



# House of Delegates Session—2021

June 5 and 7, 2021

Online Meetings

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Proceedings of the 73rd annual session  
of the ASHP House of Delegates,  
June 5 and 7, 2021

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**Paul W. Abramowitz, Secretary**

The 73rd annual session of the ASHP House of Delegates was held online due to the cancellation of the 2021 ASHP Summer Meetings in response to the COVID-19 pandemic.

### **First meeting**

The first meeting was convened at 1:00 p.m. Sunday, June 5, by Chair of the House of Delegates Casey H. White. Chair White welcomed delegates and then provided the delegates with an overview of the process used as the House conducts its business through a virtual platform for the second year.

Chair White then described the purposes and functions of the House. He emphasized that the House has considerable responsibility for establishing policy related to ASHP professional pursuits and pharmacy practice in hospitals and health systems. He reviewed the general procedures and processes of the House of Delegates.

The roll of official delegates was called during the online sign-in process. A quorum was present, including 188 delegates representing 50 states, the District of Columbia, and Puerto Rico, 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 White reminded delegates that the report of the 72nd 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 72nd House of Delegates session were received without objection.

### **Report of the Committee on Nominations.**

Chair White directed the delegates' attention to the report of the Committee on Nominations (Appendix II).<sup>a</sup> Nominees in the report were as follows:

#### *President 2022-2023*

**Paul C. Walker, Pharm.D., FASHP**, Clinical Professor and Assistant Dean Experiential Education and Community Engagement, The University of Michigan College of Pharmacy, Ann Arbor, MI

**Stephen F. Eckel, Pharm.D., M.H.A.**, Associate Dean for Global Engagement, UNC Eshelman School of Pharmacy, Chapel Hill, NC

#### *Board of Directors, 2022-2025*

**Samuel V. Calabrese, B.S.Pharm., M.B.A., FASHP**, Executive Chief Pharmacy Officer, Cleveland Clinic, Cleveland, OH

**Roy Guharoy, Pharm.D., M.B.A., FASHP, FCCP, FCP**, Clinical Professor of Medicine, University of Massachusetts Medical School, Worcester, MA

**Vivian Bradley Johnson, Pharm.D., B.S., R.Ph., M.B.A., FASHP**, Senior Vice President of Clinical Services, Parkland Health and Hospital System, Dallas, TX

**Lanita S. White, Pharm.D.**, Assistant Dean for Student Affairs and Associate Professor, University of Arkansas for Medical Sciences, College of Pharmacy, Little Rock, AR

*Chair of the House of Delegates, 2022-2024*

**Melanie A. Dodd, Pharm.D., Ph.C., BCPS, FASHP**, Associate Dean for Clinical Affairs and Associate Professor, Department of Pharmacy Practice and Administrative Sciences, University of New Mexico College of Pharmacy, Albuquerque, NM

**Jodi L. Taylor, Pharm.D., BCCCP, BCPS, FASHP**, Professor and Chair of Pharmacy Practice, Union University College of Pharmacy; and Critical Care Specialist, Jackson-Madison County General Hospital, Jackson, TN

Chair White announced that a virtual “Meet the Candidates” session will be recorded and made available to members via podcasts on the ASHP website.

**Policy committee reports.** Chair White outlined the process used to generate policy committee reports (Appendix III). He announced that Board Liaisons would introduce the recommended policies from each council consecutively. He further advised the House that any delegate could raise questions and request discussion by asking to be recognized.

Chair White 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; the double underlined type indicates material added during the Board’s due consideration and the double strikethrough marks indicate material deleted by the Board.)*

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Paul Walker, Board Liaison to the **Council on Therapeutics**, presented the Council’s Policy Recommendations 1 through 8.

### **1. Universal Influenza Vaccination**

To advocate for universal annual administration of influenza vaccinations to the United States population; further,

To advocate that annual influenza vaccination be a national public health priority; further,

To support the development of safe, effective, and affordable universal influenza vaccination, with the goal of long-term immunity.

*Note: This policy would supersede ASHP policy 0601.*

### **\*2. Vaccine Confidence**

To recognize the ~~significant negative impact vaccine hesitancy has on~~ importance of vaccination to public health in the United States; further,

To affirm that ~~pharmacists~~ members of the pharmacy workforce are integral members of the interprofessional team to ~~address vaccine hesitancy and~~ promote disease prevention efforts and health equity through vaccine confidence and access; further,

To foster education, training, and the development of resources to assist healthcare professionals in building vaccine confidence ~~identifying factors that lead to vaccine hesitancy and addressing vaccine hesitancy;~~ further,

To promote ~~pharmacist~~ pharmacy workforce engagement with ~~vaccine-hesitant~~ patients, healthcare providers, and caregivers, and to educate ~~those populations~~ patients on the risks of vaccine hesitancy and the importance of timely vaccination.

### 3. Therapeutic Indication in Clinical Decision Support

To encourage healthcare organizations to optimize use of clinical decision support systems with indications-based prescribing; further,

To advocate to the Food and Drug Administration, the National Council for Prescription Drug Programs, and other organizations to select and implement a single standard coding system for labeled therapeutic indications that can be integrated throughout the medication-use process, enabling optimum clinical workflows and decision support functionality; further,

To advocate for federal and state laws and regulations to include diagnosis-based indication(s) on medication order(s) or prescription(s), ~~with the exception of protected classes of drugs; further,~~

To advocate for federal and state laws and regulations to allow withholding of indication on medication prescription labels when patient privacy risk outweighs benefit.

*Note: This policy would supersede ASHP policy 1608.*

### 4. Preventing Exposure to Allergens

To advocate for ~~pharmacist~~ pharmacy workforce participation in the collection, assessment, documentation, and reconciliation of a complete list of allergens and intolerances pertinent to medication therapy, including food, excipients, medications, devices, and supplies; further,

To promote the education of the healthcare team and patients on the differences between medication-related allergic reactions and medication intolerances; further, [MOVED FROM BELOW]

To encourage vendors of electronic health records to create readily available and distinct data fields with consistent designations for medication allergies and intolerances; further,

To advocate that vendors of medication-related databases incorporate and maintain information about medication-related allergens and cross-reactivity; further,

To encourage the accurate and complete documentation of allergens and intolerances within the electronic medical record, including detailed descriptions of the reactions occurring upon exposure, for the purpose of clinical decision-making; further,

To advocate that pharmacists actively review allergens and intolerances pertinent to medication therapy and minimize patient and healthcare worker exposure to known allergens, as feasible; ~~further,~~

~~To promote the education of the healthcare team and patients on the differences between medication-related allergic reactions and medication intolerances. [MOVED ABOVE]~~

*Note: This policy would supersede ASHP policy 1619.*

### 5. Tobacco, Tobacco Products, and Electronic Nicotine Delivery Systems

To discourage the use, of tobacco, tobacco products, and electronic nicotine delivery systems (e.g., vaporizers, vape pens, hookah pens, and electronic cigarettes and pipes) due to their long-term adverse health effects; further,

To oppose the distribution, and sale of tobacco, tobacco products, and electronic nicotine delivery systems (e.g., vaporizers, vape pens, hookah pens, and electronic cigarettes and pipes) in and by pharmacies or facilities that contain a pharmacy; further,

To advocate for tobacco-free environments in hospitals and health systems; further,

To promote legislation that supports pharmacist prescriptive authority for tobacco-cessation medications; further,

To promote the role of pharmacist's interprofessional interdisciplinary role in tobacco-cessation counseling and comprehensive medication ~~therapy~~ management; further,

To join with other interested organizations in statements and expressions of opposition to

the use of tobacco, tobacco products, and electronic nicotine delivery systems; further,

To educate the public and patients on the risks of nicotine consumption through traditional and electronic delivery systems.

*Note: This policy would supersede ASHP policy 1625.*

### 6. Use of Race Correction in Clinical Algorithms

To recognize that clinical algorithms that only use race or ethnicity as a variable can attribute to inequities and adverse outcomes; further,

To oppose the use of race or ethnicity correction in clinical algorithms unless there is strong evidence to support its use; further,

To advocate that health systems remove algorithms based on race or ethnicity from all sources of therapy decisions, medication information, and the electronic health record, where strong evidence does not support its use; further,

To support further research on the impact of race or ethnicity on drug therapy and outcomes; further,

To advocate that if research includes considerations based on race or ethnicity, the reason for its use as a variable be specified; further,

To provide education on the limitations and appropriate use of race- or ethnicity-corrected clinical algorithms; further,

To support uniform documentation in the electronic health record of a patient-identified designation of race or ethnicity.

**7. Testing and Documentation of Penicillin Allergy as a Component of Antimicrobial Stewardship**

To advocate that state board of pharmacy regulations include penicillin allergy skin testing under pharmacists’ scope of practice; further,

To advocate involvement of pharmacists in the clarification and assessment of penicillin allergy, intolerance, and adverse drug events; further,

To advocate for documentation and de-labeling of penicillin allergies, intolerances, reactions, and severities in the medical record when appropriate to facilitate optimal antimicrobial selection; further,

To recommend the use of penicillin skin testing, graded antibiotic challenges, and oral direct challenges in appropriate candidates when clinically indicated to optimize antimicrobial selection; further,

To support the education and training of pharmacists in the assessment, management, and documentation of penicillin allergies, intolerances, and adverse events; further,

To advocate for reimbursement for pharmacists’ patient care services involved in penicillin allergy skin testing; further,

To educate patients, healthcare providers, and the public about the risks of inaccurate penicillin allergy labeling and the role of pharmacists in health-record reconciliation and the value of pharmacist-driven health-record reconciliation, including penicillin skin testing.

*Note: This policy would supersede ASHP policy 1921.*

**8. Use of Unapproved Gene Therapy Products, Drugs, Biologics, and Medical Devices (Biohacking)**

To advocate for enhanced government oversight and regulation of use of gene therapy, drugs, biologic products, and medical devices created outside of the Food and Drug Administration approval process (i.e., “biohacking”), and aggressive enforcement of those regulations; further,

To oppose use of biohacking on vulnerable and at-risk populations and those unable to provide consent; further,

To promote education of healthcare professionals regarding use of biohacking and its implications in the medical setting; further,

To encourage the pharmacy workforce to include questions about use of biohacking when obtaining medication histories; further,

To encourage the pharmacy workforce to ensure that patients using biohacking are educated about the risks and benefits of these treatments, including lack of regulatory oversight; further,

To recommend that health systems use a consistent method for documenting use of biohacking in the electronic health record.

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Julie Groppi, Board Liaison to the **Council on Education and Workforce Development**, presented the Council’s Policy Recommendations 1 through 3.

**1. Professional Identity Formation**

To encourage the pharmacy workforce and pharmacy education and training programs to foster professional identity formation, described as the process of developing a

commitment to: (1) high professional standards of pharmacy practice, (2) high personal standards of integrity and competence, (3) service to humanity, (4) a just and inclusive healthcare system and society, (5) analytical thinking and ethical reasoning, (6) continuing professional development, (7) acquisition of personal leadership skills, (8) development of effective interpersonal skills, (9) maintenance of personal well-being and resiliency, and (10) membership and participation in professional organizations.

*Note: This policy would supersede ASHP policy 1113.*

### **2. Career Opportunities for Pharmacy Technicians**

To promote pharmacy technicians as valuable contributors to healthcare delivery; further,

To advocate that pharmacy technicians complete an education and training program accredited by ASHP and the Accreditation Council for Pharmacy Education (ACPE), and maintain Pharmacy Technician Certification Board certification; further,

To advocate that pharmacy technicians complete ACPE-approved certificate programs that provide training for their current or anticipated roles; further,

To develop and disseminate information about career and training opportunities that enhance the recruitment and retention of qualified pharmacy technicians; further,

To encourage employers to offer career advancement opportunities (e.g., career ladders) for pharmacy technicians; further,

To urge compensation for pharmacy technicians commensurate with advanced roles and responsibilities.

*Note: This policy would supersede ASHP policy 1610*

### **3. Zero Tolerance of Harassment, Discrimination, and Malicious Behaviors**

To assert that the pharmacy workforce has a right to expect and responsibility to ensure a profession in which all individuals are treated with respect and civility, free of with zero tolerance for all forms of harassment, and discrimination, including but not limited to sexual harassment and malicious behaviors; further,

To commit to a culture of responsibility and accountability within the profession, and promote anti-retaliation policies and timely follow-up with zero tolerance of harassment and discrimination; further,

To ~~foster the~~ development of tools, education, and other resources to ~~promote~~ ensure such a culture.

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Jamie Sinclair, Board Liaison to the **Council on Pharmacy Management**, presented the Council's Policy Recommendations 1 through 4.

### **1. Standardizing and Minimizing the Use of Abbreviations**

To support efforts to standardize and minimize the use of abbreviations in healthcare; further,

To oppose use of abbreviations when communicating with patients to enhance transparency and understanding; further,

To encourage education of healthcare professionals and learners (e.g., residents, students) on **standardizing and** minimizing the use of abbreviations across all patient care settings.

*Note: This policy would supersede ASHP policy 0604.*

## 2. Optimal Pharmacy Staffing

To encourage pharmacy leaders to work in collaboration with physicians, nurses, health-system administrators, and others to outline key pharmacist services that are essential to safe and effective patient care and employee engagement; further,

To encourage pharmacy leaders to be innovative in their approach and to factor into their thinking the potential benefits and risks of flexible staffing models, telehealth practices, legal requirements, accreditation standards, professional standards of practice, and the resources and technology available in individual settings; further,

To encourage pharmacy leaders to develop contingency plans for changes in staffing models to accommodate rapid changes in the healthcare environment and the needs of patients and staff; further,

To encourage pharmacy leaders to develop key performance indicators to support safe staffing models.

*Note: This policy would supersede ASHP policy 2034.*

## 3. Patient Access to Pharmacist Care Within Provider Networks

To advocate for laws and regulations that require healthcare payer provider networks to include pharmacists ~~and pharmacies~~

providing patient care services within their scope of practice when such services are covered benefits; further,

To advocate for laws and regulations that require healthcare payer provider networks to ~~include~~ **consider** all qualified pharmacists ~~and pharmacies~~ who apply to participate as a provider in the network and to reimburse all participating providers fairly and equitably for services that are a covered benefit; further,

To acknowledge that healthcare payers may develop and use criteria to determine provider access to its networks to ensure the quality and viability of healthcare services provided; further,

To advocate for laws and regulations that would help ensure the same level of patient care within a payer network by requiring healthcare payers to (1) disclose to participating providers and those applying to participate the criteria used to include, retain, or exclude providers; (2) ensure that those criteria are standardized across all network providers; and (3) collect data on how well providers meet those criteria and report that data to providers; further,

To advocate for comparative, transparent sharing of performance and quality measure data based on those criteria.

*Note: This policy would supersede ASHP policy 1808.*

## 4. ASHP Statement on the Roles and Responsibilities of the Pharmacy Executive

To approve the ASHP Statement on the Roles and Responsibilities of the Pharmacy Executive.

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Kristy Butler, Board Liaison to the **Council on Pharmacy Practice**, presented the Council's Policy Recommendations 1 through 6.

### **\*1. Role of the Pharmacy Workforce in Pandemic Preparedness and Response**

To advocate that all healthcare organizations include pandemic preparedness in emergency preparedness planning; further,

To encourage all healthcare organizations to be actively engaged with their regional healthcare coalitions and to promote collaboration and communication among healthcare workers, healthcare organizations, government agencies, industry, and other stakeholders in pandemic preparedness and response; further,

To promote pharmacy workforce involvement in networks at the federal, state, local, and institutional levels for emergency response; further,

To advocate that pharmacy personnel be included as leaders on teams responsible for pandemic preparedness planning and response at the federal, state, local, and institutional levels, and that they integrate such planning into emergency preparedness planning for their workplaces; further,

To encourage all healthcare organizations to establish criteria for evidence-based medication-use decisions, even when such evidence is scarce, incomplete, or conflicting, and recognize the unique role that pharmacy personnel have in ensuring the safe and effective use of medications based on best available evidence and resources; further,

To advocate that healthcare organizations recognize the unique and collective stress a pandemic places on healthcare workers and

provide suitable resources to maintain workers' well-being and resilience; further,

To support research on and provide resources and education to aid the pharmacy workforce in preparing for and responding to pandemics.

### **2. Role of the Pharmacy Workforce in Supporting Patient Access to Medical Supplies**

To support patient access to medical supplies as part of a comprehensive treatment plan; further,

To advocate for policies that empower pharmacy personnel to facilitate patient access to and effective use of medical supplies, including reimbursement policies; further,

To educate pharmacists, other healthcare professionals, payers, and policymakers about the role of pharmacy personnel in helping patients obtain and use medical supplies; further,

To collaborate with other healthcare professional and patient advocacy organizations to advocate for expanded patient access to medical supplies.

*Note: For purposes of this policy, "medical supplies" includes durable medical equipment, Food and Drug Administration-approved medical devices, and other nondurable disposable healthcare materials.*

### **\*3. Documentation of Pharmacist Patient Care**

To promote the use of standardized, integrated documentation of clinical interventions by pharmacists care provision in a patient's health record to improve patient outcomes and allow for the attribution of

~~pharmacist services across the continuum of care; further,~~

To advocate that documentation by pharmacists in the medical record be used for billing and attribution of value without requiring additional documentation from other clinicians; further,

~~To advocate for the standardization in the standardized measurement of clinical interventions by pharmacists care provision on and the attribution of those activities to through patient-centered outcomes.~~

#### **4. Influenza Vaccination Requirements to Advance Patient Safety and Public Health**

To advocate that hospitals and health systems require healthcare workers to receive an annual influenza vaccination in accordance with U.S. Centers for Disease Control and Prevention Advisory Committee on Immunization Practices ~~guidelines~~ recommendations except when (1) it is contraindicated, or (2) the worker has religious objections, or (3) ~~the worker signs an informed declination;~~ further,

To encourage the hospital and health-system pharmacists-pharmacy workforce to take a lead role in developing and implementing policies and procedures for vaccinating healthcare workers and in providing education on the patient safety benefits of annual influenza vaccination; further,

To work with the federal government and others to improve the vaccine development and supply system in order to ensure a consistent and adequate supply of influenza virus vaccine.

*Note: This policy would supersede ASHP policy 0615.*

#### **5. Safe and Effective Extemporaneous Compounding**

To affirm that extemporaneous compounding of medications, when done to meet immediate or anticipatory patient needs, is part of the practice of pharmacy and is not manufacturing; further,

To support the principle that medications should not be extemporaneously compounded when ~~they drug products~~ are commercially and readily available in the form necessary to meet patient needs; further,

To encourage ~~pharmacists~~ the pharmacy workforce members who compound medications to use only drug substances that have been manufactured in Food and Drug Administration-registered facilities ~~that have been inspected within the past two years~~ and that meet official United States Pharmacopeia (USP) compendial requirements where those exist; further,

To advocate that all compounding activities meet applicable USP standards and federal and state regulations; further,

To support the principle that ~~pharmacists~~ the pharmacy workforce be adequately trained and have sufficient facilities and equipment that meet technical and professional standards to ensure the quality of compounded medications; further,

To encourage USP to develop drug monographs for commonly compounded preparations; further,

To educate prescribers and other healthcare professionals about the potential risks associated with the use of extemporaneously compounded preparations.

*Note: This policy would supersede ASHP policy 0616.*

## 6. Universal Immunization for Vaccine-Preventable Diseases in the Healthcare Workforce

To support policies that promote universal vaccination ~~against~~ for preventable infectious diseases among healthcare workers, including all members of the pharmacy workforce, as a safeguard to patient and public health; further,

To encourage the use of evidence-based risk assessments to determine inclusions and exemptions for mandatory vaccine requirements; further,

To support employers in establishing and implementing mandatory vaccine requirements for vaccines approved by the Food and Drug Administration (FDA) and encouraging the use of vaccines that have received FDA emergency use authorization if risk assessments determine it would promote patient and public health; further,

To urge healthcare organizations to have policies that address additional infection prevention practices required for exempted healthcare workers; further,

~~To foster the development of~~ tools, education, and other resources to ~~reduce~~ promote vaccine confidence ~~hesitancy~~, increase vaccination rates, and prevent vaccine-preventable diseases among healthcare workers.

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Nish Kasbekar, Board Liaison to the **Council on Public Policy**, presented the Council's Policy Recommendations 1 and 2.

## 1. Pharmacist Engagement in and Payment for Telehealth

To advocate for pharmacists' provision of telehealth services in all sites of care; further,

To advocate that reimbursement for pharmacists' provision of services be commensurate with the complexity and duration of service and consistent with other healthcare providers sufficient to support the practice.

## 2. Pharmacy Services in a State of Emergency

To advocate that states ~~boards of pharmacy~~ grant ~~temporary licensure to pharmacists and~~ temporary licensure, registration, or any other necessary state-mandated credential to ~~pharmacy technicians eligible pharmacies and~~ members of the pharmacy workforce during states of emergency; further,

To encourage the expedient licensure or registration for eligible members of the pharmacy workforce during states of emergency; further,

To advocate that state and federal regulatory agencies allow for flexibilities necessary to provide patient care during a declared state of emergency.

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**Amendments to ASHP Bylaws and Procedures of the House.** Paul Walker, Chair and Board Liaison to the ASHP Task Force on Racial Diversity, Equity, and Inclusion, then presented the Board's proposed changes to ASHP Bylaws and Procedures of the House (Appendix IV). Delegates approved the bylaws changes.

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**Statements of Candidates for Chair of House.** Candidates for the Chair of the House

of Delegates brief statements to the House of Delegates. The Chair described the process delegates would use to vote online between meetings of the House.

