our professional certificates, certifications programs, and accreditation services. In addition, ASHP was awarded a Health Resources and Services Administration grant to advance the well-being of the healthcare workforce. Core net income was a loss of $4.15 million. Net program development, capital budget, and investments[2] were a net loss of $4.2 million. In total, FY2022 resulted in a negative $8.4 million net change in ASHP's reserves/net assets.

Finally, the building fund[3] had a loss of $8.7 million, primarily due to investment losses. With significant positive returns in previous years, the building fund remains on track to continue supporting ASHP's office space expenses and reach its long-term financial target. ASHP's total net assets at the end of FY2022 were $137.0 million (Figure 2). Our year-end balance sheet remained strong, with an asset-to-liability ratio of 5.4:1. ASHP has prepared for tough economic times like these and remains well prepared for the future.

Fiscal Year 2023 Ending May 31, 2023—Projected

FY2023 core operations are shaping up to be a record year, with projected core gross revenue of $57.8 million. As of February 28, 2023, we anticipate that ASHP's FY2023 core net income will be in the range of $2.2 million (Figure 1). Assuming the financial markets stabilize for the remainder of the fiscal year, we are projecting a deficit of $2.6 million for program development expenses, capital budget, and investments. This results in a negative net change in reserves/net assets of $337,000. Finally, we anticipate the building fund will have a deficit of $4.6 million.

Combining the net change in reserves/net assets and the building fund for fiscal years 2021, 2022, and projected 2023, ASHP has a favorable $3.2 million net change in reserves/net assets. ASHP has performed financially well during the nearly 3-year pandemic and remains financially strong for the future.

ASHP accomplished a great deal during FY2023, including maintaining a strong and active membership, conducting a robust in-person MCM after 2 years of virtual meetings, introducing new educational offerings in our professional certificate and publications lines, and developing and introducing PharmTech Ready to help address the current technician workforce shortage. In addition, we launched the new Section of Digital and Telehealth Practitioners to address this growing area of pharmacy practice, and we created the ASHP Leadership Center to help members achieve their full clinical and administrative leadership capacity.

Figure 1. ASHP Condensed Statement of Activities (in thousands).

	Actual Fiscal Year 2021 Ended May 31, 2021	Actual Fiscal Year 2022 Ended May 31, 2022	Projection* Fiscal Year 2023 Ended May 31, 2023	Budget Fiscal Year 2024 Ended May 31, 2024
CORE OPERATIONS				
Gross Revenue	50,915	43,848	57,840	59,660
Total Expense	-45,541	-47,996	-55,594	(59,657)
CORE NET INCOME/(LOSS)	5,374	-4,148	2,246	3
NET PROGRAM DEVELOPMENT EXPENSES, CAPITAL BUDGET, AND INVESTMENTS GAIN/(LOSS)	9,862	-4,227	-2,583	240
Pension Plan Adjustment	-3,911	-	-	-
NET CHANGE IN RESERVES/NET ASSETS	11,325	-8,375	-337	243
BUILDING FUND	13,841	-8,671	-4,551	-

*Projection as of February 28, 2023.

Figure 2. ASHP Statement of Financial Position (in thousands).

	Actual as of May 31, 2021	Actual as of May 31, 2022
ASSETS		
Current assets	22,863	12,496
Fixed assets	5,708	4,644
Investments	1,57,818	1,50,601
Other assets	410	478
Total Assets	1,86,799	1,68,219
LIABILITIES		
Current liabilities	23,205	22,615
Long-term liabilities	9,500	8,556
Total Liabilities	32,705	31,171
RESERVES/NET ASSETS		
Total Net Assets	1,54,094	1,37,048
Total Liabilities and Net Assets	1,86,799	1,68,219

ASHP's robust membership provides evidence of our value to and our impact on the pharmacy profession. ASHP is the largest and most influential professional pharmacy organization in the United States and maintains a steadfast commitment to meeting the evolving and unique needs of our members throughout every stage of their professional journeys.

Fiscal Year 2024 Ending May 31, 2024—Budget

ASHP's Board of Directors has thoughtfully considered our FY2024 budget. We are seeing strong growth in FY2024 and beyond. There are many positive signs for the future now that the COVID-19 pandemic is abating.

We look forward to continuing to grow our in-person MCM and Summer Meetings, expanding our membership, and achieving many successes as we invest in and nurture our publications, professional development, accreditation, and other programs. As our workforce evolves and changes, the Board of Directors continues to position ASHP for the future to ensure we can support our members and the profession with timely, valuable resources, products, and services.

Considering these and other factors, ASHP's FY2024 budgeted net change in reserves/net assets is a surplus of $243,000, with $59.7 million in core gross revenue. The building fund, which is designed to pay for ASHP's headquarters office space, is budgeted to break even.

Conclusion

Over the past 3 years, ASHP has maintained a remarkable level of financial stability and membership growth. Sound fiscal management, coupled with visionary strategic thinking, have guided the development of a growing portfolio of products, programs, and services that advance practice, support professional development, and improve patient care. We take pride in our robust and diverse membership and the positive impact our work has on our profession each and every day. The Board

of Directors, Chief Executive Officer, and staff are steadfastly committed to ASHP's mission, vision, and strategic plan and supporting our members. We look forward to another successful year, and I am proud to serve this organization as your Treasurer!

[1]Represents the revenue and expense associated with the operations of ongoing ASHP programs, products, and services, as well as infrastructure and ASHP Foundation support.

[2]Includes investments in ASHP's program development and capital budget, building sale reserve funds, reserves/net assets spending, and investment gains/(losses). The Board of Directors approves spending during ASHP's annual budget development process. Expenditures are typically (1) associated with new, enhanced, and expanded programs; (2) associated with time-limited programs; (3) capital asset purchases; or (4) supplemental operating expenses. These expenditures are primarily funded by investment income from reserves/net assets and the building sale reserve funds.

[3]Created to hold the net gain from the sale of ASHP's previous headquarters building. The long-term investment earnings are used to pay for lease and other occupancy-related expenses associated with ASHP's current headquarters office.

Joint address from the President and the Chief Executive Officer

Be Bold, Be More: Leading Through Innovation, Collaboration, and Advocacy

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Editor's note: The following is adapted from comments delivered by Dr. Walker during the House of Delegates session of the 2023 ASHP Summer Meetings and Exhibition, held in June in Baltimore, MD.

We are better together in every way that ASHP supports its members, our profession, and the patients we serve. And we have accomplished much this past year through collaboration and a shared vision that the pharmacy profession, and ASHP, are leaders in meeting the demands of future pharmacy practice and patient care delivery models.

Good afternoon! It's great to be here in Baltimore at the 2023 Summer Meetings and the 75th gathering of the ASHP House of Delegates! I am honored to represent my good friend and colleague, ASHP CEO Dr. Paul Abramowitz, as I present our joint remarks to this esteemed audience.

A year ago in Phoenix, I presented my inaugural address. My theme for that address, and my tenure as ASHP President, has been "We are Better Together." ASHP is the largest pharmacy professional organization in the United States. We are better together when we value and amplify the diverse voices and perspectives of all our members and the pharmacy profession.

We are better together in every way that ASHP supports its members, our profession, and the patients we serve. And we have accomplished much this past year through collaboration and a shared vision that the pharmacy profession, and ASHP, are leaders in meeting the demands of future pharmacy practice and patient care delivery models.

Collaborations

Collaboration is a cornerstone of our profession and our work. We are better together because collaboration creates synergy and expands our reach and influence.

Our collaborations span numerous efforts with government, non-profit, and industry partners. For example, our collaboration with the Future of Pharmacy Care Coalition, of which ASHP is an executive committee member, has generated extensive support for the Equitable Community Access to Pharmacist Services Act,[1] which ensures patient access to pharmacist care.

ASHP continues its work with the National Academy of Medicine on 2 Action Collaboratives: Countering the U.S. Opioid Epidemic, and Well-Being and Resilience. We also continue to join forces with partners like the American Hospital Association to strengthen our advocacy efforts.

ASHP is an extremely respected and well-connected organization that regularly collaborates with the premier national organizations representing medicine, nursing, pharmacy, accreditation, and beyond. ASHP's reputation is strong because of you, our members, who work hand-in-hand as trusted colleagues with other providers and hospital and health-system

leaders. As direct patient care providers on the interprofessional team, you are the face of pharmacy and the medication specialists that patients and other team members count on. Thank you for all that you do!

Advocacy

Collaborations are also critical to strengthening the impact of our advocacy efforts. We are undoubtedly better together when we collectively advocate for our members and their patients.

The ASHP Political Action Committee, or ASHP-PAC, is one tool we use to advocate before Congress. The ASHP-PAC helps deepen our relationships with members of Congress who are interested in the issues that affect patients, such as protecting the 340B Drug Pricing Program and achieving provider status.

In the past year, ASHP has engaged in remarkable advocacy efforts on the national and state levels. Nationally, we drove change in pharmacy practice by ushering in the elimination of the X-waiver, a federal barrier to pharmacists prescribing medications for opioid use disorder. We also continued to fight to protect the 340B Drug Pricing Program, including working to pass legislation to ensure payers don't discriminate against 340B hospitals.

Additionally, we worked with partner organizations to advocate for HR 1770, the Equitable Community Access to Pharmacist Services Act,[2] which was reintroduced in Congress earlier this year. We also continued to support efforts to protect funding for PGY1 pharmacy residency programs.

On a state level, ASHP has developed model legislation for states to limit payer-mandated white bagging. Based on our model legislation, 10 states passed and 32 states introduced bills restricting payer-mandated white bagging.

In addition, ASHP developed model legislation and a model protocol to enable pharmacist prescribing of medications for opioid use disorder. We also developed model legislation to help states to protect the 340B program from payer abuses.

Our advocacy efforts are strongest when we are working together with a unified voice. We will continue to represent the interests of our members by supporting policies and legislation that protect patients and widen access to pharmacists and pharmacy services in all settings.

Workforce

We are better together when we work to envision solutions that meet the most pressing needs of our members, which include addressing the staffing challenges impacting hospitals and health systems across the country. Identifying solutions to recruit, retain, and develop the pharmacy workforce is of paramount importance.

Pharmacy leaders at all levels have been adversely impacted by mounting shortages of pharmacy technicians. In a member survey conducted by ASHP in late 2021, nearly 1 in 10 pharmacy managers indicated they had lost 41% or more of their pharmacy technicians that year.[3] Overall turnover rates in the technician workforce were reported at up to 30%. And a 2022 study conducted by the Pharmacy Technician Certification Board indicated that lack of pay, incentives, and career opportunities were the leading reasons for technicians leaving the workforce.[4]

ASHP is dedicated to identifying solutions to help reverse this trend. One of these is PharmTech Ready, a comprehensive technician training program launched last year, which will help pharmacy operations bridge these professional development and training gaps.

And in a bold move signifying ASHP's deep commitment to the technician workforce (and this is huge!), I am proud to share that ASHP is creating a new, standalone membership organization, The Pharmacy Technician Society, which will provide pharmacy technicians from all patient care settings with their very own membership home backed by the strength and support of ASHP.

We are all well aware of the current challenges facing our workforce. Only ASHP has the proven experience, deep resources, and established networks to drive meaningful progress in support of our highly valued pharmacy technicians. We are excited to draw on our decades-long history of advancing the roles of pharmacy technicians and providing education, advocacy, and practice advancement initiatives to establish this new organization and face these significant workforce challenges head-on. We believe The Pharmacy Technician Society will generate a powerful and expansive impact on the pharmacy profession, elevating and advancing pharmacy technician practice. It will create new programs and services that will give pharmacy technicians the tools and resources they need to thrive at every stage of their careers.

The new organization, which will officially launch this fall, will be exclusively for technicians and led by technicians, governed by its own Board of Directors and bylaws. Technicians who join the new society will also enjoy dual membership with ASHP with all of the associated benefits. We hope that our ASHP pharmacist members will embrace the possibilities of this new organization, ensuring that their technician colleagues can take advantage of everything The Pharmacy Technician Society will have to offer.

ASHP is also committed to promoting growth at all pharmacy and health-system leadership levels, including clinical leaders. In 2022, we launched the ASHP Leadership Center, which facilitates the continuity of leadership development for all our members, including professional development opportunities, networking and mentorship, and credentialing of leadership skills and expertise.

As part of the new center, ASHP formed a membership home for Pharmacists in C-Suites, an initiative to represent pharmacist executives with expanded roles beyond the pharmacy enterprise. It focuses on creating valuable connections and peer networking within the group. This new group will provide opportunities for current pharmacists in C-suite roles to mentor

future leaders, stimulating pathways for advancement into executive and C-suite leadership positions in hospitals and health systems.

The ASHP Certified Pharmacy Executive Leader, or CPEL, credential provides national recognition of core competencies in professionalism, leading people, leading the pharmacy enterprise, and leading within and across complex healthcare systems.

I am pleased to share that 68 ASHP members have been credentialed as Certified Pharmacy Executive Leaders after completing their respective capstone events held at ASHP over the past year. Additional capstones will be offered this year. We estimate that 130 leaders will have earned their CPEL credential by the end of 2023.

ASHP is highly focused on supporting students as they form their professional identities and embark on their leadership journeys. In fact, ASHP offers a one-year complimentary membership to P1 pharmacy students. In January, we launched the ASHP Student Leadership Development Program, a robust offering for student pharmacists or faculty who wish to design a learning course for their students. The course is closely aligned with the Accreditation Council for Pharmacy Education's personal and professional development standards, rendering it an extension of the outstanding curricula for students within their schools and colleges of pharmacy. The program guides students through presentations, readings, and hands-on activities that help them define leadership, develop their brand, foster professional relationships, improve communication, and strive to become leaders in the profession.

To further elevate ASHP's support for the nation's hospital and health-system leaders of tomorrow, the Pharmacy Administration and Leadership Residents' Collaborative (PALRC) serves as a home within ASHP for unique offerings for the Health-System Pharmacy Administration and Leadership (HSPAL) resident community. The PALRC is the advisory committee of HSPAL residents and includes 3 workgroups: Student and Resident Engagement, Advocacy and Practice Advancement, and HSPAL Resident Resources. Over the past year, the PALRC has hosted multiple virtual roundtables and published several leadership-focused resources, including a podcast and infographic.

Over the past year, ASHP's Pharmacy Executive Leadership Alliance, or PELA, convened multiple times to discuss and offer insights on critical issues for high-level pharmacy executives. PELA roundtables and panel discussions on topics such as elevating the pharmacy technician workforce, countering threats to the 340B pricing program, and future trends in medication management provide guidance for the creation of new tools and resources for ASHP members.

Well-being

An engaged and thriving pharmacy workforce is essential to optimal patient care and the resiliency of our healthcare system. We are concerned with current rates of occupational burnout, mental health challenges, and moral injury in the pharmacy workforce and other healthcare disciplines. ASHP continues to support the well-being and resilience of pharmacy professionals through our Well-Being Ambassador Program. Our fourth and final cohort begins in July, with a focus on residents, residency program directors, and preceptors. We anticipate that this exceptional program will have reached over 4,000 members of the pharmacy workforce at the conclusion of the 3-year grant period.

Innovation

We are better together when we collaborate around innovation to advance pharmacy practice. In today's ever-evolving healthcare landscape, being a leader means embracing the future.

The ASHP Innovation Center fosters high-impact partnerships to further explore how technological advances like artificial intelligence, data science, precision medicine, and digital therapeutics can enhance safe medication use, improve clinical outcomes, and streamline operations.

Our forward-looking collaboration with the University of Minnesota College of Pharmacy has led to the creation of the Pharmacogenomics Accelerator program, which supports clinicians in implementing and growing pharmacogenomics services at their institutions. The inaugural cohort of the Pharmacogenomics Accelerator program began in September with 3 institutions: Texas A&M School of Pharmacy, Froedtert Health, and Wentworth-Douglass Hospital.

Pharmaceutical cold chain management in health systems is a critical part of the ASHP Innovation Center's efforts to advance the safe and effective use of medications. We recently wrapped up a series of Cold Chain Executive Management Summits conducted in collaboration with our Innovation Partner, Cold Chain Technologies. The series has yielded 3 resource guides, which have been disseminated to our members.

To further strengthen our efforts to advance patient care through pharmacy practice innovation, this past year we launched the Section of Digital and Telehealth Practitioners to address rapidly evolving advances in virtual healthcare delivery, pharmacy practice, and digital health technology. This growing practice area was also the focus of the 2023 Commission on Goals, which examined the management of digital health technology for better patient care.

Diversity, equity, and inclusion

ASHP continues to take significant steps toward strengthening an inclusive culture for all pharmacy practitioners. We recently released a 2022 Implementation Report[5] detailing our progress toward meeting the recommendations from the 2020 ASHP Task Force on Racial Diversity, Equity, and Inclusion.[6]

One important recommendation from the task force was to increase the diversity of pharmacists practicing in

hospitals and health systems by connecting with schools with high BIPOC engagement. I'm proud to share that we have significantly increased our annual outreach to pharmacy programs at Historically Black Colleges and Universities, Hispanic-Serving Institutions, and schools with high BIPOC enrollment.

ASHP's Guided Mentorship Program, which connects student pharmacists of color with seasoned practitioners, has been very successful. The program launched in 2021, and the most recent cohort just completed the program in March. Applications for the next program cycle will open in August.

ASHP's recent revision of the pharmacy residency accreditation standards ensures that residency programs meet patient and community needs. The revised standards address the recruitment of a diverse and inclusive applicant pool, which results in a diverse pharmacy workforce. We also developed a Diversity Resource Guide to support residency programs in these initiatives.

In addition, the ASHP Foundation recently announced a scholarship to support increased representation from historically underrepresented groups in the pharmacy workforce.

The inaugural program will award a total of $25,000 in scholarships to pharmacy students enrolled at US-accredited Historically Black Colleges and Universities beginning in fall 2023.

World-class education and content

ASHP remains a leader in the development and dissemination of valuable educational resources and content in multiple formats to support the delivery of optimal clinical care, professional development, and practice advancement.

We issued nearly 595,000 statements of continuing education (CE) credit across our educational offerings in 2022. This includes our growing line of professional certificates, board certification resources, webinars, podcasts, and meeting content.

The newest additions to our line of professional certificates include Pharmacy Leadership and Specialty Pharmacy. We also recently released ASHP's first microcredential product, Pharmacist-Initiated Therapy, which offers 3 separate microcredential options: Ambulatory Respiratory Infections, Continuous Glucose Monitoring, and HIV Pre- and Post-Exposure Prophylaxis.

December marked the successful return of the largest gathering of pharmacists in the world with an in-person Midyear Clinical Meeting & Exhibition in Las Vegas. More than 20,000 attendees connected with colleagues face to face and took part in educational sessions, networking events, the Residency Showcase, the Personnel Placement Service, and more.

An important tenet of ASHP's educational offerings is to align these resources with our members' most pressing issues. We recently launched a new Compounding Resource Center to help members implement and comply with recent revisions to USP General Chapters <795> and <797>, which become enforceable on November 1, 2023, and represent significant changes from the 2008 standards. The new resource center aggregates ASHP's expansive and comprehensive offerings, including a series of documents exclusively for ASHP members that outline the fundamental changes in the revised chapters. Several podcasts and webinars are available, as is a dedicated ASHP Connect Community on compounding, which has a robust community of nearly 30,000 professionals engaged in discussion on this important topic.

This past year ASHP also began offering free CE via our award-winning ASHP Official Podcast. Recognized last month with a Golden Circle Award by the American Society of Association Executives,[7] the ASHP Official podcast has now surpassed 700 episodes and more than 1 million downloads.

I invite you all to listen to June's special Pride Series, a daily 5-minute podcast featuring ASHP members sharing reflections to inspire inclusivity, acceptance, and the celebration of diversity.

ASHP is the trusted voice of our profession and serves as a thought leader on critical public health topics, like vaccines and drug shortages. Over the past year, ASHP has been mentioned in nearly 3,500 news stories generating an estimated 7.2 billion media impressions. We have experienced remarkable growth in our flagship website, ashp.org, seeing a 25% increase in page views over the prior year.

Conclusion

The theme of this year's Summer Meetings, "Be Bold. Be More." captures the spirit and enthusiasm here in Baltimore. During my year as your ASHP President, ASHP developed many new products, programs, and services to support our members, your practice, and your patients. We are better together as we address the profession's top workforce priorities and lead pharmacy into the future by embracing AI, big data, and cutting-edge innovations that advance the practice of pharmacy. It has truly been a privilege to serve ASHP and our profession. On behalf of Dr. Abramowitz and myself, thank you for being a member of ASHP and for all you do for your patients.

Enjoy the rest of your time here in Baltimore and make the most of the remaining sessions at the Summer Meetings!

Disclosures

The authors have declared no potential conflicts of interest.

References

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Appendix VIII

House of Delegates

2023 NEW BUSINESS SUBMISSION FORM

PLEASE RETURN BY 4PM ON MONDAY, JUNE 12, TO THE
EXECUTIVE OFFICE IN ROOM 334, BALTIMORE CONVENTION CENTER

Delegates may submit items of new business several ways. Delegates may submit a new business item online using the form on HOD Calls, Forms, and Rosters page of the ASHP House of Delegates website (https://www.ashp.org/house-of-delegates/hod-calls-forms-and-rosters) or by completing this form and submitting it by 4 p.m. Baltimore time (ET) to the Executive Office in Room 334.

ASHP
HOUSE OF DELEGATES
JUNE 13, 2023
BALTIMORE, MARYLAND

To be completed by the Office of the Secretary of the House of Delegates

Date Submitted: June 12, 2023

Time Submitted: 1:03 p.m.

INTRODUCED BY (NAME):
Jodi Taylor (TN), Jesse Hogue (MI)

SUBJECT:
Discontinuing ASHP policy "Nonprescription Availability of Self-Administered Influenza Antivirals"

MOTION:
In light of the encompassing nature of the ASHP policy "Point-of-Care Testing and Treatment" approved by the House of Delegates on June 11, 2023, we move to discontinue the ASHP policy "Nonprescription Availability of Self-Administered Influenza Antivirals" approved the same day.

BACKGROUND:
Given the availability and feasibility of point-of-care testing in pharmacies, influenza antiviral therapeutics are an excellent option for pharmacist-initiated treatment. We believe the ASHP policy "Point-of-Care Testing and Treatment" sufficiently covers self-administered influenza antivirals and that individual policies for specific therapeutics are not needed. Additionally, behind-the-counter availability of self-administered influenza antivirals as described in the policy might lead to a reduction in the pharmacist's ability to advocate and screen for influenza and other indicated vaccinations, as purchase of behind-the-counter products can be transactional rather than involving the pharmacist's clinical involvement.

SUGGESTED OUTCOMES:

House of Delegates to vote to discontinue the ASHP policy proposal "Nonprescription Availability of Self-Administered Influenza Antivirals" in light of the approval of the policy proposal "Point-of-Care Testing and Treatment."

Appendix IX

House of Delegates

NEW BUSINESS SUBMISSION FORM

PLEASE RETURN BY 4PM ON MONDAY, JUNE 12, TO THE
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ASHP
HOUSE OF DELEGATES
JUNE 13, 2023
BALTIMORE, MARYLAND

To be completed by the Office of the Secretary of the House of Delegates

Date Submitted: June 12, 2023

Time Submitted: 3:06 p.m.

INTRODUCED BY (NAME):
Jaclyn Boyle - SACP
Ryan Gibbard – OR
Monica Mahoney – MA
Melissa Ortega – SCPP
Sarah Stephens – SICP

SUBJECT:
Compensation for pharmacist cognitive services

MOTION APPROVED:
To adopt the following as a new ASHP policy:

To advocate for reimbursement, pay parity, and financially sustainable models related to cognitive services of pharmacist-accountable services, regardless of site of care; further,

To educate the pharmacy workforce and stakeholders about financially sustainable models of care; further,

To advocate that compensation for healthcare services be commensurate with the level of care provided, based on the needs of the patient; further,

To advocate for the development of consistent, transparent billing, reimbursement, and alternative payment model policies and practices by both government and commercial payers.

BACKGROUND:
While the existing ASHP's Statement on the Pharmacist's Role in Primary Care describes the need for compensation and sustainability in primary care, this may not necessarily apply to pharmacists who are practicing in other areas such as acute care, Accountable Care Organizations, population health settings, specialty clinics, and other settings. While ASHP's active advocacy efforts including the ASHP's Model CMM Legislation (https://www.ashp.org/-/media/assets/advocacy-issues/docs/2023/CMM-Legislation-to-Reduce-Medication-Errors-and-Improve-Patient-Outcomes) are related to supporting reimbursement and other compensation practices, we believe that this issue is so integral to the future of the profession, and particularly the expansion of pharmacists as providers who conduct cognitive services in all practice settings, that ASHP establish a comprehensive permanent policy related to this topic as a standalone issue. This policy can also offer foundational policy language that guides ASHP work in an ever-evolving compensation/reimbursement healthcare system. ASHP Members could also utilize this policy in their own personal advocacy efforts within their individual institutions to collaborate with compliance and billing departments in expanding pharmacist-provided cognitive services.

Additional rationale from the ASHP Policy 2020, Care-Commensurate Reimbursement:
As a means to reduce costs for federal programs, the Centers for Medicare & Medicaid Services (CMS) has been aggressively expanding efforts to reduce reimbursement at certain sites of care. Specifically, CMS has cut reimbursement for care services provided at hospital outpatient departments to match the rate paid physicians' offices. CMS refers to this policy as "site-neutral payment." On the basis of site neutrality, CMS also extended cuts to hospital reimbursement for drugs purchased under the 340B drug discount program to hospital outpatient departments. Private payers have also sought to impose site-neutral payment policies.

Reimbursement for services should reflect unique factors associated with a site of care. Hospital outpatient departments are held to higher quality standards with more oversight than what is often required for alternate sites of care. In addition to the Medicare Conditions of Participation, hospital outpatient departments must meet accreditation, United States Pharmacopeia (USP), and even Food and Drug Administration requirements. These standards result in high-quality patient care, but at a higher cost than what can be accomplished without the oversight.

Patients may also derive benefits from receiving care at a hospital outpatient department. Hospital care delivery models are crafted to ensure that patients receive the highest quality care possible. For hospitals that belong to an accountable care organization or are otherwise part of an integrated network, seeing patients at the outpatient department allows providers to better coordinate care, resulting in improved patient outcomes. Care provided in this setting is often highly complex and complementary to acute care that the patient receives from the hospital. Drastic cuts to hospital

outpatient reimbursement could endanger the long-term viability of these care delivery models – if services are cut or outpatient departments are closed, patient access will suffer.

Additional rationale from the ASHP Statement on Primary Care:
Billing and reimbursement for primary care pharmacy services
The National Academy of Sciences recommends that payers, including Medicaid, Medicare, commercial insurers, and self-insured employers, should shift payments toward a hybrid model that includes fee-for-service and capitated payments, and that these models should pay prospectively for interprofessional, integrated, team-based care.[6] Financial sustainability for services provided by primary care pharmacists may be achieved using a variety of models. Due to lack of federal provider status for pharmacists and subsequent inability to directly bill Medicare as primary care providers, organizations and practices have become creative in maintaining financial sustainability of primary care pharmacist services. Some settings utilize indirect funding, while others take advantage of some of the limited direct insurance billing opportunities to fund pharmacists in primary care settings. Direct billing opportunities will vary based on the setting, hospital-based versus physician-based practices, as well as state-specific laws and regulations. Medicare, Medicaid, and commercial health plans may reimburse pharmacists for certain services, while some will require direct contracting with the health plan. Several states have passed pharmacist state provider status laws and/or reimbursement parity laws allowing for reimbursement for direct patient care pharmacist services by state Medicaid and/or commercial plans.[4]

References:
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https://www.ashp.org/-/media/assets/advocacy-issues/docs/2023/CMM-Legislation-to-Reduce-Medication-Errors-and-Improve-Patient-Outcomes

ASHP Policies 2020, 2134, 2232

SUGGESTED OUTCOMES:
This policy should supersede ASHP policy 2020, Care-Commensurate Reimbursement.

Appendix X

House of Delegates

2023 NEW BUSINESS SUBMISSION FORM

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ASHP
HOUSE OF DELEGATES
JUNE 13, 2023
BALTIMORE, MARYLAND

To be completed by the Office of the Secretary of the House of Delegates

Date Submitted: June 12, 2023

Time Submitted: 3:20 p.m.

INTRODUCED BY (NAME):
Kevin Marvin (VT) and delegates from DE, ID, IA, OH, SD, TN, and WI

SUBJECT:
Barcodes with Lot and Expiration Date Needs and Impacts

MOTION APPROVED:
To adopt the following new policy for expedited, urgent approval by the ASHP Board of Directors:

To advocate that the Food and Drug Administration and organizations who develop barcode standards require barcodes contain lot number and expiration date on all immediate product packages to enable automated collection and validation of this information during medication preparation, dispensing, and administration processes; further,

To educate regulatory and safety organizations that barcode scanning versus manual logging of lot numbers and expirations is critical for patient safety and preparation sterility and improves data visibility for medication recalls; further,

To advocate that state boards of pharmacy, regulatory agencies, and accrediting bodies delay punitive action on rules requiring logging of lot number and expiration dates during sterile product preparation until this information is made available on immediate product barcodes.

BACKGROUND:

The current Food and Drug Administration (FDA) barcode rule requires NDC, Lot Number and Expiration Date on all Saleable medication packages. FDA created an exception for immediate packages which include unit dose packages and individual vials sold as lots in boxes. More than 90% of products dispensed in a hospital are immediate packages. The exception requires that the barcodes on these immediate packages be linear (1D) barcodes. Due to the technology of 1D barcodes, it is difficult to fit the larger barcode containing additional characters needed to code lot number, expiration date and NDC on labels of inner packages. As a result, the 1D barcodes required on inner packages only contain the NDC number.

The current FDA proposed rule will allow but not require 2D barcodes and minimally encode only the NDC number in the barcode. The FDA reason for this is that the expansion of NDC to 12 digits will create issues for some manufacturers who code a 10-digit NDC number in the barcode and don't have the label space to expand the 1D barcode to 12 digits. 2D barcodes require less label space than 1D barcodes. This FDA proposed rule will not guarantee that barcodes on inner products contain lot number and expiration date. FDA representatives say that they are addressing the immediate package requirements in the revised rule but his is only true for the NDC 12 character expansion and not for the encoding of lot and expiration date.

Multiple State Boards of Pharmacy including California and Texas require hospitals to log the NDC, lot and expiration dates on all IV products compounded or repackaged. USP 797 is also adding the same requirements to be effective 11/01/2023.

The logging of lot and exp dates is not a second check but an attempt to track medications all the way to the patient in the case of recalls and event reporting. With IV workflow systems and barcodes with lot #/exp Dt, an IV can be prepared and documented with only 2 barcode scans. Current linear barcodes require scans of the ndc and multiple mouse clicks and 22 or more keystrokes on a keyboard to enter the data. Putting a keyboard into the sterile environment or pulling hands in and out of the sterile field threatens sterility. Dispersing this data entry work in the middle of a complicated IV workflow will not only create data entry or transcription errors but will increase the potential for computation errors as the preparer keys in or handwrites these seemingly random numbers while computing, measuring, and verifying doses.

In 2011 the FDA made a change to the 2004 barcode rule when they allowed vaccine manufacturers to encode NDC, Lot and Exp date on 2D barcodes on inner packages in support of the National Childhood Vaccine Injury Act of 1986.* This change supports reporting of adverse events to the Vaccine Adverse Event Reporting System. This was an allowed exception and not a requirement. This recommendation has been discussed with several software vendors who have stated that the functionality is already in their systems to capture lot number and expiration dates, if available, when barcode scanning. This functionality has not only been added to IV preparation functions but also to dispensing and medication administration. They have validated the above statements that many keyboard keystrokes can be replaced by simple barcode scans. In addition, they noted that barcode scans can be initiated by foot switches without touching the scanners and therefore minimize potential for impact on sterility. A two component IV with base solution and 1 additive was reported to require 22 keystrokes and 2 mouse clicks at a minimum if lot and expiration date are not in the barcode. One vender reported that they are in the process of adding automatic checks for expired

medications and recalled lot numbers during all medication barcode scanning functions throughout the medication process. Significant time savings can be realized through automated checking of expiration dates and recalls throughout the medication process including Automated Dispense cabinet restocking.

Current 2D scanners can read 1D and 2D barcodes. Past arguments 19 years ago that hospitals do not have the barcode readers to read 2D barcodes are no longer valid. Many products dispensed are saleable packages that only contain 2D barcodes. In addition, 2D barcode readers are significantly less expensive and more reliable than the 1D laser scanners used in the past.
GS1, the barcode standards organization that defines medication barcode standards has invited stakeholders to provide input on how GS1 can better support industry needs. This is a call-out to organizations such as ASHP to communicate the need for lot, expiration and on immediate products and to work with GS1 to assure the resulting barcodes meet the need in health systems. Such communication with GS1 should include the barcoding of repackaged products and investigational medications. This is the invite statement from GS1: "Manufacturers should be moving toward 2D to support forward movement in adoption and use. Downstream trading partners should focus on scanning and consuming - the time is now to move in this direction. As stakeholders across the healthcare supply chain begin to adopt scanning and consuming of data from GS1 DataMatrix barcodes further detail may be needed to support this industry.