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**Report of the Treasurer.** The Chair directed the delegates' attention to the Report of the Treasurer (Appendix V), which was posted online. There was no discussion.

The meeting adjourned at 3:00 p.m.

### Second meeting

The second and final meeting of the House of Delegates session convened on Tuesday, June 9, at 2:00 p.m. A quorum was present.

**Report of the Chair of the Board and the Chief Executive Officer.** The Chair directed the delegates' attention to the report, which was posted online. There was no discussion, and the delegates voted to accept the Report of the Chair of the Board and the Chief Executive Officer (Appendix VI).

**Board of Directors duly considered matters.** Pursuant to Bylaws section 7.3.1.1, the Board met on the morning of June 8 to "duly consider" the policies amended at the first meeting. Four policy recommendations were approved without amendment. Thirteen policy recommendations were amended by the House of Delegates, with suggested nonsubstantive editorial changes to four policy recommendations. The Board agreed with all the House's amendments and editorial changes, with minor editorial changes to two of the amended policies to increase their clarity or provide consistency with other ASHP policies.

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**New Business.** Chair White announced that, in accordance with Article 7 of the Bylaws,

there was one item of New Business to be considered. Chair White called on Mollie Scott (North Carolina) to introduce the item of New Business, "COVID-19 Vaccination Requirements to Advance Patient Safety and Public Health" (Appendix VII). Following discussion, the item was approved for action by ASHP. It reads as follows:

*COVID-19 Vaccination Requirements to Advance Patient Safety and Public Health*

*Motion:*

To support employers in establishing and implementing mandatory vaccine requirements for COVID-19 vaccines once approved by the Food and Drug Administration (FDA) and encouraging the use of COVID-19 vaccines under emergency use authorization; further,

To advocate that healthcare organizations limit patient and staff risk of exposure to SARS-CoV-2 from individuals who are not immunized, which may include requiring unimmunized individuals to refrain from direct contact with patients and staff; further,

To urge healthcare organizations to have policies that address additional infection prevention practices required for healthcare workers who remain unimmunized against SARS-CoV-2.

### **SUGGESTED OUTCOMES:**

That ASHP advocate healthcare organizations adopt policies to reduce risk of SARS-CoV-2 transmission in all healthcare settings.

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**Recommendations.** Chair White called on members of the House of Delegates for Recommendations. (See Appendix VIII for a complete listing of all Recommendations.)

## Proceedings of the 73rd Annual Session

**Recognition.** Chair White recognized members of the Board who were completing their terms of office as well as those who were continuing in office (Appendix IX).

As a token of appreciation on behalf of the Board of Directors and members of ASHP, Chair White noted that Immediate Past President Pawlicki will receive by mail an inscribed gavel commemorating her term of office.

President Thomas J. Johnson then recognized Chair White for his service as Chair of the House and a member of the Board of Directors.

**Installation.** Chair White then installed Linda S. Tyler as President of ASHP, Kim W.

Benner and Pamela K. Phelps as members of the Board of Directors, and Melanie A. Dodd as Chair of the House of Delegates (Appendix IX). (See Appendix X for the Inaugural Address of the Incoming President.)

**Adjournment.** The 73rd annual June meeting of the House of Delegates adjourned at 3:00 p.m.

<sup>a</sup>The Committee on Nominations consisted of James Hoffman, Chair (TN); Kelly Smith, Vice Chair (GA); Rena Gosser (WA); Donald Kishi (CA); Christy Norman (GA); Vickie Powell (NY); and Tate Trujillo (IN).

**HOUSE OF DELEGATES**  
**Casey H. White, Chair**  
**Kathleen S. Pawlicki, Vice Chair**

**As of June 8, 2021**

<b>OFFICERS AND BOARD OF DIRECTORS</b>			
Thomas J. Johnson, President			
Linda S. Tyler, President-Elect			
Kathleen S. Pawlicki, Immediate Past President			
Christene M. Jolowsky, Treasurer			
Paul W. Abramowitz, Chief Executive Officer			
Leigh A. Briscoe-Dwyer, Board Liaison, Commission on Affiliate Relations			
Kristina L. Butler, Board Liaison, Council on Pharmacy Practice			
Julie A. Groppi, Board Liaison, Council on Education and Workforce Development			
Nishaminy Kasbekar, Board Liaison, Council on Public Policy			
Jamie S. Sinclair, Board Liaison, Council on Pharmacy Management			
Paul C. Walker, Board Liaison, Council on Therapeutics			
Casey H. White, Chair, House of Delegates			
<b>PAST PRESIDENTS</b>			
R. David Anderson	Debra Devereaux	Robert Lantos	Bruce Scott
Roger Anderson	Fred Eckel	Herman Lazarus	Steven Sheaffer
John Armitstead	Rebecca Finley	Jill Martin Boone	Kelly Smith
Daniel Ashby	Lisa Gersema	James McAllister	Thomas Thielke
Paul Baumgartner	Diane Ginsburg	Gerald Meyer	Sara White
Jill Boone	Harold Godwin	John Murphy	T. Mark Woods
Cynthia Brennan	Mick Hunt	Kathleen Pawlicki	David Zilz
Bruce Canaday	Clifford Hynniman	Cynthia Raehl	
Jannet Carmichael	Marianne Ivey	Philip Schneider	
Kevin Colgan	Stan Kent	Kathryn Schultz	
<b>STATE</b>	<b>DELEGATES</b>	<b>ALTERNATES</b>	
<b>Alabama (3)</b>	Lea Eiland Laura Matthews Whitney White	Jeff Kyle	
<b>Alaska (2)</b>	Gretchen Glaspy Ursula Iha	Michelle Locke Nielsen Angharad Ratliff	
<b>Arizona (3)</b>	Melinda Burnworth Christopher Edwards Danielle Kamm	Janelle Duran Christi Jen Carol Rollins	
<b>Arkansas (2)</b>	Christy Agee Kendrea Jones		
<b>California (7)</b>	Steven Gray Lisa Gunther Donald Kishi James Scott Kethen So Martin Torres Keith Yoshizuka	Amy Kang Nicole Nguyen	

<b>Colorado (3)</b>	Sarah Anderson Karen McConnell Tara Vlasimsky	Jennifer Davis
<b>Connecticut (3)</b>	Elizabeth "Liz" Cohen Molly Billstein-Leber LeeAnn Miller	David Goffman
<b>Delaware (2)</b>	Cheri Briggs	Samantha Landolfa Sumit Gandotra
<b>Florida (5)</b>	Jeffrey Bush Elias Chahine Charzetta James Jennifer Miles Sara Panella	Jessica Bianco
<b>Georgia (3)</b>	Trisha Branam Susan Jackson Christy Norman	Collin Lee Davey Legendre Marjorie Phillips
<b>Hawaii (2)</b>	Joy Matsuyama Janelle Siu	
<b>Idaho (2)</b>	Paul Driver Heather Walser	Jordan Ferro
<b>Illinois (5)</b>	Noelle Chapman Andy Donnelly Bernice Man Mary Lynn Moody Carrie Vogler	Chris Crank Travis Hunerdosse Alifiya Hyderi Jennifer Phillips Carrie Sincak Trish Wegner
<b>Indiana (3)</b>	Chris Lowe Christopher Scott Tate Trujillo	John Hertig
<b>Iowa (3)</b>	John Hamiel Diane Reist Terrel Wiedenfeld	Anthony Pudlo Michael Schnackenberg
<b>Kansas (3)</b>	Jennifer McKenna Katherine Miller Joanna Robinson	Mary Durham Brian Gilbert Megan Ohrlund Katie Wilson
<b>Kentucky (3)</b>	Dale English Joan Haltom Brett Cornell	Tina Claypool Scott Hayes Devlin Smith
<b>Louisiana (3)</b>	Jason Chou Monica Dziuba Kisha Gant	Paul Knecht Heather Maturin Christi Parson
<b>Maine (2)</b>	Kathryn Sawicki	Ming Hoang Matthew Christie
<b>Maryland (4)</b>	Joshua Blackwell Nicole Kiehle Janet Lee Kristin Watson	Elizabeth Rodman Molly Wascher

<b>Massachusetts (4)</b>	Caryn Belisle Jackie MacCormack-Gagnon Monica Mahoney Marla O'Shea-Bulman	
<b>Michigan (4)</b>	Jesse Hogue Jessica Jones Margaret Malovrh Stephen Stout	Marla Ekola Lama Hsaiky
<b>Minnesota (3)</b>	Tamara Bezdicek Sue Haight John Pastor	Matthew Ditmore Jessica Swearingen Matt Wolf
<b>Mississippi (3)</b>	Phil Ayers Joshua Fleming Andrews Mays	
<b>Missouri (3)</b>	Laura Butkievich Joel Hennenfent Emily Owen	Davina Dell Steinbeck Ashley Duty Amy Sipe
<b>Montana (2)</b>	Starla Blank	Lindsey Firman Hugh Easley
<b>Nebraska (3)</b>	Kim Lueders Katie Reisbig Jerome Wohleb	Michele Faulkner Ken Kester
<b>Nevada (2)</b>	Kate Ward Adam Porath	
<b>New Hampshire (2)</b>	Dave DePiero Keith Foster	Tonya Carlton
<b>New Jersey (4)</b>	William Herlihy Jessica Hill Julie Kalabalik Nissy Varughese	Barbara Giacomelli Deborah Sadowski Malgorzata Slugocki
<b>New Mexico (2)</b>	Melanie Dodd Traci White	Davena Norris
<b>New York (5)</b>	Angela Cheng Ruth Cassidy Heide Christensen Travis Dick Mark Sinnet	Karen Berger
<b>North Carolina (4)</b>	Michael Melroy Mary Parker Mollie Scott Tyler Vest	
<b>North Dakota (2)</b>	Maari Loy	Brody Maack
<b>Ohio (5)</b>	Rachel Chandra Harrison Jozefczyk Kelly Evans Musch Kembral Nelson	Robert Parsons Rebecca Taylor Amanda Hansen



<b>Oklahoma (3)</b>	Emily Gray Lisa Mayer Edna Patatanian	Wiley Williams
<b>Oregon (3)</b>	Zach McCall Edwards Saito Victoria Wallace	Andrew Gibler
<b>Pennsylvania (4)</b>	Danielle Auxer Brad Cooper Arpit Mehta David Zimmerman	Scott Bolesta Lawrence Carey Paul Green
<b>Puerto Rico (2)</b>	Mirza Martinez	Stephanie Pagan Carlos Mendez
<b>Rhode Island (2)</b>	Margaret Charpentier Shannon Levesque	Martha Roberts Karen Nolan
<b>South Carolina (3)</b>	Carolyn Bell Natasha Nicol Jennifer Thompson	Sarah Desai
<b>South Dakota (2)</b>	Thaddaus Hellwig Laura Stoebner	Joseph Berendse Andrea Darr
<b>Tennessee (4)</b>	Joseph Krushinski Agatha Nolen Jennifer Pauley Jennifer Robertson	Lucy Shell
<b>Texas (6)</b>	Latresa Billings Kirk Evoy Steven Knight Sarah Lake-Wallace Patricia Meyer	Binita Patel Randy Martin
<b>Utah (3)</b>	Ashley Ryther Karen Gunning Anthony Trovato	Cole Sloan
<b>Vermont (2)</b>	Kevin Marvin	Blake Porter Jeffrey Schnoor
<b>Virginia (4)</b>	Catherine Floroff Lisa Hammond Craig Kirkwood Brad McDaniel	Darren Stevens
<b>Washington, D.C. (2)</b>	Kong Wong Michelle Eby	Meenakshi Shelat
<b>Washington State (4)</b>	Susan Teil Boyer Rena Gosser Roger Woolf Karen White	
<b>West Virginia (2)</b>	Derek Grimm	Jonathan Kline Todd Karpinski

<b>Wisconsin (4)</b>	Christina Andros Terry Audley David Hager Justin Konkol	Tom Dilworth John Muchka Kate Schaafsma Lucas Schulz
<b>Wyoming (2)</b>	Jamie Homecker Tonja Woods	Linda Martin
<b>SECTIONS AND FORUMS</b>	<b>DELEGATES</b>	<b>ALTERNATES</b>
<b>Ambulatory Care Practitioners</b>	Jessica Skelley	Daniel Trulove
<b>Clinical Specialists and Scientists</b>	Joel Marrs	Douglas Slain
<b>Inpatient Care Practitioners</b>	Gregory Burger	Delia Carias
<b>Pharmacy Informatics and Technology</b>	Seth Hartman	Barry McClain
<b>Pharmacy Practice Leaders</b>	Philip Brummond	Jeffrey Little
<b>Specialty Pharmacy Practitioners</b>	Matthew Rim	Tara Kelley
<b>Community Pharmacy Practitioners</b>	Melissa Ortega	
<b>Pharmacy Educators</b>	Timothy Brown	Marie A. Chisholm-Burns
<b>New Practitioners Forum</b>	Kellie Musch	Erin Boswell
<b>Pharmacy Student Forum</b>	Jeffrey Clark	Autumn Pinard
<b>Pharmacy Technician Forum</b>	Glen Gard	JoAnne Myhre
<b>FRATERNAL</b>	<b>DELEGATES</b>	<b>ALTERNATES</b>
<b>U.S. Air Force</b>	Maj. Rohin Kasudia	Maj. Jin Kim
<b>U.S. Army</b>	LTC Joe Taylor	LTC Rob Brutcher
<b>U.S. Navy</b>	LCDR Jason Galka	LT Chirag Patel
<b>U.S. Public Health Service</b>	LCDR Carl Coats	LCDR Kali Autrey
<b>Veterans Affairs</b>	Dr. Heather Ourth	Dr. Virginia Torrise

# House of Delegates

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## **HOUSE OF DELEGATES**

### **REPORT OF THE**

### **COMMITTEE ON NOMINATIONS**

June 6, 2021

Online Meeting

James Hoffman (Chair), Tennessee  
Kelly Smith (Vice Chair), Georgia  
Rena Gosser, Washington  
Donald Kishi, California  
Christy Norman, Georgia  
Vickie Powell, New York  
Tate Trujillo, Indiana  
Joshua Blackwell (Alternate), Texas  
Dave Lacknauth (Alternate), Florida  
Maritza Lew (Alternate), California

## ASHP COMMITTEE ON NOMINATIONS

Mister Chair, Fellow Delegates:

The Committee on Nominations consists of seven members of ASHP who were members of the House of Delegates at the time of their appointment. The Committee is appointed by the Chair of the House of Delegates and 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 nearly 58,000 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 twice virtually since the last session of the House of Delegates: on January 19 and on April 21, 2021, via teleconference. Review of nominees' materials was conducted continuously between March and April 2021 solely via secure electronic transmissions. This process has been reviewed for quality improvement and will be repeated for the 2021–2022 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 692 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: 19 accepted

CHAIR, HOUSE OF DELEGATES: 5 accepted

A list of candidates that were slated was provided to delegates following the Committee's meeting on April 21, 2021.

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**

Stephen F. Eckel, Pharm.D., M.H.A. (Chapel Hill, NC)

Paul C. Walker, Pharm.D., FASHP (Ann Arbor, MI)

#### **Board of Directors**

Samuel V. Calabrese, B.S.Pharm., M.B.A, FASHP (Cleveland, OH)

Roy Guharoy, Pharm.D., M.B.A., FASHP, FCCP, FCP (Worcester, MA)

Vivian Bradley Johnson, Pharm.D., B.S., R.Ph., M.B.A., FASHP (Dallas, TX)

Lanita S. White, Pharm.D. (Little Rock, AR)

#### **Chair, House of Delegates**

Melanie A. Dodd, Pharm.D., Ph.C., BCPS, FASHP (Albuquerque, NM)

Jodi L. Taylor, Pharm.D., BCCCP, BCPS, FASHP (Jackson, TN)

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

**CANDIDATES FOR PRESIDENT 2022–2023**

**Stephen F. Eckel, Pharm.D., M.H.A.** ([seckel@unc.edu](mailto: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's of Science in pharmaceutical sciences with a specialization in health-system pharmacy administration. This degree collaborates with eight hospitals across the country who sponsor the residency and 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.

Stephen F. 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's of health care administration from the UNC Gillings School of Global Public Health.

Stephen F. 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, and ACCP.

**Statement:**

*The one constant of healthcare is change, and the past 12 months have surely demonstrated this. While many times pharmacists do not like change, it allows for departments to promote the patient-centric practice of pharmacy. This opportunity for advancement was evident as pharmacy took leadership roles in providing COVID vaccinations across the health system. While we can fear the unknown, we can also use it as an opportunity to create the future that we desire.*

*ASHP can set the future direction and course for the pharmacy profession and how we practice on a daily basis. When change happens, people should know that ASHP has the resources and guidelines they need for success. Employing skills like creativity, innovation, and problem solving can be the differentiator between whether we will create the future or wait for someone outside of the profession to do it.*

*ASHP also must implement the recommendations from the Task Force on Racial Diversity, Equity, and Inclusion. We will not advance as an organization until all of us are able to flourish at an individual level.*

*I am passionate about leveraging change to help us meet our professional ideals and will ensure that our professional society remains diverse and inclusive.*

*I am extremely honored to receive this nomination as ASHP has always been my professional home. There are many leaders who have utilized skills in the past to bring health-system pharmacy to this point, and I am committed to do the same for future generations.*

**Paul C. Walker, Pharm.D., FASHP** ([pcwalker@umich.edu](mailto:pcwalker@umich.edu)) is clinical professor and assistant dean of experiential education and community engagement, College of Pharmacy, and manager, department of pharmacy, Michigan Medicine. Walker received his B.S. in pharmacy and Pharm.D. from Wayne State University. He completed an ASHP-accredited residency at Children's Hospital of Michigan and specialty residency in pediatric pharmacy practice at the University of Tennessee. He has served in clinical practice and leadership roles at the Detroit Medical Center and Henry Ford Health System and held faculty appointments at Wayne State University. He is passionate about advancing pharmacy

practice by innovating pharmacist services, evaluating pharmacists' impact on patient care, and especially by integrating student pharmacists into practice models and interprofessional teams through work in experiential education.

Walker has served ASHP in many capacities, most recently as a member of the Board of Directors. He chaired ASHP's recent Task Force on Racial Diversity, Equity, and Inclusion. He also served as chair of the Committee on Nominations; as a member of the Commission on Affiliate Relations and the ASHP Foundation Donor Retention Subcommittee; and as a delegate to the House of Delegates for many years.

Walker served on the board of directors of the Michigan Pharmacists Association (MPA) and the Michigan Society of Health-System Pharmacists (MSHP). He received the 2008 MSHP Professional Practice Award, the 2010 MSHP Pharmacist of the Year Award, and the 2017 MSHP Joseph A. Oddis Leadership Award. He has been inducted into the MPA Hall of Honor and is recognized as a Fellow by ASHP and MPA.

**Statement:**

*Every patient, in every setting of care, deserves to benefit from the tremendous value pharmacists provide. However, last year's significant events highlighted disparities in healthcare, emphasized critical medication issues, and challenged us to rethink and innovate how we deliver care and value for our patients. ASHP's visionary leadership and advocacy are critical as we strive to ensure patient access to pharmacist services appropriate to their needs, empower the pharmacy workforce to meet those needs, and advance our profession.*

*To achieve these outcomes, ASHP must lead by:*

- Improving healthcare in our communities, eliminating health disparities for people of color, and improving the health of the diverse patients we serve. We must improve the diversity of the pharmacy workforce, advocate for access to pharmacist care for all patients, and address critical medication issues that can adversely affect patient outcomes, including patient access to critical medications, medication costs, medication supply chain integrity, and drug shortages.*
- Creating optimal practice models that engage the whole pharmacy workforce, advance roles for pharmacists and technicians, and lead to safer, more efficient healthcare systems that improve outcomes, add value, and reduce costs.*
- Advocating for our patients, health-system pharmacists, and the pharmacy profession with legislative bodies, regulatory agencies, and all necessary audiences.*

*I am passionate about ASHP and welcome the opportunity to work with ASHP leaders and members to improve the health of our patients and advance our profession. I am deeply honored by this nomination and would consider it a great privilege to serve you as ASHP President.*

**CANDIDATES FOR BOARD OF DIRECTORS 2022–2025**

**Samuel V. Calabrese, B.S.Pharm., M.B.A., FASHP** ([calabrs@ccf.org](mailto:calabrs@ccf.org)) is the executive chief pharmacy officer for the Cleveland Clinic Enterprise in Cleveland, Ohio and holds an academic appointment at Northeast Ohio Medical University. He obtained his pharmacy degree from The Philadelphia College of Pharmacy and Science, his M.B.A. from Cleveland State University, and also obtained a certification in executive coaching from The Gestalt Institute of Cleveland. In his current role, he leads a pharmacy enterprise that encompasses a 1.5 billion dollar drug budget and 1,700 FTEs in 19 hospitals and clinics in Ohio, Florida, Nevada, Canada, England, and Abu Dhabi. Samuel is passionate about leadership development and has given several invited presentations and serves as the residency program director for Cleveland Clinic’s health-system pharmacy administration and leadership residency.

Calabrese’s ASHP service includes serving on the Commission on Affiliate Relations, the Council on Pharmacy Management, and as an ASHP delegate for Ohio. He has been an active member of the Section of Pharmacy Practice Leaders (SPPL) where he chaired the Section Advisory Group for Quality and Compliance and completed terms as director-at-large and chair for the SPPL. Calabrese is an active faculty with ASHP’s Pharmacy Leadership Academy and with ASHP’s Australia leadership boot camp. He is past president for both the Cleveland Society of Health-System Pharmacists (CSHP) and the Ohio Society of Health-System Pharmacists (OSHP). He received CSHP’s Evelyn Gray Scott Award in 2018 and OSHP’s Walter M. Frazier Award in 2020.

**Statement:**

*As we navigate through the healthcare landscape that has emerged due to the effects of COVID, we need to demonstrate that our profession is positioned to produce value to our organizations, to society, and to the bottom line. We need to capitalize on our skills and the confidence patients have in pharmacists to produce quality outcomes by adapting to virtual care settings and the new norms adopted during the pandemic. We have an obligation to our patients to provide the best care possible and deliver this in a way that meets their needs. This includes expanding our presence in outpatient clinics to collaboratively manage chronic disease, expanding care through telehealth, and evolving our practice model to focus on transitions of care. We must utilize resources wisely by leveraging technology and advancing technician roles to increase pharmacists’ direct patient care capacity. ASHP needs to continue to listen to the needs of the members to create meaningful educational materials, advocate for the profession, and be bold in establishing goals. Our attention must also focus on the impact we have financially on our patients and our health systems. We need to continue to fight for key issues such as provider status, reducing drug prices, and PBM reform. Finally, we need to have open meaningful conversations on diversity, equity, and inclusion in both our workplaces and professional organizations.*

*I am honored to be nominated for the ASHP Board of Directors and look forward to representing you on these key issues.*

**Roy Guharoy, Pharm.D., M.B.A., FASHP, FCCP, FCP** ([Rguharoy1@Umassmed.edu](mailto:Rguharoy1@Umassmed.edu)) is a clinical professor of medicine at the University of Massachusetts Medical School. He earned his Pharm.D. from University of Minnesota and M.B.A. from Peter Drucker Graduate School of Management. He has practiced in both academic and community-based settings, spanning from clinical pharmacist to serving as chief pharmacy executive at SUNY-Upstate, University of Massachusetts, Ascension, and Baptist Health System. A strong advocate of advanced pharmacy practice and innovative patient centered care model from early in his career, Roy has championed enterprise-level innovative services implementing team-based care, medication safety initiatives, supply chain management,



medication access for the poor and vulnerable, research, scholarship, educating future generation of medical-nursing-pharmacy professionals, and expansion of student training and residency programs. He has published 75 peer-reviewed articles and has given 260 invited presentations. He was the recipient of the ISMP Cheers Award in 2008 and 2016.

Roy's service to ASHP has spanned his entire career, including serving on the Council on Public Policy, Pharmacy Practice, SPPL SAG on Patient Care Quality, SSPP SAG on Outcomes Value, and as a delegate of New York and Massachusetts Society of Health-System Pharmacists for 7 years. He served as the president of the Central New York Society of Health-System Pharmacists, board member of the Massachusetts Health-System Pharmacists (MSHP) for 4 years and numerous committees of the New York Council of Health-System Pharmacists (NYSCHP). He was the recipient of 2000 NYSCHP Pharmacist of the Year and 2012 MSHP Practitioner Excellence Award.

**Statement:**

*The COVID-19 pandemic proved the vital role of the pharmacists during the public health crisis of the century. My colleagues across the nation have worked tirelessly to develop evidence-based therapy protocols, clinical monitoring, mitigate drug shortages, and lead community mass vaccination programs. The U.S. healthcare model is undergoing profound transformations and drastic changes will occur in the post-COVID era. Pharmacists are uniquely positioned to lead the future care delivery model based on the quality, outcomes, and value delivered by healthcare teams. As a profession, we need to be ahead of the curve and not settle for the status quo. However, technological and resource gaps stand as barriers. Moving forward, ASHP needs to work with other stakeholders to augment efforts to close the gaps:*

- *Pharmacist provider status allowing patients access to pharmaceutical care*
- *Optimize telehealth to connect pharmacists with patients and other team members in clinics reimbursable by third-party payers*
- *Restore funding for PGY2 programs to expand number of specialty-trained pharmacists*
- *Develop standardized training and career advancement programs for technicians*
- *Lead efforts to build a pharmacy community based on diversity and inclusion*
- *Identify evidence on best patient-specific therapy through advances in healthcare technologies and interoperability via high quality data aggregation and big data analytics*
- *Promote comparative effectiveness trials for drug approvals*
- *Develop a national metric to ensure rapid adoption of evidence-based practices by healthcare organizations.*

*I will be honored to represent you on the ASHP Board of Directors.*

**Vivian Bradley Johnson, Pharm.D., B.S., R.Ph., M.B.A., FASHP** ([Vivian.Johnson@phhs.org](mailto:Vivian.Johnson@phhs.org)) is the senior vice president of clinical services at Parkland Health and Hospital System in Dallas, Texas. She oversees pharmacy, radiology, respiratory, clinical dietary, physical medicine & rehabilitation and laboratory services.

She has spent over 35 years providing healthcare services to the underserved in Dallas County. Under Johnson's leadership, many pharmacy programs have been developed including a 340B program. She is a member of the Parkland COVID-19 Response Team and provides oversight of the COVID-19 vaccines. She serves as a subject matter expert on COVID-19 vaccines for the Dallas community and congressional constituents.

She is originally from Lake City, Florida. Johnson attended Florida Agricultural & Mechanical University, School of Pharmacy. She attained her Doctor of Pharmacy degree from Mercer University in Atlanta, Georgia and an M.B.A. from University of Dallas. She is married to Frederick with three children, Frederick II, Michelle Marva, and Erika.

Johnson has been the recipient of many awards, including the 2010 Texas Pharmacy Leadership Award. She has served on the TSHP Professional Affairs Council and the Leadership Section. Johnson is a long-term member of the American Society of Health-System Pharmacists. She is a fellow of ASHP. Johnson has served on the ASHP Residency Excellence Awards Committee, the Council on Pharmacy Management, and the ASHP Racial Diversity, Equity, and Inclusion Task Force. She was appointed to the Pharmacy Executive Leadership Alliance Advisory Panel and the ASHP Forecast 2022 Advisory Committee. She continues to be an advocate and active member in the pharmacy profession.

**Statement:**

***I believe in the value and worth of every human being.***

*I strive to make the most of my life and to help others do the same. No matter what title or position we hold, I believe we are all equal and valuable human beings with the ability to make a positive contribution to society. Pharmacists are still among the most highly trusted professions. I would like to help ASHP work with national, state, and local entities to recognize pharmacists as being an integral part of the leadership, population health, and acute care team.*

***I believe in improving conditions and processes to ensure positive outcomes.***

*I chose pharmacy to help make a positive difference in the lives of others through this profession. I believe ASHP is positioned to help pharmacists and pharmacy technicians to work collaboratively within and outside of the profession to achieve positive outcomes.*

***I believe in helping to develop and mentor others to reach their full potential.***

*I am a servant leader. I believe a great leader finds joy in helping others reach their full potential. This perspective has helped me to inspire, encourage, and guide others to contribute and pursue their personal and professional goals. I believe I can positively contribute to ASHP's leadership and mentoring programs.*

*I am honored to be among the candidates for the ASHP Board of Directors and would work hard to promote the pharmacy profession, eliminate healthcare disparities, and lend support to ASHP members seeking professional growth.*

**Lanita S. White, Pharm.D.** ([LSWhite@uams.edu](mailto:LSWhite@uams.edu)) is assistant dean for student affairs and associate professor at the University of Arkansas for Medical Sciences (UAMS), College of Pharmacy in Little Rock, Arkansas. She earned her Pharm.D. from Xavier University of Louisiana. After pharmacy school, she completed an ASHP-accredited postgraduate year one (PGY1) pharmacy practice residency and an ASHP-accredited PGY2 ambulatory care pharmacy residency, both at the Central Arkansas Veterans Healthcare System in Little Rock, Arkansas, and practiced there in the diabetes and endocrinology clinic. In 2012, Dr. White was recruited to direct the UAMS 12th Street Health and Wellness Center. The 12th Street Health and Wellness Center is an interprofessional, student-led, community-based clinic that provides real-world interprofessional training opportunities for UAMS students. The clinic offers chronic disease screenings and primary care for uninsured patients at no cost. Further, the clinic serves as a national model for faculty participating in interprofessional student precepting.

White has served ASHP in several capacities including several years as an Arkansas delegate to the ASHP House of Delegates; and member of the Task Force on Organizational Structure; Committee on Nominations; Council on Education and Workforce Development; and Task Force on Racial Diversity, Equity, and Inclusion.

**Statement:**

*As a young practitioner focused on career development, I didn't expect to develop a passion for professional service. I knew I would always support my professional organization through membership. When a dear mentor invited me to serve, that opportunity fueled my love for advocacy for the profession, practitioners, and patients. There are three critical issues where we must lead the conversation to affect change:*

- **Sustainability of the workforce** is threatened by varying degrees of profession saturation, declining interest in the profession, and growing competition from other healthcare professions.
- **Diversity of the workforce** is vital to patient care and the profession's sustainability. We know that minority patients, in particular, experience better outcomes when they have access to practitioners who look like them. Future practitioners must be able to see pharmacy as a viable professional choice.
- **Pharmacists must be included in all aspects of decision- and policy-making related to healthcare.** This inclusion should start at the institution and be modeled at the state and national levels. Pharmacists must also be prepared and willing to advocate to change the discussion and highlight the need for our presence in these conversations.

*These three issues are major concerns facing our profession. In my opinion, it is important to have a viable pipeline that feeds the diversity needed for pharmacy to be represented in all conversations. It is my sincere honor to be nominated, and I would love to represent you on the ASHP Board of Directors!*

**CANDIDATES FOR CHAIR OF THE HOUSE OF DELEGATES 2021–2024**

**Melanie A. Dodd, Pharm.D., Ph.C., BCPS, FASHP** ([mdodd@salud.unm.edu](mailto:mdodd@salud.unm.edu)) is associate dean for clinical affairs and associate professor, department of pharmacy practice and administrative sciences, The University of New Mexico (UNM) College of Pharmacy, Albuquerque, NM. A Purdue University, UNM and Presbyterian Healthcare Services residency program graduate, she began her career with the NM Medicaid DUR Program. She is now a pharmacist clinician with prescriptive authority at the UNM Senior Health Clinic, a consultant hospice pharmacist, and responsible for geriatric teaching activities with Pharm.D. and interprofessional students and residents. She plays an active role in development of and oversees new pharmacist clinical practice models, credentialing processes, and pharmacist reimbursement at UNM, including advocating for passage of and implementing NM House Bill 42, reimbursement parity to physicians for pharmacists with prescriptive authority.

Dodd's ASHP service includes vice-chair and chair of the Council on Public Policy, chair of the Section of Ambulatory Care Practitioners, PPMI delegate, and NM delegate to the House of Delegates for 13 years. She is past-president of NMSHP and faculty advisor for the UNM SSHP.

**Statement:**

*My vision is to have pharmacists providing direct patient care to all patients throughout the continuum of care as essential, reimbursed members of interprofessional teams. In addition, I believe that it is important that we embrace and advocate for the expanding roles of pharmacists, including prescriptive authority, and support the ASHP PAI. Pharmacist recognition as providers at a state and federal level is a core component to achieve this vision. Through ASHP's leadership, including the vision and efforts of the House of Delegates and our grassroots efforts, we can be successful in advancing healthcare. ASHP policy development is a core component of establishing and communicating our practice vision to our professional colleagues, our patients, and the community at large. Through my experiences as a pharmacist clinician, pharmacy educator and administrator, and my service to SSHP, NMSHP, and ASHP, including chairing the Council on Public Policy, a delegate to the House of Delegates, and chairing the Section of Ambulatory Care Practitioners, I feel I am well positioned to chair the House of Delegates and represent the membership. I am humbled and honored by this nomination and am committed to providing leadership to ASHP and the House of Delegates to continue to advance the practice of pharmacy and provide high quality patient care.*

**Jodi L. Taylor, Pharm.D., BCCCP, BCPS, FASHP** ([JLTaylor@uu.edu](mailto:JLTaylor@uu.edu)) is professor and chair of pharmacy practice at Union University College of Pharmacy and critical care specialist at Jackson-Madison County General Hospital in Jackson, Tennessee. She received her Pharm.D. from the University of Tennessee Health Science Center and completed a postgraduate year one (PGY1) residency at the Veterans Affairs Medical Center in Memphis, Tennessee. Taylor has been recognized by her students and residents as Teacher and Preceptor of the Year on multiple occasions. She has been recognized for her leadership and advocacy with the Tennessee Society of Student Pharmacists Student Advocacy Award and Phi Lambda Sigma National Alumni of the Year award.

Taylor's ASHP activities include director-at-large of the Section of Clinical Specialists and Scientists, member of the Council on Therapeutics, Tennessee delegate to the House of Delegates, Best Practices Selection Panel, Pharmacy Forecast Survey Panelist, and faculty advisor for Union University's SSHP chapter. Taylor is a past president and secretary/treasurer of Tennessee Society of Health-System Pharmacists, member of Tennessee Pharmacists Association Board of Directors, and received the 2012 Health-System Pharmacist of the Year Award.

**Statement:**

*If not now, when? Do you feel a renewed sense of energy, a push toward the next level for our profession? I certainly do! Sweeping changes are all around us, and as a profession, perhaps it is time to answer that question – if not now, when? The House of Delegates brings the best minds, the visionary and analytical, the activator and developer, together to set priorities, direction, and tone for our united work. Each voice is unique and important. Each delegate’s talents and expertise are invaluable. I hope to utilize my experiences to facilitate and cultivate discussion leading to future-directed policies that advance our profession and improve patient care. I aim to effectively communicate and represent the collective voice of the House on the Board of Directors. Together, we can do great things. If not now, when? It is my sincere and humble hope to be part of shaping our future as your next Chair of the House of Delegates. Thank you for your time and consideration!*



# House of Delegates

## Board of Directors Report: Policy Recommendations for the June 2021 House of Delegates

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# COUNCIL ON THERAPEUTICS

## POLICY RECOMMENDATIONS

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*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.*

Paul C. Walker, *Board Liaison*

### **Council Members**

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Carolyn Oxencis (Wisconsin)  
Erin Warren, *Student* (South Carolina)  
Vicki Basalyga, *Secretary*

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### **1. Universal Influenza Vaccination**

- 1 To advocate for universal annual administration of influenza vaccinations to the United
- 2 States population; further,
  
- 3 To advocate that annual influenza vaccination be a national public health priority;
- 4 further,
  
- 5 To support the development of safe, effective, and affordable universal influenza
- 6 vaccination, with the goal of long-term immunity.

*Note: This policy would supersede ASHP policy 0601.*

### **Rationale**

Influenza places a significant health burden on the United States, with estimates of 9–35 million illnesses, 4–16 million outpatient medical visits, and 139,000–708,000 hospitalizations each season. The influenza virus evolves and changes each year, with changes in its genome that require adjustments to vaccine viruses each season. Furthermore, the timing of the onset, peak, and end of each flu season varies annually, typically falling in the fall and winter. Evidence from several observational studies demonstrate that higher influenza vaccination is associated with a lower risk of influenza outbreaks, but Healthy People 2030 estimates that only 49.2% of



persons 6 months or older were vaccinated for the 2017-18 season. Influenza vaccination in low-risk individuals has also shown to be effective and can prevent many illnesses, deaths, and losses in productivity.

The *Clinical Practice Guidelines by the Infectious Diseases Society of America: 2018 Update on Diagnosis, Treatment, Chemoprophylaxis, and Institutional Outbreak Management of Seasonal Influenza* emphasize that annual vaccination is the best method for preventing or mitigating the impact of influenza, and the 2030 Infectious Disease Goals for Healthy People 2030 have a goal of minimum vaccination rates of 70%. In 2019, an Executive Order created the National Influenza Vaccine Task Force, which identified that collaborative efforts across the federal government, academia, the private sector, and international stakeholders over the past decade have advanced influenza vaccine technologies. The Task Force also noted that influenza is a public health and national security challenge, with significant gaps remaining in vaccine effectiveness, pace of vaccine production, sustainable manufacturing, and vaccine access and coverage across all populations.

### **Background**

The Council reviewed ASHP policy 0601, Universal Influenza Vaccination, as part of sunset review and voted to recommend amending it as follows below along with recommending a name change to the policy to reflect the intent of universal administration (underscore indicates new text):

To advocate for universal annual administration of influenza vaccinations to the United States population; further,

To advocate that annual influenza vaccination be a national public health priority;  
further,

To support the development of safe, effective, and affordable universal influenza vaccination, with the goal of long-term immunity.

## **2. Vaccine Hesitancy**

- 1 To recognize the significant negative impact vaccine hesitancy has on public health in
- 2 the United States; further,
- 3 To affirm that pharmacists are integral members of the interprofessional team to
- 4 address vaccine hesitancy and promote disease prevention efforts; further,
- 5 To foster education, training, and the development of resources to assist healthcare
- 6 professionals in identifying factors that lead to vaccine hesitancy and addressing vaccine
- 7 hesitancy; further,

- 8 To promote pharmacist engagement with vaccine-hesitant patients, healthcare
- 9 providers, and caregivers, and to educate those populations on the risks
- 10 of vaccine hesitancy and the importance of timely vaccination.

### **Rationale**

Immunizations have led to a significant decrease in rates of vaccine-preventable diseases and have had a significant impact on the health of adults and children. In recent years, however, vaccine hesitancy, which is a delay in acceptance or refusal of vaccination despite availability of vaccination services, has increased. Vaccine hesitancy is complex and context specific, varying across time, place, and vaccines, and is influenced by factors such as complacency, convenience, and confidence. The impact of vaccine hesitancy is significant: lower immunization rates observed in various European countries and the U.S. are likely to have contributed to the outbreaks of vaccine-preventable diseases that have been observed over recent years.

Vaccine-hesitant patients, healthcare providers, and caregivers have been found to be responsive to vaccine information, consider vaccination, and are not opposed to all vaccines, and therefore would benefit from counseling. Studies have shown that "presumptive recommendation" (informing patients and caregivers that vaccines are due) is more effective than "participatory recommendation" (asking what patients and caregivers thought about vaccines) in convincing patients and caregiver to accept vaccines. Healthcare providers, including pharmacists across healthcare settings, are trusted advisors and influencers of vaccination decisions, and they must be supported to provide trusted, credible information on vaccines.

### **Background**

The Council discussed vaccine hesitancy as a part of the sunset review of ASHP policy 0601, Universal Influenza Vaccination. During the course of that discussion, vaccine hesitancy was recognized as a significant barrier to universal administration of the influenza vaccine but not specific to flu vaccination administration, as the measles outbreaks of 2019 were due to vaccine hesitancy regarding childhood immunizations.

### **3. Therapeutic Indication in Clinical Decision Support**

- 1 To encourage healthcare organizations to optimize use of clinical decision support
- 2 systems with indications-based prescribing; further,
- 3 To advocate for federal and state laws and regulations to include diagnosis-based
- 4 indication(s) on medication order(s) or prescription(s), with the exception of protected
- 5 classes of drugs.

*Note: This policy would supersede ASHP policy 1608.*

**Rationale**

Several well-known studies have demonstrated reductions in wrong-patient errors and adverse events with the inclusion of indication on the prescription order. In 2010, Equale (*Drug Saf.* 2010; 33: 559-67) described the accuracy of indication information in electronic health records (EHRs). Galanter (*J Am Med Inform Assoc.* 2013;20:477–81) focused on preventing wrong-patient medication errors with the use of indication-based prescribing. Indication-based alerts resulted in an interception rate of 0.25 interceptions per 1000 alerts. One team of investigators conducted a trial of inpatient indication-based prescribing using computerized provider order entry (CPOE) with drugs commonly used off-label (*Appl Clin Inf.* 2011;2:94–103). Off-label prescription drug use without strong scientific evidence has also been associated with increased rates of adverse drug events (*JAMA Internal Medicine* 2016; 176:55-63). The authors suggested that use of and proper documentation of therapeutic indication can help improve surveillance and safety and decrease risk. This additional safety check is critical in limiting errors due to wrong and/or look-alike/sound-alike medications. In addition to error prevention, indication-based prescribing can improve patient engagement, patient education, and provide pharmacists with information that may be necessary for prior authorizations or claim processing. To foster successful implementation of indication-based prescribing in EHRs, several authors have documented the success of starting electronic prescriptions with a problem or indication list first before medications can be selected to reduce time and medication errors while maintaining clinician satisfaction.

In several countries, including Canada and Spain, the EHR includes indication as part of comprehensive documentation. ASHP first developed official policy on the importance of pharmacists' access to indications in 1993. In 1996, the National Coordinating Council for Medication Error Reporting and Prevention recommended including the purpose of medication orders because of concerns about safety, unless considered inappropriate by the prescribers. In 1999, the Institute for Safe Medication Practices recommended including the purpose of prescribing on all written orders. In 2004, the National Association of Boards of Pharmacy (NABP) approved a resolution encouraging national and state medical associations to support legislative and regulatory efforts to require prescribers to include indications for all oral, written, and electronically transmitted prescriptions. In 2012, the United States Pharmacopeia made amendments to the standards for prescription container labeling to include "purpose-for-use" language. In 2015, the National Council of Prescription Drug Plans drafted language to recommend diagnosis and SNOMED indication be sent with any prescription. Despite these recommendations, few states have adopted any laws requiring inclusion of indication on all medication orders or prescriptions.

More recently, the Institute for Safe Medication Practices recommended updating the five "rights" of patient, drug, dose, time, and route to include a sixth "right": the right indication. They cite benefits of indication-based prescribing as (1) helping to prevent errors by narrowing medication choices; (2) empowering and educating patients, which helps increase patient adherence; (3) improving communications among the healthcare team, patients, and families; (4) facilitating medication reconciliation; (5) helping prescribers select the best medications for their patients; and (6) aiding in measuring drug effectiveness and learning from off-label use.