GS1 US invites any organization to collaborate and share positive or negative learnings. Sharing lessons learned, what worked well and what needs more attention to fulfill the important possibilities that exist will need to continue if we are to achieve the benefits that sharing, scanning, and using advanced data about healthcare products can provide."

ASHP Policy 1003, FDA AUTHORITY ON RECALLS (Council on Public Policy) partially supports this recommendation as it contains the clause: "To urge the FDA to require drug manufacturers and the computer software industry to provide bar codes and data fields for lot number, expiration date, and other necessary and appropriate information on all medication packaging, including unit dose, unit-of-use, and injectable drug packaging, in order to facilitate compliance with recalls or withdrawals and to prevent the administration of recalled products to patients;" This policy is aimed more at human readable printing of data fields for lot and expiration date rather than encoding of that information in a barcode.

Rules are being implemented and considered by State Boards of Pharmacy and USP to track medications to the patient and validate expiration dates. There is a general lack of understanding how these rules impact IV preparation workflows and corresponding medication safety and sterility of IV preparation. It is important to educate rule makers on this impact and work with the FDA to expedite a barcode rule change to **REQUIRE** and not just allow the lot and expiration date on immediate product bar codes.

SUGGESTED OUTCOMES:
That ASHP adopt the proposed policy.

Appendix XI

Recommendations from the 2023 House of Delegates

The delegate[s] who introduced each Recommendation is [are] noted. Each Recommendation is forwarded to the appropriate person or body within ASHP for assessment and action as may be indicated. ASHP actions on the recommendations is recorded and reported to the House the following year.

	Recommendation Title/Text/Background	Sponsor(s)
1	**Enhance Diversity in Clinical Trial Participation through Patient Education** ASHP to advocate for better patient education in clinical trials to enhance equity and diversity among participants. **Background:** Pharmaceutical companies rely on individual research sites for patient education, and there is variability in this area due to deference to individual sites. Study coordinators have multiple studies they oversee and cannot always provide the robust attention and education needed to ensure patients understand the clinical trial methods and requirements. At times, the only instructions patients receive are the protocol within the consent and what is shared verbally. A patient with minimal health literacy could not effectively participate in a clinical trial due to the challenges outlined above. This may also limit the availability of ground-breaking treatments for some patients in need.	Christi Jen (SCSS), Jerome Wohleb (NE), Janelle Duran (AZ)
2	**Pharmacists Admixture of Medications for Immediate Administration** ASHP to advocate for collaboration with the American Nurses' Association in increasing awareness and education on the appropriateness of nursing administration of medications compounded/prepared by a pharmacist at bedside for emergent/urgent situations. **Background:** There have been reports of nurses refusing to administer a medication (intravenous norepinephrine) that was compounded by a pharmacist at bedside for a critical medication for an urgent/emergent situation such as code response. Nurses are being taught that only medications that they have compounded themselves may be administered to the patient.	Christi Jen (SCSS), Jerome Wohleb (NE), Lance Ray (CO), Chris Edwards (AZ), Janelle Duran (AZ)
3	**Development of Position Statement on the Role of Health-System Pharmacy in Gene and Cellular Therapy** ASHP to develop a position statement on the role of the health-system pharmacy in gene and cellular therapy.	Christi Jen (SCSS), Elyse McDonald (UT), Scott Canfield (SPP) Katherine Reibig (NE), Ashley Duty

	Background: New treatment strategies (gene and cellular therapy) have become available more recently, which has impacted health-system pharmacy from an operational, clinical, and financial perspective. ASHP needs to be at the forefront of these new therapies and collaborate with stakeholders to evaluate, define and design the role of the pharmacy workforce related to areas in research and home treatment.	(OH), Janelle Duran (AZ), Jerome Wohleb (NE)
4	**Development of Membership Engagement Opportunities & Industry Pharmacy Partners** ASHP to Industry Pharmacists Partners to foster relationships between health-system pharmacies and industry pharmacists and serve as a professional home for them. Engagement opportunities include town hall and networking sessions. **Background:** With the changing healthcare landscape, many health-system pharmacists have transitioned to career paths in industry, who firmly believe that ASHP is still their professional home. ASHP and its members need to continue to maintain and foster these relationships, understand and mitigate any conflicts of interest, and develop partnerships that positively impact both areas.	Christi Jen (SCSS), Andew Mays (SCSS), Rena Gosser (WA), Jeff Little (KS)
5	**Consideration of Louisville, Kentucky for a future summer meeting** The Kentucky Delegation asked that Louisville, KY be considered as a site for a future ASHP summer meeting **Background:** Recently finished construction of the Kentucky international convention center and revitalization of the hotels downtown it is our belief that Louisville can easily sustain an ASHP summer meeting for space and entertainment of members. We ask that ASHP consider utilizing Louisville, KY and the aforementioned spaces to host a meeting.	Jonathan Scott Hayes (KY) Dale English (KY) Thom Platt (KY)
6	**Revision of ASHP policy 2253** ASHP should review current policy 2253 Unit Dose Packaging Availability to add in language surrounding support of studies/recommendations for packaging of medications outside of original manufacturer bottles. **Background:** Increasingly manufacturers are including verbiage on medication bottles and within package inserts that state “dispense in original container” or similar. Typically, these statements are declared without any rationale, studies, or analytical support. These statements and lack of external data around stability of medications when re-packaged have led to hardships in health systems to provide medications in a ready to use product for timely administration.	Shannon Baker (RI)
7	**Inclusion of minimum number of resident check-ins to the Accreditation Standard**	John Muchka (WI)

	Recommend that ASHP updates residency accreditation standards to include guidance on a minimum number of check-ins between resident and residency leadership to promote mental well-being and mitigate burnout. **Background:** Results of a longitudinal study published in May 2022 in JAPHA should that pharmacists have a higher suicide rate than the general population. According to an article published in 2017 in the American Journal of Pharmaceutical Education, 82% of residents surveyed experience depressed mood, and 22% reported suicidal ideation. Required frequent check-ins with residency leadership may decrease stressors and create a caring atmosphere. These check-ins could potentially help with early detection of depression or suicidal ideation.	
8	**Over-The-Counter Availability of Hormonal Contraceptives** To amend ASHP Policy "Over-The-Counter Availability of Hormonal Contraceptives" as follows: To advocate that hormonal contraceptives be available over the counter (OTC) without age restriction ~~only under conditions that ensure safe use including availability of pharmacist consultation to ensure appropriate self-screening and product selection,~~ and that maintain patient confidentiality; further **Background:** Based on the rationale provided in this policy, the intent is to expand access to hormonal contraceptives by advocating for reclassification to OTC status. The current language in the first clause of this policy could be interpreted as ASHP supporting a behind-the-counter model that includes pharmacist consultation and encourages safe use. The rationale provided in this policy specifically states that ASHP does not support a behind-the-counter model for oral contraceptives. Therefore, revising the first clause of this policy to delete language that suggests the support for a behind-the-counter model would align with ASHP's intent for this policy. In addition, having a more clear policy regarding our support of broader access to hormonal contraceptives would allow ASHP to align with statements of other professional organizations such as AMA and ACOG. Additionally, we recommend that the Council on Therapeutics revise the rationale of this policy to reflect the change in terminology from "oral contraceptives" to "hormonal contraceptives" to align with the amended language of the policy as approved by the HOD.	Carla Darling (DC) Sue Carr (DC)
9	**Consolidate workforce education and training clauses into one policy** Recommend ASHP review workforce education clauses in policies and statements and consolidate them into a single policy. **Background:** Policy language is often bloated with education as well as other clauses that are repeated in numerous policies.	Kelly Bobo (TN)

	Having one comprehensive workforce education policy would allow other policy to be streamlined and focused on the purpose of the policy.	
10	**AI and The Pharmacy Workforce: Integrate Solutions for Optimal Care.** To engage key stakeholders to safely and securely integrate AI into low-leverage positions, allowing pharmacy workforce to be used at top of license. **Background:** Artificial Intelligence is breaking the mold of many industries, including pharmacy and healthcare. Pharmacy workforce challenges make utilization of AI as a pharmacy extender a logical next step. But making sure to connect to people in the role with logic is essential to optimize best practices and patient care.	James Houpt (WA)
11	**Creation of Formal Definition of Advanced Pharmacist Practice.** ASHP, working in conjunction with other pharmacy professional organizations including NABP, should create a formal definition of Advanced Pharmacist Practice which will assist in lobbying efforts for provider status at the state and national level. **Background:** Currently, the pharmacist profession suffers from an identify crisis. We want to maintain our professional responsibility to oversee the medication distribution process but at the same time we are advancing clinically as direct patient care providers. Over the past several decades our profession has actively attempted to obtain federal recognition as healthcare providers. What has made this difficult is a lack of agreement on which pharmacists should be recognized as providers. Is it all pharmacists or is it pharmacists with additional qualifications. If we look to nursing as an example, not all nurses have providers status but Nurse Practitioners, Nurse Specialists, and Nurse Midwives do. The time has come to formally define Advanced Practice Pharmacists which in turn will aid our efforts at obtaining federal recognition as providers.	Joe Anderson (NM)
12	**Education Resource Center for Pharmacy Leaders In the Area of Facilities Management of Clean Rooms** We request pharmacy leaders should have resources available for CE in the area of clean rooms. Management to better understand the scope of the environment of care that is necessary for patient and employee safety. **Background:** 1) Pharmacy leaders and facilities leaders often have to work together to solve challenges around clean room maintenance, remodeling, and constitution. 2) In order for a collaborative relationship to exist, pharmacy leaders should be exposed to non-clinical guidelines or standards such as CETA and ASHRAE to better understand the full scope of managing and maintaining a clean room.	Nissy Varughese (NJ)

13	**ASHP Provided Childcare at Meetings** ASHP should provide childcare at meetings to encourage and facilitate participation of working mothers and fathers with young families. **Background:** None	Carolyn Bell, Megan Roberts, Lisa Gibbs (SC, AL)
14	**Pharmacists as Mental Health Providers to Increase Patient Care Access and Quality** ASHP should consider developing a policy statement to improve advocacy and awareness of the pharmacist's role in improving mental healthcare access and quality. **Background (must be limited to five typewritten lines):** 1) The US is facing a mental healthcare crisis, with 56% of Americans seeking mental healthcare services. 2) There is a growing demand for mental health care, yet a significant shortage of mental health providers persists. Demand for MH providers with medication management expertise continues to increase and provides opportunity for pharmacists. 3) Pharmacist providers with expertise in mental health are mental health providers who have extensive medication management skills. 4) Such pharmacists strengthen the mental health team by working directly with patients, improving access and quality of care. 5) Goal: Increase awareness, advocacy, collaboration with other agencies (Public/Private) and training pipeline.	Lt Col Rohin Kasudia (USAF), Dr. Heather Ourth (Veterans Affairs), Dr. Julie Groppi (FL), Dr. Terri Jorgenson (MD)
15	**Pharmacist Controlled Substance Prescribing Authority** To advocate for expansion of state laws and regulations that authorize pharmacist ability to prescribe controlled substances. **Background:** Currently there are only 11 states that authorize pharmacists as DEA registered practitioners, and these states differ in their authority and vary in the schedules and supervision requirements for pharmacists. ASHP and states must work collaboratively with DEA and other stakeholders to optimize the pharmacist controlled substance prescirbing authority across states using model state practice acts. This is foundational for pharmacist supported access for medications for opioid use disorder, pain and mental health care.	Heather Ourth (Veterans Affairs), Terri Jorgenson (MD), Kali Autrey (USPHS), Amy Sipe (MO), Julie Groppi (FL), Lt Col Rohin Kasudia (USAF)
16	**ASHP Reducing Carbon Emissions to Promote Public Health** To promote reduction of ASHP's carbon emissions and improving sustainability thorough a reduction of physical waste and identification of more eco-friendly business practices. **Background:** Due to the passage of the Council on Pharmacy Practice's Policy on 'Reducing Healthcare Sector Carbon Emissions to Promote Public Health, ASHP should strive to do the same by aiming to reduce use of printed and single-use materials in National meetings and in-home mailings. A majority of ASHP members have an active email or and use social media as a primary method of info gathering. This will lead ASHP to serve as	Jacalyn Rogers (OH)

	an example for health systems in the effort for a more sustainable and eco-friendly organization. This includes paper mailings, bags full of ads at registration, and a paperless HOD survey.	
17	**Food Allergen Labeling at ASHP Meetings** ASHP should support members with food allergens similar to those outlined by the "FDA Guidelines on Food Allergen Labeling" at professional meetings. **Background:** Although food prepared by vendors is not manufactured and required to FDA labeling, it would better support the needs and diversity of attendees. In addition, providing food option diversity would improve inclusivity and reduce additional expenses of attendees.	Ashley Duty (OH)
18	**Creation of Resources to Support Successful Pharmacy Residency Reimbursement from Centers for Medicare & Medicaid in order to ensure residency programs can sustain the current fiscal climate for health-systems.** 1) Prepare centralized education and support documents for RPDs. 2) Advocate for transparency from CMS on criteria reviewed and process for determination for passthrough reimbursement. **Background:** At current state, it is not clear how to navigate the process to request passthrough funding for pharmacy residency programs through CMS. Programs are finding at the point of submission that they failed to supply necessary data on a format that is acceptable, reading to minimal or zero passthrough funds seen by the organization. RPDs noting concern in positions or program closure as a routine - for programs that maintain, reduced reimbursement limits growth, preceptor, resident development resources.	Kellie Much (OH) Ashley Duty (OH) Tom Achey (SC) Charnae Ross (NPF) Carolyn Bell (SC) Tyler Vest (NC) Jackie Rogers (OH)
19	**Address the Use of AI in Healthcare** ASHP create a policy addressing the optimal use of artificial intelligence in healthcare including the areas of clinical practice, operations, research, and education. **Background:** AI is increasingly being used and there is interest in using it on policy development and other healthcare areas. Policies need to be developed to ensure information accuracy, attribution, and privacy.	Jennifer Phillps (IL) Andy Donnelly (IL), Bernice Man (IL), Megan Corrigan (IL), Radlicka Polisetty (IL)
20	**Develop a sustainable pharmacy workforce** ASHP should engage all appropriate council(s) to develop a sustainable pharmacy workforce that addresses both growth of future workforce through student and technician enrollment and retention of existing health-system pharmacy professionals. **Background:** Workforce needs for both pharmacists and technicians are critical to the future of our profession and the future supply is in jeopardy. College applications and enrollment are down significantly, labor shortages are present in most states, and technicians shortages have been reported by a recent ASHP survey. The complexity of the situation is growing requiring	Christopher Edwards (AZ), Alice Callahan (IA), Jenna Rose (IA), John Pastor (MN), Kristi Gullickson (MN), Julie Neuman (MT), Katie Reisbig (NE), Tiffany Goeller (NE), Jessica (MI) Jones, Rebecca Maynard (MI), Monica Mahoney (MA), Francesca Mernick (MA), Jacqueline Gagnon

	immediate mitigation strategies. The lack of qualified skilled staff will compromise our role in healthcare delivery.	(MA), Rena Gasser (WA), Jackie (Jacalyn) Rogers (OH), Tonya Carlton (NH), Liz Wade (NH), Jeff Cook (AR), J. Huntley (AR), Adam Porath (NV), Victoria Wallace (ID), Audra Sandoval (ID), Christi Jen (SCSS), Cindy Jeter (PTF)
21	**Improving access to (what are now) controlled substances** To identify which medications ASHP believes should be de-scheduled and petition the Attorney General as such. **Background:** Several recently-approved anti-seizure medications have been placed into a controlled substance schedule, despite little to no published risk of abuse (e.g lacosamide). These actions create barriers for patients and place unhelpful administrative burdens onto pharmacies. Would like ASHP to reach consensus (partner with Epilepsy/Neurology organization[s]) and submit a petition to have the medication(s) de-scheduled.	Andrew Kaplan (FL)
22	**Expanded access to standardized trainings and resources for the pharmacy workforce practicing in the field of women's health** ASHP develop and encourage women's health-focused clinical training programs, certificates, and/or credentials to improve the care provided by women's health clinical pharmacists. **Background:** An increasing number of health-systems have incorporated women's health specialty pharmacists into their clinical practice despite minimal education and training opportunities in pharmacy schools and postgraduate programs. More training opportunities will improve clinical expertise to better serve the population.	Audra Sandoval (ID)
23	**Use of Recognized National Treatment Guidelines as Foundational Documents in State and Federal Legislation in Treatment or Management of Disease or Condition** ASHP advocate that National Guidelines for the treatment or management of disease or condition are standards of care and as such, are to be used to guide all local, state, and federal legislation. **Background:** Currently in the USA, laws are being enacted which are contrary to the nationally accepted standards of care. Examples of this include abortion restrictions (i.e., complete bans without exceptions – health or life of the pregnant person, rape, incest, fetal demise), outlawing gender affirming care for minors, and/or making it a felony for providers who follow these evidence-based practices and/or guidelines.	Victoria Wallace and Audra Sandoval (ID)
24	**Well-being and Resilience for Pharmacy Workforce Members Experiencing Vicarious Trauma and Moral Injury**	Christi Jen (SCSS), Jerome Wohleb (NE), Janelle

	ASHP to provide awareness and education to the pharmacy workforce on the risk for vicarious trauma when exposed to or experiencing traumatic patient care events or when experiencing moral injury. **Background:** Schools of pharmacy do not adequately our learners and clinicians on how to handle traumatic patient care events. We know these events occur and that we are exposed to them during patient care. However, they are not given sufficient preparation or tools to help manage such traumatizing events. We need ASHP to provide awareness and education through programming (webinars or podcasts) to help those who are exposed to those events. In addition, there is also a risk for burnout when our pharmacy workforce also experiences moral injury (as Dr. Wen pointed out this morning).	Duran (AZ), Edward Saito (OR)
25	**Decentralized pharmacy practice model in acute care facilities** It is recommended to update current policies or create a new one specifically promoting the use of a decentralized pharmacy practice model in acute care facilities. ASHP policies do not currently specifically encourage acute care facilities to place pharmacists not responsible for drug distribution outside of the main pharmacy or decentralize pharmacists to the patient care units. **Background:** Decentralized pharmacists positively impact the quality of care. The quality of care provided to our patients is improved by a more active role of the pharmacist in selecting and monitoring medication therapy, preventing medication misadventures and adverse reactions, improving medication therapy outcomes, and educating patients and other health care providers in the correct use of medications. The decentralized pharmacist practice model allows for pharmacists to directly care for patients through in-person care such as medication counseling, medication reconciliation and code response. Small and mid-sized facilities may look to ASHP for staffing recommendations to support the decentralized pharmacist labor model. ASHP policies 0812 and 2133 may be a starting place for insertion of advocacy for the decentralized pharmacy model. Of note we composed a decentralized pharmacy standard for CommonSpirit Health. ASHP has many documents to support clinical practice but nothing was specifically found to advocate for use of the decentralized model. A recommendation from ASHP is powerful!	Janelle Duran (AZ)
26	**Independent Prescribing Authority**	Jackie Boyle (SACP), Brody Maack (SACP), Erin Neal

	Motion that ASHP create a new policy regarding Independent Prescribing Authority or to revise/combine existing ASHP policies 2236, 2251, and 1822. **Background:** ASHP has several policies related to independent prescriptive authority, however, the SACP would like to request that a review/revision of existing policies 2236, 2251, and 1822 be considered. Additionally, we recommend that additional clauses are added related to: - Access to a diagnosis related to prescribing a given medication - Ensuring access and the ability to document in the patient's medical record - Ensuring access for pharmacists to order labs related to the prescribing/monitoring of a given medication - Establishing a credentialing and privileging process as well as a peer review process before independent prescribing authority be granted Several policies reference independent prescribing authority (ASHP Policies 2251, 2125, 2236, 2211, 2229, 2116, 1909, 1822) and there is likely an opportunity for policy to be streamlined or revised to be aspirational related to independent prescribing authority.	(TN), Melissa Ortega (SCPP)
27	**Inclusion of Term "Red Flag" in the Controlled Substances Act** To advocate for the inclusion of the term "red flags" in the controlled substances act in 21 CFR 1306. **Background:** Although the term "red flags" is used and considered apart, the term is not codified in the CSA. The lack of inclusion has presented severe issues when state regulatory agencies are challenged in drug diversion cases. The inclusion of this term in the CSA would establish consistent language to be followed by state CSAs, in addition to inclusion in the CSA, the term should also be included in the DEA's Pharmacists' (illegible text)	Diane Ginsburg (Past President)
28	**Electronic maintenance and submission of the Academic and Professional Record** The SICP recommends ASHP establish an online form or database to facilitate the maintenance and submission of the Academic and Professional Record within Pharmacademic. **Background:** Currently, the process for documenting the APR is cumbersome and inefficient both for Residency Program Directors and Preceptors. Optimization of this process to allow for online entry and maintenance is requested to ease administrative burden for all. Additionally, an online database has the ability to capture and collate information for multi-program site locations.	Sarah Stephens (SICP)
29	**Measuring the Impact of Residency Training Programs** ASHP should compile and release metrics used by health systems to assess the impact of residency programs on patient and health-	Nancy MacDonald (SCSS), Chris Edwards (AZ), Christi Jen (SCSS), Andrew Mays (MS)

	system outcomes to assist other residency programs in justifying and expanding their training. **Background:** Health systems are facing financial hardships, requiring pharmacy leaders to justify pharmacy residency training program funding. Currently, no singular dashboard exists that tracks metrics used by residency programs to aid in this justification. The open availability of these metrics will promote integration of best practices and documentation of the value of each program.	
30	**Peer Review** Motion that ASHP consider developing a policy related to peer review in any setting where pharmacists are providing direct patient care. **Background:** Currently, ASHP Policy 2236 which addresses peer review in background/rationale of interprofessional prescribing, however, we believe that ASHP should have policy outlining the peer review process of pharmacists in direct patient care as a standalone, important issue. Consideration should be made for how the peer review process would be conducted for pharmacists who practice in settings where peer review may be conducted by non-pharmacist colleagues.	Jackie Boyle (SACP); Brody Maack (SACP), Melissa Ortega (SCPP)
31	**Opposition to anti-DEI actions and legislation** ASHP should urgently develop and publicly release a statement strongly opposing legislation or actions which prohibit DEI funding, programs, and education. **Background:** ASHP currently has policies which support workforce diversity (Policy 2217) and which support advancing diversity, equity, and inclusion in education and training (Policy 2230) and recently established an ASHP Task Force on Racial Diversity, Equity, and Inclusion in 2020. Additionally, ASHP residency accreditation standards require residency programs to ensure recruitment of pharmacy personnel includes methods to promote diversity and inclusion. These policies and ASHP priorities are under attack, as there have been more than 30 proposed bills in state legislatures across the country which take aim at DEI programs. These bills are frequently aimed at colleges and universities, but they represent a dangerous attack on these programs and their impact to other educational programs and healthcare institutions such as academic medical centers remain unclear. We urge ASHP to loudly condemn these efforts and to urge leaders and policymakers to reject any legislation or other actions which seek to limit DEI efforts in higher education and health care-related professional institutions and licensing boards.	Tara Vlasimsky (CO) Melissa Ortega (MA) Kristi Gullickson (MN) Lance Oyen (MN) John Pastor (MN) Ashley Duty (OH) Kellie Musch (OH) Kembral Nelson (OH) Jackie Boyle (SACP) Brody Maack (SACP) Danny Truelove (SACP) Ashley Parrott (SACP) Jordan Wulz (SACP) Christina DeRemer (SACP) Christi Jen (SCSS) Ben Anderson (SOPIT) Lindsey Amerine (SPPL) Lindsey Kelley (SPPL) Lynnae Mahaney (Past President) Kat Miller (KS) Brian Gilbert (KS)
32	**Combatting Fraudulent Electronic Controlled Substance Prescriptions** Recommend ASHP develop policy, enhance awareness and facilitate collaboration with relevant stakeholders to understand	Liz Wade (NH), Lt. Col. Rohin Kasudia (USAF)

	the nationwide scope of the problem, identify weaknesses in the electronic prescribing of controlled substance (EPCS) process, and develop strategies to eliminate fraudulent electronic controlled substance prescriptions. **Background:** In August of 2022, the Ohio State Board of Pharmacy issued a prescription fraud warning: "The Board continues to receive notifications of prescriptions for promethazine with codeine and other controlled substances, including fraudulent prescriptions issued electronically (via ECPS). To help combat these fraudulent prescriptions, it is recommended that pharmacies verify…prescriptions with the practitioner's office by means other than the phone numbers provided on the prescriptions."	
33	**OTC vs Behind the Counter vs Prescription Medication** 1) ASHP creates clear guidance and criteria on what medications should be advocated for behind the counter vs over the counter use. 2) ASHP should consider policy that outlines medications or therapeutic categories that should be available to patients through prescriptions provided by a pharmacist. **Background:** "The ASHP SCPP appreciates the opportunity to submit a recommendation. The SCPP is pleased to see ASHP support access to reproductive health, antiviral therapies, and other medications without a prescription to patients. ASHP policies are increasingly referencing over the counter and behind the counter medications. While those terms appear to be used interchangeably in ASHP policy, there is a distinct different between the level of involvement by the pharmacist in OTC vs behind the counter medications. Currently, ASHP does not have clarity on which medications should be behind the counter (requiring pharmacist counseling and discussion with the patient) vs over the counter (readily available to patients anywhere). SCPP recommends that 1) ASHP creates clear guidance and criteria on what medications should be advocated for behind the counter vs over the counter use. 2) ASHP should consider policy that outlines medications or therapeutic categories that should be available to patients through prescriptions provided by a pharmacist. It is important that ASHP continues to support the pharmacists advanced practice roles and continues to increase access to care. This clear distinction of medications should be based on therapeutic effect and potential for harm to patients, highlighting the significance of the pharmacist's involvement that promote patient safety. If you have any additional questions, please contact the Melissa Ortega, Chair SCPP	Melissa Ortega (SCPP) Kate Schaafsma (WI)

34	**Guidance that establishes practice excellence standards across all setting of community-based practice** The ASHP Section of Community Pharmacy Practitioners recommends development of guidance that establishes practice excellence standards across all setting of community-based practice. Background: The ASHP Section of Community Pharmacy Practitioners recommends development of guidance that establishes practice excellence standards across all setting of community-based practice. Community pharmacy practitioners are skilled clinicians, operational experts, and leaders, who contribute to quality care and patient safety. It is important to consider a cross-functional discussion that involves stakeholders across community practice settings and regulators that articulate the value and expectations of excellence.	Melissa Ortega (SCPP)
35	**Standardization, interoperability, and data visibility of pharmacy barcode technology** Advocate that software developers for electronic health systems as well as pharmacy inventory, dispensing, preparation, and compounding technologies standardize reading, storing, and reporting of barcode data to assure interoperability between different systems, ease of use, and visibility to recorded data. **Background:** Barcode formats do not always translate between pharmacy and health record systems, due to character limits, prefixes, and cross sectioning. In addition, not all systems have sufficient reporting functionality to assure reproducibility of data for regulatory surveys and inspections. Standardization and interoperability is desperately needed as use of barcode technology is further integrated into pharmacy inventory, dispensing, and compounding.	Kevin Marvin (VT) Latresa Billings (TX)
36	**Pharmacy Leadership Survey** Recommend that ASHP perform a survey of health-system pharmacy leadership, similar to the surveys performed by Sara White in 2004 and 2011. **Background:** I am not aware of a comprehensive survey of pharmacy leadership since Sara White's two surveys in 2004 and 2011. I think a survey of this type would be beneficial to assess the current state of health-system pharmacy leadership. The survey can include questions similar to the ones in Sara White's surveys to assess what has changed in the last 10+ years, plus additional ones more reflective of leadership today (e.g., completion of HSPAL residencies, Masters degree training, etc.). Further, this type of survey should be performed routinely (e.g., every 5 years). I would be interested in helping with this.	Andy Donnelly (IL)
37	**Anti-policy bloat**	Chris Scott (IN)

	New and updated ASHP policies shall be composed of no more than three clauses in total. Policies should be directional and aspirational in nature and shall be designed with a goal to remain relevant for at least a sunset policy cycle (5 years). All effort should be made to prevent duplication of policies across Sections and Councils. **Background:** Feel free to contact me for any clarification.	

ASHP Board of Directors, 2023-2024

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Be The Change

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During my term as your ASHP president, I am prepared to Be The Change and elevate the vital roles that health-system pharmacy practitioners play as providers in new and emerging science, and to prepare the workforce for the digital future of pharmacy practice.

Editor's note: The following is adapted from comments delivered by Dr. Kasbekar during the 2023 ASHP Summer Meetings and Exhibition, held in June in Baltimore, MD.

Good morning colleagues, family, and friends. I want to begin today by paraphrasing one of my favorite quotes from Mahatma Gandhi: "Our future does depend on what we do today. We need to move forward together, understanding that the seeds we sow today will give us meaningful and fruitful yield for tomorrow."

The theme of this year's Summer Meetings is "Be Bold. Be More." And I am going to run with that idea, because my inaugural theme is "Be The Change."

Today I stand here as your 80th ASHP president, and I hope to share with you how my personal story has shaped my vision for the profession to manage and lead to Be The Change in the coming digital revolution.

My parents emigrated from India in the 1960s to pursue the American dream, symbolized by opportunity and success and realized through courage, sacrifice, and hard work. Like many immigrants, they left a network of family and friends, without a road map or financial means but instead with an internal compass guided by fortitude and ambition. My parents also placed an emphasis on incorporating the innovative American spirit with Indian culture and traditions.

In my childhood, I was taught the significance of working together with people from different backgrounds and viewpoints, with a focus on a balanced perspective. I learned the importance of family ideals, respect for elders, strict academic standards, and the value of the American dollar. As my parents had done, I also embraced different cultures, allowing me to broaden my insights into behaviors, attitudes, and beliefs; and, most importantly, learned to respect and cultivate differences.

This experience taught me that our country is strengthened by the energy of pioneers through common threads of hope, pride, and perseverance. Our world flourishes when different voices come together, different cultures connect, and different ideas integrate, symbolic of a true "melting pot."

Mentors and motivators

A journey like this isn't possible without a village of support. A mentor once told me, "Surround yourself with people you admire and respect, and use their strengths to guide you on what you hope to become."

Thank you to many of you here in the audience, my "ASHP Pharmily," for your wonderful support and guidance over the years. To my Penn Medicine and Penn Presbyterian Medical Center Leadership—Kevin Mahoney, Michele Volpe, and Bob Russell—thank you for allowing me to live and share my passion for all things pharmacy for the last 27 years. Your support has allowed me to advance the role of pharmacists and technicians as essential to patient-centered care.

And talking about essential to patient-centered care, I'd like to give a heartfelt shout-out to my Penn Presbyterian Medical Center Pharmacy team, who allow me to do what I love and love what I do, every day. We are pharmacy strong, and your dedication, your tenacity, and your ability to rise above any situation to deliver positive results is inspiring to me.

I have been fortunate to have a solid foundation on which to pursue my passion for pharmacy. I am very excited that today my personal and professional worlds are merging with the presence of my family here at ASHP.

Mom and Dad, thank you for your encouragement and support. Your sacrifice and unwavering confidence in my abilities have taught me that with strength, courage, and effort, the sky is the limit and anything is achievable.

My pride and joy are also here today, Karan and Kesar. Being your mom has been my most cherished title. You have taught me to multitask, to problem solve, and even sometimes kept me on my toes. I hope I have taught you not to

wait for the storm to pass but instead to dance in the rain. Thank you for allowing me to appreciate the little things and take the time to smell the roses. You both make me very proud.

And my husband, Pinak. You have always been the *one*—my partner, my teammate, and my soulmate. I could say so many positive things about you, but what I have always appreciated the most from you is your "go girl" attitude. Thank you for your unwavering support.

Speaking of unwavering support, that's what we as pharmacists have provided in the past, so how can we, the pharmacy workforce, Be The Change in this digital revolution?

As a first-generation American, I watched my parents sacrifice to fight for the things they cared about. This gave me a path forward to pursue my dream of being a clinical pharmacist.

I grew up in a home where change was my constant, and normal daily life meant accepting and being part of change. Embracing change brought personal growth, excitement, new experiences, and knowledge. I realized that if I wanted to make the world a better place, I needed to be the example: not hope for change but Be The Change to lead the way.

The idea that each of us can be the change we wish to see in the world—personally, professionally, and in our communities—is tremendously motivating.

The change imperative

Every pharmacist in this room can attest that our profession has evolved. We are medication experts, caregivers, and healthcare providers. Along the way, we have also gained other titles such as Mentor, Manager, Educator, Researcher, Leader, Advocate, and I am sure many more. As pharmacy professionals, we are lifelong learners. We keep our knowledge current. We learn new skills. We continue to pursue intellectual growth and expansion in an ever-changing field, even when it is not required. But guess what? The ongoing pursuit of knowledge *will be* required.

We will see a dramatic influx of new innovations and technologies that will increase our reliance on robotics and automation. Our world will be voice-activated. Chat GPT will provide healthcare information or serve as a digital health coach. Patients will ingest digital capsules for diagnostic or monitoring capability. Artificial intelligence will predict patient response to treatment. And our patients . . . our patients will be more engaged in their care with wearable technology. All these initiatives will move our approach from treatment to prevention.

We will not have a choice to change. It will be a requirement. Prioritization of digital healthcare is an issue critical to the future of our profession. This digital future will not decrease the role or importance of the pharmacist but will instead create new and innovative opportunities to enhance our profession. And that is why I believe we need to Be The Change.

Tools and resources for driving change

As a member of ASHP, you have access to tools and resources to help prepare you for the evolving demands of the profession, challenges in the marketplace, and dynamic pressures in the healthcare environment. I'd like to share a few ways in which ASHP supports you to Be The Change.

The ASHP Leadership Center was created last fall to facilitate leadership development at all career levels, from pharmacy students to seasoned executives. ASHP also created a new membership group for Pharmacists in C-Suites, geared toward those of you serving in high-level executive positions, to represent pharmacy professionals with expanded roles beyond the pharmacy enterprise.

Also available to you is the ASHP Certified Pharmacy Executive Leader credential. This credential demonstrates a commitment to achieving and maintaining excellence in executive pharmacy leadership. So far, 68 of you have earned this CPEL credential.

These initiatives support our pharmacy leaders to drive innovation, drive towards a better future, and drive to Be The Change.

One thing all of us should be really excited about is the new Section of Digital and Telehealth Practitioners. The 2023 Commission on Goals focused on the critical nature of this growing practice area—to address rapidly evolving advances in healthcare delivery models, and to support workforce embracement of digital technology for better patient care.

Pharmacy's key role in shaping the digital future

See the pattern here? Now you are beginning to see why we together need to Be The Change. To take ourselves to the next level, we need to build agility into the heart of our professional culture. All of us must exhibit adaptability, harness change, and spearhead innovation. We must train a diverse and multigenerational workforce that will transcend borders and is inventive and transformative.

We must lead by example. And here's what I mean by that. Let's share our success stories showing how we work together in coordinated and collaborative ways with technology trends to elevate our workforce or make patients better faster.

Of all the healthcare professionals, we are the most accessible. As the needs of our patients change, we need to change. We've all realized that a one-size-fits-all approach doesn't really work anymore. Care is going to be personalized, tailored to individual needs, and delivered to the patient at their convenience. Patients will be empowered to take an active role in their care. Wearables will provide personalization and transparency, and their use will lead to a faster turnaround for response or action. And as a profession, we will be immersed in big data for assessment, for analysis and for promoting better outcomes for our patients.

We are critical to the development and implementation of this digital future. As a profession, all of us together have the expertise to drive innovations

in medication safety across the healthcare spectrum.

Adopting new technologies quickly allows us to create efficiencies, automate functions, and offer predictive solutions for our patients and our profession. Transactional tasks will be reduced, allowing us to do what we love to do and what we are good at, which is providing expertise with humanness. This future cannot be created without us, because we remain fundamental to patient care.

How to be an agent of change

My commitment to these changes begins with me. During my term as your ASHP president, I am prepared to Be The Change and elevate the vital roles that health-system pharmacy practitioners play as providers in new and emerging science, and to prepare the workforce for the digital future of pharmacy practice.

What role will you play in this pharmacy transformation? I have asked a few of my friends to help share some tips for how you can Be The Change. They said:

- Be the voice. Share your knowledge and stories to inspire others in our profession.
- Be more. Take deliberate and strategic steps to move your career to the next level.
- Be an advocate. Influence the advancement and growth of our profession.
- Be good. Balance your life by living well and being adaptable and resilient.
- Be brave. Immerse yourself in new technologies and drive healthcare transformation.

Did you hear what I heard? They said, "Be the voice. Be more. Be an advocate. Be good. Be brave." I would like to see you be amazing and Be The Change in your organizations and in our profession.

Thank you so much.

Disclosures

The author has declared no potential conflicts of interest.

House of Delegates

REPORT ON IMPLEMENTATION OF 2023
ASHP HOUSE OF DELEGATES ACTIONS AND RECOMMENDATIONS

Council on Education and Workforce Development 2301: Education and Training in Digital Health
To acknowledge that digital health is a growing modality that supports the pharmacy workforce in providing patient care; further, To support training and education for the pharmacy workforce in innovative models that support digital health services; further, To advocate for involvement of the pharmacy workforce in research on digital health services and outcomes.
This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts. ASHP launched a new Digital Health and Artificial Intelligence Resource Center. The resource center offers the latest ASHP education, news, research, and advocacy updates — all focused on providing members with the tools and expertise necessary to advance pharmacy practice and meet the demands of an evolving digital landscape. It also serves as an important resource for ensuring pharmacy leaders and others have access to the latest ASHP tools and resources supporting technological innovation for pharmacy.
Council on Pharmacy Management 2302: Digital Therapeutics Products
To affirm the essential role of the pharmacist in the team-based evaluation, implementation, use, and ongoing assessment of digital therapeutic products to ensure the safety, effectiveness, and efficiency of medication use; further, To encourage the pharmacy workforce to promote broader and more equitable use of digital therapeutic products by identifying and addressing barriers to patient and healthcare worker access to those products; further, To encourage clinicians and researchers to establish evidence-based frameworks to guide use of digital therapeutic products; further, To advocate that insurance coverage and reimbursement decisions regarding digital therapeutic products be made on the basis of those evidence-based frameworks.
This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts. Digital therapeutics is the subject of a number of ASHP activities.

ASHP Webinars:
Innovations in Care: A Pharmacy Guide to Digital Therapeutics

ASHP Resources:
Digital Health and Artificial Intelligence
Digital Health
Digital Health Technology PAI Toolkit

ASHP News Center:
Section of Digital and Telehealth Practitioners

Council on Pharmacy Management 2303: Interoperability of Patient-Care Technologies

To encourage interdisciplinary development and implementation of standards that foster foundational, structural, semantic, and organizational interoperability of health information technology (HIT); further,

To encourage the integration, consolidation, and harmonization of medication-related databases used in patient-care technologies to reduce the risk that outdated, inaccurate, or conflicting data might be used and to minimize the resources required to maintain such databases; further,

To encourage healthcare organizations to adopt HIT that utilizes industry standards and can access, exchange, integrate, and cooperatively use data within and across organizational, regional, and national boundaries.

This policy supersedes ASHP policy 1302.

This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts. Interoperability of systems is the subject of a number of ASHP activities.

ASHP Podcasts:
Implementing Digital Health and Health Information Technology in Pharmacy

ASHP Professional Certificate:
Pharmacy Informatics Certificate (covers HIT Project Management)

ASHP Resources:
Digital Health Technology PAI Toolkit
Informatics Fundamentals: Standards and Best Practices

Council on Pharmacy Practice 2304: Patient Medication Delivery Systems

To foster the clinical and technical expertise of the pharmacy workforce in the use of medication delivery systems; further,

To advocate for key decision-making roles for the pharmacy workforce in the selection, implementation, maintenance, and monitoring of medication delivery systems; further,

To urge hospitals and health systems to directly involve departments of pharmacy and interprofessional stakeholders in performing appropriate risk assessments before new medication delivery systems are implemented or existing systems are upgraded; further,

To advocate that medication delivery systems employ patient safety-enhancing capabilities and be interoperable with health information systems; further,

To encourage continuous innovation and improvement in medication delivery system technologies; further,

To foster development of tools and resources to assist the pharmacy workforce in designing and monitoring the use of medication delivery systems.

This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts.

Council on Pharmacy Practice 2305: Education About Performance-Enhancing Substances

To encourage pharmacists to engage in and advise community outreach efforts informing the public on the risks associated with the use of performance-enhancing substances, including but not limited to medications; further,

To educate patients on the importance of disclosing the use of performance-enhancing substances that may or may not be prescribed for legitimate medical indications; further,

To encourage pharmacists to advise athletic authorities, athletes, the community, and healthcare providers on the dangers of performance-enhancing substances and other products that are prohibited in competition; further,

To advocate for the role of the pharmacist in all aspects of performance-enhancing substances control.

This policy supersedes ASHP policy 1305.

This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts.

Council on Public Policy 2306: Support for FDA Expanded Access (Compassionate Use) Program

To advocate that the Food and Drug Administration (FDA) Expanded Access (Compassionate Use) Program be the primary mechanism for patient access to drugs for which an investigational new drug application (IND) has been filed, in order to preserve the integrity of the drug approval process and assure patient safety; further,

To advocate for broader patient access to such drugs under the FDA Expanded Access Program; further,

To advocate that IND applicants expedite review and release of drugs for patients who qualify for the program; further,

To advocate that the drug therapy be recommended by a physician and reviewed and monitored by a pharmacist to assure safe patient care; further,

To advocate for the patient's right to be informed of the potential benefits and risks via an informed consent process, and the responsibility of an institutional review board to review and approve the informed consent and the drug therapy protocol; further,

To support the use of the Right-to-Try pathway in instances in which all other options have been exhausted, provided there is (1) a robust informed consent process, and (2) institutional and clinical oversight by a physician and a pharmacist.

This policy supersedes ASHP policy 1508.

This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts.

Council on Public Policy 2307: Biosimilar Medications

To encourage the development of safe and effective biosimilar medications in order to make such medications more affordable and accessible; further,

To encourage research on the safety, effectiveness, and interchangeability of biosimilar medications; further,

To support legislation and regulation to allow Food and Drug Administration (FDA) approval of biosimilar medications that are also determined by the FDA to be interchangeable and therefore supports substitution for the reference product without the intervention of the prescriber; further,

To oppose the implementation of any state laws restricting biosimilar interchangeability; further,

To oppose any state legislation that would require a pharmacist to notify a prescriber when a biosimilar deemed to be interchangeable by the FDA is dispensed; further,

To require postmarketing surveillance for all biosimilar medications to ensure their continued safety, effectiveness, purity, quality, identity, and strength; further,

To advocate for adequate reimbursement for biosimilar medications that are approved by the FDA; further,

To promote and develop education of pharmacists, providers, and patients about biosimilar medications and their appropriate use within hospitals and health systems; further,

To advocate for patient, prescriber, and pharmacist choice in selecting the most clinically appropriate and cost-effective therapy.

This policy supersedes ASHP policy 1816.

This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts.

Council on Therapeutics 2308: Pharmacogenomics

To advocate that pharmacists take a leadership role in pharmacogenomics-related patient testing, based on current or anticipated medication therapy; further,

To advocate for the inclusion of pharmacogenomic test results in medical and pharmacy records in a format that clearly states the implications of the results for drug therapy and facilitates availability of the genetic information throughout the continuum of care and over a patient's lifetime; further,

To encourage health systems to support an interprofessional, evidenced-based effort to implement appropriate pharmacogenomics services and to identify and determine appropriate dissemination of actionable information to appropriate healthcare providers for review; further,

To encourage pharmacists to educate prescribers and patients about the use of pharmacogenomic tests and their appropriate application to drug therapy management; further,

To advocate that all health insurance policies provide coverage for pharmacogenomic testing to optimize patient care; further,

To advocate that drug product manufacturers and researchers conduct and report outcomes of pharmacogenomic research to facilitate safe and effective use of medications; further,

To encourage research into the economic and clinical impact of preemptive pharmacogenomic testing; further,

To encourage pharmacy workforce education on the use of pharmacogenomics and its application to therapeutic decision-making.

This policy supersedes ASHP policy 2113.

This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts.

Council on Pharmacy Management 2309: Payer-Directed Drug Distribution Models

To advocate that insurers and pharmacy benefit managers be prohibited from mandating drug distribution models that introduce patient safety and supply chain risks or limit patient choice.

This policy supersedes ASHP policy 2248.

This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts. Drug distribution models are the subject of a number of ASHP activities.

***AJHP* Articles:**

Payer site of care mandates with oncology medications: It's time to demand payer accountability on behalf of patients

ASHP Pharmacy Executive Leadership Alliance (PELA®) Symposium: Service Line Business Development and Payer Engagement

ASHP Advocacy:

White Bagging Resources

This policy is included in our communications with policymakers and healthcare stakeholders regarding policy, practice, and regulatory considerations for pharmacist leadership, patient experience, continuity of care, and considerations related to effective system design for safe medication use and patient safety.

Council on Pharmacy Management 2310: Use of Social Determinants of Health Data in Pharmacy Practice

To encourage the use of patient and community social determinants of health (SDoH) data in pharmacy practice to optimize patient care services, reduce healthcare disparities, and improve healthcare access and equity; further,

To educate the pharmacy workforce and learners about SDoH domains, including their impact on patient care delivery and health outcomes; further,

To encourage research to identify methods, use, and evaluation of SDoH data to positively influence key quality measures and patient outcomes.

This policy supersedes ASHP policy 2249.

This policy has been published in ASHP Best Practices and used in ongoing ASHP advocacy, education, and communication efforts. SDOH are the subject of a number of ASHP activities.

***AJHP* Article:**
Spiritual practices and beliefs as a social determinant of health: When will the profession of pharmacy address the whole body-mind-spirit triad?

ASHP Webinars:
Integrating Social Determinants of Health Data and Knowledge into Clinician Workflow
Obligations of Pharmacy Professionals, Institutions, and Organizations to Address Social Determinants of Health Inequity

ASHP Professional Certificate(s):
Diversity, Equity, and Inclusion Certificate

ASHP News Center:
Organizer of Ethics Series Hopes to Help Pharmacists Better Understand Patients
Pharmacist Practitioners Are Perfectly Positioned to Improve Rural Access to Care

Council on Pharmacy Management 2311: Pharmacy Accreditations, Certifications, and Licenses

To advocate that healthcare accreditation, certification, and licensing organizations adopt consistent standards for the medication-use process, based on established evidence-based principles of patient safety and quality of care; further,

To advocate that health-system administrators allocate the resources required to support medication-use compliance and regulatory demands.

This policy supersedes ASHP policy 1810.

This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts. This policy is included in our communications with policymakers and healthcare stakeholders regarding policy, practice, and regulatory considerations for pharmacist leadership, patient experience, continuity of care, and considerations related to effective system design for safe medication use and patient safety.

Council on Pharmacy Management 2312: ASHP Statement on Leadership as a Professional Obligation

To approve the ASHP Statement on Leadership as a Professional Obligation.

This statement supersedes the ASHP Statement on Leadership as a Professional Obligation dated June 12, 2011.

This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts. Leadership is the subject of a number of ASHP activities.

***AJHP* Articles:**
ASHP Statement on the Roles and Responsibilities of the Pharmacy Executive

ASHP Podcasts:
Leadership in Pharmacy: Lifelong Learning
Pharmacists in the C-Suite: Professional Journeys and Perspectives on Healthcare (Part 3)

ASHP Resource Center:
The Leadership Center
Become a Certified Pharmacy Executive Leader (CPEL℠)
Participate in the Pharmacy Leadership Academy

ASHP Professional Certificate(s):
Pharmacy Leadership Certificate: Management Basics

Council on Pharmacy Practice 2313: Reducing Healthcare Sector Carbon Emissions to Promote Public Health

To promote reducing carbon emissions from the healthcare sector through collaboration with other stakeholders; further,

To encourage members of the pharmacy workforce to seek out opportunities to engage in efforts to reduce carbon emissions in their workplaces and communities.

This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts.

Council on Therapeutics 2314: Manipulation of Drug Products for Alternate Routes of Administration

To advocate that the Food and Drug Administration encourage drug product manufacturers to identify changes in pharmacokinetic and pharmacodynamic properties of drug products when manipulated for administration through an alternate delivery system or different route than originally studied, and to make this information available to healthcare providers; further,

To collaborate with stakeholders to increase research on clinically relevant changes to pharmacokinetic and pharmacodynamic properties of drug products when manipulated or administered through a different route and to enhance the aggregation and publication of and access to this data; further,

To research and promote best practices for manipulation and administration of drug products through alternate routes when necessary; further,

To foster pharmacist-led development of policies, procedures, and educational resources on the safety and efficacy of manipulating drug products for administration through alternate routes.

This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts.

Council on Therapeutics 2315: Responsible Medication-Related Clinical Testing and Monitoring

To recognize that overuse of clinical testing leads to unnecessary costs, waste, and patient harm; further,

To encourage the development of standardized measures of appropriate clinical testing to better allow for appropriate comparisons for benchmarking purposes and use in research; further, To promote pharmacist accountability and engagement in interprofessional efforts to promote judicious use of clinical testing and monitoring, including multi-faceted, organization-level approaches and educational efforts; further, To promote research that evaluates pharmacists' contributions and identifies opportunities for the appropriate ordering of medication-related procedures and tests; further, To promote the use of interoperable health information technology services and health information exchanges to decrease unnecessary testing. *This policy supersedes ASHP policy 1823.*
This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts.
Section of Pharmacy Educators 2316: ASHP Statement on Precepting as a Professional Obligation
To approve the ASHP Statement on Precepting as a Professional Obligation.
This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts.
Council on Pharmacy Practice 2317: Emergency Medical Kits
To recognize the importance of standardized and readily accessible emergency medical kits (EMKs) in locations with inconsistent emergency medical services; further, To advocate for the inclusion of pharmacist expertise in policy and regulations for the interprofessional decisions related to the contents, storage, and maintenance of medications in EMKs; further, To collaborate with other professions and stakeholders to standardize the contents of and locations for EMKs, and to develop guidelines and standardized training for proper use of EMK contents by designated personnel employed in those settings.
This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts.
Council on Pharmacy Practice 2318: Raising Awareness of the Risks Associated with the Misuse of Medications
To support the pharmacy workforce in outreach efforts to provide education to authorities, patients, and the community on the risks associated with use of medications for nonmedical purposes or from nonmedical sources.
This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts.
Council on Pharmacy Practice 2319: Standardization of Medication Concentrations, Dosing Units, Labeled Units, and Packaging Sizes
To support adoption of nationally standardized medication concentrations, dosing units, labeled units, and package sizes for medications administered to adult and pediatric patients, and to advocate that the number of standard concentrations, dosing units, labeled units, and package sizes be limited as much as possible; further,

To encourage interprofessional collaboration on the adoption and implementation of these standards across the continuum of care; further, To encourage manufacturers and registered outsourcing facilities to provide medications in those standardized concentrations, labeled units, and package sizes. *This policy supersedes ASHP policy 1306.*
This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts.
Council on Pharmacy Practice 2320: Pharmacoequity
To raise awareness that disparities in clinical practice negatively impact healthcare outcomes and compromise pharmacoequity; further, To recognize the impact of social determinants of health on pharmacoequity and patient outcomes; further, To advocate for drug availability, drug pricing structures, pricing transparency, and insurance coverage determinations that promote pharmacoequity; further, To advocate that the pharmacy workforce identify and address risks and vulnerabilities to pharmacoequity as part of comprehensive medication management services; further, To advocate for resources, including technology, that improve access to care for marginalized and underserved populations where pharmacy access is limited; further, To encourage the pharmacy workforce to identify and mitigate biases in healthcare decision-making that compromise pharmacoequity.
This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.
Council on Pharmacy Practice 2321: Medication Administration by the Pharmacy Workforce
To support the position that the administration of medications is within the scope of pharmacy practice; further, To advocate that states grant pharmacists and appropriately supervised student pharmacists and pharmacy technicians the authority to administer medications; further, To support the position that pharmacists should be participants in establishing procedures in their own work settings with respect to the administration of medications (by anyone) and monitoring the safety and outcomes of medication administration. *This policy supersedes ASHP policy 9820.*
This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts.
Council on Therapeutics 2322: Availability and Use of Fentanyl Test Strips
To affirm that fentanyl test strips (FTS) have a place in harm reduction strategies for people who use drugs; further,

To support legislation that declassifies FTS as drug paraphernalia; further,

To promote public availability of and access to FTS, including zero-cost options; further,

To support the pharmacy workforce in their roles as essential members of the healthcare team in educating the public and healthcare providers about the role of FTS in public health efforts.

This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts.

Council on Therapeutics 2323: DEA Scheduling of Controlled Substances

To advocate that the Drug Enforcement Administration (DEA) establish clear, measurable criteria and a transparent process for scheduling determinations; further,

To urge the DEA to use such a process to re-evaluate existing schedules for all substances regulated under the Controlled Substances Act to ensure consistency and incorporate current science-based evidence concerning scheduling criteria; further,

To advocate that the U.S. Congress, with input from stakeholders, enact clear definitions of the terms potential for abuse, currently accepted medical use, and accepted safety for use in the Controlled Substances Act; further,

To advocate for monitoring of the impact of DEA scheduling of products under the Controlled Substances Act and other abuse-prevention efforts (e.g., prescription drug monitoring programs) on patient access to therapy and on healthcare provider workload; further,

To advocate for the elimination of federal and state laws that create barriers to research on therapeutic use of Schedule I substances.

This policy supersedes ASHP policy 1315.

This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts.

Council on Therapeutics 2324: Point-of-Care Testing and Treatment by Pharmacists

To advocate for laws, regulations, and development of specific, structured criteria that include performing diagnostic point-of-care testing (POCT), interpreting test results, prescribing, dosing, and dispensing as clinically indicated by POCT within pharmacists' scope of practice, or referral; further,

To support the tracking of reportable diseases through pharmacist-managed POCT and reporting to public health agencies when appropriate; further,

To promote training and education of the pharmacy workforce to competently engage in POCT and related patient care services; further,

To foster research on patient access and public health improvements, cost savings, and revenue streams associated with pharmacist-managed POCT and related patient care services.

This policy supersedes ASHP policy 2229.

This policy has been published in ASHP Best Practices and used in ongoing ASHP advocacy, education, and communication efforts.

Council on Therapeutics 2325: Nonprescription Availability of Self-Administered Influenza Antivirals

To support a behind-the-counter practice model that expands access to self-administered influenza antivirals.

This policy supersedes ASHP policy 2116.

This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts.

Council on Therapeutics 2326: Over-the-Counter Availability of Hormonal Contraceptives

To advocate that hormonal contraceptives be available over the counter (OTC) without age restriction only under conditions that ensure safe use, including the availability of pharmacist consultation to ensure appropriate self-screening and product selection, and that maintain patient confidentiality; further,

To encourage the Food and Drug Administration to require manufacturers to include all patients of childbearing age, including adolescents, in studies to determine the safety and effectiveness of OTC hormonal contraceptives; further,

To advocate that all insurers and manufacturers maintain coverage and limits on out-of-pocket expenditure so that patient access is not compromised.

This policy supersedes ASHP policy 1410.

This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts.

Council on Therapeutics 2327: Therapeutic and Psychological Considerations of Patients Across the Gender Identity Spectrum

To recognize the role of gender-affirming care in achieving health equity and reducing health disparities; further,

To advocate that gender identity is a critical component of medication and disease management of patients across the gender identity spectrum; further,

To advocate for equitable access to gender-affirming care, including access to a pharmacist who ensures safe and effective medication use; further,

To promote research, development, and implementation of therapeutic and biopsychosocial best practices in the care of patients across the gender identity spectrum; further,

To encourage the incorporation of specific education and training regarding patient gender identity into educational standards and competencies for the pharmacy workforce; further,

To encourage easily accessed, structured documentation of a patient's sex assigned at birth, self-identified gender, chosen name, personal pronouns, and relevant medical history in electronic health records; further,

To affirm that healthcare workers should be able to provide gender-affirming care per their clinical judgment and their conscience without fear of legal consequence, workplace sanctions, social stigmatization, harassment, or harm.

This policy supersedes ASHP policy 1718.
This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts.
Council on Therapeutics 2328: Removal of Injectable Promethazine from Hospital Formularies
To advocate that injectable promethazine be removed from hospital formularies; further, To encourage regulatory and safety bodies to review patient safety data and conduct research on adverse events related to administration of injectable promethazine; further, To encourage manufacturers to produce injectable promethazine in package sizes and concentrations that reduce risk. *This policy supersedes ASHP policy 1831.*
This policy has been published in ASHP Best Practices and used in ongoing ASHP advocacy, education, and communication efforts.
Council on Education and Workforce Development 2329: Well-Being and Resilience of the Pharmacy Workforce
To affirm that occupational burnout adversely affects an individual's well-being and healthcare outcomes; further, To acknowledge that the healthcare workforce encounters unique stressors throughout their education, training, and careers that contribute to occupational burnout; further, To declare that healthcare workforce well-being and resilience requires shared responsibility among healthcare team members and between individuals and organizations; further, To provide resources to empower individuals and institutions to embrace well-being and resilience as a priority supported by organizational culture; further, To promote that pharmacy leadership collaborate with their institutions to assess the well-being and resilience of the pharmacy workforce and identify effective prevention and intervention strategies; further, To encourage hospitals and health systems to invest in the development and assessment of interprofessional programs that prevent occupational burnout while supporting well-being, and to support nonpunitive participation in these programs. *This policy supersedes ASHP policy 1825.*
This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts.
Council on Therapeutics 2330: Pharmacist Prescribing Authority for Antiretroviral Therapy for the Prevention of HIV/AIDS
To affirm that drug products for pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for human immunodeficiency virus (HIV) infection prevention should be provided to individuals in a manner that ensures safe and appropriate use; further,

To oppose reclassification of currently available drugs used for PrEP and PEP to nonprescription status; further,

To advocate for legislation and regulation that expands pharmacist scope of practice to encompass initiation of PrEP and PEP therapy; further,

To advocate that the therapies and associated care for PrEP and PEP are available to patients with zero cost-sharing; further,

To support establishment of specific and structured criteria to guide comprehensive pharmacist interventions related to PrEP and PEP; further,

To support the research, education, and training of the pharmacy workforce on the therapeutic, psychosocial, and operationalization considerations of pharmacist-provided PrEP and PEP therapy; further,

To support educating the public regarding the public health benefits of PrEP and PEP.

This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts.

House of Delegates Resolution 2331: Sustainable Billing, Reimbursement, and Payment Models

To advocate for reimbursement, pay parity, and financially sustainable models related to cognitive services of pharmacist-accountable services, regardless of site of care; further,

To educate the pharmacy workforce and stakeholders about financially sustainable models of care; further,

To advocate that compensation for healthcare services be commensurate with the level of care provided, based on the needs of the patient; further,

To advocate for the development of consistent, transparent billing, reimbursement, and alternative payment model policies and practices by both government and commercial payers.

This policy has been published in *ASHP Best Practices* and used in ongoing ASHP advocacy, education, and communication efforts. Sustainable billing, reimbursement, and payment models are the subject of a number of ASHP activities.

***AJHP* Articles:**
Impact of pharmacist-provided Medicare annual wellness visits and chronic care management on reimbursement and quality measures in a privately owned family medicine clinic
Expansion of Services within primary care clinics due to quality initiatives and revenue generation

ASHP Resource Center:
Compensation and Sustainable Business Models

ASHP Professional Certificate:
Billing and Reimbursement for Patient Care Clinical Services Certificate

ASHP Advocacy:
ASHP Advocacy Agenda

Over 100 pharmacists, students, and technicians spoke with legislators at ASHP's 2023 Legislative Day on the Hill to advocate for the Pharmacy and Medically Underserved Areas Enhancement Act (H.R. 2759 / S. 1362).

This policy is included in our communications with policymakers and healthcare stakeholders regarding policy, practice, and regulatory considerations for pharmacist leadership, patient experience, continuity of care, and considerations related to effective system design for safe medication use and patient safety.

House of Delegates Resolution 2332 : Barcoding of Lot Number and Expiration Date

To advocate that the Food and Drug Administration and organizations that develop barcode standards require barcodes contain lot number and expiration date on all immediate product packages to enable automated collection and validation of this information during medication preparation, dispensing, and administration processes; further,

To educate regulatory and safety organizations that barcode scanning versus manual logging of lot numbers and expirations is critical for patient safety and preparation sterility and improves data visibility for medication recalls; further,

To advocate that state boards of pharmacy, regulatory agencies, and accrediting bodies delay punitive action on rules requiring logging of lot number and expiration dates during sterile product preparation until this information is made available on immediate product barcodes.

This policy has been published in ASHP Best Practices and used in ongoing ASHP advocacy, education, and communication efforts. Barcoding is the subject of a number of ASHP activities.

***AJHP* Articles:**
Understanding the problem of digital medication inventory visibility in health systems

ASHP Podcasts:
Updates to the 2023 Drug Supply Chain Security Act

ASHP Resource Center:
Barcode-Enabled Technology
DCSCA 2023 Preparedness

Delegate Recommendation: Enhance Diversity in Clinical Trial Participation through Patient Education: Christi Jen, Arizona; Jerome Wohleb, Nevada; Janelle Duran, Arizona

ASHP to advocate for better patient education in clinical trials to enhance equity and diversity among participants.

This policy topic was considered by the Council on Pharmacy Practice for possible discussion during the 2023-2024 council year; however, the Council determined that ASHP has existing policy and encouraged alternate approaches for enhancing diversity in clinical trial participation through programming and resource development. The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.

Delegate Recommendation: Pharmacists Admixture of Medications for Immediate Administration: Christi Jen, Arizona; Jerome Wohleb, Nevada; Lance Ray, Colorado; Chris Edwards, Arizona; Janelle Duran, Arizona

ASHP to advocate for collaboration with the American Nurses' Association in increasing awareness and education on the appropriateness of nursing administration of medications compounded/prepared by a pharmacist at bedside for emergent/urgent situations.
The Council on Pharmacy Practice considered this recommendation while discussing policy topics for the 2023-2024 policy year and concluded that ASHP should monitor the issue to better understand the scope and impact of it and to consider opportunities to collaborate with interprofessional organizations, such as reaching out to the American Nurses Association. The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: Development of Position Statement on the Role of Health-System Pharmacy in Gene and Cellular Therapy: Christi Jen, Arizona; Elyse McDonald, Utah; Scott Canfield, SPP; Katherine Reibig, Nevada; Ashley Duty, Ohio; Janelle Duran, Arizona; Jerome Wohleb, Nevada
ASHP to develop a position statement on the role of the health-system pharmacy in gene and cellular therapy.
The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings. The Council on Pharmacy Management has acted on the Council on Therapeutic's proposed revisions to ASHP policy on gene therapy, and the revised policy will be considered by the House of Delegates in November.
Delegate Recommendation: Development of Membership Engagement Opportunities & Industry Pharmacy Partners: Christi Jen, SCSS; Andew Mays, SCSS; Rena Gosser, Washington; Jeff Little, Kansas
ASHP to Industry Pharmacists Partners to foster relationships between health-system pharmacies and industry pharmacists and serve as a professional home for them. Engagement opportunities include town hall and networking sessions.
ASHP values members who work in the industry and the involvement of these members in ASHP activities. Based on recent ASHP market research with industry pharmacists, their perception is that ASHP can and should continue to serve as their professional home since they support the mission of ASHP. ASHP members who work for industry are welcome to participate and do serve in member leadership positions including Section Executive Committees, advisory groups, and policy councils. Members who work in industry also value the opportunities provided by ASHP to network with practitioners in their specialty areas of practice, especially at meetings, and keep up with clinical news in areas outside their specialty. A recommendation that was made by industry pharmacists is to educate others on their professional roles and communicate their value. ASHP is incorporating their recommendations in educational sessions and has identified a group of industry pharmacists to maintain discussions about how to partner with industry in various aspects. ASHP continues to foster these relationships and provide valuable engagement opportunities for members who work in the industry. The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: Consideration of Louisville, Kentucky for a future summer meeting: Jonathan Scott Hayes, Kentucky; Dale English, Kentucky; Thom Platt, Kentucky
The Kentucky Delegation asked that Louisville, KY be considered as a site for a future ASHP summer meeting.
ASHP understands the importance of rotating the host city of our various meetings, conferences, and specialty courses each year. I want to assure you that ASHP regularly explores the viability of numerous meeting venues and will consider Louisville, Kentucky. Several criteria are considered in selecting a location, and we must keep the following in mind along with other intangibles: geography, ease of access for travel, venue – meeting space and hotel access, availability of preferred dates, price, previous experience/evaluation data, and potential for weather impacting success of meeting. The recommendation

was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: Revision of ASHP policy 2253: Shannon Baker, Rhode Island
ASHP should review current policy 2253 Unit Dose Packaging Availability to add in language surrounding support of studies/recommendations for packaging of medications outside of original manufacturer bottles.
The Council on Pharmacy Management revised policy 2253 in response to this recommendation. The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: Inclusion of minimum number of resident check-ins to the Accreditation Standard: John Muchka, Wisconsin
Recommend that ASHP updates residency accreditation standards to include guidance on a minimum number of check-ins between resident and residency leadership to promote mental well-being and mitigate burnout.
ASHP has made several updates to the residency accreditation standard that address resilience and well-being in several areas. The standard update was published and active as of 7/1/23. The Commission on Credentialing reviewed this recommendation at its March 2024 meeting. The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: Over-The-Counter Availability of Hormonal Contraceptives: Carla Darling, DC and Sue Carr, DC
To amend ASHP Policy "Over-The-Counter Availability of Hormonal Contraceptives" as follows: To advocate that hormonal contraceptives be available over the counter (OTC) without age restriction ~~only under conditions that ensure safe use including availability of pharmacist consultation to ensure appropriate self-screening and product selection,~~ and that maintain patient confidentiality; further
The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings. The Council on Therapeutics reviewed this recommendation but declined to suggest any change to a policy that has just been approved by the House of Delegates.
Delegate Recommendation: Consolidate workforce education and training clauses into one policy: Kelly Bobo, Tennessee
Recommend ASHP review workforce education clauses in policies and statements and consolidate them into a single policy.
This topic was added to the Council on Education and Workforce Development agenda and was discussed during the CEWD Policy Week meetings in September 2023. The Council reviewed several ASHP policies and statements with related workforce education clauses. The Council felt the specific education and training clauses in other policies were included with intentionality and that an overarching policy would dilute the intent of those policies. For example, "to educate" may also mean to bring awareness to a critically important or rapidly evolving issue. The Council also stressed the importance of keeping educators and education in policy, given their role in supporting the future of the workforce and advancing new and emerging areas of practice. Furthermore, the Council noted that ASHP policy 1706, ASHP Guidelines, Statements, and Professional Policies as an Integral Part of the Educational Process, addresses the concept of a broader policy related to the use of ASHP policies in educating and training the pharmacy workforce. The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: AI and The Pharmacy Workforce: Integrate Solutions for Optimal Care: James Houpt, Washington

To engage key stakeholders to safely and securely integrate AI into low-leverage positions, allowing pharmacy workforce to be used at top of license.
The ASHP Pharmacy Futures Meeting 2024 will feature our first-ever AI summit focused on the impact of AI in pharmacy practice and healthcare. Anticipated outcomes from the summit will guide the education and application of AI in pharmacy practice in addition to fostering research into applicability, usefulness, and potential of AI technologies in healthcare. With AI being such a rapidly developing area, the Council suggested that it may be best to consider putting the review of AI-related policies and statements onto an every-other-year cadence, as the true healthcare applications of AI are at the precipice of exponential growth.
Delegate Recommendation: Creation of Formal Definition of Advanced Pharmacist Practice: Joe Anderson, New Mexico
ASHP, working in conjunction with other pharmacy professional organizations including NABP, should create a formal definition of Advanced Pharmacist Practice which will assist in lobbying efforts for provider status at the state and national level.
The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: Education Resource Center for Pharmacy Leaders In the Area of Facilities Management of Clean Rooms: Nissy Varughese, New Jersey
We request pharmacy leaders should have resources available for CE in the area of clean rooms. Management to better understand the scope of the environment of care that is necessary for patient and employee safety.
ASHP has and continues to develop education for pharmacy leaders, front line staff, and others related to compounding, including facilities. ASHP will consider this recommendation as it further develops materials and educational resources. The certificate programs, the compounding resource center, webinars, and many recorded/archived programs are some of the most accessed this year. The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: ASHP-Provided Childcare at Meetings: Carolyn Bell, Megan Roberts, Lisa Gibbs (South Carolina, Alabama)
ASHP should provide childcare at meetings to encourage and facilitate participation of working mothers and fathers with young families.
Prior to COVID, ASHP provided childcare at the Midyear Clinical Meeting. Out of an abundance of caution for our members' and their children's health and safety, ASHP has paused providing childcare services. We plan to reevaluate the feasibility of offering childcare resources for future meetings. The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: Pharmacists as Mental Health Providers to Increase Patient Care Access and Quality: Lt Col Rohin Kasudia, USAF; Dr. Heather Ourth, Veterans Affairs; Dr. Julie Groppi, Florida; Dr. Terri Jorgenson, Maryland
ASHP should consider developing a policy statement to improve advocacy and awareness of the pharmacist's role in improving mental healthcare access and quality.
This policy topic was discussed by the Council on Pharmacy Practice during the 2023-2024 council year. A new policy, Role of the Pharmacy Workforce in Improving Mental Health, is advancing for delegate consideration during the March 2024 Virtual House of Delegates. The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.