ASHP also has policy on off-label use that encourages the use of the three authoritative

drug compendia, peer-reviewed literature, and consultation with experts in research and clinical practice to make specific coverage decisions. ASHP supports informed decision-making that promotes third-party reimbursement for FDA-approved drug products appropriately prescribed for unlabeled uses. Furthermore, ASHP believes that diagnosis should not be required for all medication orders, particularly the six protected categories of drugs: 1) antidepressants; 2) antipsychotics; 3) anticonvulsants; 4) immunosuppressants for treatment of transplant rejection; 5) antiretrovirals; and 6) antineoplastics, as these may inadvertently cause result in breaches in patient privacy.

### **Background**

The Council reviewed ASHP policy 1608, Therapeutic Indication in Clinical Decision Support, as part of sunset review and voted to recommend amending it as follows (underline indicates new text; ~~strikethrough~~ indicates deletions):

To ~~advocate that~~ encourage healthcare organizations to optimize use of clinical decision support systems with indications-based prescribing ~~by including the appropriate indication for medications;~~ further,

To advocate for federal and state laws and regulations to include diagnosis-based indications on medication orders or prescriptions, with the exception of protected classes of drugs.

#### **4. Preventing Exposure to Allergens**

1 To advocate for pharmacist participation in the collection, assessment, documentation  
2 and reconciliation of a complete list of allergens pertinent to medication therapy,  
3 including food, excipients, medications, devices, and supplies; further,

4 To encourage vendors of electronic health records to create readily available and  
5 distinct data fields with consistent designations for medication allergies and  
6 intolerances; further,

7 To advocate that vendors of medication-related databases incorporate and maintain  
8 information about medication-related allergens and cross reactivity; further,

9 To encourage the accurate and complete documentation of allergens within the  
10 electronic medical record, including detailed descriptions of the reactions occurring  
11 upon exposure, for the purpose of clinical decision-making; further,

12 To advocate that pharmacists actively review allergens pertinent to medication therapy  
13 and minimize patient and healthcare worker exposure to known allergens, as feasible;  
14 further,

15

- 16 To promote the education of the healthcare team and patients on the differences between medication-related allergic reactions and medication intolerances.

*Note: This policy would supersede ASHP policy 1619.*

### **Rationale**

The common theme of several ASHP policies is that patients may be exposed to potentially life-threatening allergens in items encountered in the medication-use process (e.g., natural rubber latex, drugs, drug product excipients, devices, and supplies). Pharmacy involvement in collection, assessment, and documentation of a complete list of allergens pertinent to the medication-use process, including food, excipients, medications, devices, and supplies, would assist in clinical decision-making. Pharmacists should also minimize patient and healthcare worker exposure to known allergens, for example by limiting or banning the use of latex gloves in pharmacies and striving for latex-safe medication formularies. Although allergy information is becoming more readily accessible through the electronic health record (EHR) and clinical decision support systems, some well-known cross-sensitivities are good candidates to be included in medication-related databases.

Only about 5-10% of all medication-related adverse events are allergic in nature. Patients are often labeled with an allergy to many drugs on the basis of a side effect or intolerances such as headache or GI disturbance. Allergen misidentification and documentation can be detrimental to patient care by preventing the use of optimal drug agents or by causing re-exposure to a true allergen. Pharmacists can help clarify and provide detailed documentation in the EHR regarding patient allergens. Furthermore, there is inconsistent standards on how and where allergies are located in the EHR and as such, there should be a consistent and standardized approach to documentation.

### **Background**

The Council reviewed ASHP policy 1619, Preventing Exposure to Allergens, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

To advocate for ~~pharmacy~~ pharmacist participation in the collection, assessment, ~~and~~ documentation, and reconciliation of a complete list of allergens pertinent to medication therapy, including food, excipients, medications, devices, and supplies, ~~for the purpose of clinical decision-making~~; further,

To encourage vendors of electronic health records to create readily available and distinct data fields with consistent designations for medication allergies and intolerances; further,

To advocate that vendors of medication-related databases incorporate and maintain information about medication-related allergens and cross-sensitivities reactivity; further,

To encourage the accurate and complete documentation of allergens within the

electronic medical record, including detailed descriptions of the reactions occurring upon exposure, for the purpose of clinical decision-making; further,

To advocate that pharmacists actively review allergens pertinent to medication therapy and minimize patient and healthcare worker exposure to known allergens, as feasible; further,

To ~~encourage~~ promote the education of the healthcare team and patients of pharmacy personnel on the differences between medication-related allergens allergic reactions and medication intolerances.

### 5. Tobacco, Tobacco Products, and Electronic Nicotine Delivery Systems

- 1 To discourage the use, distribution, and sale of tobacco, tobacco products, and  
2 electronic nicotine delivery systems (e.g., vaporizers, vape pens, hookah pens, and  
3 electronic cigarettes and pipes) in and by pharmacies; further,
- 4 To advocate for tobacco-free environments in hospitals and health systems; further,
- 5 To promote the role of pharmacists in tobacco-cessation counseling and comprehensive  
6 medication management; further,
- 7 To join with other interested organizations in statements and expressions of opposition  
8 to the use of tobacco, tobacco products, and electronic nicotine delivery systems;  
9 further,
- 10 To educate the public and patients on the risks of nicotine consumption through  
11 traditional and electronic delivery systems.

*Note: This policy would supersede ASHP policy 1625.*

#### **Rationale**

Pharmacists, as healthcare providers, have long discouraged the use of tobacco and tobacco products as a threat to public health. Electronic nicotine delivery systems (e.g., vaporizers, vape pens, hookah pens, and electronic cigarettes and pipes) are new and unregulated delivery systems for nicotine. The contents of these systems include flavorings, propylene glycol, glycerin, and other unknown ingredients, and the long-term effects of their use have not been studied. Given these uncertainties, pharmacists should discourage their use as well.

Furthermore, pharmacists have a role in recommending and managing drug therapy to support cessation of nicotine-containing products, including tobacco and electronic nicotine delivery systems, as described in the [ASHP Therapeutic Position Statement on Cessation of Tobacco Use](#). Newer therapies, including varenicline, are associated with more and evolving safety risks when compared to nicotine replacement therapies. Given the complexity of drug

therapy, pharmacists should play a central role in ensuring the safe and appropriate use of these therapies.

### **Background**

The Council reviewed ASHP policy 1625, Tobacco, Tobacco Products, and Electronic Nicotine Delivery Systems, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~striketrough~~ indicates deletions):

To discourage the use, distribution, and sale of tobacco, tobacco products, and electronic nicotine delivery systems (e.g., vaporizers, vape pens, hookah pens, and electronic cigarettes and pipes) in and by pharmacies; further,

To advocate for tobacco-free environments in hospitals and health systems; further,

~~To seek, within the bounds of public law and policy, to eliminate the use and distribution of tobacco, tobacco products, and electronic nicotine delivery systems in meeting rooms and corridors at ASHP-sponsored events; further,~~

To promote the role of pharmacists in tobacco-cessation counseling and comprehensive medication ~~therapy~~ management; further,

To join with other interested organizations in statements and expressions of opposition to the use of tobacco, tobacco products, and electronic nicotine delivery systems; further,

To educate the public and patients on the risks of nicotine consumption through traditional and electronic delivery systems.

## **6. Use of Race Correction in Clinical Algorithms**

- 1 To recognize that clinical algorithms that only use race or ethnicity as a variable can
- 2 attribute to inequities and adverse outcomes; further,
  
- 3 To oppose the use of race or ethnicity correction in clinical algorithms unless there is
- 4 strong evidence to support its use and, when clinically relevant, to support uniform
- 5 documentation in the electronic health record of a patient-identified designation of
- 6 race or ethnicity; further,
  
- 7 To advocate that health systems remove algorithms based on race or ethnicity from all
- 8 sources of therapy decisions, medication information, and the electronic health record,
- 9 where strong evidence does not support its use; further,

- 10 To support further research on the impact of race or ethnicity on drug therapy and
- 11 outcomes; further,
- 12 To advocate that if research includes considerations based on race or ethnicity, the
- 13 reason for its use as a variable be specified; further,
- 14 To provide education on the limitations and appropriate use of race- or ethnicity-
- 15 corrected clinical algorithms.

### **Rationale**

As outlined in the ASHP Statement on Racial and Ethnic Disparities in Health Care, race and ethnicity are social constructs with a cultural rather than a scientific basis. Although patient care can and should be informed by a patient's racial or ethnic identity, healthcare providers need to recognize the limited utility of that information

There are currently numerous clinical algorithms and practice guidelines that use a patient's race or ethnicity to determine outcomes. The clinical algorithms are then used by providers to help guide individualized risk assessments and clinical decisions. In return, these algorithms may direct attention and resources away from racial and ethnic minorities. However, the majority of these clinical algorithms do not have data to support a patient's race or ethnicity as a clinical factor. When a rationale is given and traced to its origins, the answer leads to outdated, suspect racial science, or biased data. Additionally, these algorithms do not take into account socioeconomic factors and other social determinants of health that may have a large influence on health outcomes.

Currently, a patient's race or ethnicity plays a role in a clinical algorithms or practice guidelines in almost every therapeutic class, including cardiology, surgery, nephrology, obstetrics, urology, and oncology. For example, the American Heart Association Get with the Guidelines - Heart Failure adds 3 points to the risk score of a patient that is non-Black. The higher scores in this tool predict higher in-hospital mortality. Ultimately, this tool is used to help guide clinical decisions for allocations of healthcare resources and referral to cardiology. The consequences of adding race to this algorithm would mean less direct patient care due to the patient being deemed as lower risk. There are many other clinical algorithms that adds points to their risk score for a patient that is non-Black, such as the STONE Score, Urinary Tract Infection Calculator, and Osteoporosis Risk SCORE. Another example is the estimated glomerular filtration rate (eGFR) MDRD and CKD-EPI equations. Both these equations report higher eGFR for Black patients than for other patients with the same serum creatinine levels. Originally, this disparity was thought to be due to patients that identify as Black having a higher average serum creatinine. However, there have been some concerns that this is not always true, especially when looking at the complexity of patient's racial backgrounds. Overestimating a patient's renal function can delay the time to referral to a kidney specialist or transplantation. In short, the addition of race to the clinical algorithms leads to less patient-specific interventions and ultimately worse patient outcomes.

Healthcare providers using the clinical algorithms and practice guidelines should be educated on how to critically evaluate the addition of race and ethnicity, along with the



consequences of adding race when not clinically appropriate. Many providers do not assess the algorithm prior to implementing the results, which can lead to improper treatment of a patient.

Education on the limitations of the clinical algorithms can help providers and patients overcome the barriers that the addition of race and ethnicity has created. Additionally, the medical community needs to advocate to re-evaluate our current clinical algorithms and evaluate future algorithms to determine if there is an evidence-based reason that race should be included. It is imperative that the medical community, primarily researchers, understand how race and ethnicity affects the outcome before adding it into a clinical algorithm.

Researchers have developed guidelines to follow when trying to rationalize when race and ethnicity should be included or excluded in a study, such as explaining how the category was determined, considering all confounders, and determining whether there is uncertainty in the algorithm. Researchers should then favor the practices that will help close health inequities over practices that might amplify them. Appropriately determining if race should be included in the algorithm will then help decrease the inappropriate clinical implementation of these tools.

Future research is needed to determine the relationship between pharmacogenomics, race, and ethnicity. Most providers and researchers use the standard five races and two ethnicities categories determined by the Office of Management and Budget to categorize people according to race and ethnicity. However, many individuals do not fit into these categories due to their complex racial and ethnic backgrounds, which may ultimately fail to account for genetic differences.

Drug therapy stems from these clinical algorithms and practice guidelines, and pharmacists need to work with other providers to critically evaluate the current tools. Additionally, pharmacists could collaborate with other providers to perform research to help better understand the differences between genomics and race. Therefore, providers could assess when race and ethnicity should be added to future clinical algorithms and practice guidelines.

### ***Background***

The Council discussed the need for an ASHP policy on the use of race in clinical algorithms as more data has been published demonstrating that many of the studies that used race as a variable within the algorithms did not correctly consider the impact of factors outside of race, such as social determinants of health, when created. The Council also discussed the impact that social determinants of health, genomics, and socioeconomic status have on health. Council members shared their experiences with students, residents, and members of the healthcare team who were not aware of the role that these factors play in creating clinical algorithms and agreed that more education is needed. Council members also recognized that many of these algorithms are a part of a health system's medical record system and can also be found in order sets, laboratory results, and other areas, and there should be a concerted effort to remove algorithms based on race from these areas.

## 7. Testing and Documentation of Penicillin Allergy as a Component of Antimicrobial Stewardship

- 1 To advocate that state board of pharmacy regulations include penicillin allergy skin  
2 testing under pharmacists' scope of practice; further,
- 3 To advocate involvement of pharmacists in the clarification and assessment of penicillin  
4 allergy, intolerance, and adverse drug events; further,
- 5 To advocate for documentation and de-labeling of penicillin allergies, intolerances,  
6 reactions, and severities in the medical record when appropriate to facilitate optimal  
7 antimicrobial selection; further,
- 8 To recommend the use of penicillin skin testing, graded antibiotic challenges, and oral  
9 direct challenges in appropriate candidates when clinically indicated to optimize  
10 antimicrobial selection; further,
- 11 To support the education and training of pharmacists in the assessment, management,  
12 and documentation of penicillin allergies, intolerances, and adverse events; further,
- 13 To advocate for reimbursement for pharmacists' patient care services involved in  
14 penicillin allergy skin testing; further,
- 15 To educate patients, healthcare providers, and the public about the risks of inaccurate  
16 penicillin allergy labeling and the role of pharmacists in health-record reconciliation and  
17 the value of pharmacist-driven health-record reconciliation, including penicillin skin  
18 testing.

*Note: This policy would supersede ASHP policy 1921.*

### **Rationale**

Approximately 10% of all patients in the United States report having a penicillin allergy; however, only 1 in 10 patients with a labeled penicillin allergy are truly allergic. Furthermore, approximately 80% of patients with an IgE-mediated penicillin allergy lose their sensitivity after 10 years. Specific rates of cross-reactivity between penicillins and cephalosporins vary depending on specific resources, although the likelihood of cross-reactivity is lower than previously described. Historically, it has been estimated that 10% of patients with a true penicillin allergy will experience an allergic reaction if administered a cephalosporin, but this data is from early cross-reactivity studies with potential contamination of early cephalosporin products with penicillin G. More recent data suggest cross-reactivity rates of less than 1%. Cross-reactivity is more closely associated with structurally similar R-1 side chains than with the beta-lactam ring itself.

Penicillin allergies have led to considerable public health risks and unintended consequences, including receipt of more broad-spectrum antibiotics, suboptimal therapy for infectious disease management, more antibiotic-related costs, increased risk of adverse effects, and increased risk of methicillin-resistant *Staphylococcus aureus* and *Clostridioides difficile*. As such, structured and thorough interview assessments with appropriate documentation and de-labeling of penicillin allergies are necessary to combat these potential negative consequences of labeled penicillin allergies. Penicillin skin testing and graded or oral challenges are excellent opportunities to assist in the assessment and de-labeling of penicillin allergies. Although pharmacists are well positioned to be involved in these processes, state boards of pharmacy have different regulations regarding whether penicillin skin testing is within pharmacists' scope of practice. Penicillin allergy assessment, management, and documentation are excellent opportunities to improve pharmacist involvement in patient care and to improve antimicrobial stewardship initiatives for health systems, and offer a potential opportunity for pharmacists to bill for their services.

The American Academy of Allergy, Asthma, and Immunology, as part of the [Choosing Wisely](#) campaign, recommends against the overuse of non-beta-lactam antibiotics in patients with a history of penicillin allergy, without appropriate evaluation. In a research abstract from the Canadian Society of Allergy and Clinical Immunology meeting in 2014, researchers found that only 15% of hospital-discharged patients notified a family physician of a negative penicillin allergy evaluation; at the same time, 30% were still listed as penicillin allergic upon readmission to the hospital. Additionally, the existence of a pharmacist-provided allergy skin test has proven to positively impact patient care by optimizing antibiotic regimens and accelerate discharges for patients while reducing healthcare costs.

### **Background**

The Council reviewed ASHP policy 1921, Testing and Documentation of Penicillin Allergy as a Component of Antimicrobial Stewardship, as part of the discussion on the Pharmacist Role in Penicillin Testing and voted to recommend amending it as follows (underscore indicates new text):

To advocate that state board of pharmacy regulations include penicillin allergy skin testing under pharmacists' scope of practice; further, [clause moved from below]

To advocate involvement of pharmacists in the clarification and assessment of penicillin allergy, intolerance, and adverse drug events; further,

To advocate for documentation and de-labeling of penicillin allergies, intolerances, reactions, and severities in the medical record when appropriate to facilitate optimal antimicrobial selection; further,

To recommend the use of penicillin skin testing, graded antibiotic challenges, and oral direct challenges in appropriate candidates when clinically indicated to optimize antimicrobial selection; further,

To support the education and training of pharmacists in the assessment, management, and documentation of penicillin allergies, intolerances, and adverse events; further,

~~To advocate that state board of pharmacy regulations include penicillin allergy skin testing under pharmacists' scope of practice. [clause moved above]~~

To advocate for reimbursement for pharmacists' patient care services involved in penicillin allergy skin testing; further,

To educate patients, healthcare providers, and the public about the risks of inaccurate penicillin allergy labeling and the role of pharmacists in health-record reconciliation and the value of pharmacist-driven health-record reconciliation, including penicillin skin testing.

## 8. Use of Unapproved Gene Therapy Products, Drugs, Biologics, and Medical Devices (Biohacking)

- 1 To advocate for enhanced government oversight and regulation of use of gene therapy,  
2 drugs, biologic products, and medical devices created outside of the Food and Drug  
3 Administration approval process (i.e., "biohacking"), and aggressive enforcement of  
4 those regulations; further,
- 5 To oppose use biohacking on vulnerable and at-risk populations and those unable to  
6 provide consent; further,
- 7 To promote education of healthcare professionals regarding use of biohacking and its  
8 implications in the medical setting; further,
- 9 To encourage the pharmacy workforce to include questions about use of biohacking  
10 when obtaining medication histories; further,
- 11 To encourage the pharmacy workforce to ensure that patients using biohacking are  
12 educated about the risks and benefits of these treatments, including lack of regulatory  
13 oversight; further,
- 14 To recommend that health systems use a consistent method for documenting use of  
15 biohacking in the electronic health record.

### **Rationale**

Biohacking has been defined as "do-it-yourself biology or "do-it-yourself citizen science merging body modification with technology" (Yetisen AK. Trends Biotechnol. 2018; 36:744-7).

Biohacking is performed by biology enthusiasts, citizen scientists, and other like-minded individuals and includes neurohacking (focuses on brain stimulation for change); manufacturing of pharmaceutical products; implantation of modified technology; and the genetic modification of bacteria, yeast, plants, and humans (as a form of self-experimentation) to improve oneself or treat a disease.

Genetic biohacking in particular has proven to be easy and affordable, with individuals using inexpensive, semi-professional and portable labs to carry out their experiments, including Clustered Regularly Interspaced Short Palindromic Repeats (CRISPR) technology, which permits the user to edit the genome by removing, adding, or altering sections of DNA. It is estimated that more than 30,000 people are involved in do-it-yourself biology in the United States alone. Furthermore, many see themselves as serving the greater health interests of the patient community at large with the right to experiment and create treatments such as gene therapy as a form of social justice. However, many of these biohackers have little to no formal training in safety and do not obtain ethical reviews of their work as one would in an institution with an internal review board. Although most biohackers currently experiment only on themselves, concern about the practice may grow as the cost of traditional therapies, particularly biologics, increases, luring sick and desperate patients to biohackers in hopes of cheaper or more accessible treatments.

The other concern about the biohacking movement is bioterrorism. The Federal Bureau of Investigation continues to form relationships with labs where genetic experimentation occurs to police this threat, but the concern remains.

Currently in the United States, there is no ban on genome editing outside of licensed laboratories. Although the Food and Drug Administration (FDA) does have jurisdiction over regular raw biological products, traditional drug products, and do-it-yourself CRISPR kits, they have not taken public enforcement action against those conducting genome editing. This may be due to practicality, however, as many biohackers are individuals or work within a small community and are hard to track. Additionally, many current laws are outdated and apply only to agricultural genetic modification. The FDA has issued draft guidance for the regulation of intentionally altered genomic DNA in animals and stated that “any use of CRISPR/Cas9 gene editing in humans [is] gene therapy” and therefore subject to regulation.

Another facet of biohacking that must be addressed is its potential impact on manufacturing. For example, due to the high cost of biosimilar insulins, a community of biohackers has created the Open Insulin Project to develop an insulin production method for personal use. This and similar projects may lead to intellectual property, regulatory, patent, and legal issues that could impact manufacturing.

Another aspect of do-it-yourself biology is implantation of devices into one’s body for medical purposes. Many of these devices are used to monitor a medical condition or to optimize drug delivery to manage disease, such as implantation of veterinary chips for monitoring vital signs, use of a wearable artificial kidney that performs dialysis via a coated skin port, and homemade insulin pumps. Pharmacists need to be aware of these devices, as they impact how patients receive medications and how they are treated. At some point in their health journey, patients using these devices are likely to be admitted to a hospital, a mechanism for documentation of this information in the electronic health record is necessary. Furthermore, pharmacists will need to understand the impact these devices have on the

pharmacokinetics, pharmacodynamics, and other aspects of drug therapy.

An overall approach that should be considered is that of education of those engaged in the biohacking movement regarding the role of the federal agencies in consumer protection, risks and benefits and establish practice standards and norms that minimize harm.

### **Background**

The Council discussed biohacking as a topic of interest from the ASHP membership at large. The Council discussed this emerging area, noting that there are gaps in regulatory oversight as well as the need for education for pharmacists. The Council believed that a policy in this area is necessary given the safety, ethical, and regulatory hurdles this movement will encounter, as well as the risk to patients.

## **Board Actions**

### **Sunset Review of Professional Policies**

As part of sunset review of existing [ASHP policies](#), the following policy was reviewed by the Council and Board and found to be still appropriate. (No action by the House of Delegates is needed to continue this policy.)

- Patient-Reported Outcome Tools (1107)
- Appropriate Use of Antipsychotic Drug Therapies (1604)
- Safety of Epidural Steroid Injections (1605)

## **Other Council Activity**

### **Joint Meeting on Pandemic Preparedness**

On Tuesday, September 22, members of all councils and the Commission on Affiliate Relations met to hear presentations from Don R. Boyce and Joe Pinto of the Mount Sinai Health System on the lessons learned from Mount Sinai's experience with the COVID-19 pandemic. Council and Commission members were asked to reflect on current evidence, the presentations, background reading, meeting discussion, best practices, and personal experience to advise ASHP on pandemic-related policy issues relevant to the Council's purview. Council members considered existing and potential pharmacist roles in both operational and patient care aspects of the pandemic, and how the lessons learned from the pandemic could be applied to future crises that present similar circumstances. Key objectives of the discussion included considering the need for new or revised ASHP professional policy regarding pandemic preparedness and response, and suggesting elements of that policy, as well as reviewing current pharmacy practice related to pandemic preparedness and response and providing advice on ways ASHP can help advance pharmacy practice through the development of member tools and resources, best practices, education, and other programmatic approaches.

### **Adoption of Drug Therapies with Limited Data or Efficacy**

The Council discussed the issues that the current pandemic has brought to light, particularly surrounding the amount of information that has been published in the wake of the COVID-19

pandemic. The Council observed that there has been an incredible number of articles, case reports, and other publications in a short period of time about the care for these patients. These resources are often lacking in sample size, fail to demonstrate statistical or clinical significance, lack peer review, or have variable outcomes. The Council discussed how pharmacists and other medical professionals should balance the risks and benefits of relying on such studies in a time of urgent need, such as a pandemic, when safe and effective therapies are needed more urgently, considering the following:

- how to approach outcomes data where the effect of therapy on morbidity and mortality aren't clear;
- how to change disease management as therapies change as more information becomes available;
- how to assess free, open-access articles and press releases;
- the role of the pharmacist in therapy decision-making; and
- how ASHP and pharmacists at large should collaborate with other professional organizations to promote quality patient care.

Because the other councils were also looking at this topic as a larger discussion regarding pandemic preparedness, and the Council on Pharmacy Practice was creating policy on this issue, the Council on Therapeutics shared recommended clauses on the above-discussed areas with the Council on Pharmacy Practice.

### **Continuous Infusion Vancomycin Monitoring in the Outpatient Setting**

The Council reviewed the newly revised guideline: Therapeutic monitoring of vancomycin for serious methicillin-resistant *Staphylococcus aureus* infections and discussed the logistical and therapeutic considerations for continuous vancomycin monitoring, the patient populations would benefit most from outpatient continuous monitoring, barriers to this approach antimicrobial therapy, considerations for Bayesian monitoring, and education strategies providers to monitor this patient population. Ultimately, the Council believed that ASHP should provide more education on these published guidelines in the form of webinars, podcasts, and other media to aid pharmacists in evaluating and implementing these guidelines into their practice.

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# COUNCIL ON EDUCATION AND WORKFORCE DEVELOPMENT POLICY RECOMMENDATIONS

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*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.*

Julie A. Groppi, *Board Liaison*

## **Council Members**

Garrett Schramm, *Chair* (Minnesota)  
Christopher Edwards, *Vice Chair* (Arizona)  
Joseph Barone (New Jersey)  
Angela Bingham (Pennsylvania)  
Lauren Busch, *Student* (Missouri)  
Carol Heunisch (Illinois)  
Jesse Hogue (Michigan)  
Amy Holmes (North Carolina)  
Norman Hooten (Florida)  
Denise Kelley (Texas)  
Ann Lloyd (Oklahoma)  
Tiffani Neubel-Johnson (Texas)  
Jennifer Sternbach (New Jersey)  
Erika Thomas, *Secretary*

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## **1. Professional Identity Formation**

- 1 To encourage the pharmacy workforce and pharmacy education and training programs
- 2 to foster professional identity formation.

*Note: This policy would supersede ASHP policy 1113.*

### **Rationale**

The terms “professionalism” and “professional identity” are sometimes mistakenly used interchangeably. Professionalism is defined by behaviors that are often outwardly visible (e.g., credentialing, continuing education, efforts to advance the profession). In contrast, professional identity formation (PIF) is defined as the process of internalizing a profession’s core values and beliefs. PIF incorporates the three domains of thinking, feeling, and acting. PIF in pharmacy may be described as the process of developing a commitment to: (1) high professional standards of pharmacy practice, (2) high personal standards of integrity and competence, (3) serving humanity, (4) creating a just and inclusive healthcare system and society, (5) analytical thinking and ethical reasoning, (6) continuing professional development, (7) acquiring personal leadership skills, (8) developing effective interpersonal skills, (9) maintaining personal well-being and resiliency, and (10) membership and participation in professional organizations.





Pharmacy professionals and educators have a direct or indirect responsibility to support the growth and success of others in the pharmacy workforce through mentorship and modelling. As pharmacy professionals interact with learners, new practitioners, and even seasoned colleagues, they have the ability to model professional behavior, integrity, ethical standards, and service to the community. Pharmacy professionals who serve in formal or informal leadership roles are in a unique position to mentor others in leadership skills. Pharmacy professionals should mentor others in the various career paths they may pursue as well as encourage them to elevate their practice level and education.

Some of the barriers to PIF include mentors and preceptors being pressured into a role rather than being allowed to decide whether they choose to do so voluntarily, increased pharmacy workload, and staff burnout. Developing student professionalism (sometimes referred to as “professional socialization”) has been part of pharmacy education for decades, but a broader focus on PIF more generally will better serve the profession of pharmacy during a time of practice transformation than the current approach to teaching professionalism. Colleges of pharmacy, other providers of education and training programs, and employers could promote PIF by providing mentorship programs and other resources.

### **Background**

The Council reviewed ASHP policy 1113, Professional Socialization, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

To encourage ~~pharmacists~~ the pharmacy workforce and pharmacy education and training programs ~~to serve as mentors to students, residents, and colleagues in a manner that fosters~~ professional identity formation. the adoption of: (1) high ~~professional standards of pharmacy practice, (2) high personal standards of integrity and competence, (3) a commitment to serve humanity, (4) analytical thinking and ethical reasoning, (5) a commitment to continuing professional development, and (6) personal leadership skills.~~

## **2. Career Opportunities for Pharmacy Technicians**

- 1 To promote pharmacy technicians as valuable contributors to healthcare delivery;
- 2 further,
- 3 To advocate that pharmacy technicians complete an education and training program
- 4 accredited by ASHP and the Accreditation Council for Pharmacy Education (ACPE), and
- 5 maintain Pharmacy Technician Certification Board certification; further,
- 6 To advocate that pharmacy technicians complete ACPE-approved certificate programs
- 7 that provide training for their current or anticipated roles; further,

- 8 To develop and disseminate information about career and training opportunities that  
9 enhance the recruitment and retention of qualified pharmacy technicians; further,
- 10 To encourage employers to offer career advancement opportunities (e.g., career  
11 ladders) for pharmacy technicians; further,
- 12 To urge compensation for pharmacy technicians commensurate with advanced roles  
13 and responsibilities.

*Note: This policy would supersede ASHP policy 1610.*

### **Rationale**

As the responsibilities of pharmacy technicians expand and their role as a vital member of the healthcare team is recognized, it is imperative that pharmacy technicians be well trained and competent to perform those responsibilities. Pharmacists cannot provide quality patient care without the support of competent pharmacy technicians. To support pharmacists and promote retention, it is important that pharmacy technician positions be viewed as a career and not just a job. Pharmacy technicians should be provided opportunities for life-long advancement and compensated appropriately for advanced roles that they assume. There is current ASHP policy 1912 that addresses the *Pharmacy Technician Training and Certification*, which advocates for the education, training, and certification for new pharmacy technicians. This covers a need for the on-going professional development and career advancement for pharmacy technicians.

### **Background**

The Council reviewed ASHP policy 1610, Career Opportunities for Pharmacy Technicians, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strike through~~ indicates deletions):

To promote pharmacy technicians as valuable contributors to healthcare delivery; further,

To advocate that pharmacy technicians complete an education and training program accredited by ASHP and the Accreditation Council for Pharmacy Education (ACPE), and maintain Pharmacy Technician Certification Board certification; further,

To advocate that pharmacy technicians complete ACPE-approved certificate programs that provide training for their current or anticipated roles; further,

To develop and disseminate information about career and training opportunities that enhances the recruitment and retention of qualified pharmacy technicians; further,

To ~~support~~ encourage employers to offer pharmacy technician career advancement opportunities (e.g., career ladders) for pharmacy technicians, commensurate with training and education; further,

To ~~encourage~~ urge compensation models for pharmacy technicians ~~that provide a living wage~~ commensurate with advanced roles and responsibilities.

### 3. Zero Tolerance of Harassment and Discrimination

- 1 To assert that the pharmacy workforce has a right to expect and responsibility to ensure
- 2 a profession in which all individuals are treated with respect and civility, free of all
- 3 harassment and discrimination, including but not limited to sexual harassment and
- 4 malicious behaviors; further,
- 5 To commit to a culture of responsibility and accountability within the profession with
- 6 zero tolerance of harassment and discrimination; further,
- 7 To foster the development of tools, education, and other resources to promote such a
- 8 culture.

#### **Rationale**

The [Code of Ethics for Pharmacists](#) states that “A pharmacist acts with honesty and integrity in professional relationships.” The [ASHP Statement on Professionalism](#) includes among the elements of professionalism pride in and service to the profession, conscience and trustworthiness, and ethically sound decision-making. All forms of discrimination (e.g., race, color, sex, national origin, religious, sexual orientation/identity, age, disability), harassment (including sexual harassment), and malicious behaviors such as bullying, intimidation, or exploitation go against the core beliefs of the profession. All members of the pharmacy workforce have a professional responsibility to create and sustain a culture of responsibility and accountability within the profession in which all individuals are treated with respect and civility, with zero tolerance of harassment and discrimination.

A culture of responsibility and accountability requires that employers and organizations establish mechanisms for retaliation-free reporting of harassment and discrimination. For such a culture to thrive, the pharmacy workforce must recognize its professional obligation to not only follow institutional policies regarding prevention, reporting, and consequences for such behaviors but to seek out ways to improve the effectiveness of those policies and procedures. This culture of responsibility and accountability includes the workplace and learning environments but extends even to such personal but quasi-public conduct as interactions on social media. As stated in the [ASHP Statement on the Use of Social Media by Pharmacy Professionals](#), the “higher standards of conduct expected of professionals, even in personal behavior” imply that “[p]ostings on social media should be subject to the same professional standards and ethical considerations as other personal or public interactions.”

As stated in the [ASHP Statement on Professionalism](#), “[o]ne of the fundamental services of a professional is recruiting, nurturing, and securing new practitioners to that profession’s ideals and mission.” Formal and informal mentorship relationships are fundamental to the

growth and health of any profession, and abuses of those positions of trust are especially injurious to victims and the profession. These relationships should be subjected to the strictest scrutiny and oversight to ensure they are held to the highest standards of conduct.

To further the goal of creating and sustaining a culture of responsibility and accountability regarding harassment and discrimination, ASHP commits to fostering the development of tools, education, and other resources to help members, employers, and other organizations address these important issues.

### **Background**

Recent events in society and the pharmacy profession have drawn attention to sexual harassment, discrimination, and malicious behaviors. The Council reviewed ASHP policy position 1916, Intimidating and Disruptive Behaviors, and the [ASHP Statement on Professionalism](#) to determine whether ASHP policy fully addresses these issues. Although these policies include relevant elements, the Council concluded that ASHP and its members would benefit from policy that more directly and clearly expresses ASHP's stance on sexual harassment, discrimination, and malicious behaviors. The Council recognized the ASHP's webinar series "Creating Respectful Organizations: Your Rights and Responsibilities" served as an example of how ASHP is already providing resources to help members, employers, and other organizations address these important issues.

## **Board Actions**

### **Sunset Review of Professional Policies**

As part of sunset review of existing [ASHP policies](#), the following were reviewed by the Council and Board and found to be still appropriate. (No action by the House of Delegates is needed to continue these policies.)

- Quality of Pharmacy Education and Expansion on Colleges of Pharmacy (1108)
- Residency Equivalency (1109)
- Innovative Residency Models (1112)
- Cultural Competency (1613)

## **Other Council Activity**

### **Joint Meeting on Pandemic Preparedness**

On Tuesday, September 22, members of all councils and the Commission on Affiliate Relations met to hear presentations from Don R. Boyce and Joe Pinto of the Mount Sinai Health System on the lessons learned from Mount Sinai's experience with the COVID-19 pandemic. Council and Commission members were asked to reflect on current evidence, the presentations, background reading, meeting discussion, best practices, and personal experience to advise ASHP on pandemic-related policy issues relevant to the Council's purview. Council members considered existing and potential pharmacist roles in both operational and patient care aspects

of the pandemic, and how the lessons learned from the pandemic could be applied to future crises that present similar circumstances. Key objectives of the discussion included considering the need for new or revised ASHP professional policy regarding pandemic preparedness and response, and suggesting elements of that policy, as well as reviewing current pharmacy practice related to pandemic preparedness and response and providing advice on ways ASHP can help advance pharmacy practice through the development of member tools and resources, best practices, education, and other programmatic approaches.

## Endorsement of Camden Coalition Core Competencies

The Council voted to recommend endorsing the Camden Coalition Core Competencies for Front-Line Complex Care Providers.

## Recent Pharmacy Workforce-Related Survey Results and Updates

The Council discussed several recent pharmacy workforce-related survey results, including the AACP New Graduate Surveys, the 2019 National Pharmacist Workforce Survey (NPWS) and the recently launched Pharmacy Demand Report developed by the Pharmacy Workforce Center (PWC), to determine whether there are implications for ASHP policy.

The Council received an update on the Pharmacy Career Information Center (PCIC) and efforts underway to improve the pharmacy school applicant pipeline were highlighted. The Council discussed the importance of communicating to ASHP members that the profession is changing and the pharmacy workforce needs to be proactive about its future. The Council discussed how the profession should take this opportunity to highlight what pharmacists are trained to do and how we can continue to expand the scope of currently provided services.

## Pharmacy Residency Trends

The Council was provided pharmacy residency-related surveys, including Pharmacy Match 2020 statistics and high-level findings from the inaugural ASHP Resident Survey, to determine whether there are implications for ASHP policy. During the update on residencies, it was announced that the number of residency programs has exceeded 2600, although early estimates show a slowing of recruitment growth for the 2021-2020 pharmacy residency year, which could be related to workforce recruitment/retention impacted by the COVID-19 global pandemic. There has been a 39% growth in the number of residency programs in the past five years and continued growth in the early commitment process for PGY2 residency positions. Demographic data for residents and residency programs were previously removed due to the risk of discrimination; however, ASHP Accreditation Services has requested the addition of demographic data from Liaison International to connect the trends in pharmacy applicant, student, and resident diversity to evaluate the profession's journey on diversity, equity, and inclusion. Council members inquired about individual program level data from the resident and preceptor surveys, and ASHP will evaluate how to aggregate to minimize potential retaliation against residency program participants.

## ASHP Residency-Trained Credential

The Council discussed the topic of an ASHP residency credential in response to a

recommendation from the ASHP House of Delegates. Currently, there is no credential awarding pharmacists a letter designation (e.g., "RTP" for "residency trained pharmacist") for completion of an accredited residency training program. In the 2019 ASHP *Long-range Vision for the Pharmacy Workforce in Hospitals and Health Systems*, credentials are addressed, with no recommendation for a residency-trained letter designation. Specialty Board Certifications through the Board of Pharmacy Specialties (BPS) were emphasized instead. Council members noted the September 2020 ASHP letter to the sponsoring organizations of a recently released Emergency Medicine Residents Association (EMRA) Joint Statement on Post-Graduate Training of Nurse Practitioners and Physician Assistants, expressing ASHP's grave concern over the statement's call to limit use of the terms "resident," "residency," "fellow," and "fellowship" in a medical setting to postgraduate clinical training of medical school physician graduates within GME training programs.

The Council addressed this topic to explore the policy implications of creating a residency-trained credential to be used by pharmacists who have successfully completed an ASHP-accredited residency training program. Members agreed that this issue is most appropriately addressed through educational efforts to bridge divisions between pharmacy workforce practitioners rather than through creation of a separate credential for this segment of the pharmacy workforce.

## Workforce Support During Unprecedented Times

During this extraordinary time, hospitals and health systems were required to make decisions affecting their employees and took many approaches to stabilize their workforce. Now, as society continues through a global health threat, the Council was asked to reconsider workforce support and whether the pharmacy workforce is essential. As part of the conversation, Council members considered the definition of essential workers. According to the U.S. Department of Homeland Security, essential workers are those who conduct a range of operations and services that are typically essential to continue critical infrastructure operations. An essential employee is a designated employee who is required to work during a business closure in order to meet operational requirements. Council members reflected on the local impact of the ASHP Statement on Pharmacy Residency Furloughs from the COVID-19 pandemic, although the statement did not address the entire pharmacy workforce. Council members noted that the visibility of the role of pharmacists had in responding to the COVID-19 pandemic may assist with the Pharmacy is Right for Me campaign, a national online pharmacy student recruitment campaign that ASHP supports.

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# COUNCIL ON PHARMACY MANAGEMENT

## POLICY RECOMMENDATIONS

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*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.*

Jamie S. Sinclair, *Board Liaison*

### **Council Members**

Staci Hermann, *Chair* (New Hampshire)  
Arpit Mehta, *Vice Chair* (Pennsylvania)  
Jennifer Belavic (Pennsylvania)  
Daniel Dong (California)  
Monica Dziuba (Louisiana)  
Kaitlyn Grieves, *Student* (Kentucky)  
Amanda Hays (Missouri)  
Jessica Hill (New Jersey)  
Rondell Jagers (Georgia)  
Trinh Le (North Carolina)  
Bonnie Levin (Maryland)  
Christopher Scott (Indiana)  
Eric Maroyka, *Secretary*

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### **1. Minimizing the Use of Abbreviations**

- 1 To support efforts to minimize the use of abbreviations in healthcare; further,
- 2 To encourage education of healthcare professionals and learners (e.g., residents,
- 3 students) on minimizing the use of abbreviations across all patient care settings.

*Note: This policy would supersede ASHP policy 0604.*

### **Rationale**

Although there are anecdotal examples of medical abbreviations causing harm to patients, there is little good clinical evidence to demonstrate that medical abbreviation use is dangerous or is causing problems in the delivery of care. Nevertheless, minimizing or even eliminating the use of medical abbreviations in healthcare has been encouraged for decades. The Institute of Safe Medication Practices regularly receives reports of errors, some of which have resulted in adverse events, due to misinterpretation of medical abbreviations. The Joint Commission has regularly issued updates and guidance on the safe use of medical abbreviations and has also published a short list of dangerous medical abbreviations and dose expressions that should never be used. However, despite many key organizations discouraging the use of medical abbreviations, they continue to be used at an alarming rate. Such use can place new practitioners at great risk when they have to interpret the abbreviations, as the new practitioner may have limited knowledge about what the abbreviations mean.

**Background**

The Council reviewed ASHP policy 0604, Minimizing the Use of Abbreviations, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~striketrough~~ indicates deletions):

To support efforts to minimize the use of abbreviations in health care; further,

~~To collaborate with others in the development of a lexicon of a limited number of standard drug name abbreviations that can be safely used in patient care.~~

To encourage education of healthcare professionals and learners (e.g., residents, students) on minimizing the use of abbreviations across all patient care settings.

The Council suggested ASHP provide education and resources for healthcare professionals, students, and residents to help ensure they are equipped to identify and minimize or even eliminate the use of medical abbreviations in practice. The Council reviewed ASHP policy 0720, Standardizing Prefixes and Suffixes in Drug Product Names, as part of the background for this topic discussion and proposed that ASHP heighten its advocacy regarding its collaborative efforts to standardize drug prefixes and suffixes.

**2. Optimal Pharmacy Staffing**

- 1 To encourage pharmacy leaders to work in collaboration with physicians, nurses, health-
- 2 system administrators, and others to outline key pharmacist services that are essential
- 3 to safe and effective patient care and employee engagement; further,
  
- 4 To encourage pharmacy leaders to be innovative in their approach and to factor into
- 5 their thinking the potential benefits and risks of flexible staffing models, telehealth
- 6 practices, legal requirements, accreditation standards, professional standards of
- 7 practice, and the resources and technology available in individual settings; further,
  
- 8 To encourage pharmacy leaders to develop contingency plans for changes in staffing
- 9 models to accommodate rapid changes in the healthcare environment and the needs of
- 10 patients and staff; further,
  
- 11 To encourage pharmacy leaders to develop key performance indicators to support safe
- 12 staffing models.