Delegate Recommendation: Pharmacist Controlled Substance Prescribing Authority: Heather Ourth, Veterans Affairs, Terri Jorgenson, MD; Kali Autrey, USPHS), Amy Sipe (MO), Julie Groppi (FL), Lt Col Rohin Kasudia (USAF)
To advocate for expansion of state laws and regulations that authorize pharmacist ability to prescribe controlled substances.
ASHP's is actively advocating to expand pharmacists' ability to prescribe controlled substances. Following ASHP's advocacy efforts, Congress recently eliminated the X-waiver, a federal barrier to pharmacists prescribing medications for opioid use disorder (MOUD). States can now use pharmacists to improve access to MOUD, namely buprenorphine. ASHP has developed model legislation and a model protocol to help states expand access to MOUD. We would be happy to work with you to implement these models in your state. The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: ASHP Reducing Carbon Emissions to Promote Public Health: Jacalyn Rogers, Ohio
To promote reduction of ASHP's carbon emissions and improving sustainability thorough a reduction of physical waste and identification of more eco-friendly business practices.
ASHP partners with meeting convention centers, hotels, shuttle bus companies, and other vendor partners to reduce our carbon footprint. ASHP also strives to reduce waste and eliminate the unnecessary use of printed materials. During the last several years, ASHP has strategically reduced its use of printed materials based on feedback from our members and meeting attendees. For example, we no longer print an onsite program book for the Summer and Midyear meetings. While onsite guides are still provided, they have fewer pages than in the past, and many of our attendees continue to find them valuable. In addition, we no longer print the majority of handouts and instead post the information on the meeting app. ASHP also encourages the use of personal water bottles instead of plastic cups for water at the meetings. The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: Food Allergen Labeling at ASHP Meetings: Ashley Duty, Ohio
ASHP should support members with food allergens similar to those outlined by the "FDA Guidelines on Food Allergen Labeling" at professional meetings.
ASHP strives to provide a variety of food options that meet the diverse dietary needs of our meeting attendees. ASHP continues to work with our catering partners to include vegan, gluten-free, and other options and to provide appropriate labeling. In addition, we strive to manage the cost of catering and other expenses to minimize any registration fee price increases. The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: Creation of Resources to Support Successful Pharmacy Residency Reimbursement from Centers for Medicare & Medicaid in order to ensure residency programs can sustain the current fiscal climate for health-systems: Kellie Much, Ohio; Ashley Duty, Ohio; Tom Achey, South Carolina; Charnae Ross (NPF), Carolyn Bell, South Carolina; Tyler Vest, North Carolina and Jackie Rogers, Ohio.
1) Prepare centralized education and support documents for RPDs. 2) Advocate for transparency from CMS on criteria reviewed and process for determination for passthrough reimbursement.
Safeguarding pharmacy residency programs is a key ASHP advocacy priority. ASHP is focused on addressing the lack of CMS programmatic guidance for several years, meeting with CMS and members of Congress numerous times and participating in litigation around unfair residency program audits. ASHP's advocacy around residency funding and CMS guidance during our last two ASHP Policy Weeks, ASHP and is working with several affiliates on state-specific efforts with their legislators. Further, ASHP hopes to meet with HHS

Secretary Becerra and the CMS Administrator on this issue in the near term and we continue to work directly with Hill offices on a potential legislative solution. In the interim, ASHP is developing a list of "tips" for residency program compliance. ASHP will also continue to work one-on-one with programs undergoing audits to try to address incorrect audit findings before they progress to disallowances. Regardless, getting programmatic guidance remains our top priority so that programs have some degree of comfort with growth and can approach audits without concern about unfair passthrough disallowances. The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: Address the Use of AI in Healthcare: Jennifer Phillps, Illinois; Andy Donnelly, Illinois; Bernice Man, Illinois; Megan Corrigan, Illinois; Radlicka Polisetty, Illinois
ASHP create a policy addressing the optimal use of artificial intelligence in healthcare including the areas of clinical practice, operations, research, and education.
The ASHP Councils discussed this as a joint policy topic during their September 2023 Council meetings and suggested several actions, including two new policies and revision of the existing ASHP Statement on the Use of Artificial Intelligence in Pharmacy. The ASHP Section of Pharmacy Informatics and Technology and Section of Digital and Telehealth may also explore the topic further to plan for and implement additional actions such as education or resource development. The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: Develop a sustainable pharmacy workforce: Christopher Edwards, Arizona; Alice Callahan, Indiana; Jenna Rose, Iowa; John Pastor, Minnesota; Kristi Gullickson, Minnesota; Julie Neuman, Montana, Katie Reisbig, Nebraska, Tiffany Goeller, Nebraska; Jessica Jones, Michigan; Rebecca Maynard, Michigan, Monica Mahoney, Massachusetts; Francesca Mernick, Massachusetts; Jacqueline Gagnon, Massachusetts, Rena Gasser, Washington; Jackie (Jacalyn) Rogers, Ohio; Tonya Carlton, New Hampshire; Liz Wade, New Hampshire, Jeff Cook, Arizona; J. Huntley, Arizona; Adam Porath, Nevada; Victoria Wallace, Indiana; Audra Sandoval, Indiana; Christi Jen, SCSS; Cindy Jeter, PTF
ASHP should engage all appropriate council(s) to develop a sustainable pharmacy workforce that addresses both growth of future workforce through student and technician enrollment and retention of existing health-system pharmacy professionals.
On June 22, ASHP announced an expenditure of $3 million dollars approved by the ASHP Board of Directors to develop a comprehensive national awareness campaign to bring visibility and recognition to the critical and diverse roles of pharmacists and pharmacy technicians in hospitals and health systems. Moreover, the Council on Education and Workforce Development reviewed Policy 1828, Promoting the Image of Pharmacists and Pharmacy Technicians, as part of sunset review and voted to recommend amending the policy to reflect the need to collaborate with key stakeholders to enhance the public image and understanding of the pharmacy profession's roles in patient care. Further, Council members felt this policy needed to underscore the many benefits of diverse careers in pharmacy and address recruitment to the profession more broadly. The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: Improving access to (what are now) controlled substances: Andrew Kaplan, Florida
To identify which medications ASHP believes should be de-scheduled and petition the Attorney General as such.
The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings. The recommendation is being pursued by ASHP staff.
Delegate Recommendation: Expanded access to standardized trainings and resources for the pharmacy workforce practicing in the field of women's health: Audra Sandoval, Indiana

ASHP develop and encourage women's health-focused clinical training programs, certificates, and/or credentials to improve the care provided by women's health clinical pharmacists.
ASHP has had a number of recent educational programs focusing on women's health, including the Federal Forum and individual sessions at the 2022 Midyear, a session at the 2023 Summer Meeting, and the Spotlight on Science at the 2023 Midyear. ASHP has presented news stories and podcasts about individuals practicing in the area of women's health. ASHP will begin to include questions on related educational needs and about the number of pharmacists practicing in this specialty. ASHP will consider the creation of certificate programs, credentialing, and opportunities regarding women's health. The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: Use of Recognized National Treatment Guidelines as Foundational Documents in State and Federal Legislation in Treatment or Management of Disease or Condition: Victoria Wallace and Audra Sandoval, Indiana
ASHP advocate that National Guidelines for the treatment or management of disease or condition are standards of care and as such, are to be used to guide all local, state, and federal legislation.
ASHP is committed to protecting patient access to evidence-based care and to protecting pharmacists and pharmacy technicians who participate in that care from any potential civil and/or criminal liability related to that care. ASHP's policy statement 2250, Access to Reproductive Health Services, reinforces the need for advocacy to ensure patients have access to medications and care for reproductive health. ASHP works closely with our state affiliates to address state laws aimed at limiting access to reproductive health, gender-affirming care, and PEP and PrEP, including pushing back on legislation or regulations that do not comport with evidence-based medicine standards and/or national guidelines. Additionally, during Policy Week 2023, the Council on Public Policy discussed this issue and developed draft policy advocating for protection of pharmacists and pharmacy technicians from civil and/or criminal liability for providing evidence-based patient care for reproductive health or other issues (e.g., gender-affirming care, PEP and PrEP) that might be limited by state law. Pending Board review, this policy will likely be considered by the House of Delegates later this year. The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: Well-being and Resilience for Pharmacy Workforce Members Experiencing Vicarious Trauma and Moral Injury: Christi Jen, SCSS; Jerome Wohleb, Nevada; Janelle Duran, Arizona; Edward Saito, Oregon
ASHP to provide awareness and education to the pharmacy workforce on the risk for vicarious trauma when exposed to or experiencing traumatic patient care events or when experiencing moral injury.
Through our grant with the Health Resources and Services Administration, ASHP is connected to important work that the Workforce Change Collaborative (WCC) (link: https://www.gwhwi.org/workplace-change-collaborative.html) is doing around moral injury. They introduced some early materials to ASHP members at a May event that ASHP offered titled, "Roadmap to Pharmacy Workforce Well-Being: A Virtual Dialogue with Members." Once the WCC finalizes this work, ASHP will be disseminating them more broadly to members. ASHP also discussed it at a workshop during the ASHP Leaders Conference in October and the 2023 Midyear Meeting. ASHP will consider how to reach learners to ensure they have a better understanding of how to handle traumatic events. The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: Decentralized pharmacy practice model in acute care facilities: Janelle Duran, Arizona
It is recommended to update current policies or create a new one specifically promoting the use of a decentralized pharmacy practice model in acute care facilities. ASHP policies do not currently specifically

encourage acute care facilities to place pharmacists not responsible for drug distribution outside of the main pharmacy or decentralize pharmacists to the patient care units.
ASHP's Practice Advancement Initiative (PAI) 2030 provides a means, through its 59 future-focused recommendations and associated gap assessment tool, to help organizations and ASHP state affiliates determine ways the pharmacy profession can meet the demands of future practice and patient-care-delivery models. Manuscript submissions to *AJHP* in support of decentralized pharmacy staffing models and standards are encouraged to bring successful action stories to life.
Delegate Recommendation: Independent Prescribing Authority: Jackie Boyle, SACP; Brody Maack, SACP; Erin Neal, Tennessee; Melissa Ortega, SCPP
Motion that ASHP create a new policy regarding Independent Prescribing Authority or to revise/combine existing ASHP policies 2236, 2251, and 1822.
The Council on Pharmacy Practice revised ASHP policy on pharmacist prescribing authority at it Policy Week meetings, and the House will consider it in this policy cycle. The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: Inclusion of Term "Red Flag" in the Controlled Substances Act: Diane Ginsburg, Past President
To advocate for the inclusion of the term "red flags" in the controlled substances act in 21 CFR 1306.
The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings. ASHP government relations staff will use this recommendation in advocacy with federal legislators and regulators.
Delegate Recommendation: Electronic maintenance and submission of the Academic and Professional Record: Sarah Stephens, SICP
The SICP recommends ASHP establish an online form or database to facilitate the maintenance and submission of the Academic and Professional Record within Pharmacademic.
This change is currently in progress and will be released shortly to residency sites. ASHP's goal is to streamline this process to ensure it as efficient as possible for preceptors and residency directors. The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: Measuring the Impact of Residency Training Programs: Nancy MacDonald, SCSS; Chris Edwards, Arizona; Christi Jen, SCSS; Andrew Mays, Mississippi
ASHP should compile and release metrics used by health systems to assess the impact of residency programs on patient and health-system outcomes to assist other residency programs in justifying and expanding their training.
The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: Peer Review: Jackie Boyle, SACP; Brody Maack, SACP; Melissa Ortega, SCPP
Motion that ASHP consider developing a policy related to peer review in any setting where pharmacists are providing direct patient care.
The Council on Pharmacy Practice considered this recommendation while discussing policy topics for the 2023-2024 policy year and concluded that existing ASHP policy addresses peer review. The recommendation was also posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: Opposition to anti-DEI actions and legislation: Tara Vlasimsky, Colorado; Melissa Ortega, Massachusetts; Kristi Gullickson, Minnesota; Lance Oyen, Minnesota; John Pastor, Minnesota; Ashley Duty, Ohio; Kellie Much, Ohio; Kembral Nelson, Ohio; Jackie Boyle, SACP; Brody Maack, SACP; Danny Truelove, SACP; Ashley Parrott, SACP; Jordan Wulz, SACP; Christina DeRemer, SACP;

Christi Jen, SCSS; Ben Anderson, SOPIT; Lindsey Amerine, SPPL; Lindsey Kelley, SPPL; Lynnae Mahaney, Past President; Kat Miller, Kansas; Brian Gilbert, Kansas
ASHP should urgently develop and publicly release a statement strongly opposing legislation or actions which prohibit DEI funding, programs, and education.
ASHP is concerned about anti-DEI actions and especially the potential negative impact on schools of pharmacy and residency training. The ASHP Office of Government Relations is identifying opportunities to address this from a federal and state perspective. The Office of Government Relations see the potential to partner with other pharmacy and health professional organizations, our Section of Pharmacy Educators, and residency programs to assess the impact and respond. For example, ASHP is working with the Accreditation Council for Graduate Medical Education and American Nurses Credentialing Center to harmonize standards in the clinical learning environment and this issue was recently raised as a concern needing to be addressed. The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: Combatting Fraudulent Electronic Controlled Substance Prescriptions: Liz Wade, New Hampshire, Lt. Col. Rohin Kasudia, USAF; Melissa Ortega, SCPP; Kate Schaafsma, Wisconsin; Melissa Ortega, SCPP
Recommend ASHP develop policy, enhance awareness and facilitate collaboration with relevant stakeholders to understand the nationwide scope of the problem, identify weaknesses in the electronic prescribing of controlled substance (EPCS) process, and develop strategies to eliminate fraudulent electronic controlled substance prescriptions.
The Council on Pharmacy Practice discussed this topic during the ASHP 2023 Policy Week. The Council suggested that further investigation and research need to be conducted to identify system failures and risks to EPCS in order to optimize patient and population health and protect pharmacists and pharmacy technicians from liability. The Council determined that new ASHP policy was not needed; however, they suggested that the Council on Pharmacy Management consider including EPCS in a clause or rationale in ASHP policy 2042, Controlled Substances Diversion Prevention. The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: OTC vs Behind the Counter vs Prescription Medication: Melissa Ortega, SCPP; Kate Schaafsma, Wisconsin
1) ASHP creates clear guidance and criteria on what medications should be advocated for behind the counter vs over the counter use. 2) ASHP should consider policy that outlines medications or therapeutic categories that should be available to patients through prescriptions provided by a pharmacist.
The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: Guidance that establishes practice excellence standards across all setting of community-based practice: Melissa Ortega, SCPP
The ASHP Section of Community Pharmacy Practitioners recommends development of guidance that establishes practice excellence standards across all setting of community-based practice.
Practice excellence across all settings is very much aligned with ASHP's mission and vision. ASHP would like to further explore the intent and objectives of this guidance and its impact on community pharmacy practice. ASHP will request that the ASHP Section of Community Pharmacy Practitioners discuss this recommendation and frame the scope, objectives, and expected outcomes of the guidance. This additional background will help inform further action. The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings.
Delegate Recommendation: Standardization, interoperability, and data visibility of pharmacy barcode technology: Kevin Marvin, Vermont; Latresa Billings (TX)

Advocate that software developers for electronic health systems as well as pharmacy inventory, dispensing, preparation, and compounding technologies standardize reading, storing, and reporting of barcode data to assure interoperability between different systems, ease of use, and visibility to recorded data.
Further action by the ASHP Section of Pharmacy Informatics and Technology to conduct an inventory and review of ASHP policy positions, statements, and guidelines related to barcode technology is in formative stages to identify which policies may need revision and offer aspirational guidance on where they envision machine-readable coding to be 10–15 years from now. ASHP offers an online resource on the topic: **ASHP Resource Center:** Barcode-Enabled Technology
Delegate Recommendation: Pharmacy Leadership Survey: Andy Donnelly, Illinois
Recommend that ASHP perform a survey of health-system pharmacy leadership, similar to the surveys performed by Sara White in 2004 and 2011.
The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings. ASHP staff are investigating the need for and the feasibility of such a survey.
Delegate Recommendation: Anti-policy bloat: Chris Scott, Indiana
New and updated ASHP policies shall be composed of no more than three clauses in total. Policies should be directional and aspirational in nature and shall be designed with a goal to remain relevant for at least a sunset policy cycle (5 years). All effort should be made to prevent duplication of policies across Sections and Councils.
The recommendation was posted on the House of Delegates section of the ASHP website and published in the House of Delegates Proceedings. Councils and sections have undertaken to provide succinct policies, sunset outdated policies, and consolidate policies when possible.

House of Delegates

REPORT ON THE VIRTUAL HOUSE OF DELEGATES

March 15-22, 2024

RESULTS OF THE VOTING

Between March 15 and 22, the ASHP House of Delegates (roster attached as an Appendix) voted on 20 policy recommendations. Delegates approved 12 policy recommendations by 85% or more, the threshold for final approval. Eight policy recommendations did not receive 85% of votes cast and will be sent to the June House of Delegates.

POLICY RECOMMENDATIONS APPROVED

The 12 policy recommendations **approved** are as follows (percentage of delegates voting to approve follows the policy title):

Role of the Pharmacy Workforce in Improving Mental Health (94.6%)
Source: Council on Pharmacy Practice
To advocate for equitable and destigmatized access to mental healthcare services for all patients across their lifespan, including members of the healthcare workforce; further,

To affirm the essential role of pharmacists, as members of the interprofessional care team, in increasing patient access to mental healthcare services; further,

To urge all members of the pharmacy workforce to raise awareness of, screen for, triage, and provide education on mental health conditions; further,

To advocate for expansion of mental health-related comprehensive medication management services provided by pharmacists; further,

To advocate for adequate funding of mental health awareness programs and for funding that promotes equitable access to mental healthcare services.

Suicide Awareness, Prevention, and Response (95.5%)
Source: Council on Pharmacy Practice
To support the goal of zero suicides; further,

To collaborate with key stakeholders in support of suicide awareness, prevention, and response; further,

To acknowledge that optimal suicide awareness, prevention, and response efforts focus both on patients and on the healthcare workforce; further,

To recognize that pharmacists, as key members of the interprofessional care team, are integral to suicide awareness, prevention, and response efforts, and to acknowledge the vital role of other members of the pharmacy workforce in those efforts; further,

To foster the use and development of clinically validated tools to aid the pharmacy workforce in assessing the influence of medications and other factors on suicidality; further,

To advocate for adequate government and healthcare organization funding for suicide awareness, prevention, and response; further,

To enhance awareness of local, state, national, and global suicide awareness, prevention, and response resources.

Note: This policy would supersede ASHP policy 1901.

Emergency Supplies of Drug Products (98.0%)
Source: Council on Public Policy
To discontinue ASHP policy 1906, Emergency Supplies of Drug Products, which reads:

> To advocate for states to allow any pharmacist, during a declared emergency, to dispense without a prescription an emergency supply of a drug product in quantities that meet the needs of patients.

Drug Nomenclature (100%)
Source: Council on Public Policy
To discontinue ASHP policy 9011, Drug Nomenclature, which reads:

> To work with the FDA, USP, and pharmaceutical industry to assure that drug products are named in a manner that clearly and without confusion permits identification of ingredients' strengths and changes.

Medication Stewardship Programs (93.6%)
Source: Council on Therapeutics
To advocate that pharmacists are foundational members of any medication stewardship program; further,

To affirm that pharmacists bring unique clinical, operational, safety, and financial expertise to help organizations develop and manage medication stewardship programs; further,

To promote pharmacist leadership in medication stewardship teams; further,

To encourage healthcare organizations to develop comprehensive medication stewardship programs that align with applicable laws, regulations, and accreditation standards; further,

To support incorporation and development of the pharmacy workforce in medication stewardship efforts; further,

To enhance awareness that medication stewardship includes disease state management across all levels of care and addresses barriers at the patient and system levels in order to improve the quality, safety, and value of patient care.

Research on Drug Use in Obese Patients (98.0%)
Source: Council on Therapeutics
To discontinue ASHP policy 1920, Research on Drug Use in Obese Patients, which reads:

> To encourage drug product manufacturers to conduct and publish pharmacokinetic and pharmacodynamic research in obese patients to facilitate safe and effective dosing of medications in this patient population, especially for medications most likely to be affected by obesity; further,
>
> To encourage manufacturers to include in the Food and Drug Administration (FDA)–approved labeling detailed information on characteristics of individuals enrolled in drug dosing studies; further,
>
> To advocate that the FDA develop guidance for the design and reporting of studies that support dosing recommendations in obese patients; further,
>
> To advocate for increased enrollment and outcomes reporting of obese patients in clinical trials of medications; further,
>
> To encourage independent research on the clinical significance of obesity on drug use, as well as the reporting and dissemination of this information via published literature, patient registries, and other mechanisms; further,
>
> To recognize that pharmacists are medication therapy experts who should provide guidance on appropriate drug dosing for obese patients.

Therapeutic Interchange (95.5%)
Source: Council on Therapeutics
To discontinue ASHP policy 8708, Therapeutic Interchange, which reads:

> To support the concept of therapeutic interchange of various drug products by pharmacists under arrangements where pharmacists and authorized prescribers interrelate on the behalf of patient care.

Flexible Workforce Models (92.0%)
Source: Council on Education and Workforce Development
To advocate for flexible workforce models that promote patient safety and continuity of care, optimize pharmacy operations, and enhance recruitment and retention of the pharmacy workforce.

Pharmacist Access to Provider Networks (97.0%)
Source: Council on Pharmacy Management
To advocate for laws and regulations that require healthcare payers to include pharmacists in their provider networks as standard coverage when providing patient care services within their scope of practice and the services are covered benefits; further,

To advocate that payers provide comparative, transparent sharing of performance and quality measure data for all providers in their networks, including pharmacists.

Note: This policy would supersede ASHP policy 2134.

Risk Assessment of Health Information Technology (98.0%)
Source: Council on Pharmacy Management
To urge hospitals and health systems to directly involve departments of pharmacy in performing appropriate risk assessment before new health information technology (HIT) is implemented or existing HIT is upgraded, and as part of the continuous evaluation of current HIT performance; further,

To advocate that HIT vendors provide estimates of the resources required to implement and support new HIT; further,

To collaborate with HIT vendors to encourage the development of HIT that improves patient-care outcomes and user experience; further,

To advocate for changes in federal law that would recognize HIT vendors' safety accountability.

Note: This policy would supersede ASHP policy 1418.

Unit Dose Packaging Availability (91.1%)
Source: Council on Pharmacy Management
To advocate that pharmaceutical manufacturers provide all medications used in health systems in unit dose packages or, when applicable, in packaging that optimizes medication safety, improves operational efficiency, and reduces medication waste; further,

To urge that the Food and Drug Administration require pharmaceutical manufacturers to provide stability data to support the repackaging of medications outside of their original manufacturer bulk containers in the interest of public health, healthcare worker and patient safety, and reduced waste.

Note: This policy would supersede ASHP policy 2253.

Optimizing the Medication-Use Process (96.0%)
Source: Council on Pharmacy Management
To discontinue ASHP policy 9903, Optimizing the Medication-Use Process, which reads:

> To urge health-system pharmacists to assume leadership, responsibility, and accountability for the quality, effectiveness, and efficiency of the entire medication-use process (including prescribing, dispensing, administration, monitoring, and education) across the continuum of care; further,
>
> To urge health-system pharmacists to work in collaboration with patients, prescribers, nurses, and other health care providers in improving the medication-use process.

POLICY RECOMMENDATIONS NOT APPROVED

The House **voted to not approve** the following eight policy recommendations (percentage of delegates voting to approve follows the policy title):

Independent Prescribing Authority (56.2%)
Source: Council on Pharmacy Practice
To affirm that prescribing is a collaborative process that includes patient assessment, understanding of the patient's diagnoses, evaluation and selection of available treatment options, monitoring to achieve therapeutic outcomes, patient education, and adherence to safe and cost-effective prescribing practices; further,

To recognize that pharmacists are highly trained medication experts on the interprofessional care team capable of making independent and autonomous evidence-based decisions on medication therapy management; further,

To advocate that pharmacists have independent and autonomous authority to initiate, modify, and deprescribe all schedules and classes of medications; further,

To advocate that healthcare delivery organizations establish credentialing and privileging

processes for pharmacists that delineate scope of practice, support pharmacist prescribing, and ensure that pharmacists who prescribe are accountable, competent, and qualified to do so; further,

To advocate that all pharmacists have a National Provider Identifier that is recognized by payers.

Note: This policy would supersede ASHP policies 2236 and 2251.

Pharmacist's Role on Ethics Committees (73.4%)
Source: Council on Pharmacy Practice
To advocate that pharmacists should be included as members of, or identified as a resource to, hospital and health-system ethics committees; further,

To encourage pharmacists to actively seek ethics consultations or solicit input from their institution's ethics committee, as appropriate; further,

To encourage pharmacists serving on ethics committees to seek advanced training in healthcare ethics.

Note: This policy would supersede ASHP policy 1403.

Safe Handling and Administration of Hazardous Drugs (62.2%)
Source: Council on Pharmacy Practice
To advocate that pharmaceutical manufacturers eliminate surface contamination on packages and vials of hazardous drugs (HDs); further,

To inform pharmacists and other personnel of the potential presence of surface contamination on the packages and vials of HDs; further,

To advocate that all healthcare settings proactively conduct an interprofessional assessment of risk for exposure to HDs during handling and administration, including the use of closed-system transfer devices (CSTDs); further,

To advocate for pharmacist involvement in the development of policies, procedures, and operational assessments regarding administration of HDs, including when CSTDs cannot be used; further,

To advocate that the Food and Drug Administration require standardized labeling and package design for HDs that would alert handlers to the potential presence of surface contamination, including development of CSTD-compatible, ready-to-administer HD products; further,

To encourage healthcare organizations, wholesalers, and other trading partners in the drug supply chain to adhere to published standards and regulations.

Note: This policy would supersede ASHP policies 1615 and 1902.

Order Verification (55.4%)
Source: Council on Public Policy
To advocate that a prescriber should not be solely responsible for medication ordering, dispensing, and administration as well as any patient monitoring and evaluation, except when a double check would limit patient access to care.

Liability Protection (62.5%)
Source: Council on Public Policy
To advocate that pharmacists be able to provide evidence-based dispensing and care to patients without fear of criminal or civil legal consequences, harassment, or liability; further,

To advocate that protection against liability extend to referrals for out-of-state care and for dispensing to patients from another state.

State Prescription Drug Monitoring Programs (62.9%)
Source: Council on Public Policy
To support continued state implementation of prescription drug monitoring programs that collect real-time, relevant, and standard information from all dispensing outpatient entities about controlled substances and monitored prescriptions; further,

To advocate that such programs seek adoption into health information exchanges to best integrate into electronic health records and to allow prescribers, pharmacists, and other practitioners to proactively monitor data for appropriate assessment and dispensing; further,

To advocate that such programs improve their interstate data integration to enhance clinical decision-making and end-user satisfaction; further,

To encourage policies that allow practicing pharmacists to gain access to databases without holding licensure in each state; further,

To promote research on the effects of prescription drug monitoring programs and electronic health record programs on opioid prescribing, dispensing, misuse, morbidity, and mortality.

Note: This policy would supersede ASHP policy 1408.

Nonprescription Status of Rescue and Reversal Medications (67.3%)
Source: Council on Therapeutics
To support the over-the-counter (OTC) status of medications intended for evidence-based rescue use or reversal of potentially fatal events; further,

To work with federal, state, and local governments and others to improve the rescue and reversal medication development and supply system to ensure an adequate and equitably distributed supply of these medications; further,

To advocate that all insurers and manufacturers maintain coverage and limits on out-of-pocket expenditure so that patient access to rescue and reversal medications is not compromised; further,

To support and foster standardized education and training on the role of rescue and reversal medications and their proper administration, safe use, and appropriate follow-up care.

Pharmacy Residency Training (73.4%)
Source: Council on Education and Workforce Development
To continue efforts to increase the number of ASHP-accredited pharmacy residency training programs and positions available; further,

To promote efforts to increase recruitment and retention of residents in ASHP-accredited pharmacy residency programs; further,

To encourage stakeholders to evaluate priority areas within pharmacy for future residency training needs.

Note: This policy would supersede ASHP policy 0917.

NOTES ON VOTING

Ninety-four percent (203) of delegates to the virtual House of Delegates participated in the voting, with 94% (153) of state delegates voting. All registered past presidents voted, and 85% of state delegations had 100% participation by their delegates.

HOUSE OF DELEGATES

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Paul C. Walker, Vice Chair

As of March 22, 2024

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Jennifer E. Tryon, Board Liaison, Council on Pharmacy Practice

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Nebraska (3)	Tiffany Goeller Katie Reisbig David Schmidt	Jolyn Merry
Nevada (2)	Adam Porath Kate Ward	
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New Jersey (4)	Rich Artymowicz Julie Kalabalik-Hoganson Deb Sadowski Craig Sastic	Barbara Giacomelli Agnieszka Pasternak Jennifer Sternbach
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West Virginia (2)	Chris Fitzpatrick Derek Grimm	
Wisconsin (4)	John Muchka Sarah Peppard William Peppard Kate Schaafsma	Monica Bogenschutz Edward Conlin Carmen Gust David Reeb
Wyoming (2)	Linda Gore Martin Jessica Papke	
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Pharmacy Student Forum	Heather Howell	Charbel Aoun
Pharmacy Technician Forum	Tyler Darcy	Daniel Nyakundi
FRATERNAL	**DELEGATES**	**ALTERNATES**
U.S. Air Force	Lt Col Rohin Kasudia	Maj. Elizabeth Tesch
U.S. Army	LTC Victoria O'Shea	MAJ Danielle Zsido
U.S. Navy	LT Staci Jones	LCDR Chirag Patel
U.S. Public Health Service	CDR Christopher McKnight	
Veterans Affairs	Heather Ourth	Tera Moore Anthony Morreale

House of Delegates

REPORT ON THE VIRTUAL HOUSE OF DELEGATES

May 10-16, 2024

RESULTS OF THE VOTING

Between May 10 and 16, the ASHP House of Delegates (roster attached as Appendix A) voted on three policy recommendations. Delegates approved two policy recommendations by 85% or more, the threshold for final approval. One policy recommendation did not receive 85% of the votes and will be sent to the June House of Delegates.