*Note: This policy would supersede ASHP policy 2034.*

**Rationale**

The advancement of the pharmacy profession over the past decade has prepared and



positioned pharmacists to care for complex patients and adapt to the dynamic and rapidly progressive field of medicine. Throughout the years, an increased involvement of pharmacists in specialty areas such as transplant, critical care, oncology, and pain and palliative care has been observed. Therefore, it is imperative that such advancement is considered when developing staffing models, in order to ensure the pharmacy workforce is appropriately allocated for the provision of consistent, safe, and high-quality patient care.

The complexity of patient care will continue to increase, and with that, so will the expected responsibilities, opportunities, and skills of the pharmacy workforce. Consequently, pharmacists engaged in direct patient care are encouraged to pursue and maintain their training and credentialing in order to continue to enhance their competency, skills, and participation in innovative practice. The expansion and dynamic nature of the pharmacy profession requires new approaches to explore flexible staffing models to avoid a stagnant practice, encourage continual advancement, and accommodate the evolving priorities of the pharmacy workforce.

The development and implementation of flexible staffing models can enable pharmacists to engage in further professional development and career advancement (e.g., training in areas of specialization, degree programs) and enjoy a more stable work-life integration experience. Recently, more attention has been drawn to burnout, resilience, and job satisfaction among the pharmacy workforce. Research has shown that pharmacists are reporting increased job stress over the previous years and that approximately 53% of pharmacists are reporting a high degree of burnout, which can consequently threaten patient safety. Therefore, there is an imperative to develop staffing models to meet staff members' changing priorities and provide additional flexibility in the workplace. Implementation of flexible staffing models could improve performance and promote employee engagement in the workplace. Pharmacy leaders should be committed to maintaining high-quality and consistent patient care services and to also promote models that balance patient care with staff priorities.

Various options to consider when exploring flexible staffing models include telehealth practices, remote order review and verification (i.e., telecommuting), and productivity measures to ensure patient census is well distributed among pharmacists in charge of providing clinical services. Another concept related to flexible staffing models is leveraging pharmacy technicians' roles to support pharmacist engagement in direct patient care activities. Some institutions have explored data-driven, staffing-to-demand models based on real-time patient-volume metrics. The concept is to allocate staff to tasks based on the current workload, which is evaluated daily. Other institutions are also utilizing metrics such as number of doses dispensed at a certain point in time and volume of order verification throughout the day in order to divide patient care units evenly among pharmacists that perform order verification or provide clinical services. Flexible staffing models should support the following principles:

- Sufficient qualified staff must exist to ensure safe and effective patient care.
- During periods of staff shortages, pharmacists must exert leadership in directing resources to services that are the most essential to safe and effective patient care.
- Within their own organizations, pharmacists should develop contingency plans to be implemented in the event of insufficient staff—actions that will preserve services that

are the most essential to safe and effective patient care and will, as necessary, curtail other services.

- Among the essential services for safe and effective patient care is pharmacist review of new medication orders before the administration of first doses; in settings where patient acuity requires that reviews of new medication orders be conducted at any hour and similar medication-use decisions be made at any hour, there must be 24-hour access to a pharmacist.

The COVID-19 pandemic and the ensuing reduction in elective procedures, routine visits, and admissions amplified the emphasis on flexing staff to volume. To support fiscal solvency during and in the aftermath of the pandemic, organizations had to quickly pivot and align staff to accommodate shifts in volume, resulting in redesigned staffing models to optimize scheduling. These models have included a mix of onsite and remote offering of services to perform synchronous and asynchronous work in a more efficient manner, as well as staff furloughs. Flexing pharmacy staffing models have been previously described, such as pharmacy staffing-to-demand models; alternative work schedules; and productivity monitoring to guide hiring and staffing decisions.

Other healthcare disciplines (e.g., nursing) have historically utilized flexible staffing models to optimize services, reduce the risk of adverse events, and improve patient outcomes. The different models explored by nursing include patient ratio, key performance indicators, patient acuity, collaborative staffing, and supplemental staffing models. There is limited literature on the use of flexible staffing models, but the concept is being explored by various health-system pharmacy departments.

### **Background**

The Council reviewed ASHP policy 2034, Staffing for Safe and Effective Care, and voted to recommend amending it as follows (underscore indicates new text; ~~striketrough~~ indicates deletions):

To encourage pharmacy leaders to work in collaboration with physicians, nurses, health-system administrators, and others to outline key pharmacist services that are essential to safe and effective patient care and employee engagement; further,

To encourage pharmacy leaders to be innovative in their approach and to factor into their thinking the potential benefits and risks of flexible staffing models, telehealth practices, legal requirements, accreditation standards, professional standards of practice, and the resources and technology available in individual settings; further,

To encourage pharmacy leaders to develop contingency plans for changes in staffing models to accommodate rapid changes in the healthcare environment and the needs of patients and staff; further,

To encourage pharmacy leaders to develop key performance indicators to support safe staffing models.

Recognizing that organizations are increasingly facing the prospect of staff expense reduction, the Council recommended ASHP explore the development of a statement or a set of guidelines related to best practice staffing model considerations for hospitals and health systems. The Council acknowledged that productivity metrics in and of themselves cannot be relied upon to support a particular practice model and that a combination of factors most effectively expresses the work and efforts of a pharmacy service. Different assumptions about staffing discussed by the Council, which could serve as a list of concepts for a best practice document, include: integration of onsite and remote staffing; extending reach with telehealth pharmacy practice (e.g., extension of baseline acute and ambulatory care clinical service capability to rural sites); and use of key performance indicators, taking into account census and non-census-based characteristics.

A concern voiced with an increased shift to remote work is potential degradation in relationship and trust building with onsite staff. The Council suggested ASHP review the ASHP Guidelines on Remote Order Entry Processing to determine whether revision of the document is required to reflect contemporary approaches. ASHP should further consider advocacy or partnership with organizations and state affiliates regarding options and education on changing expectations for remote work.

Finally, the Council recognized that there is now an opportunity for ASHP to take advantage of the lessons of COVID-19 to advocate for interstate pharmacist licensure (ASHP policy 2030) or a licensure compact to expand the mobility of pharmacists, particularly as it relates to remote work.

### 3. Patient Access to Pharmacist Care Within Provider Networks

- 1 To advocate for laws and regulations that require healthcare payer provider networks
- 2 to include pharmacists and pharmacies providing patient care services within their
- 3 scope of practice when such services are covered benefits; further,
  
- 4 To advocate for laws and regulations that require healthcare payer provider networks
- 5 to include all qualified pharmacists and pharmacies who apply to participate as a
- 6 provider in the network and to reimburse all participating providers fairly and equitably
- 7 for services that are a covered benefit; further,
  
- 8 To acknowledge that healthcare payers may develop and use criteria to determine
- 9 provider access to its networks to ensure the quality and viability of healthcare services
- 10 provided; further,
  
- 11 To advocate for laws and regulations that would help ensure the same level of patient
- 12 care within a payer network by requiring healthcare payers to (1) disclose to
- 13 participating providers and those applying to participate the criteria used to include,
- 14 retain, or exclude providers; (2) ensure that those criteria are standardized across all

- 15 network providers; and (3) collect data on how well providers meet those criteria and  
16 report that data to providers; further,
- 17 To advocate for comparative, transparent sharing of performance and quality measure  
18 data based on those criteria.

*Note: This policy would supersede ASHP policy 1808.*

### **Rationale**

As hospitals and healthcare organizations have become more engaged in developing ambulatory care and specialty pharmacy services, pharmacies and pharmacists providing patient care services within those settings increasingly find themselves excluded from healthcare payer networks and non-integrated delivery networks with specialty pharmacies. Insurers continue to carve out care from hospitals and health systems by providing patient care offerings that include but are not limited to infusion services. Vertical integration of the healthcare value chain has given payers more control over healthcare costs and has better positioned them to link directly with providers and negotiate value-based contracts. Vertically integrated systems allow payers to steer patients towards lower-cost-of-care options and block health-system pharmacies and pharmacists providing patient care services from joining their networks. ASHP acknowledges that healthcare payers may develop and use criteria to determine provider access to its networks to ensure the quality of services and the financial viability of providers (i.e., ensuring sufficient patient volume to profitably operate), but when creating provider networks, payers should include pharmacies and pharmacists providing patient care services, within their scope of practice, when such services are covered benefits. To ensure equal treatment for healthcare providers, payers should be required to disclose to participating providers and those applying to participate in a provider network the criteria used to include, retain, or exclude providers. When pharmacists obtain provider status, the infrastructure required to implement direct, independent patient care and billing for provider-based services needs to be in place and accessible. Although a possible risk of payer transparency is a reduction in market competition, comparative, transparent sharing of performance and quality measure data, based on standardized criteria, reveals the level of patient care provided and demonstrates to payers and providers where their performance and quality fall in comparison to others. Ensuring pharmacists and pharmacies have the opportunity to engage and have access to payers and payer networks improves coordination of care and patient access to pharmacists' care; reduces the burden on patients (e.g., access to limited distribution drugs, eliminating additional copays); and ensures laws, rules, regulations, standards, and best practices for medication management are implemented and enforced.

### **Background**

The Council reviewed ASHP policy 1808, Patient Access to Pharmacist Care Within Provider Networks, in response to a recommendation from the ASHP House of Delegates, and voted to recommend amending it as follows (underline indicates new text; ~~strikethrough~~ indicates deletions):

To advocate for laws and regulations that require healthcare payer provider networks to include pharmacists and pharmacies providing patient care services within their scope of practice when such services are covered benefits; further,

To advocate for laws and regulations that ~~allow~~ require healthcare payer provider networks to include all qualified pharmacists and pharmacies who apply to participate as a provider within a healthcare payer's in the network and to reimburse all participating providers fairly and equitably for services that are a covered benefit if the pharmacist or pharmacy meets the payer's criteria for providing those healthcare services; further,

To acknowledge that healthcare payers may develop and use criteria to determine provider access to its networks to ensure the quality and viability of healthcare services provided; further,

~~To advocate that healthcare payers be required to disclose to pharmacists and pharmacies applying to participate in a provider network the criteria used to include, retain, or exclude pharmacists or pharmacies.~~

To advocate for laws and regulations that would help ensure the same level of patient care within a payer network by requiring healthcare payers to (1) disclose to participating providers and those applying to participate the criteria used to include, retain, or exclude providers; (2) ensure that those criteria are standardized across all network providers; and (3) collect data on how well providers meet those criteria and report that data to providers; further,

To advocate for comparative, transparent sharing of performance and quality measure data based on those criteria.

Due to the far-reaching and complex implications of the policy, the Council sought review of proposed amendments and suggestions on wording from the executive committees of the Section of Specialty Pharmacy Practitioners (SSPP) and the Section of Pharmacy Practice Leaders (SPPL). The SSPP and SPPL executive committees reviewed the draft policy position and provided constructive edits, consistent with the intent of the policy rationale, to ensure the policy recommendation is relevant and assertive.

#### **4. ASHP Statement on the Roles and Responsibilities of the Pharmacy Executive**

To approve the ASHP Statement on the Roles and Responsibilities of the Pharmacy Executive (Appendix A).

## Board Actions

### Sunset Review of Professional Policies

As part of sunset review of existing [ASHP policies](#), the following were reviewed by the Council and Board and found to be still appropriate. (No action by the House of Delegates is needed to continue these policies.)

- Computerized Provider Order Entry (0105)
- Surface Contamination on Packages and Vials of Hazardous Drugs (1615)

## Other Council Activity

### Joint Meeting on Pandemic Preparedness

On Tuesday, September 22, members of all councils and the Commission on Affiliate Relations met to hear presentations from Don R. Boyce and Joe Pinto of the Mount Sinai Health System on the lessons learned from Mount Sinai's experience with the COVID-19 pandemic. Council and Commission members were asked to reflect on current evidence, the presentations, background reading, meeting discussion, best practices, and personal experience to advise ASHP on pandemic-related policy issues relevant to the Council's purview. Council members considered existing and potential pharmacist roles in both operational and patient care aspects of the pandemic, and how the lessons learned from the pandemic could be applied to future crises that present similar circumstances. Key objectives of the discussion included considering the need for new or revised ASHP professional policy regarding pandemic preparedness and response, and suggesting elements of that policy, as well as reviewing current pharmacy practice related to pandemic preparedness and response and providing advice on ways ASHP can help advance pharmacy practice through the development of member tools and resources, best practices, education, and other programmatic approaches.

### ASHP Statement on the Role of Health-System Pharmacists in Emergency Preparedness

The Council recommended that the Council on Pharmacy Practice consider revision of the ASHP Statement on the Role of Health-System Pharmacists in Emergency Preparedness. As preliminary guidance for a drafting team, the Council drafted suggestions on how the guidelines could be improved.

The Council also discussed the idea of an emergency preparedness self-assessment survey, similar to the web-based Practice Advancement Initiative gap assessment tools, as a tangible member tool for ASHP to explore. The intent of the tool would be to inform emergency preparedness readiness posture with a possibility to consider a mentor/match process to help struggling hospitals close significant emergency preparedness gaps. The Council proposed ASHP develop and promote education and training opportunities (e.g., a professional certificate program, journal theme collection) to ensure appropriate attention is placed on leadership and engagement with emergency preparedness and response and its impact on current and future

pharmacy operations. Continued efforts to amplify ASHP resources on well-being and resilience was also recommend by the Council.

## Ensuring the Security of Medications Stored in Perioperative Areas

During its June 2020 summer call, the Council discussed the practice implications of a position statement of the American Society of Anesthesiologists (ASA) that supports leaving noncontrolled medications in or on top of unlocked anesthesia carts in an operating room suite for brief periods. Subsequent to the summer call, a few Council members participated on a separate call to explore ASHP policy needs related to this topic and evaluate the different options in advance of 2020 Policy Week.

## ASHP Statement on Telepharmacy

The Council discussed the ASHP Statement on Telepharmacy as part of sunset review. The Council decided that the statement needs revision to take into account the near-term and emerging future roles of telehealth pharmacy practice. The term “telehealth pharmacy practice” was the terminology the Council agreed upon as a suggested replacement for “telepharmacy.” The Council developed a bullet-point list of topics that serves as preliminary policy guidance to address in the revised statement and suggested a joint drafting team, consisting of volunteers from the Council and section(s) (e.g., SOPIT, SPPL, SACP), be charged with revising the ASHP Statement on Telepharmacy.

There was brief discussion of telehealth pharmacy practice that suggested the Council would favor the development of guidelines or a more easily adaptable toolkit. Additionally, this may present an opportunity to align with or consolidate with other existing ASHP guidelines.

As stated elsewhere, the Council proposed ASHP investigate advocacy options regarding the pursuit and realization of an interstate pharmacist licensure (related ASHP policies 2030, 2024, and 1310) to enable leveraging use of tele-technologies across state lines.

The Council also suggested ASHP pursue survey and publication opportunities (e.g., case studies, journal theme collection) to capture how telehealth pharmacy practice is being effectively utilized to demonstrate gains in efficiency and improved patient access and medication safety. Finally, the Council encouraged strategic communications to improve awareness of the ASHP Telehealth Resource Center on [ashp.org](http://ashp.org).

## ASHP Guidelines on the Recruitment, Selection, and Retention of Pharmacy Personnel

The Council reviewed the ASHP Guidelines on the Recruitment, Selection, and Retention of Pharmacy Personnel and recommended that they be updated. The Council focused on creating a list of higher-level concepts that should be addressed in the guidelines and which would be addressed more in depth by the actual drafting team. Some concepts for the drafting team to consider when amending the guidelines include labor contracts; virtual and alternate work schedules; job sharing; generational differences; contemporary interview questions; career ladder opportunities; diversity, equity, and inclusion; and pharmacy technician recruitment.

## **ASHP Guidelines on Medication Cost Management Strategies for Hospitals and Health Systems**

The Council reviewed ASHP Guidelines on Medication Cost Management Strategies for Hospitals and Health Systems and recommended that they be revised to account for the current approaches to cost-saving initiatives and issues related to patient-centered care and fiscal stewardship. The Council suggested how the guidelines could be improved by offering higher-level concepts that should be addressed in the guidelines and which would be addressed more in depth by the actual drafting team.

The Council believed that physician leadership and front-line pharmacy staff do not always have an understanding of revenue cycle, proper chargemaster management, and medication cost-containment strategies. The Council suggested ASHP provide education on cost-containment strategies geared toward enhancing pharmacy staff understanding and physician leader buy-in that aligns with these strategies.

## **ASHP Statement on the Roles and Responsibilities of the Pharmacy Executive**

The Council reviewed the draft statement with amendments prepared by members of the Section of Pharmacy Practice Leaders (SPPL) Executive Committee. The Council felt key components were addressed to update the statement, taking into account contemporary and emerging roles of the pharmacy executive, but offered a few suggestions on how the document could be strengthened.

## **ASHP Statement on Leadership as a Professional Obligation**

The Council reviewed the ASHP Statement on Leadership as a Professional Obligation and recommended that it be updated.

## **ASHP Guidelines on Preventing Diversion of Controlled Substances**

The Council reviewed the ASHP Guidelines on Preventing Diversion of Controlled Substances and recommended that they be updated.



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# COUNCIL ON PHARMACY PRACTICE

## POLICY RECOMMENDATIONS

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*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.*

Kristina L. Butler, *Board Liaison*

### **Council Members**

Andrew Stivers, *Chair* (Georgia)  
Amanda Hansen, *Vice Chair* (Ohio)  
Michael Dickens (Idaho)  
Karl Gumper (Massachusetts)  
Barbara Hintzen (Minnesota)  
Molly Leber (Connecticut)  
Karen McConnell (Colorado)  
Alex Mersch (Iowa)  
Christopher Pack (Oklahoma)  
Kuldip Patel (North Carolina)  
Brittany Riley (West Virginia)  
Jamielynn Sebaaly (North Carolina)  
Kenny (Jon) Wilson, *Student* (Alabama)  
Anna Legreid Dopp, *Secretary*

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### **1. Role of the Pharmacist and Pharmacy Technician in Pandemic Preparedness and Response**

- 1 To advocate that all healthcare organizations include pandemic preparedness in
- 2 emergency preparedness planning; further,
  
- 3 To promote collaboration and communication among healthcare workers, healthcare
- 4 organizations, government agencies, industry, and other stakeholders in pandemic
- 5 preparedness and response; further,
  
- 6 To advocate that pharmacy personnel be included as leaders on teams responsible for
- 7 pandemic preparedness planning and response at the federal, state, local, and
- 8 institutional levels, and that they integrate such planning into emergency preparedness
- 9 planning for their workplaces; further,
  
- 10 To encourage all healthcare organizations to establish criteria for evidence-based
- 11 medication-use decisions, even when such evidence is scarce, incomplete, or conflicting,
- 12 and recognize the unique role that pharmacy personnel have in ensuring the safe and
- 13 effective use of medications based on best available evidence and resources; further,

- 14 To advocate that healthcare organizations recognize the unique and collective stress a  
15 pandemic places on healthcare workers and provide suitable resources to maintain  
16 workers' well-being and resilience; further,
- 17 To support research on and provide resources and education to aid the pharmacy  
18 workforce in preparing for and responding to pandemics.

### **Rationale**

ASHP has long advocated “that hospital and health-system pharmacists must assertively exercise their responsibilities in preparing for and responding to disasters, and the leaders of emergency planning at the federal, regional, state, and local levels must call on pharmacists to participate in the full range of issues related to pharmaceuticals.” (ASHP Statement on Emergency Preparedness)

The Coronavirus Disease 2019 (COVID-19) global pandemic differs from other types of disasters in significant respects, testing the resiliency of the healthcare system and workforce. Treating patients with a novel viral pathogen has driven rapid evolution in therapies, forcing healthcare providers to make patient care decisions based on scarce, incomplete, or conflicting information. These decisions have sometimes been complicated by shortages of crucial drugs, equipment, or staff, creating a crisis standard of care in which difficult patient care decisions must be made. The patient surges that healthcare organizations have had to manage have lasted significantly longer than those of other disasters. Healthcare workers have faced stressful patient care situations and extended shifts for a longer period of time than in other disasters. In addition, the fear of infection and of spreading that infection to family members and others has added additional stress. Infection control procedures have shut down some areas of healthcare operations, forcing healthcare workers into unfamiliar roles and care settings.

ASHP advocates that the lessons learned from the COVID-19 pandemic be shared broadly and incorporated into emergency planning at the federal, state, local, institutional, and pharmacy department levels. Pharmacy leaders, with their unique understanding of medication-use processes, should be relied upon to provide strategic direction on the full range of issues related to medication use, especially when evidence is scarce, incomplete, or conflicting, and drugs or other critical resources are in shortage. The pharmacy workforce should incorporate the lessons learned in its emergency planning efforts, integrating those efforts into the efforts of their institutions and communities. ASHP pledges to promote collaboration and communication among the various stakeholders in pandemic preparedness and response, and to provide resources and education to aid the pharmacy workforce and others in preparing for and responding to pandemics, including resources regarding novel therapies, shortages of drugs and other critical supplies, and healthcare worker well-being and resilience.

### **Background**

The Council considered the topic at the suggestion of ASHP members and staff and after participating in the Joint Council and Commission Meeting on Pandemic Preparedness and Response. The Council recognized that the topic has far-ranging implications for ASHP policy

and that other councils and the Commission on Affiliate Relations were also examining ASHP policy on the topic. The Council agreed that their proposed policy may need to be consolidated or harmonized with the recommendations of those other committees, and that that the topic would need to be addressed in a variety of ways, through revision of ASHP statements and guidelines, and through the development of other resources (see Other Council Activity for other Council actions).

## 2. Role of the Pharmacist and Pharmacy Technician in Supporting Patient Access to Medical Supplies

- 1 To support patient access to medical supplies as part of a comprehensive treatment
- 2 plan; further,
- 3 To advocate for policies that empower pharmacy personnel to facilitate patient access
- 4 to and effective use of medical supplies, including reimbursement policies; further,
- 5 To educate pharmacists, other healthcare professionals, payers, and policymakers
- 6 about the role of pharmacy personnel in helping patients obtain and use medical
- 7 supplies; further,
- 8 To collaborate with other healthcare professional and patient advocacy organizations to
- 9 advocate for expanded patient access to medical supplies.

*Note:* For purposes of this policy, “medical supplies” includes durable medical equipment, Food and Drug Administration-approved medical devices, and other nondurable disposable healthcare materials.

### **Rationale**

Pharmacists and pharmacy technicians have the knowledge and skills to support patient access to medical supplies and equipment, durable medical equipment (DME), and medical devices. These tools, like medications, are essential components to a patient’s personalized care plan. Although many providers combine medical supplies and equipment, DME, and medical devices under the umbrella term “medical supplies,” as is done here for purposes of this policy, there are critical differences between them that determine how these items are accessed and reimbursed. Under Centers for Medicare & Medicaid Services (CMS) rules, “medical supplies and equipment” (e.g., bandages and gauzes) are nondurable disposable healthcare materials used to serve a medical purpose that cannot be used in the absence of illness or injury or repeatedly by different individuals. CMS typically does not consider medical supplies and equipment as a covered benefit. DME (e.g., blood sugar monitors, blood sugar test strips, continuous glucose monitors, and infusion pumps and supplies) are durable healthcare materials used at home that can withstand repeated use, provide a medical purpose, and are not used in the absence of an illness or injury. In contrast to medical supplies and equipment, DME is covered under Medicare Part B. Finally, the Food and Drug Administration (FDA) defines

a medical device as an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory (FDA. Medical Devices. Available at: <https://www.fda.gov/medical-devices>. Accessed August 20, 2020).

Pharmacists are experts in initiating and managing a patient's comprehensive medication management (CMM) plan. A CMM is an individualized care plan that helps patients achieve specific goals of therapy. The patient-centered medical home: integrating comprehensive medication management to optimize patient outcomes resource guide, 2nd ed. ([www.pcpc.org/sites/default/files/media/medmanagement.pdf](http://www.pcpc.org/sites/default/files/media/medmanagement.pdf)). Any intervention that supplements medication goals and improves a patient's quality of life and patient outcomes should be considered in the CMM process and plan, including use of medical supplies and equipment, DME, and medical devices, and provide an opportunity for a pharmacist or pharmacy technician to improve patient care.

ASHP has long advocated for the role pharmacists have in helping patients obtain and properly use drug delivery systems and devices. The ASHP Statement on the Pharmacist's Role with Respect to Drug Delivery Systems and Administration Devices states:

Pharmacists bear a substantial responsibility for ensuring optimal clinical outcomes from drug therapy and are suited by education, training, clinical expertise, and practice activities to assume responsibility for the professional supervision of drug delivery systems and administration devices. As a natural extension of efforts to optimize drug use, pharmacists should participate in organizational and clinical decisions with regard to these systems and devices.

Extension of those responsibilities to medication-related medical supplies and equipment, DME, and medical devices is a natural progression in pharmacist patient care. There are many actions that pharmacists can implement to help improve patient outcomes in regards to medical supplies and equipment, DME, and medical devices. To increase patient access, pharmacists can collaborate with patients and physicians to determine which device to use based on patient indication, preferences, and product specifications. Pharmacists could also collaborate with CMS and other insurance plans to ensure that patients have adequate coverage of DME along with advocating to allow pharmacists to submit claims for reimbursement. Furthermore, ASHP could collaborate with patient advocacy organizations and disease specific organizations (e.g., American Diabetes Association) to advocate for increased patient access to specific medical supplies and equipment.

Additionally, pharmacists can advocate for broader pharmacy management of medical supplies and equipment, DME, and medical devices along with medications as a part of the patient's CMM plan. Pharmacists can support patient access through documentation required for coverage, provide education on how to use the device, monitor the device for safety and efficacy, and interpret results if applicable. Collaborative practice agreements and credentialing and privileging are two ways pharmacist can use data provided from the devices to help make necessary changes to the patient's medication plan. Pharmacists' expertise should be leveraged to help patients procure and manage their medical supplies and equipment, DME, and medical devices to provide all-encompassing comprehensive medication management.

**Background**

The Council considered the topic at the suggestion of ASHP members and staff. Council members each had a unique perspective on the topic but universally agreed that there is considerable variation in and challenges with navigating pathways to support patient access to medical supplies and equipment, DME, and medical devices. Potential actions that the Council agreed to include development of professional policy, dissemination of education and resources, and advocacy efforts. Overall goals of these activities are to advocate for appropriate, safe, and transparent criteria for use by insurers and suppliers; enhance patient care by streamlining patient access; and close loopholes that prevent pharmacists from reliably billing for DME in their institutions. Council members also agreed that pharmacy technicians should be leveraged to support pharmacists in their efforts based on their scope of duties.

**3. Standardized Documentation and Attribution of Clinical Interventions by Pharmacists**

- 1 To promote the use of standardized documentation of clinical interventions by
- 2 pharmacists in a patient's health record to improve patient outcomes and allow for the
- 3 attribution of pharmacist services across the continuum of care; further,
- 4 To advocate for the standardization in the measurement of clinical interventions by
- 5 pharmacists on patient outcomes.

**Rationale**

ASHP has advocated for the importance of documentation of pharmacist care in patient medical records to ensure accurate and complete documentation of the care and services provided to the patient. However, differences in pharmacy practice within and across health systems make it hard to standardize such documentation in the electronic health record (EHR). The differences are caused by diverse clinical practices, EHR permissions, and documentation elements of the clinical interventions made by pharmacists. Documentation by the pharmacist may change depending on care settings, the value of intervention, or in respect to reimbursement. As a result, it is hard to validate and evaluate pharmacists' impact on patient outcomes due to the incomplete measurement and attribution of such interventions and lack of standardized documentation.

Other healthcare providers have released similar statements on documentation within their fields. The American College of Physicians states that physicians should define professional standards regarding clinical documentation and use macros and templates appropriately (Kuhn T, Basch P, Barr M et al. Clinical documentation in the 21st century: executive summary of a policy position paper from the American College of Physicians. *Ann Intern Med.* 2015; 162:301-3). The American Nurses Association (ANA) Principles for Nursing Documentation states that if patient documentation is not timely, accurate, accessible, complete, legible, readable, and standardized, it will interfere with the ability of those who were not involved in and are not familiar with the patient's care to use the documentation (ANA's Principles for Nursing Documentation: Guidance for Registered Nurses. 2010).

[www.nursingworld.org/~4af4f2/globalassets/docs/ana/ethics/principles-of-nursing-documentation.pdf](http://www.nursingworld.org/~4af4f2/globalassets/docs/ana/ethics/principles-of-nursing-documentation.pdf)). The American Speech-Language-Hearing Association (ASHA) states that speech-language pathologists should participate in the development of the templates that they will use for billing and clinical documents so that the information that is necessary is provided (ASHA. Documentation in health care.

[www.asha.org/PRPSpecificTopic.aspx?folderid=8589935365&section=References](http://www.asha.org/PRPSpecificTopic.aspx?folderid=8589935365&section=References)).

Other healthcare providers have recognized the benefits of requiring their documentation to be recorded in a standardized form that allows other healthcare stakeholders to quickly access the information. Employing accessible, standardized documentation improves communication and knowledge sharing between providers. Pharmacists are valuable members of the healthcare team that contribute significantly to patient care. More consistency and standardization of a pharmacist's documentation can provide essential information on a patient's care, such as therapeutic drug monitoring, appropriateness and effectiveness of patient's medications, or pain and antibiotic management, for example. Standardized notes enable healthcare team members to review the pharmacist note and become aware of the medication plan. Implementing standardized documentation across all healthcare providers, especially pharmacists, will allow for increased interactions and information to be shared between healthcare providers to improve overall patient care.

Implementing a standardized clinical pharmacy documentation system will also inform and enable a measurement approach for evaluation of the impact of pharmacist services. Many institutions use different tools for operational internal and external benchmarking to meet these measures; however, the tools are limited in their use for clinical benchmarking (Rough SS, McDaniel M, Rinehart JR. Effective use of workload and productivity monitoring tools in health-system pharmacy, pt 1. *Am J Health Syst Pharm.* 2010; 67:300–11). Institutions have tried to implement their own clinical pharmacy productivity measures tools to help demonstrate the value of de-centralized pharmacists on patient care teams. However, no current measure or measure set accurately identifies the impact pharmacists have on patient care outcomes or allows comparison and benchmarking across institutions. In response to this need, the ASHP Pharmacy Accountability Measures (PAM) Work Group seeks to identify pharmacy-related clinical quality measures that institutions could use for benchmarking (Andrawis MA, Carmichael J. A suite of inpatient and outpatient clinical measures for pharmacy accountability: recommendations from the Pharmacy Accountability Measures Work Group. *Am J Health Syst Pharm.* 2014; 71:669–78).

The PAM Workgroup evaluated quality measures endorsed by the National Quality Forum (NQF) and curated those selected into six therapeutic areas, which include antithrombotic safety, cardiovascular control, glycemic control, pain management, behavioral health, and antimicrobial stewardship (Andrawis M, Ellison C, Riddle S et al. Recommended quality measures for health-system pharmacy: 2019 update from the Pharmacy Accountability Measures Work Group. *Am J Health Syst Pharm.* 2019; 76:874–87). Using the NQF-endorsed measures along with appropriate documentation of these interventions may allow institutions to more readily benchmark performance.

After determining the most appropriate pharmacy quality measures, the documentation of the interventions should be standardized and efficient. Implementing standardized

templates and more retrievable data fields in the documentation process has been shown to improve workflow for pharmacists. One study demonstrated that by implementing EHR note templates that allowed retrievable data to be incorporated, pharmacists increased the amount of time providing value-added services from 47% to 72% and in providing direct patient care from 27% to 53% (Ekstrand MJ, Kobany JM, Pestka DL. Leveraging quality improvement principles in comprehensive medication management pharmacy practice: a case example. *J Am Pharm Assoc.* 2020; 60:509-15.e1.).

Finally, pharmacists must also be properly educated on how to use a standardized pharmacy documentation system. In one study, a health system that had implemented an improved pharmacist clinical intervention documentation system found that a focused education initiative increased the number of pharmacy clinical interventions 120%, and associated cost avoidance dollars increased proportionally (Rector KB, Veverka A, Evans SK. Improving pharmacist documentation of clinical interventions through focused education. *Am J Health-Syst Pharm.* 2014; 71:1303–10). Overall, research has shown that focused education has helped increase the number of clinical interventions documented in a standardized way, leading ultimately to better care for patients and demonstrating the value of pharmacy services.

### **Background**

The Council considered the topic at the suggestion of ASHP members and staff. Dr. McConnell reviewed a presentation she gave on the topic at the 2019 Midyear Clinical Meeting. Dr. Pack also pointed to similar approaches used for clinical pharmacy services in the Indian Health Service. Council members reviewed ASHP Policy 1419, Documentation of Patient Care Services in the Permanent Health Record, and felt a new policy was still warranted based on the topic of interest. The Council saw a great deal of alignment between the work of the PAM Workgroup and efforts to implement standardized documentation of clinical pharmacist interventions. The Council also voted to work with other ASHP component bodies to establish a workgroup to develop standardized clinical pharmacy documentation and metrics (e.g., key performance indicators) and to write a commentary for submission to AJHP regarding the need for standardized clinical pharmacy documentation and metrics (see Other Council Activity).

#### **4. Influenza Vaccination Requirements to Advance Patient Safety and Public Health**

- 1 To advocate that hospitals and health systems require healthcare workers to receive an
- 2 annual influenza vaccination except when (1) it is contraindicated, or (2) the worker has
- 3 religious objections, or (3) the worker signs an informed declination; further,
  
- 4 To encourage hospital and health-system pharmacists to take a lead role in developing
- 5 and implementing policies and procedures for vaccinating healthcare workers and in
- 6 providing education on the patient safety benefits of annual influenza vaccination;
- 7 further,

8 To work with the federal government and others to improve the vaccine development  
9 and supply system in order to ensure a consistent and adequate supply of influenza  
10 virus vaccine.

*Note: This policy would supersede ASHP policy 0615.*

### **Rationale**

The Centers for Disease Control and Prevention (CDC) estimates that the 2019-2020 influenza season was associated with 38 million illnesses, 18 million medical visits, 405,000 hospitalizations, and 22,000 deaths. The economic burden of influenza-attributable illness is estimated at over \$83 billion, encompassing direct costs such as hospitalizations and outpatient visits and indirect costs such as lost productivity from missed days at work.

Influenza immunization of healthcare workers can improve patient safety and decrease morbidity and mortality by protecting vulnerable patients such as young children and elderly, immunocompromised, and critically ill patients. The CDC has recommended vaccination of healthcare workers since 1981. In its recommendation, the CDC considers healthcare workers as including (but are not limited to) physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual staff not employed by the healthcare facility, and persons (e.g., clerical, dietary, housekeeping, laundry, security, maintenance, administrative, billing, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from health care workers and patients. In the 2019-2020 season, approximately 80% of healthcare workers were immunized against influenza, with rates over 90% among hospital employees, despite the fact that only approximately 70% of hospitals currently require an annual influenza vaccination, according to the CDC. Pharmacists have a responsibility, as knowledgeable purveyors of evidence-based medication information, to lead by example in receiving annual influenza vaccinations and to educate other healthcare workers and patients about the importance of influenza vaccination.

### **Background**

The Council reviewed ASHP policy 0615, Influenza Vaccination Requirements To Advance Patient Safety and Public Health, as part of sunset review and voted to recommend amending it as follows (~~strikethrough~~ indicates deletions):

To advocate that hospitals and health systems require healthcare workers to receive an annual influenza vaccination except when (1) it is contraindicated, or (2) the worker has religious objections, or (3) the worker signs an informed declination; further,

~~To encourage all hospital and health-system pharmacy personnel to be vaccinated against influenza; further,~~

To encourage hospital and health-system pharmacists to take a lead role in developing and implementing policies and procedures for vaccinating healthcare workers and in providing education on the patient safety benefits of annual influenza vaccination;



further,

To work with the federal government and others to improve the vaccine development and supply system in order to ensure a consistent and adequate supply of influenza virus vaccine.

The Council recognized that pharmacy personnel are included in the first clause's description of "healthcare workers" and recommended that the second clause be struck because it could be read as contradicting the first. This contradiction was introduced when the House of Delegates changed "healthcare workers with direct patient care responsibilities" in the first clause to just "healthcare workers." The original language of the first clause could have been read as excluding some pharmacy personnel, making the second clause necessary. In addition, the Council observed that some states have removed the religious exemption from their mandates but declined to remove that exemption from the policy. Finally, the Council recognized the importance of addressing vaccine hesitancy in ASHP policy but recommended that the topic is better suited for inclusion in another ASHP policy position or the ASHP Guidelines on the Pharmacist's Role in Immunization, as this policy is focused on the healthcare workforce rather than on the public.

## 5. Safe and Effective Extemporaneous Compounding

1 To affirm that extemporaneous compounding of medications, when done to meet  
2 immediate or anticipatory patient needs, is part of the practice of pharmacy and is not  
3 manufacturing; further,

4 To support the principle that medications should not be extemporaneously  
5 compounded when they are commercially and readily available in the form necessary to  
6 meet patient needs; further,

7 To encourage pharmacists who compound medications to use only drug substances that  
8 have been manufactured in Food and Drug Administration-registered facilities that have  
9 been inspected within the past two years and that meet official United States  
10 Pharmacopeia (USP) compendial requirements where those exist; further,

11 To advocate that all compounding activities meet applicable USP standards and federal  
12 and state regulations; further,

13 To support the principle that pharmacists be adequately trained and have sufficient  
14 facilities and equipment that meet technical and professional standards to ensure the  
15 quality of compounded medications; further,

16 To encourage USP to develop drug monographs for commonly compounded  
17 preparations; further,

- 18 To educate prescribers and other healthcare professionals about the potential risks  
19 associated with the use of extemporaneously compounded preparations.

*Note: This policy would supersede ASHP policy 0616.*

### **Rationale**

The practice of compounding has evolved along with the profession of pharmacy and it remains an essential component of patient care and pharmacy practice. With advances in pharmaceutical manufacturing, the need for preparation of individualized medications based on a prescription or medication order has decreased but not disappeared. Extemporaneous compounding of medications, when done to meet immediate or anticipatory patient needs, will likely always be an essential part of the practice of pharmacy, and cannot be replaced by any manufacturing model currently envisioned. Commercially and readily available drug products in the form necessary to meet patient needs should always be preferred to extemporaneously compounded alternatives. When extemporaneous compounding is required, it should meet strict requirements to protect patients from receiving substandard or poor-quality medications that pose a safety risk to their health and well-being. In particular, extemporaneously compounded sterile preparations must ensure highest quality. Extemporaneous compounding should be performed only using drug substances that have been manufactured in Food and Drug Administration-registered facilities that have been inspected within the past two years and that meet official United States Pharmacopeia (USP) compendial requirements. Such compounding should only be performed by adequately trained pharmacists and pharmacy technicians, in facilities and with equipment that meet technical and professional standards to ensure the quality and integrity of the compounded medication, and in accordance with USP standards and other applicable federal and state regulations. To facilitate such a high level of compounding, USP should develop drug monographs for commonly compounded preparations. ASHP and its members have always devoted a great deal of effort to promoting safe extemporaneous compounding, through education of pharmacists and pharmacy technicians, publication of best practices, and advocacy, recognizing the inherent risks of any such endeavor. Pharmacists and pharmacy technicians have a responsibility to safely prepare and distribute compounded medications to meet the unique and customized therapeutic needs of their patients, and ASHP and pharmacists therefore have a responsibility to educate prescribers and other healthcare professionals about the potential risks associated with the use of extemporaneously compounded preparations.

### **Background**

The Council reviewed ASHP policy 0616, Safe and Effective Extemporaneous Compounding, as part of sunset review and voted to recommend amending it as follows (underline indicates new text; ~~strike through~~ indicates deletions):

To affirm that extemporaneous compounding of medications, when done to meet immediate or anticipatory patient needs, is part of the practice of pharmacy and is not manufacturing; further,

To support the principle that medications should not be extemporaneously compounded when they are commercially and readily available in the form necessary to meet patient needs; further,

To encourage pharmacists who compound medications to use only drug substances that have been manufactured in Food and Drug Administration-~~approved~~ registered facilities that have been inspected within the past two years and that meet official United States Pharmacopeia (USP) compendial requirements where those exist; further,

To advocate that all compounding activities meet applicable USP standards and federal and state regulations; further,

To support the principle that pharmacists be adequately trained and have sufficient facilities and equipment that meet technical and professional standards to ensure the quality of compounded medications; further,

To encourage USP to develop drug monographs for commonly compounded preparations; further,

To educate prescribers and other healthcare professionals about the potential risks associated with the use of extemporaneously compounded preparations.

The revisions suggested by the Council align with more contemporary standards and regulations that exist for compounding.

## **6. Universal Immunization Against Vaccine-Preventable Diseases in the Healthcare Workforce**

- 1 To support policies that promote universal vaccination against preventable infectious
- 2 diseases among healthcare workers, including all members of the pharmacy workforce,
- 3 as a safeguard to patient and public health; further,
  
- 4 To encourage the use of evidence-based risk assessments to determine inclusions and
- 5 exemptions for mandatory vaccine requirements; further,
  
- 6 To support employers in mandatory vaccine requirements if risk assessments determine
- 7 it would promote patient and public health; further,
  
- 8 To urge healthcare organizations to have policies that address additional infection
- 9 prevention practices required for exempted healthcare workers; further,
  
- 10 To foster the development of tools, education, and other resources to reduce vaccine

- 11 hesitancy, increase vaccination rates, and prevent vaccine-preventable diseases among
- 12 healthcare workers.

### **Rationale**

Vaccine-preventable diseases (VPDs) pose a threat to vulnerable patients, the healthcare workforce, and public health. Vaccines are effective in protecting the healthcare workforce and the patients they care for and with whom they interact. Although voluntary vaccination of healthcare workers (HCWs), supported by employer-offered strategies, increases vaccination rates to some extent, mandatory vaccination requirements carry heavier weight and can result in near-universal vaccination rates. The effectiveness of this approach has led to HCW vaccination requirements from the Occupational Safety and Health Administration, recommendations from the Centers for Disease Control and Prevention (CDC), policy endorsements from numerous professional organizations, and quality measures for federal and commercial payer reporting programs. For example, the CDC Advisory Committee on Immunization Practices proposes recommendations for the immunization of healthcare workforce based on (1) those diseases for which routine vaccination or documentation of immunity is recommended for healthcare personnel because of risks to them in their work settings and, should healthcare personnel become infected, to the patients they serve; and (2) those diseases for which vaccination of healthcare personnel might be indicated in certain circumstances. The current list of VPDs in which healthcare personnel are considered to be at substantial risk for acquiring or transmitting and in which vaccination is recommended includes hepatitis B, influenza, measles, mumps, rubella, pertussis, and varicella. In the future, this list may include vaccination against SARS-CoV-2.