POLICY RECOMMENDATIONS APPROVED

The two policy recommendations **approved** are as follows (percentage of delegates voting to approve follows the policy title):

Supporting High Reliability in Pharmacy Practice (85.0%)
Source: Council on Pharmacy Management
To state that a commitment to the principles and science of high reliability, with the goals of zero medication errors and zero harm, are foundational to pharmacy excellence; further,

To encourage hospitals and health systems to commit to high-reliability principles; further,

To encourage research that informs the creation of best practices in high reliability and progress toward implementation of high-reliability principles in all pharmacy services.

ASHP Statement on the Community Pharmacist's Role in the Care Continuum (94.5%)
Source: Section of Community Pharmacy Practitioners
To approve the ASHP Statement on the Community Pharmacist's Role in the Care Continuum (Appendix B).

POLICY RECOMMENDATIONS NOT APPROVED

The House **voted to not approve** the following policy recommendation (percentage of delegates voting to approve follows the policy title):

Prehospital Management of Medications (54.7%)
Source: Council on Pharmacy Practice
To assert that variation in the prehospital management and use of medications is a risk to patient safety and continuity of care; further,

To advocate for pharmacy workforce involvement in clinical and operational decision-making for prehospital management and utilization of medications; further,

To encourage the pharmacy workforce to assume responsibility for medication-related aspects of ensuring the continuity of care as patients transition from prehospital care to other care settings; further,

To collaborate with stakeholders involved in prehospital medication-use cycle decisions to improve patient safety, minimize variation, and reduce inefficiencies.

NOTES ON VOTING

Ninety-two percent (204) of delegates to the virtual House of Delegates participated in the voting, with 93% (152) of state delegates voting. Ninety-three percent of registered past presidents voted, and 81% of state delegations had 100% participation by their delegates.

HOUSE OF DELEGATES

Melanie A. Dodd, Chair
Paul C. Walker, Vice Chair

As of May 10, 2024

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U.S. Navy	LT Staci Jones	LCDR Chirag Patel
U.S. Public Health Service	CDR Christopher McKnight	
Veterans Affairs	Heather Ourth	Tera Moore Anthony Morreale

ASHP Statement on the Community Pharmacist's Role in the Care Continuum

Position

The American Society of Health-System Pharmacists (ASHP) believes that community pharmacists are skilled clinicians who play an important role in the care continuum as equal, essential, and valued members of the healthcare team. Community pharmacists provide direct patient care, advance team-based care, manage patient-centered clinical services, and serve as leaders within their communities and health systems. Community pharmacists optimize care by providing educational consultations, medication safety and optimization services, chronic condition management, patient empowerment, wellness services, care coordination, and other services.

Community pharmacists lead teams that support patient access and safety through clinical care, medication preparation and dispensing services, regulatory compliance, operational efficiency, and integration services across settings of care. Further, community pharmacists lead, manage, and contribute to innovative practices and operations that advance pharmacy practice and contribute to financial sustainability.

The purpose of this statement is to recognize the patient-centered care services provided by community pharmacists and encourage healthcare leaders to utilize community pharmacists to the full extent of their expertise by continuing to integrate them across the continuum of care. This statement will describe current practice of health-system-based community pharmacy and identify future opportunities for practice advancement, though the patient-centered core responsibilities described are generalizable to all community pharmacy practice settings.

Community pharmacists should be recognized as medication experts and accountable partners for optimal health outcomes. ASHP urges community pharmacists and leaders to advocate for the value of community pharmacists to internal and external stakeholders so their outcomes-oriented clinical and business expertise is recognized.

Background

Community pharmacies are found across an array of practice areas, including health systems, traditional retail sites, clinics, independent pharmacies, and integrated within ambulatory care settings. Community pharmacy ranks among the most frequent patient touch points in healthcare. More than 90% of Americans live within 5 miles of a pharmacy,[1] and patients visit their community pharmacist 12 times more frequently than their primary care provider.[2]

Patients can benefit from convenient access to healthcare services, and community pharmacy practitioners are uniquely positioned to take an active role in improving therapeutic outcomes and providing comprehensive and longitudinal patient-centered care. According to the Centers for Disease Control and Prevention, nearly half of Americans use at least one prescription medication each month,[3] and 40% of U.S. adults are managing two or more chronic conditions.[4] Innovative community pharmacy practices have the potential to significantly impact outcomes, such as reducing hospital readmission rates, preventing drug-induced harm, and increasing medication access and adherence.[5-7] Studies have also shown that community pharmacist–led interventions have a positive impact on a wide range of chronic diseases, including diabetes, cardiovascular disease, hyperlipidemia, and HIV/AIDS, and have

demonstrated a decrease in medical and healthcare costs.[8-10] As the healthcare landscape shifts toward a value-based framework, there is general agreement on the favorable impact of community pharmacists in increasing access to care and providing preventive health services.[11-16]

Core responsibilities

Patient care. Pharmacists practicing in community settings can both integrate into specific patient care teams and act as health and wellness advocates in their practice setting. Health-system-based community pharmacists have uniquely integrated tools, including electronic health record (EHR) access and communication methods, that facilitate these patient care activities. Community pharmacists are critical in ensuring that patients in the outpatient setting receive the medications they need through patient-centered dispensing, while also providing clinical services that optimize patient care and outcomes. The following encompasses many of the core clinical responsibilities of community pharmacists.

1. ***Medication utilization reviews:*** Patients may routinely seek care from many different sources and may or may not choose to use a single pharmacy for prescriptions. Community pharmacists are well positioned to utilize the information from their own system as well as information obtained from the patient and other pharmacy locations to compile a comprehensive medication list. Community pharmacists can then use this information to optimize the patient's medication therapies. Optimization includes, but is not limited to, utilizing this list to ensure that each medication is an appropriate agent, prescribed at an appropriate dose and for an appropriate duration. Information elucidated in this broad-spectrum patient care approach can then be communicated to the patient's entire healthcare team, reducing the risk for adverse outcomes related to incomplete understanding of the patient's medication regimen.
2. ***Medication access:*** Community pharmacists identify and help resolve medication access barriers. No other care setting offers the opportunity to routinely identify and overcome barriers to medication access and appropriate use such as cost, availability, harm reduction (e.g., providing naloxone), and dosage form modifications. During dispensing and at the point of sale, community pharmacists have the opportunity to engage the patient in a discussion regarding affordability of and access to their medications. These discussions often incorporate a variety of resources, including manufacturer discount programs, therapeutic interchanges, and use of charitable resources. In some settings, community pharmacists assist with the prior authorization process as well. Programs offered by community pharmacies (e.g., medication bedside delivery in acute care settings and home delivery in ambulatory care settings) can overcome transportation-related access barriers. These services are part of a broader effort to improve health equity.
3. ***Comprehensive medication management:*** Community pharmacists are trained to assess and improve medication regimens. Community pharmacists provide cognitive services to patients that go beyond the dispensing-focused prospective drug utilization reviews, including comprehensive medication reviews, medication reconciliation, and chronic disease management. These services can be especially impactful for patients

experiencing transitions between acute and ambulatory care with a significant change in health status. In addition, community pharmacists integrate targeted services such as medication adherence support, therapeutic optimization, reversal agent access, and duplicative therapy adjustments into their daily workflow.

4. ***Point-of-care testing and treatment:*** Advances in technology have increased the availability of testing that can be done outside laboratories, increasing access and convenience for patients. The advent of direct-to-consumer testing, in addition to CLIA-waived testing, has spurred a need for healthcare professionals to assist in providing and/or interpreting test results, formulating next steps, and in some cases initiating appropriate treatment. Community pharmacists perform and/or interpret point-of-care testing, including patient-initiated pharmacogenomics testing, and assist patients in understanding their test results. This service may lead to provision of targeted treatment for acute infections or recommendations to modify medication regimens that can be shared with the patient's other healthcare providers. Recognizing that not all patients with healthcare needs may be able to come to a pharmacy, community health screening events offer a mechanism for community pharmacists to identify patients in need of additional assessment and treatment for previously undiagnosed conditions (e.g., high blood pressure, hyperlipidemia, diabetes, chronic kidney disease).
5. ***Preventive care provision:*** Community pharmacists support patient wellness, both in a usual or daily setting and when patients can be exposed to new or potentially hazardous conditions. Wellness care involves preventive interventions (e.g., Medicare Wellness Visits, health screenings) or travel consultations to prepare travelers for pathogens and adverse conditions they may encounter abroad. Other preventive and wellness services may include provision of pre- or post-exposure prophylaxis against HIV infection or oral contraceptives. In addition, access to many different vaccines with different payer models is a unique aspect of community pharmacy that has increased patient access to vaccines. The COVID-19 pandemic highlighted the value of community pharmacists in ensuring that patients could easily receive recommended vaccines, and rates of routine immunizations have increased as community pharmacists have expanded vaccination services.[17,18]
6. ***Patient and community education:*** Community pharmacists have chosen to practice in a setting that enables them to be a resource for patient education on many different levels. This role includes not only patient education and counseling regarding specific medications, over-the-counter products, and complementary and alternative medicines, but also more comprehensive medication education (e.g., storage, appropriate administration, safe combinations with other medications or supplements, recommended disposal). Many community pharmacists and pharmacies offer programs that provide education and support for specific conditions, such as the Diabetes Self-Management Education and Support (DSMES) program.[19] Community pharmacists may be involved in identifying patients who struggle with substance use disorders and can offer resources and referrals to additional care providers. Pharmacists in this setting can also serve as educational resources for the broader community during health screenings, drug take-back events, and community wellness and outreach events. The

community pharmacist provides this education in a manner that is tailored to each patient's educational needs, including language and health-literacy barriers.

7. ***Medication safety:*** Community pharmacists serve as advocates for the safe use of medications in many ways. The interventions of community pharmacists are highly impactful on patient safety, whether this is in implementation of the Institute for Safe Medication Practices Community Pharmacy Action Agenda items,[20] recognition and mitigation of dangerous drug-drug or drug-disease interactions, or ensuring a patient's understanding of their medication regimen. Community pharmacists also support safe use of medications by working on a broader scale within their organizations or locations to perform continuous quality improvement processes and providing medication safety resources for other healthcare disciplines. Outreach to the community can raise awareness of the risks associated with medication misuse and can prevent harm.

Operations. In addition to core patient care responsibilities, community pharmacists are responsible for day-to-day operations of the pharmacy and ensuring compliance with state and federal laws and regulations, as well as accreditation standards. The following encompasses the core operations of the community pharmacy that the pharmacist manages or supports.

1. ***Team supervision:*** Community pharmacists oversee daily operations, including day-to-day staffing levels and maintaining appropriate pharmacist-to-technician staffing ratios, developing workstation and workflow expectations and optimizations, and supervising learners.
2. ***Regulatory compliance:*** Community pharmacists ensure compliance with all regulations, including all state and federal laws, Drug Enforcement Administration regulations, applicable United States Pharmacopeia (USP) standards (e.g., USP 795), 340B program compliance as applicable, and additional requirements of accreditation and governing bodies.
3. ***Record-keeping:*** Community pharmacists maintain all records (e.g., inventory, dispensing) in compliance with the Health Insurance Portability and Accountability Act of 1996, state, and federal regulations.
4. ***Inventory management:*** Community pharmacists manage the pharmacy's inventory to ensure the needs of the patients are served while preventing a surplus of inventory. Inventory management includes examination of inventory turns, proper security and storage of medications, and proper inventory management practices as it relates to the 340B program. Additionally, community pharmacists navigate drug shortages.
5. ***Fiscal management:*** Community pharmacists manage billing, revenue cycles, inventory costs, labor, and operational expenses in a fiscally responsible way. Pharmacy leaders also develop annual budgets and create volume projections for the pharmacy.
6. ***Compounding:*** Compounding services can be offered to patients when individualized pharmaceutical products are not commercially available. If the community pharmacy is part of a health system, compounded nonsterile preparations available to patients when admitted to the hospital can be made available in the community pharmacy for continuation of therapy. Many community pharmacists are able to refer patients to sterile compounding facilities if needed.

7. ***Program and protocol development:*** Community pharmacies offer relevant services such as vaccination and meds-to-beds services as applicable. Additional clinical services may also be provided, such as medication synchronization, medication adherence packaging, and medication delivery programs. Clinical services such as hormonal contraception prescribing, smoking cessation, COVID therapeutics, and immunizations may be provided through standing orders or collaborative practice agreements as allowed by state and federal laws.
8. ***Customer service:*** Community pharmacists provide excellent customer service not only to patients and customers but also to internal providers and stakeholders in the organization. Pharmacists can connect with the patient's providers to determine alternatives in the event of a drug shortage, to navigate insurance restrictions as needed, and to accommodate financial restrictions limiting patient access.
9. ***Access to health data:*** Community pharmacists utilize the patient's EHR to ensure comprehensive care for patients. Where EHR access is not available, community pharmacists may pursue access to health information exchange platforms. Similarly, community pharmacies may integrate their dispensing records into the patient's EHR.
10. ***Health literacy:*** Community pharmacists promote health equity by recognizing and accommodating the health literacy of their patients. Community pharmacists can provide prescription labels and care notes in the patient's preferred language or in the preferred modality for visually or hearing-impaired patients, at an appropriate reading level, and utilizing the patient's preferred name.
11. ***Drug disposal:*** With the rise of the opioid epidemic and overdoses, some community pharmacies serve as drug disposal sites, allowing patients to safely dispose of unwanted medications.

Expanded roles

While the clinical and operational functions described above are fundamental in today's practice for community pharmacists, there are many opportunities to expand how community pharmacists demonstrate value in providing direct patient care. Community pharmacists are poised to expand their roles due to their accessibility, in-depth knowledge of the medication-use process, and ability to quickly pivot and adapt to the changing healthcare landscape (Table 1).

Table 1. Domains of opportunity for expanded community pharmacist roles.

Impacting Health Outcomes	• Expand the use of and design new collaborative practice agreements. • Provide access to point-of-care testing for a variety of disease states (e.g., influenza, group A *Streptococcus*, human immunodeficiency virus, hepatitis C, coronaviruses, oral contraceptives, and chronic diseases). • Engage patients in health and wellness initiatives (e.g., smoking cessation, weight management, asthma, chronic heart failure,

	chronic obstructive pulmonary disease, diabetes, hyperlipidemia, hypertension, anticoagulation, medication adherence). • Promote preventive care such as establishing a primary provider and health screenings.
Education	• Incorporate learners at all levels by expanding opportunities for clinical rotation experiences and residency programs. • Continue to support technician education and advancement initiatives. • Encourage practitioners to meet the needs of evolving patient populations through gaining advanced clinical knowledge.
Health Equity	• Overcome barriers that cause health inequities in patient care.
Technology	• Identify how technology can be leveraged to create operational efficiencies in practice. • Expand or partner in developing precision medicine and pharmacogenomics opportunities. • Develop and evaluate artificial intelligence and cognitive support tools. • Support patients in their wellness journey by use of technology such as health apps, wearable devices, and other tools.
Patient-centric Models	• Perform ongoing evaluations of the patient-centered medical home model or hospital-at-home services. • Leverage technology to offer clinical services through in-person care, health applications, patient portals, and telehealth options.
Innovation	• Collaborate with clinicians to increase pharmacy-offered clinical services to alleviate provider burnout. • Enhance the patient experience by offering a team-based approach to the continuum of care. • Identify opportunities that not only advance patient care but also increase the pharmacy department's financial contribution to the organization. • Continue to advocate for billing avenues and recognition of services by payers.
Public Health	• Evaluate and investigate community health issues. • Educate the community about public health. • Engage in organizational efforts to prepare and respond to emergencies which may include leadership roles on emergency managements teams. • Develop and implement programs related to medication and vaccine access. • Offer wellness, disease prevention, and treatment services (e.g. immunizations, antimicrobial stewardship, HIV prevention,

	diabetes prevention programs, hormonal contraception education, substance abuse prevention/treatment). • Support disease surveillance and monitoring initiatives (e.g. antiviral dispensing rates for infectious disease data trending, asthma inhaler use and environmental or air quality concerns)
Population Health	• Participate in the development of metrics to identify and care for specific patient populations. • Promote vaccine confidence within communities. • Extend services to virtual care and video visits. • Partner with clinicians, health plans, and health system leaders to understand value-based payment models and associated metrics. • Ensure effective chronic disease management that includes evidence-based medication optimization and monitoring. • Identify associated quality measures and develop initiatives to support or address open care gaps (e.g., order routine lab testing, ensure appropriate statin usage, and encourage eye exams for patients with diabetes). • Promote medication adherence and support initiatives to improve medication access. • Promote health equity by identifying and addressing Social Determinants of Health (SDOH) to reduce health care disparities. • Participate in transition of care services to reduce readmissions in target patient populations. • Support and promote cost-effective medication usage to control cost of healthcare
Research	• Pursue opportunities to participate in investigational drug research, including dispensing and counseling for commercial and investigational drugs within clinical trials. • Contribute to the body of literature by sharing results of outcomes-based research. • Encourage patient and clinician participation in research. • Contribute to research through data collection.

To be successful in the development of expanded roles for community pharmacy practitioners, all pharmacy team members must be trailblazers, early adopters of practice change, and actively advocating for pharmacy practice advancement.

Practice challenges

Although community pharmacists are well equipped to improve therapeutic outcomes and patient care, practice challenges exist. Declining reimbursements to pharmacies by insurance plans have become increasingly problematic. Since the establishment of performance-based pharmacy contracts by Medicare Part D plans in 2012, price concessions charged to pharmacies

by insurance plans and pharmacy benefit managers increased 170%.[21] Further, limited payment of pharmacists for clinical services has led to serious financial strains on community pharmacies, forcing closures, and has resulted in lack of access to community pharmacy services in rural settings. Studies showed that 1 in 8 pharmacies closed between 2009 and 2015, a statistic that disproportionally affected independent pharmacies and low-income neighborhoods.[22]

The lack of ready access to a pharmacy, a phenomenon labeled "pharmacy deserts," is a persistent practice challenge. In rural areas, travel time to the nearest pharmacy may hinder access. And although more than 90% of Americans live within 5 miles of a pharmacy, proximity does not guarantee access.[23] Patients may still be stymied by lack of public transportation, limited pharmacy hours, or mobility issues. To promote health equity, patients should be provided easy access to community pharmacy services. Telepharmacy is one option that has been shown to increase patient access to pharmacy services.[24]

Limited revenue for community pharmacies has further been aggravated by a changing economy and workforce. In a recent report by the National Community Pharmacy Association, 93% of community pharmacists noted their business was affected by inflation. Concurrently, 80% of respondents indicated being affected by supply chain shortages, and more than three quarters of community pharmacists have experienced staffing shortages recently.[25]

Access to patients' health information also presents a challenge to optimal care, as community pharmacies often do not have access to the patient's complete electronic medical record. To combat this, community pharmacies should pursue access to health information exchange platforms. Similarly, community pharmacy dispensing records should be accessible in the EHR.

Staffing shortages in the community pharmacy and financial strains impact care. Despite increasing evidence favoring community pharmacist involvement in advanced clinical services, uptake is slow. The 2019 National Pharmacist Workforce Study[26] found that services such as vaccinations, medication assistance programs, medication therapy management, and medication synchronization are offered in most community pharmacy sites. However, only 43% of community pharmacy respondents indicated that they provide comprehensive medication management, 25%, opioid deprescribing; 24%, disease state management; 20%, point-of-care testing; 19%, injection administration; and 4%, pharmacogenomics testing. The study also identified high workload and inadequate staffing as the top two stressors for pharmacists.

The public perception of the range of roles of pharmacists may also pose a challenge. Though pharmacists provide a myriad of clinical and operational services, patients are often unaware of the extent of the role of the pharmacist in the medication-use process.[27] Patients visiting their local community pharmacy may not see the clinical decisions that pharmacists make daily and may not be aware that pharmacists act as a part of their interprofessional care team.

Leveraging pharmacy technicians

As community pharmacists face increased workload demands and limited time, advanced pharmacy technicians can be utilized as pharmacist extenders, furthering pharmacy practice and patient care.[28-30]

Traditional community pharmacy technician roles include entering prescriptions into the pharmacy dispensing system, counting medications, compounding, managing inventory, dealing with billing issues and insurance, and providing customer service at the point of sale. Limiting pharmacy technicians to only these roles does not utilize their full potential.[29] An advanced pharmacy technician is an individual who has responsibilities and tasks that go beyond the traditional duties of a standard pharmacy technician and requires a higher level of training, expertise, and often additional certifications. Nontraditional and advanced roles for pharmacy technicians can contribute to the overall impact of community pharmacy practice in patient care.[28,31-34] Some of these advanced pharmacy technician responsibilities are listed in Table 2. The role of pharmacy technicians is variable depending on the laws of each state and responsibilities highlighted may not encompass all technicians.

Table 2. Advanced pharmacy technician responsibilities in community pharmacy.

Patient care responsibilities	Operational responsibilities
• Administer immunizations and promote vaccine confidence. • Collect medication history. • Conduct point-of-care tests. • Identify and resolve barriers to medication access or care. • Enroll patients in patient assistance programs. • Serve as patient advocate. • Assist with patient adherence efforts. • Leverage patient relationships to promote preventive and essential health services. • Obtain additional training (e.g., as a community health worker).	• Engage in technician product verification and tech-check-tech programs. • Coordinate 340B activities. • Manage billing, prior authorizations, and financial affairs. • Manage pharmacist schedules and consultations. • Supervise ancillary staff. • Provide peer education and training. • Gather data and generate metrics and reports. • Oversee medication inventory and surveillance. • Assist in pharmacy workflow optimization. • Contribute to continuous quality improvement and patient safety efforts.

By redesigning the pharmacy workflow and using pharmacy technicians as pharmacist extenders, community pharmacies can optimize the pharmacists' accessibility and provide quality healthcare to their communities. Community pharmacists and leaders should support advanced community pharmacy technician training opportunities, which will allow pharmacy technicians to elevate their practice and contribute to advanced roles.

Professional obligations of community pharmacists

Community pharmacists have a long-standing commitment to make a tremendous, positive impact in patient care and the communities they serve. To overcome the financial and

workforce challenges currently impacting care, community pharmacists have a professional obligation to be advocates for the pharmacy profession and their practice in the following ways.

Community pharmacists should

- Engage in advocacy efforts, through state and national partners, to advance and protect the interests of patient care and the pharmacy profession.
- Continue to pursue educational and training opportunities that further their clinical and professional skills.
- Seek opportunities to engage in advanced roles that optimize patient outcomes, patient safety, operational efficiencies, and fiscal health for their patients and organizations.
- Commit to being innovators, who adapt to and lead contemporary models of care.
- Act as positive and ethical role models for their patients, colleagues, and the community.
- Serve as mentors and educators for student pharmacists and pharmacy residents, contributing to succession planning for a diverse and healthy workforce.
- Encourage the advancement and recognition of pharmacy technician partners.
- Participate in research evaluating the services that they provide.

Conclusion

The role of community pharmacists has evolved significantly. Pharmacists in community-based settings are operational leaders for the financial sustainability of healthcare institutions as well as valuable clinicians in providing comprehensive management of patient's medication therapy in collaboration with other healthcare colleagues.

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Appendix B: ASHP Statement on the Community Pharmacist's Role in the Care Continuum 11

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Disclosures

The authors have declared no potential conflicts of interest.

Additional information

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House of Delegates

HOUSE OF DELEGATES

REPORT OF THE

COMMITTEE ON NOMINATIONS

June 9, 2024

Portland, Oregon

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Linda Tyler (Vice Chair), Utah
Joshua Blackwell, Texas
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ASHP COMMITTEE ON NOMINATIONS

Madam Chair, Fellow Delegates:

The Committee on Nominations consists of seven members of ASHP who are appointed by the Immediate Past President. The Committee is charged with the task of presenting to you our best judgments about those persons who possess the tangible and intangible attributes of leadership that qualify them to serve as our officers and directors.

Selection of nominees for ASHP office involves a series of very challenging decisions on the part of the Committee. Ultimately, those decisions are intended to permit the membership to select leaders with the professional, intellectual, and personal qualities of leadership that will sustain the dynamism and pioneering spirit that have characterized both ASHP and its more than 60,000 members who provide patient care service across the entire spectrum of care.

First, the Committee must determine that a prospective nominee for office is an active member as required in the Charter. This is generally the easiest and most straightforward part of the Committee's work. The Committee must ascertain that each prospective nominee can perform the duties required of the office or offices to which he or she has been nominated. All nominees must be able to perform the duties of a Director, set forth in section 5.4 of the Bylaws. Presidential nominees must also be able to perform the duties of that office, set forth in article 4 of the Bylaws.

The more difficult part of the Committee's work is to assess those intangible qualities of emotional intelligence (empathy, self-awareness, self-regulation, social skills, and motivation), leadership, vision, engagement, and overall professional awareness that characterize the standout candidates – those truly able to provide leadership for ASHP and the profession. The Committee assesses the attributes of prospective candidates for office in areas such as:

- Professional experience, career path, and practice orientation.
- Leadership skills and leadership experience including but not limited to the extent of leadership involvement in ASHP and its affiliates.
- Knowledge of pharmacy practice and vision for practice and ASHP.
- Ability to represent ASHP’s diverse membership interests and perspectives.
- Communication and consensus building skills.

There are no right or wrong answers to these criteria. Certain qualities may be weighed differently at various points in the evolution of the profession.

The Committee’s year-long process of receiving nominations and screening candidates is designed to solicit extensive membership input and, ultimately, to permit the Committee to candidly and confidentially assess which candidates best fit ASHP’s needs. The Committee has met three times since the last session of the House of Delegates: on December 5, 2023, at the ASHP Midyear Clinical Meeting; on February 23, 2024, via teleconference; and in person on April 17, 2024, at ASHP Headquarters. Review of nominees’ materials was conducted continuously between March and April 2024 solely via secure electronic transmissions. This process has been reviewed for quality improvement and will be repeated for the 2024–2025 nomination cycle.

As in the past, the Committee used various means to canvass ASHP members and state affiliates for candidates who they felt were most qualified to lead us. All members were invited via announcements in ASHP News and Daily Briefing, social media, online ASHP NewsLink bulletins, and the ASHP website to submit nominations for the Committee's consideration. Nominations from affiliated state societies were solicited through special mailings and the "state affiliate" edition of the online NewsLink service.

Based upon recommendations from membership, state affiliates, and ASHP staff, the Committee contacted over 849 individuals identified as possible candidates. Some individuals were invited to accept consideration for more than one office. Of the nominees who responded to the invitation to place themselves in nomination, the breakdown by office is as follows:

PRESIDENT-ELECT: 7 accepted
BOARD OF DIRECTORS: 17 accepted
CHAIR, HOUSE OF DELEGATES: 8 accepted

A list of candidates that were slated was provided to delegates following the Committee's meeting on April 17, 2024.

The Committee is pleased to place in official nomination the following candidates for election to the indicated offices. Names, biographical data, and statements have been distributed to the House.

President-Elect (2025-2026)

Melanie A. Dodd, PharmD, PhC, BCPS, FASHP (Albuquerque, NM)
Stephen F. Eckel, PharmD, MHA (Chapel Hill, NC)

Board of Directors (2025-2028)

Marie A. Chisholm-Burns, PharmD, PhD, MPH, MBA, FACHE, FASHP, FAST (Portland, OR)
Todd W. Nesbit, PharmD, MBA, CPEL, FASHP (Baltimore, MD)
Mollie A. Scott, PharmD, BCACP, CPP, FASHP, FNCAP (Asheville, NC)
Majid R. Tanas, PharmD, MHA, MS, FASHP (Portland, OR)

Chair, House of Delegates (2024-2027)

Jesse H. Hogue, PharmD (Kalamazoo, MI)
Martin J. Torres, PharmD, FCSHP (Orange, CA)

Madam Chair, this completes the presentation of candidates by the Committee on Nominations. Congratulations to all the candidates.

CANDIDATES FOR PRESIDENT-ELECT 2025–2026

Melanie A. Dodd, PharmD, PhC, BCPS, FASHP (mdodd@salud.unm.edu) is associate dean for clinical affairs and professor, The University of New Mexico (UNM) College of Pharmacy, Albuquerque. She graduated from Purdue University and UNM and completed her residency at Presbyterian Healthcare Services. Dodd oversees innovative clinical models and faculty clinical services, including credentialing, contracting, billing and reimbursement. She provides key pharmacy professional advocacy and serves on academic and health-system leadership committees. Dodd is a pharmacist clinician in geriatric primary care with broad prescriptive authority at the UNM Hospitals Senior Health Clinic and is a consultant pharmacist for 340B-eligible and other ambulatory clinics. She is responsible for extensive didactic and clinical teaching activities in the UNM PharmD program and Health Sciences Center, including geriatric syndromes, pharmacy law, interprofessional education, and serves as a residency preceptor. Her research includes geriatric syndromes, advanced practice pharmacist models, and scholarship of teaching.

Dodd's ASHP service includes member of the Board of Directors and chair, ASHP House of Delegates (2021-2024), chair of the Council on Public Policy, chair of the Section of Ambulatory Care Practitioners (SACP), member, Pharmacy Forecast Advisory Committee, and NM delegate to the House of Delegates for 14 years. She is past president of NMSHP and faculty advisor for the UNM SSHP. She has received numerous awards for her service to the profession, including the ASHP Pharmacy Champion Award, SACP Distinguished Service Award, Fellow of ASHP, and NMSHP Dorothy Dillon Memorial Lecture Award.

Statement:
Access to optimal, safe, and effective healthcare is a cornerstone of a thriving community. My vision is to ensure pharmacists are recognized as direct patient care providers for all people, in all communities, throughout the continuum of care in all healthcare settings and future models of care. Pharmacist leaders need to always be at the table for key discussions regarding medication use and global issues affecting healthcare such as health equity, access to primary care, financing, evolving technology, and workforce shortages.

In alignment with the ASHP Practice Advancement Initiative, we must embrace and advocate for expanding roles of pharmacists, technicians, and students, including prescriptive authority. These new roles will require changes in education and training.

Lastly, in order for ASHP to achieve its mission into the future, we need to continue to focus on engaging new and mid-career members in activities that support leadership development and role advancement, and provide professional resources. ASHP's leadership in professional policy development and advocacy and collaboration with key stakeholders is essential to advance pharmacy practice change and address contemporary issues like drug shortages and artificial intelligence. ASHP must continue to be nimble to address the quickly changing healthcare and technological environment and new generational needs, including workforce wellness. I am humbled and honored by this nomination and am committed to providing leadership to continue to advance the pharmacy profession.

Stephen F. Eckel, PharmD, MHA (seckel@unc.edu) is the associate dean for global engagement at the UNC Eshelman School of Pharmacy. He is also an associate professor in the division of practice advancement and clinical education. In addition, he leads a two-year Master of Science in pharmaceutical sciences with a specialization in health-system pharmacy administration. This degree collaborates with 16 different health systems across nine states who sponsor the residency. It also has an online option for working professionals. At UNC Medical Center, he is residency program director of the two-year program in health-system pharmacy administration. He has worked with almost 250 residents over the years.

Eckel received his Bachelor of Science in pharmacy and Doctor of Pharmacy from the University of North Carolina at Chapel Hill. He completed a pharmacy practice residency at Duke University Medical Center and then joined UNC Hospitals as a clinical pharmacist. Eckel also holds a master of health care administration from the UNC Gillings School of Global Public Health.

Eckel has been very active in the North Carolina Association of Pharmacists, serving as chair of the ASHP state affiliate, a term on the board, and as president of the merged organization. He is a frequent author in *AJHP*, past chair of the ASHP Council of Pharmacy Practice, and past member of the ASHP Board of Directors. In 2015, the ASHP Foundation awarded him the Pharmacy Residency Excellence Preceptor Award. He is a Fellow of ASHP, APhA, ACCP, NCAP, and NAP.

Statement:
One constant of healthcare is change. While many pharmacists do not like change, it creates opportunities to take leadership roles during stressful and uncertain situations. Our profession needs to fill those gaps. One prime opportunity, I believe, is for pharmacists to take responsibility for the medication-use process and in so doing, will make patient care better, safer, more efficient, and less expensive. It will also increase our involvement in the patient-centric practice of pharmacy. To do this, health-system pharmacists need to be innovative leaders within their spheres of influence. Employing skills like creativity, innovation, and problem-solving can be the differentiator between whether we will create the future or someone outside of the profession will do it.

I have focused my career on providing novel and creative ideas to solve the challenges that face our profession and leveraging the uncertainty of change in helping us meet our professional ideals. I have also educated and mentored pharmacists as they take increasing responsibilities within their workplace.

I am passionate and committed that our professional society remains diverse and inclusive for all. We will not advance as an organization or profession until all of us are able to flourish at an individual level.

I am extremely honored to receive this nomination as ASHP has always been my professional home. There are many leaders who have utilized their skills in the past to bring health-system pharmacy to this point, and I am committed to do the same for future generations.

CANDIDATES FOR BOARD OF DIRECTORS 2025–2028

Marie A. Chisholm-Burns, PharmD, PhD, MPH, MBA, FACHE, FASHP, FAST (chishmar@ohsu.edu) is the executive vice president and provost of Oregon Health & Science University (OHSU) and the J.S. Reinschmidt Endowed Professor in the OHSU School of Medicine. She is also founder and director of the Medication Access Program, which has helped thousands of solid-organ transplant recipients receive more than $119 million in prescription medications.

Chisholm-Burns received her BS in pharmacy and Doctor of Pharmacy degrees from the University of Georgia, Master of Public Health degree from Emory University, Master of Business Administration degree from the University of Memphis, and PhD degree from the University of South Dakota. She completed her residency at Piedmont Hospital in Atlanta, Georgia. She has also achieved FACHE certification and practiced in several regions of the U.S.

Chisholm-Burns has been an active member of ASHP for over 30 years. She previously served in several ASHP leadership positions; for example, she served as the inaugural chair of the ASHP Section of Pharmacy Educators Executive Committee, as director-at-large of the ASHP Section of Clinical Specialists and Scientists Executive Committee, as a member of the Center for Health-System Pharmacy Leadership Advisory Panel, and as a member of the *AJHP* editorial board. She is a member of the Pharmacy Forecast Advisory Committee and contributed to several Forecasts over the years, including 2024 (public health priorities), 2023 (health disparities), and 2021 (healthcare access). Additionally, Chisholm-Burns has received several awards from ASHP, including the 2022 Board of Directors' Distinguished Leadership Award.

Statement:
Equitable healthcare access and delivery are of utmost importance to the health of our communities. Access and success are central to my vision for pharmacy practice – specifically, access to healthcare and success in achieving health equity and optimizing patient outcomes. I have illuminated the value of pharmacists in advancing access and success in patient care throughout my career, including documenting extensive evidence of the beneficial effects of pharmacist-provided direct patient care, with the support of ASHP and its members. Such evidence supports inclusion of pharmacists in interprofessional healthcare delivery models as a strategy to increase access, improve outcomes, and reduce healthcare costs.

To achieve this vision of access and success, we must recognize and respond to challenges facing the profession, including drug shortages, technological advances, financial sustainability, and workforce shortages, stress, and burnout. We must work together to build bridges to success in each of these areas. Further, we should amplify equitable healthcare for all patients and communities we serve. And we should strive to promote access and success by:

- *Advocating for pharmacists to practice at the top of their license and for improved reimbursement mechanisms.*
- *Supporting the well-being of patients and the pharmacy workforce, including reducing burnout and stress.*
- *Facilitating growth of the pharmacy technician workforce.*
- *Expanding practice and care delivery, including greater participation on interprofessional healthcare teams.*
- *Eliminating healthcare disparities and advancing equity for all.*

I am honored to be nominated for the ASHP Board of Directors. It would be my privilege to serve our esteemed membership.

Todd W. Nesbit, PharmD, MBA, CPEL, FASHP (tnesbit@jhmi.edu) serves as chief pharmacy officer for The Johns Hopkins Hospital and vice president for pharmacy services for Johns Hopkins Health System in Baltimore, Maryland. As executive pharmacy leader, he is responsible for directing hospital and health-system practice, research, and education, and implementing system-wide pharmacy services across the continuum. He is the residency program director for the HSPAL residency program at The Johns Hopkins Hospital and has served as preceptor and mentor to pharmacy students and residents for more than 30 years.

Nesbit received his BS in pharmacy degree from Ohio Northern University, his Doctor of Pharmacy degree from The Ohio State University, and his MBA degree in medical services management from Johns Hopkins University. Through positions of increasing responsibility held in diverse hospitals and academic medical centers, he has worked to promote and advance the role of the pharmacist and clinical pharmacy in health systems.

He has extensive experience serving ASHP and state affiliates, including ASHP Forecast Advisory Committee member and chapter author; Pharmacy Competency Assessment Center Advisory Board member and section editor; co-chair of the Maryland Society of Health-System Pharmacy (MSHP) Practice Model Task Force; voting member of the inaugural Pharmacy Practice Model Summit; and delegate to the Pharmacy Stakeholders Conference on MTM Services. Nesbit has been recognized as a Fellow of ASHP and has achieved the status of Certified Pharmacy Executive Leader by the organization. Nesbit received the MSHP W. Arthur Purdum Award for significant contributions to health-system pharmacy.

Statement:
My philosophy begins with the belief that the patient must always be at the center of our individual and collective decision-making. Medication-use systems must be designed to ensure that the needs of our patients are met holistically within and across all care settings for which we are responsible. Meeting these needs necessitates ownership and accountability by all pharmacists and pharmacy technicians alike, to directly manage drug therapy and ensure the safety and quality of medication use. Professional staff should be empowered through credentialing and privileging and engagement in collaborative practice agreements with other professional colleagues, for optimal efficiency and effectiveness. Leveraging the collective expertise of our technicians is critical to extend their scope and impact the care of more patients. We should deploy automation and robotic systems to reduce the burden of repetitive tasks, optimizing the work to be completed by scarce human resources. Robust analytic frameworks are also essential to validate the patient care impact and outcomes that we intend. We should embrace new and evolving approaches for data management and knowledge generation, through expanded use of artificial intelligence and machine learning. It is imperative that we continue to foster a culture of innovation through research, to support new understanding of disease processes and advances in treatment options for our patients such as genetic and cellular therapies. Lastly, it is crucial that we foster supportive and diverse learning environments, to ensure the availability of the future pharmacy workforce that will be needed to care for our patients.

Mollie A. Scott, PharmD, BCACP, CPP, FASHP, FNCAP (mollies@email.unc.edu) is regional associate dean and clinical professor at UNC Eshelman School of Pharmacy and chair of pharmacotherapy at Mountain Area Health Education Center (MAHEC). She practices as a clinical pharmacist practitioner in an interprofessional osteoporosis clinic. Mollie received her BS degree in biology from Meredith College and her Doctor of Pharmacy degree from UNC Eshelman School of Pharmacy before completing a specialty pharmacy residency in geriatrics at the Durham VA Medical Center. She has practiced in inpatient internal medicine, long-term care, and ambulatory care and for the past 20 years has focused on ambulatory care, administration, and academia.

Mollie served as vice chair and chair for the Section of Ambulatory Care Practitioners (SACP) Section Advisory Group on Clinical Practice Advancement, where she led the development of an Ambulatory Care Career Tool. She served six years on the SACP Executive Committee, first as director-at-large, and later, as chair, and co-authored the ASHP Statement on the Role of Pharmacists in Primary Care. She is currently a member of the House of Delegates and the Advocacy and PAC Advisory Committee. Mollie led the North Carolina Association of Pharmacists (NCAP) Task Force on Hormonal Contraception, which resulted in new legislation allowing pharmacists to prescribe a variety of medications, including contraception. She is the recipient of multiple awards for contributions to the profession of pharmacy, including the NCAP Don Blanton Award, ASHP SACP Distinguished Service Award, and Bowl of Hygeia. She has been recognized as a Fellow of NCAP and ASHP.

Statement:
Pharmacists are members of a distinguished and honored profession who serve as medication experts and improve the health of patients through medication optimization. Upon graduation, we promise to consider the welfare of humanity and relief of suffering our primary concerns, and providing patient-centered care is a cornerstone of our profession. It has been a joy to serve my patients and community as a pharmacist for the past 31 years.

The American healthcare system is currently challenged by a shortfall of primary care physicians, closure of rural hospitals and community pharmacies, medication shortages, high costs of care, the impact of social determinants of health, and a post-pandemic world. I believe that the profession of pharmacy can increase access, equity, and quality of care and create healthy communities by:

1. *Leading policy efforts to overcome barriers that prevent pharmacists from practicing at the top of our licenses.*
2. *Incorporating social determinants of health into education, research, and practice to improve delivery of equitable and holistic care.*
3. *Creating best practices for incorporating artificial intelligence into pharmacy practice and education.*
4. *Advocating for financial sustainability of rural and small health systems and independent community pharmacies to improve access to care.*
5. *Partnering with healthcare leaders in medicine, nursing, social work, health policy, government, and professional organizations to create collaborative solutions to healthcare problems.*

ASHP is at the forefront of advocating for our profession and our patients, and it is an honor to be slated for the Board of Directors.

Majid R. Tanas, PharmD, MHA, MS, FASHP (mtanas@lhs.org) is the vice president of pharmacy and chief pharmacy officer at Legacy Health, an eight-facility, 1,200-bed community health system ranging from a Level 1 trauma center to Critical Access Medical Center, including pediatric and psychiatric specialty services. Tanas earned a BS in biochemistry from Whitworth University, an MS in biotechnology from Washington State University, and a Doctorate in pharmacy from Washington State University. He earned a Master of Health Administration as a part of his two-year pharmacy administration residency at the University of Washington.

Tanas has been an active member of ASHP over the past 20 years, beginning as a student in 2003. Since graduating from pharmacy school, he has served in the following appointments:

- New Practitioners Forum Advisory Groups:
  - Communications and Public Affairs (2007)
  - Leadership and Career Development (2008)
- New Practitioners Forum Executive Committee (2009):
  - Pharmacy Practice Advisory Group – Executive Liaison
  - Science and Research Advisory Group – Executive Liaison
- Council of Pharmacy Practice (2010, 2011, 2012)
- House of Delegate: Alternate (2014), Member (elected in 2015)
- Board of Canvassers (2019-2022)
- Section Advisory Group on Multi-Hospital Pharmacy Executives: Member (2021), Vice-Chair (2022), Chair (2022-2023), Chair (2022-2024)

He serves as a faculty member for the ASHP Practical Training in Compounding Sterile Preparations Certificate (2022-2023), presented at numerous ASHP conferences, represented ASHP at DUPHAT, an international conference as a delegate, and was recognized as a Fellow of ASHP in June 2022.

Statement:
The challenge ahead of pharmacy is evolving from an auditor of prescriptions to an initiator of care. Our charge is to elevate clinical care at the bedside/clinic/counter, improve an organization's financial viability, and the safety of medications.

With nearly three million nurses and one million physicians, the 300,000 pharmacists that make up our profession may be few in comparison, but our voice and impact in healthcare are far-reaching. Health systems must rapidly adapt from established business practices due to diminishing reimbursement. The members of ASHP stand at the crossroads to advance health-system pharmacy and healthcare. We must forge ahead to find new ways to meet our community's needs.

Health systems are essential for our communities and must enhance the care model, expanding the continuum of services across phases of care – a unique niche that health systems occupy. Breaking down the silos between inpatient clinical care, ambulatory care, and outpatient pharmacy requires working together to move care to patients in new and creative ways. We must create integrated networks that meet patient care at every level to meet the sacred responsibility of returning ailing patients to their loved ones.

Let's not wait for an operational plan to be handed to our profession. Instead, we must preemptively identify how health-system pharmacy provides stability in uncertain times, how we can provide readily

accessible services to our patients, and how pharmacy can create a safe and healing environment. We will go farther and are better…together.

CANDIDATES FOR CHAIR, HOUSE OF DELEGATES 2024–2027

Jesse H. Hogue, PharmD (hoguej@bronsonhg.org) is the pharmacy education coordinator, the postgraduate year 1 pharmacy residency director and an emergency department pharmacist at Bronson Methodist Hospital in Kalamazoo. He also serves as an affiliate preceptor for the Ferris State University (FSU) College of Pharmacy. Hogue received his Doctor of Pharmacy degree from FSU and completed residency training at Bronson Methodist Hospital. After residency, he worked in trauma and orthopedics, then had the opportunity to establish pharmacy services in the emergency department, where he worked for several years prior to assuming his current role.

Hogue currently serves on the ASHP Commission on Credentialing and has been a Michigan delegate to the ASHP House of Delegates for 15 years. He has previously served on the ASHP Council on Education and Workforce Development. Hogue has also been very engaged on the state level, having served as president, treasurer, and executive board member for the Michigan Society of Health-System Pharmacists (MSHP), as an executive board member for the Michigan Pharmacists Association (MPA), as a delegate in the MPA House of Delegates for many years, and as a member on numerous MSHP and MPA committees and taskforces. He has been recognized in Michigan for his contributions to the profession as a Fellow of MPA and a member of the MPA Hall of Honor. Additionally, he has received the MSHP Pharmacist of the Year Award, the MSHP Joseph A. Oddis Leadership Award, and the MPA Distinguished Young Pharmacist of the Year Award.

Statement:
"We are better together."
- Paul Walker, ASHP past-president

The pharmacy workforce continues to innovate and move the practice and delivery of healthcare forward. Pharmacists play a vital role in both leadership and on the front lines. Even for non-medication-related issues, we are often called upon to contribute - and even lead - due to our demonstrated proficiency and valued perspectives.

To support that, ASHP joins us together as a unified profession, providing forums for education and idea sharing, establishing best practices, and crafting practice resources. When combined with initiatives to promote and grow our profession and ensure a diverse and inclusive workforce, ASHP's efforts help us improve care and expand access to pursue our mission to help people achieve optimal health outcomes.

But we face challenges. Drug shortages. Decreasing pharmacy school enrollment. Technician shortages. 340B and CMS pass-through funding. Opposition from groups such as the American Medical Association. ASHP is helping us meet and overcome these challenges through advocacy efforts and media campaigns, often directed by our professional policy positions. Therefore, it is critical that the House of Delegates Chair, for which I am honored to have been nominated, ensures decisions on policy statements are made in an equitable way - prioritizing open communication and making sure everyone is allowed to share their views without being dominated by others in those conversations. The ASHP policy process must ensure that viewpoints of our diverse membership are

considered, regardless of role or practice area. Because we are one pharmacy profession – better together.

Martin J. Torres, PharmD, FCSHP (martit3@hs.uci.edu) is a director of pharmacy at UC Irvine Medical Center in Orange, California with administrative oversight of quality, safety, education, and research. He is also an adjunct professor of pharmacology at the Southern California College of Optometry in Fullerton in addition to serving as a volunteer faculty member at the UCI School of Pharmacy and Pharmaceutical Sciences. He received his PharmD from the USC School of Pharmacy, completed a 1-year residency in clinical pharmacy, and began his career establishing an ICU satellite pharmacy and multiple clinical programs in a community hospital. After initially providing direct patient care for seven years, he has had the opportunity to lead teams both in acute care and outpatient settings in developing patient services across multiple transitions of care.

His ASHP service includes member, Council on Affiliate Relations (2022-current), and California delegate to the ASHP House of Delegates (2018-2021). He has been very active with the California Society of Health-System Pharmacists as chair of the House of Delegates (2018-2021), co-chair/member, Committee on Professional Affairs (2014-2017), president, Orange County Society of Health-Systems Pharmacists (2017-2018), and a member of multiple seminar planning and Pacific Coast Patient Safety Conference committees.

He has developed additional insights into organizational leadership through volunteer activities as a board chair/member of multiple community organizations, including a community foundation board, technology committee, chair of a parks and recreation committee, and others. His goal in every community engagement was to be "the pharmacist" for the organization and its members.

Statement:
Dear Friends and Colleagues,

As I share my thoughts, I want to first thank those who made time to model and mentor during my journey. As a profession, we have much to celebrate yet so much more to accomplish, all for the care of our patients. There are many priorities which must be addressed, but taking control of how we are represented should have a sense of urgency. The pharmacists I support do not "verify" orders, they "evaluate" orders. Evaluate better represents the cognitive application of our medication management expertise, whereas "verify" might simply imply the click of a mouse. Let's use the power of words and images consistently in our messaging, where every reference to our wonderful profession conveys caring for patients. Yes, OUR patients!

A pharmacist with a spatula "saving lives counting by fives"? Pharmacy directors or pharmacy executives? Pharmacy departments or pharmacy enterprises? Pharmacy leaders or leaders in healthcare? If there are opportunities for incremental improvement, let's have a renewed focus on how we represent ourselves through every policy we draft and every position statement issued.

If we don't control the narrative, who knows, we may end up being the only patient care profession that is reimbursed based on issuing a product. Imagine that. Better yet, reimagine that! I look forward to learning from you and working together with you not only for the benefit of our profession, but for our patients.

I would love to hear your thoughts if you are willing to share. Thank you.

ashp
pharmacists advancing healthcare®

House of Delegates

REPORT OF THE

COMMITTEE ON RESOLUTIONS

June 9, 2024

Portland, Oregon

Nishaminy Kasbekar, Chair
Leigh A. Briscoe-Dwyer, Vice Chair
Paul C. Walker
Christene M. Jolowsky
Kimberley W. Benner
Melanie A. Dodd
Kristine K. Gullickson
Vivian Bradley Johnson
Pamela K. Phelps
Vickie L. Powell
Jennifer E. Tryon
Paul W. Abramowitz, Chief Executive Officer

Article 7.2.2.1 of the ASHP Rules of Procedure for the House of Delegates states:

> Resolutions not voluntarily withdrawn by the submitter that meet the requirements of the governing documents shall be presented to the House of Delegates by the Committee on Resolutions at the first meeting and acted upon at the second meeting. They shall be submitted to delegates with one of the following recommendations: (a) recommend adoption, (b) do not recommend adoption, (c) recommend referral for further study, or (d) presented with no recommendation of the Committee on Resolutions.
>
> Action by the House of Delegates shall be on the substance of the resolutions and not on the recommendation of the Committee on Resolutions.

Pursuant to the above article, the Committee on Resolutions presents the attached resolution (Appendix A) to the House of Delegates. The recommendation of the Committee is to **refer the resolution to the Council on Pharmacy Management for further study.** The Committee noted that the Council on Pharmacy Management is slated to perform a sunset review of ASHP policy 2042, Controlled Substances Diversion Prevention (Appendix B), in September. The Committee expressed support for the substance of the resolution, noting that it reflects best practices ASHP includes in the ASHP Guidelines on Preventing Diversion of Controlled Substances and the ASHP Statement on the Pharmacist's Role in Substance Abuse Prevention, Education, and Assistance, but agreed that incorporating the concepts of the resolution into a revision of policy 2042 would provide necessary context. The Committee reiterated ASHP's support, as expressed in the guidelines and statement, for distinguishing between diversion to support a substance use disorder or for financial gain and for a process to support recovery for such employees that includes assessment of an employee's ability to return to patient care. The Committee emphasized, however, that an empathetic approach to employee substance use disorders must be balanced with other priorities, including patient safety, legal and regulatory compliance, and employee protection, as outlined in the fourth clause of policy 2042 (i.e., controlled substances diversion prevention programs should "support a safe patient-care environment, protect co-workers, and discourage controlled substances diversion.") The Committee concluded that the ASHP policy committee process, with its studied reflection and multiple layers of review, would be the best way to arrive at policy that expresses a nuanced stance on these complex and competing issues.

Delegates are reminded that they are voting on the substance of the resolution, which is approval of the motion as follows:

> To advocate that hospitals adopt alternatives to discipline programs for healthcare workers (HCWs) who have diverted controlled substances to support their own substance use disorder; further,
>
> To encourage state licensing boards to provide structured rehabilitation programs for such HCWs that lead to return to practice upon successful completion.

The options for House action on the resolution, to be taken at the second meeting, are to (a) approve the motion; (b) defeat the motion; (c) refer the motion for further study by a committee or task force to be determined by the Board of Directors **(the option recommended by the Committee on Resolutions)**; or (d) amend the resolution, which would then require due consideration by the Board of Directors at its next meeting in September.

Resolution for the 2024 ASHP House of Delegates: Alternatives to Discipline Programs in Drug Diversion

Submitted by:
Samantha Roberts
Woodstock, GA
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Subject: Alternatives to Discipline Programs in Drug Diversion

Received: February 28, 2024

Motion
To advocate that hospitals adopt alternatives to discipline programs for healthcare workers (HCWs) who have diverted controlled substances to support their own substance use disorder; further,

To encourage state licensing boards to provide structured rehabilitation programs for such HCWs that lead to return to practice upon successful completion.

Background
At least one in every 100 healthcare workers (HCWs) is estimated to have diverted medication.[1] Because most drug diversion goes undetected, the true number is likely much higher. Moreover, an estimated 10-15% of HCWs will misuse substances within their career.[2] Due to the physical demands of the job, increasing levels of burnout, and ease of access to controlled substances (CS), occupational risk factors contribute to substance misuse in the healthcare setting. Substance use disorders are formally recognized by The Diagnostic and Statistical Manual of Mental Disorders (DSM), Fifth Edition, with decades of research linking these disorders to changes in brain chemistry.[3]

Historically, the stigma associated with such diagnoses and the fear of license revocation have prevented HCWs from seeking treatment. Many hospitals and health systems have begun to offer confidential faculty and staff assistance programs (FSAPs); however, these resources continue to be underutilized. Even after diverters have been caught, many will not admit to any wrongdoing for fear of loss of employment. These situations can lead to the diverter resigning and seeking employment elsewhere. Typically, the behavior will continue, putting patients and co-workers at risk for safety events. Furthermore, the risk of suicide is high after personnel are confronted about diversion.

To prevent adverse outcomes, HCWs need to retain insurance and access treatment on a leave of absence or disability basis, with return to work after completing state board-

mandated protocols. Since 1991, ASHP has supported employer-sponsored drug programs that promote the recovery of impaired individuals.[4] Less punitive approaches are more recently recommended in the 2022 ASHP Guidelines on Preventing Diversion of Controlled Substances, which state that "sanctions should take into account whether the HCW is supporting his or her own substance use disorder (or that of an associate) or there has been theft of CS for sale and financial gain." The guidelines further recommend that when an HCW is diverting to support a substance use disorder, the diversion "should be referred to applicable licensing boards, and the HCW should be referred to a substance abuse program." The guidelines encourage healthcare organizations to "establish a process to support recovery for HCWs who are diverting CS for an active substance abuse problem (i.e., an employee assistance program process, which may include mandatory program referral, reporting to the relevant state board or professional assistance program, and a contract for the HCW's return to work)."[5] A 2021 ASHP survey found that 83% of surveyed healthcare organizations supported employee substance use recovery programs, and 65% had return-to-work policies for employees who wanted to reenter the workforce following recovery.[6]

State boards of pharmacy have embraced employee substance use recovery programs and return-to-work policies. As of 2017, 46 states had programs for assisting pharmacy professionals.[7] Given their essential role in enabling HCWs to return to practice, ASHP encourages all state bodies responsible for licensing HCWs to provide structured rehabilitation programs for HCWs with substance use disorders that lead to return to practice upon successful completion.

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Suggested Outcome

Adoption of this resolution would support changes in health systems' human resources approach to mandatory termination upon discovery of a diversion by a healthcare worker. Such changes would allow for thoughtful deliberation of commensurate consequences. Adoption of the resolution would also encourage state licensing boards to provide rehabilitation-based avenues for return to work for HCWs affected by substance use disorder.

ASHP Policy 2042, Controlled Substances Diversion Prevention

Source: Council on Pharmacy Management

To enhance awareness by the pharmacy workforce, other healthcare workers, and the public of the potential threats to the public and patient care and safety presented by diversion of controlled substances; further,

To encourage healthcare organizations to develop controlled substances diversion prevention programs (CSDPPs) and supporting policies that delineate the core administrative elements and system- and provider-level controls needed to deter diversion of controlled substances at all stages of medication use; further,

To encourage healthcare organizations to address in their CSDPPs the roles, responsibilities, and oversight of all workers who may have access to controlled substances to ensure compliance with applicable laws and scopes of practice; further,

To encourage healthcare organizations to ensure that all healthcare workers are appropriately screened for substance abuse prior to initial employment and that surveillance, auditing, and monitoring are conducted on an ongoing basis to support a safe patient-care environment, protect co-workers, and discourage controlled substances diversion; further,

To advocate that pharmacists take principal roles in collaborative, interdisciplinary efforts by organizations of healthcare professionals, patient advocacy organizations, and regulatory authorities to develop and promote best practices for preventing drug diversion and appropriately using controlled substances to optimize and ensure patient access and therapeutic outcomes; further,

To advocate that the Drug Enforcement Administration and other regulatory authorities interpret and enforce laws, rules, and regulations to support patient access to appropriate therapies, minimize burdens on pharmacy practice, and provide reasonable safeguards against fraud, misuse, abuse, and diversion of controlled substances.

This policy supersedes ASHP policies 1614 and 1709.

House of Delegates

Board of Directors Report: Policy Recommendations for the June 2024 House of Delegates

COUNCIL ON PHARMACY PRACTICE POLICY RECOMMENDATIONS

The Council on Pharmacy Practice is concerned with ASHP professional policies related to the responsibilities of pharmacy practitioners. Within the Council's purview are (1) practitioner care for individual patients, (2) practitioner activities in public health, (3) pharmacy practice standards and quality, (4) professional ethics, (5) interprofessional and public relations, and (6) related matters.

Jennifer Tryon, *Board Liaison*

1. Prehospital Management of Medications

To assert that variation in the prehospital management and use of medications is a risk to patient safety and continuity of care; further,

To advocate for pharmacy workforce involvement in clinical and operational decision-making for prehospital management and utilization of medications; further,

To encourage the pharmacy workforce to assume responsibility for medication-related aspects of ensuring the continuity of care as patients transition from prehospital care to other care settings; further,

To collaborate with stakeholders involved in prehospital medication-use cycle decisions to improve patient safety, minimize variation, and reduce inefficiencies.

Rationale

ASHP advocates that the pharmacy workforce "assume responsibility for medication-related aspects of ensuring the continuity of care as patients move from one care setting to another" (ASHP policy 2205). Prehospital management and utilization of medications varies greatly through patient emergency services, transport, and transfers. The pharmacy workforce has established clinical and operational expertise across the spectrum of medication use, which would add value and safety measures to the prehospital management and utilization of medications. That expertise could inform decision-making regarding standardization, management of medication shortages, and prevention of medication errors, among other things. Ensuring pharmacy workforce involvement in these medication-related activities and decisions would optimize medication use, improving prehospital care and patient safety during emergent situations and patient transfers.

Background

The Council examined this topic in response to a recommendation from the 2023 House of Delegates. Council members noted that a similar gap in ASHP policy led to the development of ASHP policy 2317, Emergency Medical Kits, and agreed that an ASHP policy position was needed to fill this gap.

2. Role of Artificial Intelligence in Pharmacy Practice

To recognize artificial intelligence (AI) as a tool with tremendous potential to improve patient care and the medication-use process, which should be implemented with caution due to potential unforeseen risks; further,

To encourage healthcare organizations to develop policies, procedures, and guidelines to determine which care settings, medications, and patient populations are appropriate candidates for the use of AI; further,

To advocate for pharmacy workforce involvement and transparency in the decision-making, design, implementation, and ongoing evaluation of AI-related applications and technologies that affect medication-use processes and tasks; further,

To oppose any use of AI that compromises human interaction or replaces ethical decision-making, professional judgment, or critical thinking or is implemented solely to reduce healthcare staffing and resources; further,

To advocate for regulations and standards that permit the use of AI in circumstances in which it has proven safe and effective.

Rationale

Artificial intelligence (AI) is an emerging technology described as intelligent computer programs or software capable of learning human cognition and processes. AI falls under two categories: machine learning (ML) for data set analysis and natural learning processes for information extraction from existing data. In recent years, AI technology has evolved at an immense speed, and healthcare has been increasingly digitizing data, raising two questions: how to best use both to improve patient-specific care on a grand scale without compromising patient safety and outcomes, and how to retain the expertise, autonomy, and humanity (e.g., empathy and compassion) of the interprofessional care team.

The healthcare community recognizes the potential benefit and risk of AI in patient care. Examples of opportunities include but are not limited to optimizing patient health, reducing variation in patient care services, translating evidence to practice, streamlining workflows and creating efficiencies, and reducing cognitive load on the interprofessional care team. Risks may include potential for breaches in patient privacy and safety; failure to incorporate ethical and moral decision-making; lack of transparency; automation biases; and narrow algorithm development that does not account for diverse populations, widening health disparities in undeserved or underrepresented patient populations. Given these risks, pharmacists and other healthcare professionals must retain oversight of AI applications and their implementation. Even if there comes a time when AI technology can account for every possible variable, the healthcare team must retain the right to make the final decisions on patient care to mitigate its inherent risks.

Pharmacy should take a leading role on the interprofessional healthcare team to research, develop, implement, and improve the quality of AI/ML-based clinical models that affect medication-use processes and tasks. The potential for improvement of care, lower costs, and comprehensive medication management could significantly impact healthcare, but healthcare providers must recognize the need for sufficient purview and monitoring to guarantee patient safety and effective therapy. Pharmacists, as leaders in AI health technology, can guide healthcare professionals and future generations on the implementation of AI in healthcare.

Background

The Council discussed AI following the Joint Council and Commission Meeting on the Role of Artificial Intelligence in Pharmacy. Their initial focus was on the ethical considerations in AI; however, the Council felt there was a need to discuss how AI impacts pharmacy practice more broadly. The Council agreed on the need for new ASHP policy. The Council also agreed that the ASHP Statement on the Use of Artificial Intelligence in Pharmacy should be revised to address ethical considerations for AI in healthcare and pharmacy practice, such as what tasks should always be performed by a human and never be replaced by AI, and what ethical considerations are needed for initial evaluation, implementation, and ongoing quality assurance of AI technologies.

3. Independent Prescribing Authority

To affirm that prescribing is a collaborative process that includes patient assessment, understanding of the patient's diagnoses, evaluation and selection of available treatment options, monitoring to achieve therapeutic outcomes, patient education, and adherence to safe and cost-effective prescribing practices; further,

To recognize that pharmacists are highly trained medication experts on the interprofessional care team capable of making independent and autonomous evidence-based decisions on medication therapy management; further,

To advocate that pharmacists have independent and autonomous authority to initiate, modify, and deprescribe all schedules and classes of medications; further,

To advocate that healthcare delivery organizations establish credentialing and privileging processes for pharmacists that delineate scope of practice, support pharmacist prescribing, and ensure that pharmacists who prescribe are accountable, competent, and qualified to do so; further,

To advocate that all pharmacists have a National Provider Identifier that is recognized by payers.

Note: This policy would supersede ASHP policies 2236 and 2251.

Rationale

Pharmacists are highly trained medication experts skilled in providing comprehensive medication management (CMM) services across the continuum of care. Nearly all states include pharmacist prescribing authority within their state practice acts, although those acts differ in how pharmacist prescribing authority is described, terminology used, and the degree of prescribing autonomy (i.e., autonomous or collaborative). Regulations at the state level are critical to ensuring that pharmacists can seamlessly provide CMM services within the interprofessional team and to the top of their skills and abilities. Pharmacists are a core healthcare team member, well-positioned to provide high-quality, cost-effective care that increases patient access and reduces the burden on other healthcare providers. Hundreds of studies published in peer-reviewed literature, conducted throughout a variety of organizations and health systems, have consistently demonstrated the benefits of pharmacist-directed patient care across a variety of clinical practice settings. A 2010 comprehensive systematic review of 298 studies of U.S. pharmacists' effect as a member of the patient care team found positive results on therapeutic and safety metrics (Chisholm-Burns MA, Kim Lee J, Spivey CA, et al. US pharmacists' effect as team members on patient care: systematic review and meta-analyses. *Med Care.* 2010; 48:923-33).

Autonomous prescribing allows pharmacists to be fully optimized as a part of the

interprofessional healthcare team and ensures that their skills are used to the fullest potential to allow them to be responsible and accountable and fully execute CMM treatment plans. Pharmacist prescribing is implicit to interprofessional care delivery, but the form and manner of pharmacist prescribing varies among health systems and organizations. Independent and autonomous drug therapy decision-making by pharmacists is already common and accepted by other licensed practitioners (e.g., physicians, physician assistants, and nurse practitioners). Practitioners participating in interprofessional teams that include pharmacists rely on the knowledge, demonstrated competency, and expertise of those pharmacists for CMM. Pharmacists in specialty practice areas such as anticoagulation management, solid organ transplant, and nutrition support have long functioned in roles in which autonomous prescribing authority has improved clinical outcomes in the management and monitoring of medication therapy. In settings such as the Indian Health Service and Veterans Health Administration systems, prescribing authority for pharmacists providing CMM services has been in place for over 40 years and has demonstrated positive clinical impact and increased patient access across the continuum of care.

Many health systems authorize pharmacists to manage drug therapy by enacting pharmacy and therapeutics committee policies that require use of medical staff protocols and physician oversight for pharmacist-initiated orders. While this model works effectively for specific scenarios (e.g., management of population-specific patients), it does not allow the pharmacist to fully function and fulfill the CMM needs of their patients. Depending on the patient, medication, and degree of trust with the pharmacist, physicians often delegate therapeutic decision-making and medication treatment planning to pharmacists, based on the trust relationship developed through the interprofessional team and shared experiences in successfully dealing with challenging clinical situations, rather than through formal collaborative practice agreements. Common examples of pharmacist prescribing include independently managing symptoms and adverse events in oncology patients, identifying and resolving drug-induced disease or problems, managing anticoagulant therapy for patients whose clinical status falls outside specified parameters, and responding to general directives to simply “fix the problem” when medication therapy is indicated. Further, there are settings of care and pharmacy practice models that allow for autonomous and accountable prescribing authority by pharmacist practitioners as core component of CMM, without the need for collaborative practice authority for specific patients or populations. Pharmacist autonomous prescribing authority should be the gold standard for practice, especially when appropriate credentialing and privileging is in place and there is a separation of duties to ensure that a prescribing pharmacist is not responsible for the processing and dispensing of that medication order.

Pharmacists who prescribe must be recognized by payers and receive equitable payment for performing these advanced practice services. All pharmacist prescribers on the interprofessional team must possess a National Provider Identifier to monitor the care provided as well as reimburse for services rendered. Credentialing and privileging of individual healthcare providers is essential for determining who is authorized to prescribe and should ensure the appropriate evaluation of the quality of care provided. The credentialing procedures used to establish pharmacists’ competency to prescribe must ensure that patients receive treatment from highly qualified caregivers. In addition to verifying appropriate education,

licensure, and certification, the process should include

- the same transparency and rigor applied to other prescribers,
- criteria used to measure patient care quality, and
- peer review by similar or higher-level peers (i.e., pharmacist prescribers or other licensed practitioners who are authorized to prescribe).

Healthcare organizations should use privileging methods that establish the scope of practice and clinical services that pharmacists are authorized to provide commensurate with their demonstrated competency within an area or areas of clinical expertise. The practice of credentialing and privileging should be consistent between hospitals health systems, accountable care organizations, and other organizations where the pharmacists function as a part of the interprofessional team. Finally, interdisciplinary health professional training programs should incorporate the concept of pharmacist prescribing in a standard way to ensure consistency amongst pharmacists practicing in similar practice settings and with similar levels of responsibilities.

Background

The Council examined this topic in response to a recommendation from the 2023 House of Delegates to consolidate and harmonize ASHP policies related to pharmacist prescribing authority. The Council consolidated ASHP policies 2251, Qualifications and Competencies Required to Prescribe Medications, and 2236, Pharmacist Prescribing in Interprofessional Patient Care, and updated them for readability and consistency as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To affirm that prescribing is a collaborative process that includes patient assessment, understanding of the patient's diagnoses, evaluation and selection of available treatment options, monitoring to achieve therapeutic outcomes, patient education, and adherence to safe and cost-effective prescribing practices; further, **[from policy 2251]**
>
> ~~To affirm that safe prescribing of medications, performed independently or collaboratively, requires competent professionals who complement each others' strengths at each step.~~ **[from policy 2251]**
>
> To recognize that pharmacists are highly trained medication experts on the interprofessional care team capable of making independent and autonomous evidence-based decisions on medication therapy management; further,
>
> To advocate that pharmacists have independent and autonomous authority to initiate, modify, and deprescribe all schedules and classes of medications; further,
>
> To advocate that healthcare delivery organizations establish credentialing and privileging processes for pharmacists that delineate scope of practice, support pharmacist prescribing, and ensure that pharmacists who prescribe are accountable, competent, and qualified to do so; further, **[from policy 2236]**

~~To advocate for comprehensive medication management that includes autonomous prescribing authority for pharmacists as part of optimal interprofessional care; further,~~ **[from policy 2236]**

To advocate that all pharmacists ~~on the interprofessional team~~ have a National Provider Identifier ~~(NPI); further,~~ that is recognized by payers. **[from policy 2236]**

~~To advocate that payers recognize pharmacist NPIs~~. **[from policy 2236]**

The Council drafted the new second clause ("To recognize that pharmacists are highly trained medication experts…") to emphasize that pharmacists have the skills to make decisions regarding medication therapy management, including prescribing. The Council drafted the new third clause ("To advocate that pharmacists have independent and autonomous authority…") to capture the intent of the clause struck from policy 2236 and to more clearly define the scope of pharmacists' prescribing authority.

4. Pharmacist's Role on Ethics Committees

To advocate that pharmacists should be included as members of, or identified as a resource to, hospital and health-system ethics committees; further,

To encourage pharmacists to actively seek ethics consultations or solicit input from their institution's ethics committee, as appropriate; further,

To encourage pharmacists serving on ethics committees to seek advanced training in healthcare ethics.

Note: This policy would supersede ASHP policy 1403.

Rationale

Many hospitals have a committee or other process by which they consider ethical decisions related to patient care. Many issues that face these committees involve medications, yet often pharmacists do not serve on the committee or are not directly involved in the decision-making process. The number of ethical issues involving medications is expected to increase, given many new and unique drug products coming into the market. These include patient access to high-cost medications, considerations during medication shortages, and other ethical considerations that surface as part of the formulary process. Pharmacist involvement would better inform these committees and consultations. To effectively contribute to decision-making on ethics, pharmacists will require advanced education on the subject.

Background

The Council reviewed ASHP policy 1403, Pharmacist's Role on Ethics Committees, as part of

sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To advocate that pharmacists should be included as members of, or identified as a resource to, hospital and health-system ethics committees; further,
>
> To encourage pharmacists to actively seek ethics consultations or solicit input from their institution's ethics committee, as appropriate; further,
>
> To encourage pharmacists serving on ethics committees to seek advanced training in healthcare ethics.

This policy was last reviewed in 2019 by the Council on Pharmacy Practice. The Council determined the policy needed to be revised to capture pharmacists serving as an expert or resource to ethics committees. Council members also indicated that ASHP needs to offer more education and resources in ethics and ethical decision-making. In particular, the Council felt more programming is needed related to ethical decisions specific to medication use, medication shortages, and high-cost medications.

5. Safe Handling and Administration of Hazardous Drugs

To advocate that pharmaceutical manufacturers eliminate surface contamination on packages and vials of hazardous drugs (HDs); further,

To inform pharmacists and other personnel of the potential presence of surface contamination on the packages and vials of HDs; further,

To advocate that all healthcare settings proactively conduct an interprofessional assessment of risk for exposure to HDs during handling and administration, including the use of closed-system transfer devices (CSTDs); further,

To advocate for pharmacist involvement in the development of policies, procedures, and operational assessments regarding administration of HDs, including when CSTDs cannot be used; further,

To advocate that the Food and Drug Administration require standardized labeling and package design for HDs that would alert handlers to the potential presence of surface contamination, including development of CSTD-compatible, ready-to-administer HD products; further,

To encourage healthcare organizations, wholesalers, and other trading partners in the drug supply chain to adhere to published standards and regulations.

Note: This policy would supersede ASHP policies 1615 and 1902.

Rationale

Hazardous drugs (HDs) present well-known risks to healthcare workers who handle them. Most HDs are administered orally or intravenously; however, other routes of administration are sometimes used, such as intrathecal, intraventricular, or intravesicular administration, or perfusion into a vessel or organ cavity. These procedures are becoming more common. Healthcare providers are required to use personal protective equipment and other protective devices, such as closed-system transfer devices (CSTDs), when the dosage form allows. The protective precautions required for administration through these routes is well described in United States Pharmacopeia (USP) General Chapter 800, the ASHP Guidelines on Handling Hazardous Drugs, the Oncology Nursing Society's Safe Handling of Hazardous Drugs, and other sources.

HDs are sometimes administered through other routes (e.g., Ommaya reservoirs, intraperitoneal infusion) for which protective precautions are not as well described or CSTD use is not possible. ASHP encourages all healthcare settings to conduct an interprofessional, proactive assessment of the risk of such procedures to assess the potential exposure risks for healthcare providers and identify mitigating measures. Given their depth of knowledge

regarding the handling of HDs, pharmacists should be involved in the development of policies, procedures, and operational assessments regarding administration of HDs in such circumstances. To reduce the risks to healthcare providers, ASHP encourages device and pharmaceutical manufacturers and the Food and Drug Administration (FDA) to deploy new production and processing standards to mitigate exposures, including labeling and package design that alerts handlers to the possibility of contamination. In addition, manufacturers and the FDA should develop CSTD-compatible, ready-to-administer HD drug products with the goal that CSTDs be utilized for all routes of administration of HD products as a best practice. However, when such use is not possible, an assessment of risk could identify gaps and ensure there are pharmacy-guided policies to address the handling, compounding, and administration for all healthcare staff coming into contact with HDs during administration via nontraditional routes. Such policies could also address any specialized training for staff in procedural areas, or the availability of a HD-specialized trained staff member to assist in the administration of the drug (e.g., a "chemo nurse").

The outer surfaces of vials of hazardous drugs have been shown to be contaminated with hazardous substances, and pharmacy and other personnel handling those vials may unknowingly be exposed. ASHP advocates that individuals involved in drug distribution, receiving, and inventory control adhere to safe handling guidelines, including ASHP guidelines and United States Pharmacopeia Chapter 800, to avoid undue exposure to hazardous substances but recognizes the limits of these best practices. Pharmaceutical manufacturers have a responsibility to provide vials that are devoid of surface contamination by ensuring adequate vial-cleaning procedures such as using decontamination equipment and protective sleeves during the manufacturing process.

Background

The Council reviewed ASHP policy 1902, Safe Administration of Hazardous Drugs, as part of sunset review, and voted to recommend consolidating it with ASHP policy 1615, Protecting Workers from Exposure to Hazardous Drugs, as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To advocate that pharmaceutical manufacturers eliminate surface contamination on packages and vials of hazardous drugs (HDs); further, **[from policy 1615]**
>
> To inform pharmacists and other personnel of the potential presence of surface contamination on the packages and vials of HDs ~~hazardous drugs~~; further, **[from policy 1615]**
>
> To advocate that all healthcare settings proactively conduct an interprofessional assessment of risk for exposure to ~~hazardous drugs (~~HDs~~)~~ during handling and administration, including the use of ~~when~~ closed-system transfer devices (CSTDs)~~ cannot be used~~; further, **[from policy 1902]**
>
> To advocate for pharmacist involvement in the development of policies, procedures, and operational assessments regarding administration of HDs, including when CSTDs

cannot be used; further, **[from policy 1902]**

To advocate that the Food and Drug Administration require standardized labeling and package design for HDs ~~hazardous drugs~~ that would alert handlers to the potential presence of surface contamination~~; further~~, **[from policy 1615]**

~~To encourage device and pharmaceutical manufacturers and the Food and Drug Administration to foster~~ including development of CSTD-compatible, ready-to-administer HD products; further, **[from policy 1902]**

To encourage healthcare organizations, wholesalers, and other trading partners in the drug supply chain to adhere to published standards and regulations~~, such as ASHP guidelines and United States Pharmacopeia Chapter 800, to protect workers from undue exposure to hazardous drugs~~. **[from policy 1902]**

COUNCIL ON PUBLIC POLICY
POLICY RECOMMENDATION

The Council on Public Policy is concerned with ASHP professional policies related to laws and regulations that have a bearing on pharmacy practice. Within the Council's purview are (1) federal laws and regulations, (2) state laws and regulations, (3) analysis of public policy proposals that are designed to address important health issues, (4) professional liability as defined by the courts, and (5) related matters.

Sam Calabrese, *Board Liaison*

1. Order Verification

To advocate that a prescriber should not be solely responsible for medication ordering, dispensing, and administration as well as any patient monitoring and evaluation, except when a double check would limit patient access to care.

Rationale

As pharmacy practice has evolved to include more direct patient care services, oversight of these services has not kept pace. This trend was exacerbated by the COVID-19 pandemic, which ushered in new test-to-treat models for pharmacy teams and introduced new flexibilities into telehealth. As care has shifted, pharmacists may be placed in situations in which they are overseeing many aspects of medication use, from independent prescribing to dispensing, without any additional verification checks. Other clinicians, including physicians and nurse practitioners, may also be in similar positions. Regardless of setting, without adequate patient safety safeguards (e.g., high-reliability process, technology and/or human review), placing one clinician in charge of the elements of medication-use process related to ordering, dispensing and administration, as well as any patient evaluation and monitoring, increases the risk for errors and adverse outcomes. While human checks are preferable for high-risk drugs, nothing in this policy should be considered to oppose appropriate autoverification of orders.

Background

The Council discussed how independent prescribing authority has shifted pharmacy practice, resulting in situations in which a single pharmacist is responsible for all patient-focused elements of the medication-use process (e.g., ordering, administration, dispensing, and evaluation and/or monitoring). The Council noted that this is also the case for physicians and certain nonphysician practitioners, but agreed that regardless of clinician type, checks are needed to ensure patient safety. The Council reviewed both ASHP policies 2133, Optimal Pharmacy Staffing Levels, and 2246, Autoverification of Medication Orders, and concluded that this issue merited its own policy rather than inclusion in an existing policy.

The Council discussed the Board's recommended edits to the policy, but felt that they did not fully capture the Council's intent. Specifically, the Council reiterated its concerns that no clinician, including pharmacists, should be placed in a position in which they maintain responsibility for the entire medication-use process without any checks. The Council agreed that checks could be provided by technology and should not be the basis for limiting patient access to treatment when such checks were unavailable (particularly in rural and/or underserved areas). The Council reworked the original policy language to incorporate the last portion of the Board's revisions and suggested some edits to the rationale, as indicated above. The Council felt strongly that this policy would not impede uptake of test-to-treat models, given that the language is inclusive of all providers and makes allowances for situations in which additional checks are not feasible.

COUNCIL ON PUBLIC POLICY
POLICY RECOMMENDATIONS

The Council on Public Policy is concerned with ASHP professional policies related to laws and regulations that have a bearing on pharmacy practice. Within the Council's purview are (1) federal laws and regulations, (2) state laws and regulations, (3) analysis of public policy proposals that are designed to address important health issues, (4) professional liability as defined by the courts, and (5) related matters.

Vivian Bradley Johnson, *Board Liaison*

2. Liability Protection

To advocate that pharmacists be able to provide evidence-based dispensing and care to patients without fear of criminal or civil legal consequences, harassment, or liability; further,

To advocate that protection against liability extend to referrals for out-of-state care and for dispensing to patients from another state.

Rationale

In some states, pharmacists face potential civil or criminal liability for providing certain evidence-based patient care, including services related to reproductive health, gender-affirming care, and prevention and post-prophylaxis for HIV. Subjecting pharmacists to such liability for providing evidence-based patient care not only inappropriately infringes on the practice of pharmacy, it increases risks to patients. Given the chilling effect of the laws impeding evidence-based patient care services, patient access to services may be reduced or eliminated. Treatment delays, particularly for time-sensitive care related to reproductive health and provision of post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP), adversely impact patient care and outcomes and may result in patient or fetal mortality. Further, fear of prosecution could unduly limit not only the number of pharmacists willing or able to provide

these services, but also significantly hinder training and specialization in these areas in the next generation of clinicians, damaging our nation's clinical pipeline.

Background

The Council reviewed ASHP policy 2250, Access to Reproductive Health Services, to ensure that no changes were needed to address state law shifts following the Dobbs decision. The Council felt that no changes to policy 2250 were needed, but voiced concern about the growing threat of prosecution or civil liability for pharmacists providing evidence-based reproductive health, gender-affirming care, and PEP and PrEP. The Council felt that ASHP should provide education and analysis of new state laws to avoid chilling effects related to fear of prosecution or liability. Further, the Council recommended some edits to the rationale of policy 2250 to note the need for education related to potential areas of liability (e.g., reproductive health, PEP and PrEP, and gender-affirming care).

3. State Prescription Drug Monitoring Programs

To support continued state implementation of prescription drug monitoring programs that collect real-time, relevant, and standard information from all dispensing outpatient entities about controlled substances and monitored prescriptions; further,

To advocate that such programs seek adoption into health information exchanges to best integrate into electronic health records and to allow prescribers, pharmacists, and other practitioners to proactively monitor data for appropriate assessment and dispensing; further,

To advocate that such programs improve their interstate data integration to enhance clinical decision-making and end-user satisfaction; further,

To encourage policies that allow practicing pharmacists to gain access to databases without holding licensure in each state; further,

To promote research on the effects of prescription drug monitoring programs and electronic health record programs on opioid prescribing, dispensing, misuse, morbidity, and mortality.

Note: This policy would supersede ASHP policy 1408.

Rationale

ASHP recognizes the important contributions to public health made by state prescription drug monitoring programs (PDMPs). To be effective, these programs need to be mandatory; must

collect standardized, relevant, and real-time information for analysis and comparison among states; and need to be universal.

All states have implemented PDMPs, with the final state, Missouri, implementing its on January 20, 2023. While this is a great step forward, continued improvement of PDMP utilization is required. A recent review of PDMP reviews by Tay et al. in the Journal of Drug and Alcohol Dependence identified the following barriers still exist: PDMP system-related (i.e., usability, data quality), end-user related (i.e., satisfaction, workflow efficiency), and broader issues (i.e., electronic health record (EHR) integration, data sharing). More importantly, not all states mandate provider use of PDMP prior to controlled substance prescribing, and states that due mandate its use are slow to hold providers/pharmacists accountable for not using it. Due to these factors, it is difficult for practitioners to make relevant clinical decisions.

For states to see improvement in PDMP~~s~~ there needs to be improved data sharing between different jurisdictions, enhanced interoperability with EHRs and information exchanges, and increased evidence of PDMPs' impacts on patient outcomes to increase utilization. Finally, adequate state and federal funding is essential to sustain the viability of these programs and to encourage research, education, and implementation of best practices in PDMPs.

Background

The Council reviewed ASHP policy 1408, State Prescription Drug Monitoring Programs as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To ~~advocate for mandatory, uniform~~ support continued state implementation of prescription drug monitoring programs that collect real-time, relevant, and standard information from all dispensing outpatient entities about controlled substances and monitored prescriptions; further,
>
> ~~To advocate that the design of these programs should balance the need for appropriate therapeutic management with safeguards against fraud, misuse, abuse, and diversion; further,~~
>
> To advocate that such programs seek adoption into health information exchanges to best integrate into ~~be structured as part of~~ electronic health records and ~~exchanges~~ to allow prescribers, pharmacists, and other practitioners to proactively monitor data for appropriate assessment and dispensing; further,
>
> ~~To advocate for full interstate integration to allow for access by prescribers, pharmacists, and other qualified designees across state lines; further,~~
>
> ~~To advocate for federal and state funding to establish and administer these programs; further,~~

~~To promote research, education, and implementation of best practices in prescription drug monitoring programs.~~

To advocate that such programs improve their interstate data integration to enhance clinical decision-making and end-user satisfaction; further,

To encourage policies that allow practicing pharmacists to gain access to databases without holding licensure in each state; further,

To promote research on the effects of prescription drug monitoring programs and electronic health record programs on opioid prescribing, dispensing, misuse, morbidity, and mortality.

The Council updated the wording of the policy to reflect the fact that all states have now adopted PDMPs. It also updated language around integration of PDMP usage into EHRs and information exchanges to better reflect current technology and usage.

COUNCIL ON THERAPEUTICS
POLICY RECOMMENDATIONS

The Council on Therapeutics is concerned with ASHP professional policies related to medication therapy. Within the Council's purview are (1) the benefits and risks of drug products, (2) evidence-based use of medicines, (3) the application of drug information in practice, and (4) related matters.

1. Testing for Pregnancy Status

To affirm that pregnancy testing should occur only with informed consent and only when the test results would change medical management; further,

To affirm that a positive pregnancy test should not compromise the integrity of evidence-based, patient-centered care.

Rationale

Screening and testing for the pregnancy status of patients prior to admission to a hospital or surgical center or before initiation of a teratogenic drug therapy has long been a routine practice, as the pregnancy status of a patient has many ethical and legal considerations when medical management is considered for patient care. Chief pharmacy officers often oversee laboratory medicine departments, and pharmacists are often involved in creating protocols and order sets in which pregnancy testing and screenings are embedded and as a result are key stakeholders.

It is important to note that this policy pertains to testing without informed consent when therapy may need to be changed due to a positive test. The balance between unnecessary testing and testing when initiating a medication therapy is supported by a 2015 study that found that pregnancy assessment was underutilized in the emergency department when patients were prescribed a pregnancy category D or X drug. This policy does not advocate

that healthcare professionals should not include pregnancy screening as a part of a patient history, only that pregnancy testing should occur only with informed consent and not be a requirement for care. The incidence of unknown pregnancy in adult women presenting to a hospital for surgical procedures varies from 0.125 to 1.2%, depending on the procedure.

This policy also aligns ASHP with the American Society of Anesthesiologists statement that recommends "pregnancy testing may be offered to female sex patients of childbearing age and for whom the result would alter the patient's management, but testing should not be mandatory. Informed consent or assent of the risks, benefits, and alternatives related to preoperative pregnancy testing should ideally be obtained. Best practice may employ shared decision-making between patients and providers."

Background

The Council reviewed and discussed ASHP policy positions 2315, Responsible Medication-Related Clinical Testing and Monitoring; 0013, Patient's Right to Choose; and 2320, Pharmacoequity, in their discussion about this topic, and concluded that a standalone policy is needed.

2. 5-HT_2 Agonist, Entactogen, and Empathogen (Psychedelic) Assisted Therapy

To recognize that psychedelic-assisted therapy (PAT) has demonstrated therapeutic potential and should be further researched; further,

To recognize that in PAT there is not a standardized product subject to the same regulations as a prescription drug product, and to support the development of standardized formulations of psychedelics that would provide consistent potency and quality; further,

To encourage state boards of pharmacy, regulatory agencies, and safety bodies with an interest in PAT to promote research best practices and regulatory standards for medication preparation, compounding, and administration to ensure safety and quality; further,

To advocate that when psychedelics are used for PAT, healthcare providers, including pharmacists, should assess patients for medical, pharmacologic, and psychosocial contraindications prior to use and provide medical assistance as needed.

Rationale

There has been growing interest in the therapeutic potential of psychedelic drugs for use in the treatment of conditions such as depression, posttraumatic stress disorder, substance use disorders, and other conditions. The U.S. Food and Drug Administration (FDA) includes among these psychedelic drugs the "classic psychedelics," typically understood to be 5-HT_2 agonists

such as psilocybin and lysergic acid diethylamide (LSD), as well as entactogens or empathogens such as 3,4 methylenedioxymethamphetamine (MDMA). As a result of the growing interest, the FDA issued guidance that provides general considerations to sponsors developing psychedelic drugs for treatment of medical conditions.

Many studies report that psychedelic compounds are associated with few adverse events in trials, but the populations studied are not generalizable to the larger population. Psychological safety is a potential concern, and psychological distress is common, though not necessarily harmful in the long term. Increased blood pressure and heart rate due to the distress experienced during the administration session may put individuals with uncontrolled blood pressure or coronary artery disease at risk of ischemic events and may be considered a relative contraindication. Psychiatric illnesses, including schizophrenia, psychosis, and bipolar disorder, are considered a likely contraindication to psychedelic therapy. Drug-drug interactions of psilocybin, including tricyclic antidepressants, monoamine oxidase inhibitors, selective serotonin reuptake inhibitors, and QT interval-prolonging medications, are of concern and underscore the importance of pharmacists in the management of policies and practices related to the use of psychedelic compounds. Small sample sizes, a lack of diversity in enrollment, a lack of effective blinding, varied doses studied, and selective enrollment are just some of the critiques of trials assessing the use of psychedelic compounds. Psilocybin has been studied mainly in the treatment of psychological distress associated with life-threatening illnesses and major depressive disorder, while MDMA has been studied most extensively in the treatment of posttraumatic stress disorder. Despite promising results of some of the studies, the limitations of the studies prevent firm conclusions from being drawn.

In 2023, the American Medical Association also released new Current Procedural Terminology (CPT) III codes for Continuous In-Person Monitoring and Intervention During Psychedelic Medication Therapy. The code will provide a mechanism to track and report on the delivery of psychedelic treatments and will cover multiple psychedelic compounds with psychological support models, if approved, as well as various staffing structures, and numbers and credentials of qualified healthcare professionals.

Currently, psychedelic compounds with proposed therapeutic benefit, including psilocybin and MDMA, remain Schedule I substances, with no recognized therapeutic uses. Two states, Oregon and Colorado, have passed laws allowing the legal consumption of psychedelic compounds. Medical organizations have expressed concern about state efforts to circumvent federal laws through this approach, particularly when in the guise of medical treatment. In Oregon, for example, the administration of psychedelics is accompanied by assisted psychotherapy to maximize the possible therapeutic benefits. Prior to administration of the psychedelic compound, the individual will meet with a facilitator in a “preparation” session to review safety and support planning, transportation, and expectations for the administration of the psychedelic compound. The individual is then administered the dose under the supervision of the facilitator. Although these individuals are encouraged to share their past medical histories with the facilitator, it is not required, and the screening needed to ensure an appropriately selected client may fail to detect contraindications or significant drug-drug interactions. Furthermore, facilitators are required to have only a high school diploma and are not required to undergo medical training. This lack of training is of particular concern because individuals who are not trained medical professionals are likely unable to distinguish between

medical emergencies and the side effects of the psychedelic compounds.

ASHP policy also aligns with the American Psychiatric Association position that recognizes the emerging scientific evidence for using psychedelic drugs within the context of approved investigational studies and that "clinical treatments should be determined by scientific evidence in accordance with applicable regulatory standards and not by ballot initiatives or popular opinion."

It is important to recognize that mushrooms containing psilocybin have long been used for rituals and religious ceremonies around the world. As this use is falls within indigenous cultural and religious traditions and is not intended as a medical treatment, this policy does not address those uses.

Background

The Council reviewed the current evidence supporting the use of psychedelics along with the federal and state laws surrounding their use. Council members also discussed the trend of state law circumventing federal law for Schedule I substances and acknowledged that, despite promising results, the state approach to permitting use is concerning. The Council also recognized that although the ideal approach to PAT would be through controlled studies, PAT outside of investigational studies is already expanding, so the policy is written to reflect this reality and to encourage the presence of a medical professional at sites where PAT is provided. The Council also suggested that since more states are enacting legislation permitting the use of psychedelics, ASHP could provide resources on drug-drug interactions, toxicology, and education on PAT.

3. Nonprescription Status of Rescue and Reversal Medications

To support the over-the-counter (OTC) status of medications intended for evidence-based rescue use or reversal of potentially fatal events; further,

To work with federal, state, and local governments and others to improve the rescue and reversal medication development and supply system to ensure an adequate and equitably distributed supply of these medications; further,

To advocate that all insurers and manufacturers maintain coverage and limits on out-of-pocket expenditure so that patient access to rescue and reversal medications is not compromised; further,

To support and foster standardized education and training on the role of rescue and reversal medications and their proper administration, safe use, and appropriate follow-up care.

Rationale

As part of public health initiatives, certain medications used for rescue and reversal have

moved from prescription to over-the-counter (OTC) status. The opioid reversal agent naloxone is the most recent approval, with naloxone nasal spray approved in March of 2023 to help combat the opioid epidemic in the United States. Rescue and reversal medications such as naloxone and epinephrine require an additional level of action from patients and caregivers because they are used to initially treat life-threatening conditions, in contrast to other OTC agents. These patients will often require an additional level of care to monitor for safety and potential adverse events in the event of an opioid overdose or anaphylactic reaction. Therefore, it is important that rescue and reversal medications considered for OTC status have evidence that supports their use.

As barriers to access are removed, patient demand for these life-saving agents will almost certainly skyrocket, aligning with the intended purpose of such initiatives. To forestall the possibility of counterproductive market shortages, efforts to support and enhance manufacturing processes should be bolstered, with the U.S. Food and Drug Administration (FDA) likely being the most effective entity for these interventions. These interventions may include new drug application (NDA) provisions that require a certain threshold of product availability prior to OTC approval or a mandate that all manufacturers of an approved product transition their agent-specific supply chain to OTC distribution. Further, the FDA should optimize the NDA process itself, which may include a fast track for rescue and reversal medications, subsidies for all or part of the process, or standardized product labeling — which may serve the dual purpose of also supporting patient education initiatives — and other such measures.

Similarly, pricing for rescue and reversal medications should be minimized as much as possible, including efforts to eliminate patient cost entirely. OTC status often results in loss of third-party payer coverage, although there are notable exceptions to this trend (e.g., aspirin, vitamin D). The Affordable Care Act established a precedent for requiring insurer coverage of preventive drugs, and similar provisions could be made for rescue and reversal agents. Government efforts could include other related efforts, such as developing manufacturing cost subsidies, supporting tax-exempt status designations, and augmenting the wholesale distribution process and related infrastructure.

Finally, because the use of rescue and reversal medications often occurs in an emergency situation, easy-to-understand instructions on how to use these drugs and how to escalate if a person does not respond should be encouraged by all manufacturers. These instructions should be designed, tested, and validated in a similar design to the Drug Fact Label created by the FDA, which is designed to assess whether all the components of the product with which a user would interact could be used safely and effectively as intended.

Background

The Council discussed the approval of naloxone spray as an OTC agent and the potential for other rescue and reversal medications to become OTC. In light of the FDA announcement of naloxone's change to OTC status, the Council reviewed ASHP policy position 2211, Naloxone Availability, for potential updates and found that, even with the recent change to OTC status, the policy language is still relevant and did not require updating. When discussing other drugs, injectable epinephrine was the next drug that was considered. OTC inhaled epinephrine is OTC as the branded Primatene Mist HFA, which is indicated for treatment of mild to intermittent

asthma but is not a part of any treatment guideline. Its approval in 2018 was the cause of much concern in the medical community. Due to this experience, the Council expressed a desire to ensure that FDA approvals for rescue and reversal medication are evidence-based and guideline-driven, given the emergent nature of their use. Council members also noted that in Massachusetts there is a push to change albuterol to OTC, which reinforced the need for a clause that speaks to evidenced-based and guideline-driven approvals. The Council also discussed their concern of supply chain shortages, as occurred with prescription epinephrine in 2018, and therefore included language about ensuring that supply can keep up with demand for rescue and reversal medications.

COUNCIL ON EDUCATION AND WORKFORCE DEVELOPMENT POLICY RECOMMENDATIONS

The Council on Education and Workforce Development is concerned with ASHP professional policies, related to the quality and quantity of pharmacy practitioners. Within the Council's purview are (1) student education, (2) postgraduate education and training, (3) specialization, (4) assessment and maintenance of competence, (5) credentialing, (6) balance between workforce supply and demand, (7) development of technicians, and (8) related matters.

Kristi Gullickson, *Board Liaison*

Council Members
Joshua Blackwell, *Chair* (Texas)
Michelle Estevez, *Vice Chair* (Florida)
Aliyah Cruz (Wisconsin)
Stacy Dalpoas (North Carolina)
Sandeep Devabhakthuni (Maryland)
Johnnie Early II (Florida)
Glen Gard, *Pharmacy Technician* (Illinois)
Devon Hess, *Student* (North Carolina)
Tera Moore (Federal Service)
Vipul Patel (California)
Jennifer Robertson (Tennessee)
Kate Taucher (Colorado)
Ted Walton (Georgia)
Sophia Chhay, *Secretary*

1. Opposition to Pharmacy Jurisprudence Examination Requirement

To advocate the removal of a standalone examination of federal or state pharmacy law as a requirement for licensure; further,

To advocate that employers provide initial and ongoing education of the pharmacy workforce on pertinent federal and state pharmacy laws; further,

To acknowledge that it is a professional obligation of a pharmacist to practice in compliance with federal and state laws.

Rationale

National pharmacy associations have recently joined in advocacy for a more portable pharmacist license. Pharmacist interstate movement and practice are inhibited by the state-specific nature of the pharmacy jurisprudence examination. The pharmacist's licensing process includes one clinical knowledge exam (the NAPLEX), and in 48 states a jurisprudence exam is required, typically the Multistate Pharmacy Jurisprudence Examination (MPJE) — a 2.5-hour, adaptive, and proctored test. In contrast, physicians take three clinical knowledge exams, and only Texas, Oklahoma, Maine, and Oregon require a jurisprudence exam, which is taken online and is open-resource. Nurses are required to take one clinical knowledge exam (the NCLEX),

and only Texas and Kentucky require a jurisprudence exam, which is also online and open-resource. A 2017 working paper from the National Bureau of Economic Research found that pharmacists ranked among the lowest in terms of between-state migration, at -47%, compared to nurses (+5.5%) and physicians (+33%). While licensure in multiple states has always been almost a prerequisite for practitioners whose systems are in multi-state areas (e.g., VA, MD, DC), the advances in telehealth have made multistate licensure compulsory for many more pharmacists.

Accreditation Council for Pharmacy Education accreditation standards require pharmacy law as part of the curriculum, but student pharmacists may not practice in the state in which they receive their education, and employers should provide training on pertinent federal and state pharmacy laws. Even absent the state law exams, continuing education requirements and professional responsibility require pharmacists to know the laws in the state(s) in which they are licensed.

Background

The Council reviewed licensing requirements across states and professions, the relevance of continued law examination for pharmacists, and potential outcomes of eliminating the MPJE, and determined that ASHP needs a policy advocating the removal of a standalone examination of federal or state pharmacy law as a requirement for licensure. The Council felt eliminating this requirement would allow for greater flexibility regarding interstate movement and practice and align pharmacy with other healthcare professions.

2. Pharmacy Technician Education Requirements

To recognize that highly trained and skilled pharmacy technicians working in advanced roles regularly perform complex and critical medication-use procedures, and that a safe and effective medication-use process depends significantly on the skills, knowledge, and competency of those pharmacy technicians to perform those tasks; further,

To reaffirm that all pharmacy technicians should complete an ASHP-accredited training program, be certified by the Pharmacy Technician Certification Board, and be licensed by state boards of pharmacy; further,

To advocate that beyond those requirements, pharmacy technicians working in advanced roles should complete at a minimum an associate of science degree and demonstrate ongoing competencies specific to the tasks to be performed; further,

To advocate that expansion of pharmacy technician duties into expanded, advanced roles should include consideration of potential risk to patients and that ongoing quality assurance metrics should be established to assure patient safety.

Note: This policy would supersede ASHP policy 1203.

Rationale

Pharmacy technician roles have undergone a significant transformation within health systems throughout the years. In today's intricate healthcare landscape, these pharmacy technicians take on advanced responsibilities beyond their traditional duties. These extended roles include managing information systems, sterile product preparation, handling logistics, and implementing cutting-edge technology. According to the 2022 ASHP National Survey, more advanced pharmacy technician roles are emerging, including 340B Drug Pricing Program management, responsibility for USP chapter 797 (USP <797>) compliance, initiation of medication reconciliation, and supervision of other technicians. Pharmacy administrators have also reported a range of functions that health-system technicians perform, including sterile and nonsterile compounding, inventory management, purchasing, hazardous drug handling, controlled substance system management, medication order distribution, supervisory responsibilities, billing and reimbursement, and technician education and training. These advanced roles will require different skills and competencies, and pharmacy technicians should demonstrate competency before being allowed to perform such tasks, which will require additional, task-specific training.

The advancement of the pharmacy technician workforce includes credentialing, licensing, and on-the-job training. Moreover, engaging in formal education such as an associate of science degree equips pharmacy technicians with the necessary skill set to excel in these multifaceted roles, aids human resources departments in assigning an appropriate job code and pay grade, and elevates the pharmacy profession more broadly. Furthermore, other technical personnel in the healthcare sector (e.g., radiology technicians, respiratory therapist, laboratory technicians) are moving towards requiring a minimum of an associate degree and completion of an accredited training program, and aligning pharmacy technician requirements with other professions provides another pathway for enhanced remuneration. In addition, these measures would promote recruitment and retention of the pharmacy technician workforce within hospitals and health systems.

Background

The Council reviewed ASHP policy 1203, Qualifications of Pharmacy Technicians in Advanced Roles, as part of the discussion of pharmacy technician formal education requirements for health systems. The Council voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To recognize that highly trained and skilled pharmacy technicians working in advanced roles regularly perform complex and critical medication-use procedures, and that a safe and effective medication-use process depends significantly on the skills, knowledge, and competency of those pharmacy technicians to perform those tasks; further,
>
> To reaffirm that all pharmacy technicians should complete an ASHP-accredited training program, be certified by the Pharmacy Technician Certification Board, and be licensed by state boards of pharmacy; further,
>
> To advocate that beyond those requirements, pharmacy technicians working in

advanced roles should ~~have additional training~~ complete at a minimum an associate of science degree and ~~should~~ demonstrate ongoing competencies specific to the tasks to be performed; further,

To advocate that expansion of pharmacy technician duties into expanded, advanced roles should include consideration of potential risk to patients and that ongoing quality assurance metrics should be established to assure patient safety.

3. Implications of Artificial Intelligence for Professional Integrity

To encourage hospitals, health systems, and colleges of pharmacy to adopt policies regarding the appropriate use of artificial intelligence and ongoing surveillance of these tools.

Rationale

The rapid advancement of generative artificial intelligence (AI) technologies, such as ChatGPT, has introduced new possibilities and challenges across society, particularly in the realm of education. These technologies appear to offer innovative ways to assist learners, enhance educational experiences, and streamline administrative processes. However, the integration of AI tools raises concerns about academic integrity, plagiarism, and the potential for unethical use that could undermine the educational process. As such, hospitals, health systems, and colleges of pharmacy should adopt policies regarding the appropriate use of AI across the continuum of learning from didactic to experiential and within the clinical learning environment.

AI tools require extensive education and ongoing surveillance about their potential utility and limitations. Ethical and regulatory implications must be considered, as AI is increasingly incorporated into practice, education, and training. Furthermore, pharmacists must be prepared to engage in the development, validation, and implementation of AI to ensure such tools are being leveraged appropriately to support optimal patient care.

Background

At its Policy Week meeting, the Council reflected on the implications of ChatGPT and AI for academic integrity and guidance to student pharmacists, pharmacy residents, educators, and preceptors. The Council identified a need for ASHP policy on this issue.

4. Pharmacy Residency Training

To continue efforts to increase the number of ASHP-accredited pharmacy residency training programs and positions available; further,

To promote efforts to increase recruitment and retention of residents in ASHP-accredited pharmacy residency programs; further,

To encourage stakeholders to evaluate priority areas within pharmacy for future residency training needs.

Note: This policy would supersede ASHP policy 0917.

Rationale

ASHP is committed to achieving the goal that "pharmacists who provide direct patient care should have completed an ASHP-accredited residency or have attained comparable skills through practice experience" and advocates that "the completion of an ASHP-accredited postgraduate year one residency be required for all new college or school of pharmacy graduates who will be providing direct patient care." (ASHP policy position 2027) Furthermore, in the Practice Advancement Initiative (PAI) 2030, recommendation B4 states, "Health systems should require completion of ASHP-accredited residency training as a minimum credential for new pharmacist practitioners." There are opportunities to evaluate recruitment and retention of residents to increase the number who successfully complete residency training programs. In addition, key stakeholders (e.g., colleges of pharmacy, academic medical centers, healthcare organizations, and government agencies) should evaluate priority areas within pharmacy for future training needs, which may include health-system pharmacy administration and leadership, population health management and data analytics, pain and palliative care, medication-use safety and policy, pharmacy informatics, and others.

Background

The Council reviewed ASHP policy 0917, Pharmacy Residency Training, as part of the discussion of pharmacy residency trends. The Council voted to recommend amending it as follows (underscore indicates new text):

> To continue efforts to increase the number of ASHP-accredited pharmacy residency training programs and positions available; further,
>
> To promote efforts to increase recruitment and retention of residents in ASHP-accredited pharmacy residency programs; further,
>
> To encourage stakeholders to evaluate priority areas within pharmacy for future residency training needs.

COUNCIL ON PHARMACY MANAGEMENT POLICY RECOMMENDATIONS

The Council on Pharmacy Management is concerned with ASHP professional policies related to the leadership and management of pharmacy practice. Within the Council's purview are (1) development and deployment of resources, (2) fostering cost-effective use of medicines, (3) payment for services and products, (4) applications of technology in the medication-use process, (5) efficiency and safety of medication-use systems, (6) continuity of care, and (7) related matters.

Kim Benner, *Board Liaison*

Council Members
Christy Norman, *Chair* (Georgia)
Jennifer Miles, *Vice Chair* (Florida)
Thomas Achey (South Carolina)
Timmi Anne Boesken, *Pharmacy Technician* (Ohio)
Elissa Chung, *Student* (Washington)
Rox Gatia (Michigan)
Davey Legendre (Georgia)
Ryan Naseman (Kentucky)
Rebecca Ohrmund, *Pharmacy Technician* (Illinois)
Daniel O'Neil (West Virginia)
Joseph Pinto (New York)
Ellen Revak (Wisconsin)
Kate Schaafsma (Wisconsin)
Tara Vlasimsky (Colorado)
Jason Wong (Oregon)
Eric Maroyka, *Secretary*

1. Documentation of Patient-Care Services in the Permanent Health Record

To advocate for public policies that support documentation of patient-care services provided by the pharmacy workforce in the permanent patient health record; further,

To promote inclusion of the pharmacy workforce in organization-based credentialing and privileging processes and in collaboration with an organization's clinical informatics team to ensure accurate and complete documentation of the care provided to patients and to validate the impact of patient care provided by the pharmacy workforce on patient outcomes and cost of care; further,

To advocate that electronic health records be designed with a common documentation space to accommodate all healthcare team members and support the communication needs of pharmacy.

Note: This policy would supersede ASHP policy 1419.

Rationale

Documentation in the patient record is critical for a complete record for patient care and communication among members of the healthcare team. Documentation should be done within an electronic health record (EHR). Organization-based privileging is the process used by a healthcare organization, after evaluating a practitioner's credentials, to assure stakeholders that the healthcare professional has the competencies and experience to provide certain direct patient care services. Privileging grants that individual practitioner permission to deliver those patient care services and document the rendering of those services in the permanent health record. ASHP supports the use of use of post-licensure credentialing, privileging, and competency assessment, in a manner consistent with other healthcare professionals, to practice pharmacy as a direct patient-care practitioner (see ASHP policies 2011, Credentialing and Privileging by Regulators, Payers, and Providers of Collaborative Practice, and 1415, Credentialing, Privileging, and Competency Assessment). Pharmacy technicians, within their scope of practice, have documented activities (e.g., medication history documentation) in the record as part of team-based care documentation. When documenting electronically, use of standardized and coded formats allows for improved measurement of patient outcomes.

Background

The Council reviewed ASHP policy 1419, Documentation of Patient-Care Services in the Permanent Health Record, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To advocate for public ~~and organizational~~ policies that support ~~pharmacist~~ documentation of patient-care services provided by the pharmacy workforce in the permanent patient health record; further,
>
> To promote inclusion of the pharmacy workforce in organization-based credentialing and privileging processes and in collaboration with an organization's clinical informatics team to ensure accurate and complete documentation of the care provided to patients and to validate the impact of ~~pharmacist~~ patient care provided by the pharmacy workforce on patient outcomes and ~~total~~ cost of care; further,
>
> To advocate that electronic health records be designed with a common documentation space to accommodate all healthcare team members and support the communication needs of pharmacy.

The Council discussed the lengthy first clause in the existing policy and felt advocating for public policies seems reasonable but not so for organizational policies. Promoting incorporation in an organization-based credentialing and privileging process and in collaboration with an organization's clinical informatics team seem practical and actionable. There is some crossover with ASHP policy 2137, Documentation of Pharmacist Patient Care, but that policy focuses more on documentation, billing, and attribution for services rendered. There was some discussion

about a need for advocacy to support documentation of activities by pharmacy technicians within their scope of practice (e.g., medication history documentation) as part of team-based care documentation.

2. Safe Medication Sourcing, Preparation, and Administration in All Sites of Care

To advocate that all sites of care be required to meet the same regulatory standards for medication sourcing, preparation, and administration to ensure safety and quality.

Note: This policy would supersede ASHP policy 1914.

Rationale

Globally, health spending as a share of the overall economy has been steadily increasing since the 1980s, as spending growth has outpaced economic growth across all high-income countries, the United States included. This growth is multifactorial but is largely due to advances in medical technologies, including specialty medications; exponential and disparate price increases in the health sector across all markets; and higher demand for services, especially from a growing, aging population (Commonwealth Fund, Peterson-KFF). Based on data from 2021, the United States spent 18.3% of gross domestic product (GDP) on healthcare, nearly twice as much as the average country in the Organisation for Economic Co-operation and Development (Peterson-KFF, CMS). Over 2022-2031, average growth in national health expenditures (5.4%) is projected to outpace that of average GDP growth (4.6%), resulting in an increase in the health spending share of GDP, from 18.3% in 2021 to 19.6% in 2031 (CMS). This increasing cost of healthcare in the United States has motivated stakeholders across the care paradigm to search for strategies to curtail costs. Over the last decade, payers have implemented strategies that fragment providers' comprehensive care management of the patient. These strategies include but are not limited to site-of-care (SOC) optimization, which shifts care away from hospitals, and payer-directed drug distribution models (see ASHP policy 2309, Payer-Directed Drug Distribution Models), which undermine hospitals' patient safety protections and jeopardize patient care. The payers' overarching goal is cost containment, while maintaining access to the prescribed therapy. Cost containment efforts have shifted beyond the traditional pharmacy point-of-sale management intended for self-administered medications under the pharmacy benefit, such as formulary tiering, prior authorization requirements, drug exclusions, and step therapy implementation. These newer payer strategies targeting provider-administered medications under the medical benefit present risks to patient care and safety. Patients are increasingly being required to receive care at lower-cost nonhospital SOCs, rather than at traditional venues, such as hospital outpatient infusion centers. Alternative or nonhospital SOCs include nonhospital-affiliated outpatient infusion centers, physician's offices, ambulatory infusion centers, or patients' homes. Payer-imposed SOC restrictions and policies

jeopardize the continuity of care for the patient by introducing incongruent providers and systems (see ASHP policy 2031, Continuity of Care in Insurance Payer Networks). These same policies also create additional logistical challenges for the patient to navigate and can impede timely access to care for patients who require additional special assistance or services, such as access to emergency staff in the event of an adverse reaction. Further, the level of infrastructure required to adequately address regulatory and accreditation requirements focused on quality and safety (e.g., United States Pharmacopeia Chapters 797 and 800, state board of pharmacy regulations, and the standards of accreditors such as The Joint Commission and Det Norske Veritas Healthcare) varies across SOCs, with hospitals carrying the greatest administrative burden and costs. As a result, health systems should collaborate with pharmacy leadership when exploring ways to optimize medication access and appropriate utilization in nonhospital SOCs.

Background

The Council reviewed ASHP policy 1914, Safe Medication Preparation, Compounding, and Administration in All Sites of Care, as part of sunset review and in response to recommendations made by an ASHP member advisory panel and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To advocate that all sites of care be required to meet the same regulatory standards for medication sourcing, preparation, ~~compounding,~~ and administration to ensure safety and quality.

The Council discussed opportunities to make the policy recommendation and associated rationale reflective of current practice, healthcare trends, and pharmacy opportunities to ensure optimal patient care. The Council proposed ASHP continue advocacy in opposition to specific payer strategies that restrict access points, interfere with shared provider-patient decision-making, and jeopardize patient care.

2024 Report of the ASHP Treasurer

Christene M. Jolowsky

The Treasurer has the responsibility to report annually on ASHP's financial condition to the membership. ASHP's fiscal year is from June 1 through May 31, coinciding with our policy development process and timetable. This report describes ASHP's actual financial performance for fiscal year FY2023, projected financial performance for FY2024, and an FY2025 budget status update.

Fiscal Year 2023 Ending May 31, 2023—Actual

ASHP's FY2023 financial statement audit for the year ending May 31, 2023, was performed by Aprio, LLP. The audit resulted in ASHP receiving the best opinion available, an unmodified opinion.

ASHP's core operations[1] experienced a strong post-COVID recovery. Core gross revenue was $58.8 million (Figure 1), up by $15.0 million compared to FY2022. The gross revenue increase was primarily attributable to the Midyear Clinical Meeting & Exhibition (MCM) being held in person versus a virtual meeting during FY2022. In addition, we held the Summer Meetings for the first time after a two-year hiatus due to COVID and had successes with membership, *American Journal of Health-System Pharmacy* (*AJHP*), special publishing, professional certificates, accreditation services, and the Health and Human Services Administration grant. Core net income was a surplus of $4.4 million. Net program development, capital budget, and investments[2] were a net loss of $1.9 million, which is attributable to short-term investment losses. In total, FY2023 resulted in a favorable $2.5 million net change in ASHP's reserves/net assets.

Finally, the building fund[3] had a loss of $4.9 million, primarily due to short-term investment losses. With significant positive returns in previous years, the building fund remains on track to continue supporting ASHP's office space expenses and reach its long-term financial target. ASHP's total net assets at the end of FY2023 were $134.6 million (Figure 2). Our year-end balance sheet remained strong, with an asset-to-liability ratio of 3.95:1. ASHP remains well-prepared for the future.

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[1]Represents the revenue and expense associated with the operations of ongoing ASHP programs, products, and services, as well as infrastructure and ASHP Foundation support.

[2]Includes investments in ASHP's program development and capital budget, building sale reserve funds, reserves/net assets spending, and investment gains/(losses). The Board of Directors approves spending during ASHP's annual budget development process. Expenditures are typically (1) associated with new, enhanced, and expanded programs; (2) associated with time-limited programs; (3) capital asset purchases; or (4) supplemental operating expenses. These expenditures are primarily funded by investment income from reserves/net assets and the building sale reserve funds.

[3]Created to hold the net gain from the sale of ASHP's previous headquarters building. The long-term investment earnings are used to pay for lease and other occupancy-related expenses associated with ASHP's current headquarters office.

Report of the ASHP Treasurer

Fiscal Year 2024 Ending May 31, 2024—Projected

Fiscal year 2024 core operations are shaping up to have another record year, with projected core gross revenue of $61.0 million. As of February 29, 2024, we anticipate that ASHP's FY2024 core net income will be in the range of $1.7 million (Figure 1). Assuming the financial markets remain steady for the remainder of the fiscal year, we are projecting a deficit of $443,000 for program development expenses, capital budget, and investments. This deficit is primarily due to ASHP's current year $1.5 million investment in a national public awareness campaign to educate the public about the roles of pharmacists and pharmacy personnel in hospitals, health systems, and clinics. This results in a projected positive net change in reserves/net assets of $1.3 million. Finally, we anticipate the building fund will have a surplus in the range of $17,000.

ASHP accomplished a great deal during FY2024, including maintaining a strong and active membership and launching The Pharmacy Technician Society (TPTS), a stand-alone 501(c)6 membership organization for pharmacy technicians. Initial interest and engagement with TPTS has been strong. The aforementioned national public awareness campaign launched to a strong positive reaction. We continue to build back our in-person meetings and remain at the forefront of pharmacy training and education.

ASHP's engaged and growing membership is a testament to our efforts to help pharmacy practitioners address today's most pressing challenges and prepare for dynamic changes ahead. As the largest and most influential professional pharmacy organization in the United States, ASHP remains dedicated to addressing the individualized and evolving needs of our members in every practice setting and at every step of their careers.

Fiscal Year 2025 Ending May 31, 2025—Budget

ASHP's Board of Directors has thoughtfully considered our FY2025 budget. There are many positive signs for the future.

We look forward to continuing to grow our MCM and Pharmacy Futures meeting (formerly the Summer Meetings), expanding our membership, and achieving many successes as we invest in and nurture our publications, professional development, accreditation, and other programs. As our workforce evolves and changes, the Board of Directors continues to position ASHP for the future to ensure we can support our members and the profession with timely and valuable resources, products, and services.

Considering these and other factors, ASHP's FY2025 budgeted net change in reserves/net assets is a deficit of $559,000, with $60.4 million in core gross revenue. The deficit is primarily attributable to ASHP's continued investment in the national public awareness campaign. The building fund, which is designed to pay for ASHP's headquarters office space, is budgeted to have a $323,000 surplus.

Conclusion

As ASHP works to support our members, the profession, and the patients we serve through this transformative era, we have experienced sustained financial stability and membership growth. ASHP proudly represents the diversity and vibrancy of the pharmacy profession. Effective financial stewardship, innovative thinking, and a collaborative spirit ensure that we have a strong pipeline of products, programs, and services to enhance practice, foster career

development, and most importantly, positively impact safe and effective medication use and improved patient outcomes. The Board of Directors, Chief Executive Officer, and staff are wholly dedicated to ASHP's mission, vision, and strategic plan and supporting our members. We look forward to another successful year, and I am proud to serve this organization as your Treasurer!

Figure 1. ASHP Condensed Statement of Activities (in thousands)

	Actual Fiscal Year 2022 Ended May 31, 2022	Actual Fiscal Year 2023 Ended May 31, 2023	Projection* Fiscal Year 2024 Ended May 31, 2024	Budget Fiscal Year 2025 Ended May 31, 2025
CORE OPERATIONS				
Gross Revenue	43,848	58,775	61,015	60,370
Total Expense	(47,996)	(54,384)	(59,295)	(60,367)
CORE NET INCOME/(LOSS)	(4,148)	4,391	1,720	3
NET PROGRAM DEVELOPMENT EXPENSES, CAPITAL BUDGET, AND INVESTMENTS GAIN/(LOSS)	(4,227)	(1,929)	(443)	(562)
NET CHANGE IN RESERVES/NET ASSETS	(8,375)	2,462	1,277	(559)
BUILDING FUND	(8,671)	(4,867)	17	323

*Projection as of February 29, 2024

Figure 2. ASHP Statement of Financial Position (in thousands)

	Actual as of May 31, 2022	Actual as of May 31, 2023
ASSETS		
Current assets	12,496	22,204
Fixed assets	4,644	3,851
Investments	150,601	141,424
Other assets	478	12,850
Total Assets	168,219	180,329
LIABILITIES		
Current liabilities	22,615	27,783
Long-term liabilities	8,556	17,903
Total Liabilities	31,171	45,686
RESERVES/NET ASSETS		
Total Net Assets	137,048	134,643
Total Liabilities and Net Assets	168,219	180,329

House of Delegates

2024 ASHP HOUSE OF DELEGATES MEETINGS AT A GLANCE

Oregon Convention Center
Portland, Oregon

- **House of Delegates Registration**
  Saturday, June 8, 7:00 a.m. – 11:00 a.m. (Satellite, Hyatt Lobby) — **Deschutes Ballroom**
  Saturday, June 8, 9:00 a.m. – 5:45 p.m. (Convention Center) — **Pre-Function C, Level 1**
  Sunday, June 9, 7:00 a.m. – 11:00 a.m. (Convention Center) — **Pre-Function C, Level 1**
  (After then, delegates may register in the Executive Office, Room A104, Level 1)

- **Open Forum for Members** — **Room C123**
  Saturday, June 8, 2:30 – 4:30 p.m. — Level 1

- **Delegate Primer on HOD Processes** — **Room B114**
  (For all delegates and alternate delegates) — Level 1
  Saturday, June 8, 4:30 – 5:30 p.m.

- **First Delegate Caucus** — **Room C123**
  Sunday, June 9, 9:30 – 11:30 a.m. — Level 1

- **Second Delegate Caucus** — **Room C123**
  Tuesday, June 11, 12:15 – 2:00 p.m. — Level 1

- **Other Caucuses** — **Room C121**
  Small and Rural Hospital Caucus, Sunday, June 9, 7:30 – 8:30 a.m. — Level 1
  Federal Pharmacist Caucus, Sunday, June 9, 8:30 – 9:30 a.m.

- **First House of Delegates Meeting** — **Exhibit Hall A**
  Sunday, June 9, 1:00 – 5:00 p.m. — Level 1

- **Meet the Candidates** — **Room C123**
  Monday, June 10, 12:15 – 1:45 p.m. — Level 1

- **Delegate Reception** — **Regency Ballroom B**
  Monday, June 10, 5:30 – 6:30 p.m. — Level 2
  Hyatt Regency

- **Second House of Delegates Meeting** — **Exhibit Hall A**
  Tuesday, June 11, 4:00 – 6:00 p.m. — Level 1

House of Delegates

AGENDA

First Delegate Caucus

June 9, 2024
9:30 – 11:30 a.m.
Oregon Convention Center, Room C123

The First Delegate Caucus has two purposes:

1) To review the agenda for the first meeting of the House of Delegates and answer questions delegates have about the agenda.
2) To facilitate the work of delegates who wish to amend policy recommendations.

1. Review of First Meeting Agenda

1. Call to Order
2. Roll Call of Delegates
3. Report on Previous Session
4. Ratification of Previous Actions
5. Report of Committee on Nominations
6. Report of Committee on Resolutions
7. Statements of Candidates, House of Delegate Chair
8. Board of Directors Reports:
   A. Council on Pharmacy Practice
   B. Council on Public Policy
   C. Council on Therapeutics
   D. Council on Education and Workforce Development
   E. Council on Pharmacy Management
9. Report of the Treasurer
10. Recommendations of Delegates
11. Announcements
12. Adjournment of First Meeting

2. Amendments to Policy Recommendations

House of Delegates

AGENDA

Second Delegate Caucus

June 11, 2024
12:15 – 2:00 p.m.
Oregon Convention Center, Room C123

The Second Delegate Caucus has four purposes:

1) To review the agenda for the second meeting of the House of Delegates and answer any questions delegates have about the agenda.
2) To review the Report of the Committee on Resolutions and provide an opportunity for delegate discussion of the resolution and the Committee's recommendation.
3) To present the Board's actions on policy recommendations amended by the House ("unfinished business").
4) To present new business items coming before the House.

1. Review of Agenda

1. Call to Order
2. Quorum Call
3. Election of the Chair of the House of Delegates
4. Report of the Committee on Resolutions
5. Unfinished and New Business
6. Report of the President and the CEO
7. Recommendations of Delegates
8. Installation of Officers and Directors
9. Announcements
10. Adjournment of Second Meeting

2. Report of the Committee on Resolutions

3. Unfinished Business

4. New Business

House of Delegates

AGENDA

House of Delegates Open Forum

June 8, 2024
2:30 – 4:30 p.m.
Oregon Convention Center, Room C123
Presiding – Melanie A. Dodd
Chair, House of Delegates

The House of Delegates Open Forum has three purposes:

1) To present the proposed policies and reports that will be acted upon by the House to all interested meeting participants, and to give them an opportunity to share their views;
2) To provide a forum for all interested meeting participants to discuss other issues that influence the practice of pharmacy in hospitals and health systems, including those that might merit consideration by the House and ASHP; and
3) To install the elected members of the ASHP section executive committees and recognize outgoing forum executive committee members.

I. Installation of Section Executive Committee Members and Recognition of Outgoing Forum Executive Committee Members

II. Discussion of Treasurer's Report

III. Discussion of Policy Recommendations before the House – House of Delegates Chair will open the floor for questions about their respective reports and recommendations:
- Council on Pharmacy Practice
- Council on Public Policy
- Council on Therapeutics
- Council on Education and Workforce Development
- Council on Pharmacy Management

IV. Open discussion of other issues of interest to Open Forum participants, with emphasis on (a) new business items being contemplated by delegates, and (b) items that merit future exploration for policy development and programmatic areas that should be considered by ASHP.

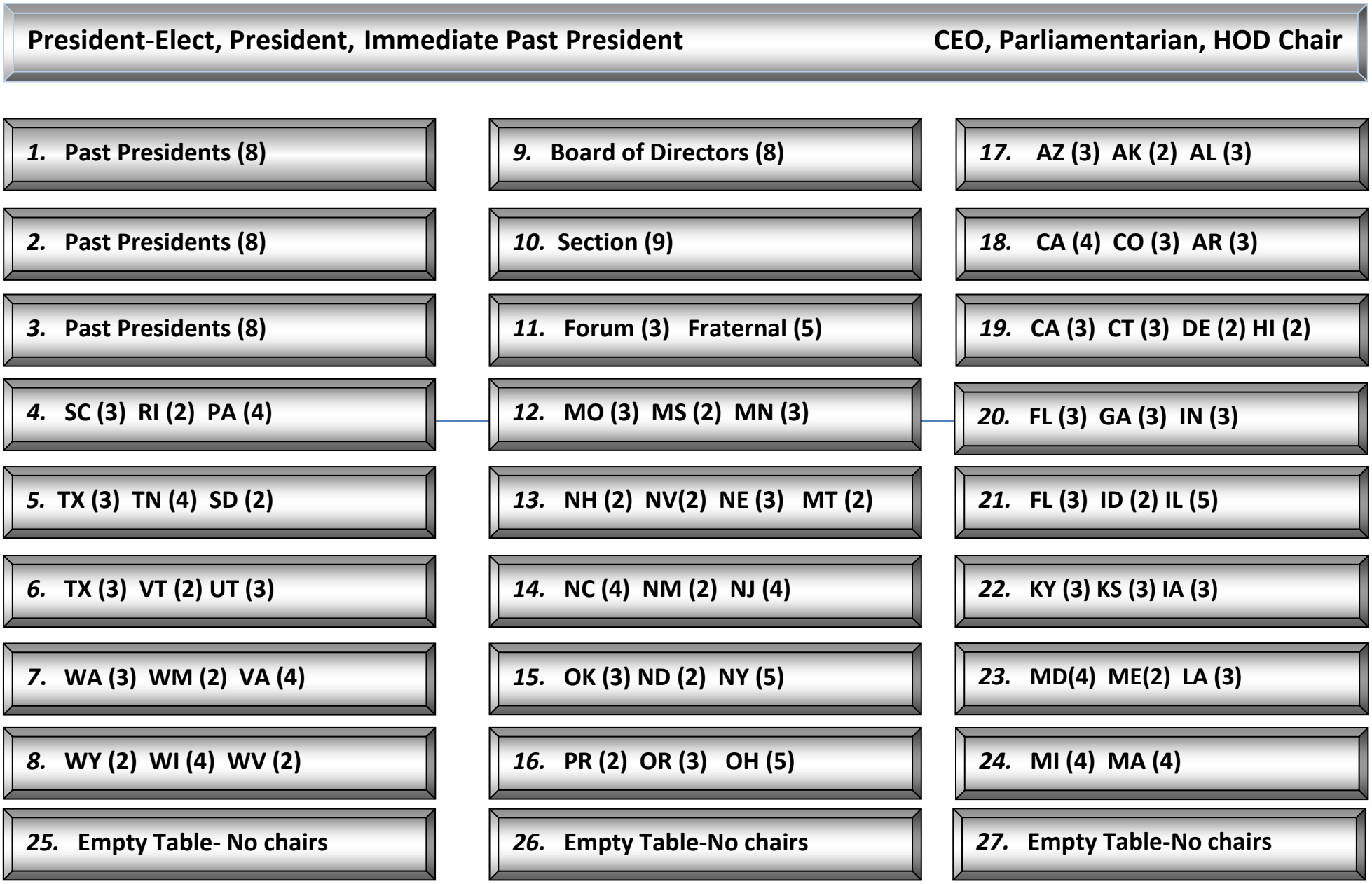
House of Delegates
June 9 and 11, 2024

Antitrust Statement

ASHP has a policy of strict compliance with federal and state antitrust laws. ASHP policymakers, including delegates to the House of Delegates, need to be aware of the possible antitrust exposure that may arise when representatives of competing entities with market power meet to discuss the types of issues on House of Delegates agendas. Although your service in the ASHP House of Delegates has as its express purpose carrying on discussions for the purpose of optimizing therapeutic outcomes and patient care, and is a voluntary venture, not undertaken on behalf of your respective employers or businesses, your activities may be interpreted as actions by competitors. It is important that delegates understand that they cannot come to understandings or agreements on activities or positions that might:

1) raise, lower or affect prices, reimbursement levels, discounts, fees, wages, and/or other terms and conditions for doing business;
2) allocate or divide markets or territories;
3) indicate a refusal to deal with particular customers, companies, or third-party payors; or
4) affect supply and demand of products and/or services.

It is acceptable to discuss pricing models, methods, systems, and other forms of voluntary consensus standards or guidelines based on objective evidence that do not lead to an agreement on restraining prices, wages, or related matters. Information may be presented with regard to historical pricing activities so long as such information is general in nature and does not include specific data on current prices or wages in a particular trade area. Any discussion by delegates to the ASHP House of Delegates of current or future pricing, wages, fees, or other terms and conditions, which may lead to an agreement or consensus on prices, wages, or fees, is strictly prohibited. A violation of the antitrust laws may be inferred from discussions about pricing or wages followed by parallel decisions by group members, even in the absence of an oral or written agreement.



2024 ASHP House of Delegates Seating Chart Final

Parliamentary Terms and Procedures Often Used in the ASHP House of Delegates (HOD)

To:	You say:	2nd needed	Vote needed	Examples
Be recognized on floor of HOD	"Madam Chair, my name is ___; I am a delegate for ___; and I rise to ___."	N/A	N/A	Delegates and others speaking at HOD must be recognized by Chair before speaking; this is done by approaching microphone to get Chair's attention. Note: No delegate may speak more than twice to same question on the same day, and no delegate may make second speech on same question on same day until every member who desires to speak on it has had opportunity to do so once.
Introduce main motion (proposal)	"I move that…" or "I move to…"	Yes	Majority	Main motion is only motion whose introduction brings business before HOD.
Separate policy from main motion	"I'd like to separate Policy ___ for the purpose of ___."	No	No	To separate item (e.g., policy recommendation) from rest for separate consideration or action (typically used so that amendments to policy recommendation may be offered).
Amend motion	"I move to amend by…"	Yes	Majority	To amend policy recommendations, resolutions, or new business. Notes: 1) You may amend by: (a) inserting word(s) or paragraph; (b) striking word(s) or paragraph; (c) striking word(s) and inserting word(s); or (d) substitute by striking out entire paragraph, section, or article—or complete main motion or resolution—and inserting different paragraph or other unit in its place. 2) Only two proposed amendments may be pending at one time (i.e., amendment to main motion [primary amendment] and amendment to that amendment [secondary amendment]). 3) After motion (e.g., policy recommendation) is amended, it still must be adopted, as amended.
Refer [to Board]	"I move to refer…"	Yes	Majority	To refer an item to the Board of Directors for further consideration.
End debate	"I move the previous question."	Yes	2/3	To have HOD end debate and vote on pending motion(s).
Call upon Chair to enforce rules	"Point of order"	No	Chair rules	Raised when delegate thinks that rules of HOD (i.e., ASHP Bylaws, ASHP Rules of Procedure for HOD, or *Robert's Rules of Order Newly Revised*) are being violated, thereby calling upon Chair to rule and enforce regular rules.
Request information	"Request for information"	No	No	Request directed to Chair, or through Chair to another officer or delegate, for information relevant to business at hand but not related to parliamentary procedure.
Reconsider	"I move to reconsider the vote on…"	Yes	2/3	To bring back for further consideration HOD-amended policy on which vote has already been taken.
Limit or extend limits of debate	"I move to limit discussion to two minutes per speaker."	Yes	2/3	Can limit debate by: 1) reducing number or length of speeches permitted; or 2) requiring that, at certain later hour or after debate for specified length of time, debate shall be closed. It can extend limits of debate by allowing more and longer speeches than under regular rules.