The vaccination-related policies of various healthcare professional organizations contain similar themes. These policies recognize that mandatory vaccination policies improve vaccination rates, protecting patients and the healthcare workforce; acknowledge circumstances that may preclude an HCW from being vaccinated (e.g., medical contraindications, religious beliefs); express support for following evidence-based practices in determining which vaccines should be mandatory; and support education of the healthcare workforce on the benefits of vaccination.

### **Background**

The Council prioritized discussion of universal vaccination given recent authorization of COVID-19 vaccines and the urgency in protecting patients and HCWs from exposure risk of SARS-CoV-2. The Council felt it was important to broaden their consideration to include all VPDs rather than focusing on one. The Council concluded that, although this new policy may overlap slightly with ASHP policy position 0615, Influenza Vaccination Requirements to Advance Patient Safety and Public Health, ASHP should have policy addressing all VPDs and continue to advocate for influenza vaccination as a separate policy, due to the annual need for influenza vaccination.

## Board Actions

### Sunset Review of Professional Policies

As part of sunset review of existing [ASHP policies](#), the following were reviewed by the Council and Board and found to be still appropriate. (No action by the House of Delegates is needed to continue these policies.)

- Ready-to-Use Packaging for All Settings (0402)
- Pharmacist Accountability for Patient Outcomes (1114)
- Just Culture (1115)
- Ethical Use of Placebos in Clinical Practice (1116)

## Other Council Activity

### Joint Meeting on Pandemic Preparedness

On Tuesday, September 22, members of all councils and the Commission on Affiliate Relations met to hear presentations from Don R. Boyce and Joe Pinto of the Mount Sinai Health System on the lessons learned from Mount Sinai's experience with the COVID-19 pandemic. Council and Commission members were asked to reflect on current evidence, the presentations, background reading, meeting discussion, best practices, and personal experience to advise ASHP on pandemic-related policy issues relevant to the Council's purview. Council members considered existing and potential pharmacist roles in both operational and patient care aspects of the pandemic, and how the lessons learned from the pandemic could be applied to future crises that present similar circumstances. Key objectives of the discussion included considering the need for new or revised ASHP professional policy regarding pandemic preparedness and response, and suggesting elements of that policy, as well as reviewing current pharmacy practice related to pandemic preparedness and response and providing advice on ways ASHP can help advance pharmacy practice through the development of member tools and resources, best practices, education, and other programmatic approaches.

### ASHP Guidelines on the Pharmacy and Therapeutics Committee and the Formulary System

The Council voted to recommend approval of the ASHP Guidelines on the Pharmacy and Therapeutics Committee and the Formulary System.

### ASHP Guidance on Pandemic Preparedness Planning

The Council voted to revise the ASHP Statement on the Role of Health-System Pharmacists in Emergency Preparedness and to develop and maintain a web resource to assist the pharmacy workforce in pandemic preparedness planning.

### Standardized Clinical Pharmacy Documentation and Metrics

The Council voted to work with other ASHP component bodies to establish a workgroup to

develop standardized clinical pharmacy documentation and metrics. The Council also voted to write a commentary for submission to *AJHP* regarding the need for standardized clinical pharmacy documentation and metrics.

### **ASHP Guidance on Single Unit and Unit Dose Packaging**

The Council voted to consolidate into one guidance document and update the ASHP Statement on Unit Dose Drug Distribution, the ASHP Technical Assistance Bulletin on Repackaging Oral Solids and Liquids in Single Unit and Unit Dose Packages, and the ASHP Technical Assistance Bulletin on Single Unit and Unit Dose Packages of Drugs.

### **Pharmacist and Pharmacy Technician Response to Withdrawal or Recall of Medications from the Market**

The Council voted to revise the ASHP Technical Assistance Bulletin on Hospital Drug Distribution and Control as an ASHP guideline and include guidance on the handling of medication withdrawals and recalls.

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# COUNCIL ON PUBLIC POLICY

## POLICY RECOMMENDATIONS

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*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.*

Nishaminy Kasbekar, *Board Liaison*

### **Council Members**

Steve Riddle, *Chair* (Washington)  
Rusol Karralli, *Vice Chair* (Texas)  
Charzetta James (Florida)  
Brian Kawahara (California)  
Bernice Man (Illinois)  
Emily McTish, *Student* (South Carolina)  
Luke Miller (Texas)  
Matthew Pond (Arizona)  
Adam Porath (Nevada)  
Jeffrey Schnoor (Vermont)  
Elizabeth Shlom (New York)  
Elizabeth Rodman (Maryland)  
Jillanne Schulte Wall, *Secretary*

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### **1. Pharmacist Engagement in and Payment for Telehealth**

- 1 To advocate for pharmacists' provision of telehealth in all sites of care; further,
- 2 To advocate that reimbursement for telehealth be sufficient to support the practice.

### **Rationale**

During the COVID-19 public health emergency, hospitals, health systems, and clinics quickly pivoted to providing patient services via telehealth. The Centers for Medicare & Medicaid Services, commercial payers, and state policymakers have indicated that they would like to maintain telehealth services post-pandemic. Because pharmacists are not Medicare-eligible, it has been a struggle to ensure that they can be reimbursed for services provided via telehealth. In particular, it is vital that services be reimbursed at a level commensurate with complexity and duration and at an amount sufficient to support the practice, to ensure that patients can maintain access to services.

### **Background**

The Council discussed the issue of telehealth broadly. They reviewed a number of current policies, including ASHP policies 2029, Preserving Patient Access to Pharmacy Services by Medically Underserved Populations; 2034, Staffing for Safe and Effective Patient Care; 2020, Care-Commensurate Reimbursement; 1301, Payer Processes for Payment Authorization and

Coverage; and 1808, Patient Access to Pharmacist Care Within Provider Networks. Overall, the Council felt that the current policies addressed many of the issues related to pharmacist payment and engagement. However, after extensive discussion, they agreed that a policy specific to telehealth was warranted. Rather than enumerate multiple changes necessary for effective telehealth provision, including access to, and support for, technology and billing and coding at specific levels, the Council agreed that a general statement would best serve member needs, allowing flexibility to address technological and payment shifts in a fast shifting environment.

## 2. Pharmacy Services in a State of Emergency

- 1 To advocate that state boards of pharmacy grant temporary licensure to pharmacists and
- 2 temporary licensure, registration, or any other necessary state-mandated credential to
- 3 pharmacy technicians during states of emergency; further,
- 4 To advocate that state and federal regulatory agencies allow for flexibilities necessary to
- 5 provide patient care during a declared state of emergency.

### ***Rationale***

During the COVID-19 pandemic, both state and federal policymakers scrambled to provide the regulatory flexibility necessary to allow patients to access pharmacist services. Although states are generally willing to be flexible about dispensing during a public health emergency, pharmacy services themselves are not subject to the same degree of flexibility. Specifically, pharmacists, more so than other clinicians, struggled to get temporary licensure across state lines. The lack of access to temporary licensure impeded the ability of pharmacists to move to areas of great need or to volunteer in states with patient surges. Further, pharmacy services require flexibility, particularly around inventory control and the ability to reallocate product and the ability to quickly establish alternate sites of care. During the COVID-19 public health emergency, remdesivir was allocated to the states, and then the state retained full control over distribution, which resulted in situations in which hospitals could not transfer product across state lines to other hospitals, even to related entities, that needed the product more.

### ***Background***

During the Council's broad discussion of COVID-19 treatment and insurance, a number of members felt that a significant policy gap exists regarding how pharmacy services are treated during any state of emergency, including a public health emergency. In particular, they noted that although there is current ASHP policy addressing emergency dispensing, there is not policy focused on the ability of pharmacists to practice during an emergency. Similarly, they noted that COVID-19 has underscored the need for general flexibility that can be quickly built out prior to an emergency. In particular, Council members focused on the need for flexible practice across state lines, flexibility on inventory control, and flexibility to quickly establish alternate sites of care.



Regarding interstate practice, the Council felt that there is generally difficulty in establishing and maintaining licensure across state lines, and the pandemic merely highlighted the issue. Further, the Council was concerned that because that National Association of Boards of Pharmacy is doing away with its Passport Program, which is the established database for connectivity between states, the process would be even more complex. Additionally, regarding inventory control, the Council discussed issues of allocation and distribution for remdesivir. During the public health emergency, remdesivir was allocated to states, and hospitals did not have the ability to send the drug over state lines to meet patient needs, even when the out-of-state hospital was part of the same health system.

## Board Actions

### Sunset Review of Professional Policies

As part of sunset review of existing [ASHP policies](#), the following were reviewed by the Council and Board and found to be still appropriate. (No action by the House of Delegates is needed to continue these policies.)

- Poison Control Center Funding (1121)
- Manufacturer Promotion of Off-label Uses (1620)
- Timely Board of Pharmacy Licensing (1621)
- Home Intravenous Therapy (1623)
- Ban on Direct-to-Consumer Advertising for Prescription Drugs and Medication-Containing Devices (1624)

## Other Council Activity

### Joint Meeting on Pandemic Preparedness

On Tuesday, September 22, members of all councils and the Commission on Affiliate Relations met to hear presentations from Don R. Boyce and Joe Pinto of the Mount Sinai Health System on the lessons learned from Mount Sinai's experience with the COVID-19 pandemic. Council and Commission members were asked to reflect on current evidence, the presentations, background reading, meeting discussion, best practices, and personal experience to advise ASHP on pandemic-related policy issues relevant to the Council's purview. Council members considered existing and potential pharmacist roles in both operational and patient care aspects of the pandemic, and how the lessons learned from the pandemic could be applied to future crises that present similar circumstances. Key objectives of the discussion included considering the need for new or revised ASHP professional policy regarding pandemic preparedness and response, and suggesting elements of that policy, as well as reviewing current pharmacy practice related to pandemic preparedness and response and providing advice on ways ASHP can help advance pharmacy practice through the development of member tools and resources, best practices, education, and other programmatic approaches.

## COVID-19 Treatment and Insurance

The Council undertook a comprehensive discussion of COVID-19 treatment and insurance, with a focus on identifying emerging issues that might require new policy.

The discussion then turned to the issue of vaccine hesitancy and concerns that the public might not be quick to adopt a new COVID-19 vaccine. The Council suggested that ASHP consider other options for combatting vaccine hesitancy, including working directly with federal agencies and/or other provider groups on vaccine outreach strategies, including public relations campaigns.

Finally, during the course of the COVID-19 treatment and insurance discussion, the issue of regulatory barriers impeding treatment arose. It was during this discussion that the problem of quickly getting temporary licensure across state lines was raised, which eventually resulted in the proposed new policy, Pharmacy Services in a State of Emergency.

## Sourcing Raw Materials for Drug Manufacturing

The Council considered whether new policy is needed specific to the sourcing of active pharmaceutical ingredient (API) from foreign countries. At the outset of the pandemic, major concerns arose about whether the concentration of API manufacturing in China and India would create global drug shortages.

The Council felt that ASHP should focus on global reinforcement of supply chains, meaning that investments should be made not only in domestic manufacturing but in strengthening manufacturing across the world. The Council noted that calls to focus solely on domestic manufacturing capacity could create shortage problems by concentrating the supply chain in a single geographic locale rather than building in redundancies. The Council recommended that the rationale for ASHP policy 1905, Mitigating Drug Product Shortages, be updated to note the importance of geographically and commercially diversified API manufacturing operations.

## Discriminatory Laws and Interference with the Patient/Provider Relationship

The Council formalized a recommendation to the Council on Education and Workforce Development (CEWD) and/or to the ASHP Task Force on Racial Diversity, Equity, and Inclusion to consider policy requiring implicit bias training for pharmacists. Specifically, the Council recommended that CEWD or the Taskforce consider the following items:

- Mandatory training on implicit bias, including education at the pharmacy school and workforce levels, for all healthcare providers;
- Supporting research on healthcare disparities; and
- Equipping patients for shared decision-making regarding treatment.

## 340B Sustainability and Manufacturer Actions

The Council discussed potential revisions to existing ASHP policy to address recent manufacturer actions that threaten the sustainability of the 340B Drug Pricing Program, including placing limits on contract pharmacies and requiring the use of third-party vendors to

access 340B discounts.

The Council recommended that ASHP survey members on the level of detail they are comfortable disclosing regarding their 340B savings and data and resolved to reconsider this issue at a future meeting.



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## ASHP Statement on the Roles and Responsibilities of the Pharmacy Executive

1 **Position**

2 Leading hospitals and health systems must have a strategic and innovative pharmacy executive  
3 who plans and oversees the design and operation of the entire and complex medication-use  
4 process throughout the system. It is essential that this leader report to an executive who can  
5 help the leader execute the practice models of tomorrow that include business outside normal  
6 hospital practice.

7 As the most knowledgeable leader of the medication-use process, this leader (may be  
8 referred to as the “chief pharmacy officer” but hereafter “the pharmacy executive”) proactively  
9 aligns pharmacy goals with strategic organizational initiatives to advocate for pharmacy  
10 practice advancement and improved patient care. The intrinsic value a pharmacy executive  
11 brings to the organization’s enterprise and executive leadership includes the following:

- 12 • Ensuring the enterprise’s strategic planning leverages pharmacy services across the  
13 continuum of care to improve health outcomes.
- 14 • Ensuring pharmaceuticals and pharmaceutical benefit designs focus on total health through  
15 the formulary, with procurement driven by clinical efficacy.

- 1 • Collaborating with healthcare executives within and external to the health system to foster  
2 and build cross-functional relationships and to align interdisciplinary services with initiatives  
3 such as quality metrics and financial performance.
- 4 • Advancing patient care services through the promotion of pharmacy best practices by the  
5 creation and adoption of emerging technologies and innovative services.

6

## 7 **Background**

8 Significant changes in pharmacy practice, healthcare, and health-system management over the  
9 past 20 years have dramatically transformed the traditional role of the pharmacy director.<sup>1</sup>  
10 More widespread use of the title “chief pharmacy officer” was first proposed in 2000 in an  
11 attempt to meet these new transformations and to enhance the contribution pharmacy makes  
12 to patient care by creating organizational parity between the pharmacy executive and other  
13 executive officers (e.g., chief nursing, medical, and information officers).<sup>2</sup>

14

## 15 **Responsibilities and value of the pharmacy executive**

16 The pharmacy executive assesses the ever-changing healthcare environment for emerging  
17 trends and identifies opportunities to leverage the pharmacy team’s expertise to improve the  
18 value of care across the healthcare continuum. Success as a pharmacy executive is predicated  
19 on building and maintaining relationships with diverse groups of people in order to be part of  
20 setting the overall strategy for the organization. Navigating solid and dotted-line reporting  
21 relationships, such as in a matrix organizational structure, requires the pharmacy executive to  
22 exercise a wider range of influence and persuasiveness rather than relying on traditional

23 hierarchy and formal control to accomplish objectives. As it relates to patient care and clinical  
24 services, the pharmacy executive leads all pharmacists and pharmacy staff across the  
25 organization. The pharmacy executive ensures that pharmacists are optimally positioned and  
26 resourced to improve the quality, safety, and efficiency of medication management and  
27 patient outcomes in the most cost-effective manner. The pharmacy executive leads the  
28 pharmacy's financial performance within the context of the broader health system through  
29 the evaluation of medication expenditure patterns and reimbursement trends, including  
30 value-based reimbursement and purchasing. As reimbursement and revenue capture become  
31 increasingly complex, the pharmacy executive can provide leadership across multiple  
32 disciplines (e.g., finance, nursing, medicine, pharmacy) to optimize reimbursement from  
33 involved government and commercial payment programs and meet metrics for value-based  
34 contract requirements.<sup>3,4</sup> She or he is also responsible for medication access in their  
35 organization to ensure patients have the most effective and affordable medications.

36 In performing these responsibilities, the pharmacy executive must bring continuous and  
37 evergreen value to the pharmacy team, the health system's executive team, and the  
38 organization as a whole. The pharmacy executive establishes key relationships with both  
39 internal multidisciplinary executives and external vendors, group purchasing organizations, and  
40 manufacturers to elevate services and optimize the pharmaceutical supply chain, respectively.  
41 In addition to optimizing the supply chain, the pharmacy executive plays a key role in  
42 developing a vision for information and technology solutions in the medication-use process and  
43 must work collaboratively with the chief information officer to advance pharmacy informatics  
44 and technology. During all phases of a public health emergency or disaster event, pharmacy

45 executive presence in a hospital or health system’s emergency operations center is pivotal for  
46 proactive planning and maintaining secure, functional, and resilient health and public health  
47 critical infrastructure. The pharmacy executive is integral in advancing pharmacy services in the  
48 midst of rising competitors, ensuring the vitality of the organization as healthcare transforms.<sup>5-</sup>  
49 7 She or he must maintain a focused effort to acquire, share, and reinvest in their own self-  
50 development and the development of the leadership team striving for a continuous pursuit of  
51 practice advancement.

52

### 53 **Experience and education of the pharmacy executive**

54 The pharmacy executive is a professionally competent, legally licensed pharmacist with a broad  
55 level of experience in health-system pharmacy practice and management and with a strategic  
56 vision for the profession. Additional qualifications may include an advanced management  
57 degree; a clearly evident successful record of leading people, operations, finance, and clinical  
58 services; and completion of a pharmacy residency program accredited by ASHP (e.g., health-  
59 system pharmacy administration and leadership residency).

60 What distinguishes the pharmacy executive from the established director of pharmacy  
61 position is the increased breadth and depth of the involvement in the health system’s strategic  
62 planning and decision-making processes at the most senior levels. The pharmacy executive has  
63 experience in leading the medication-use process, including optimizing the pharmaceutical  
64 supply chain, making evidence-based systematic clinical decisions, supporting medication-  
65 management systems and policies, implementing technology to elevate patient care, and  
66 optimizing financial performance. The pharmacy executive, therefore, provides pharmacy’s

67 unique clinical and business perspectives in decisions related to changes in the medication-  
68 management system.<sup>8-10</sup> To support these changes, the pharmacy executive leverages  
69 technology to develop the most cost-effective labor model.

70

### 71 **Reporting structure**

72 The pharmacy executive has a market-competitive title internally consistent with others  
73 reporting at that organizational level, reports directly to the organization's principal executive  
74 (e.g., chief executive officer [CEO], chief operating officer [COO]), participates as a member of  
75 the medical executive committee, and routinely engages with the health system's executive  
76 leadership as well as the board of directors. By working collaboratively with others at this most  
77 senior executive level, the pharmacy executive ensures that health-system pharmacy services  
78 are optimally positioned to most effectively contribute to the organization's strategic initiatives  
79 and address systemwide opportunities. A structure in which pharmacy leadership reports  
80 directly to the principal executive rather than through layers of management allows the  
81 pharmacy executive to engage in critical decision-making and be more effective and influential  
82 in helping the health system anticipate and address rapid change.

83

### 84 **Conclusion**

85 Optimal patient care, quality health outcomes, and pharmacy practice advancement requires  
86 progressive hospitals and health-systems that have an educated pharmacy executive  
87 responsible for the strategic planning, design, operation, and improvement of the  
88 organization's pharmacy services across the care continuum. Because of these expected



89 contributions, the pharmacy executive must be properly positioned within the health system's  
90 senior executive management team to ensure that health-system pharmacy services are best  
91 leveraged to meet the ever-changing demands of the future of healthcare delivery.

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Developed through the ASHP Council on Pharmacy Management and approved by the ASHP Board of Directors on February 2, 2021. This statement would supersede a previous version dated June 7, 2015.

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# House of Delegates

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## Proposed ASHP Bylaws Amendments

### **1. What are the proposed amendments to the ASHP bylaws that were recommended by the ASHP Task Force on Racial Diversity, Equity, and Inclusion and approved by the ASHP Board of Directors?**

The proposed bylaws amendments (noted in red in the attached document) modify the process of appointment of the ASHP Committee on Nominations and broaden the eligibility for member service on the committee. The Committee on Nominations is the membership committee that determines the slate of candidates for ASHP President-Elect, Board Members at Large, and Chair of the House of Delegates.

Presently, the Committee on Nominations is appointed by the Chair of the House of Delegates. Committee eligibility is limited to members who have been delegates to the House of Delegates within the previous five (5) years at the time of their appointment.

The bylaws amendments propose that the ASHP Immediate Past President appoint the Committee on Nominations and broaden the eligibility for service so that all active members with ASHP membership in good standing for at least five (5) consecutive years may serve on the Committee on Nominations.

These proposed amendments are a recommendation from the ASHP Task Force on Racial Diversity, Equity, and Inclusion. The ASHP Board of Directors voted to approve the Task Force recommendations in January 2021.

### **2. Why did the ASHP Task Force on Racial Diversity, Equity, and Inclusion and ASHP Board of Directors believe that the proposed amendments would help further the diversity, equity, and inclusion of ASHP's membership?**

In January 2021, the ASHP Board of Directors approved the recommendations of ASHP's Task Force on Racial Diversity, Equity, and Inclusion. The Task Force was convened in June 2020 amid the national reckoning around racial and social justice to advise ASHP on specific, actionable steps to further address and take inventory of matters of racial diversity, equity, and inclusion as they relate to issues facing Black Americans, and for making related recommendations on new or enhanced efforts ASHP may undertake. The Task Force subsequently broadened its focus to be on issues facing black, Indigenous, and people of color (BIPOC).

To promote greater engagement and diversity with respect to governance and committee recommendations, the Task Force recommended that ASHP appoint a more racially diverse Committee on Nominations for the 2020-2021 election cycle and in subsequent years, and that ASHP bylaws be changed to make all active members of ASHP eligible to serve on the Committee on Nominations. Service in the ASHP House of Delegates is preferred rather than required. The Task Force believed that these steps would help increase the diversity of candidates for ASHP elected offices, including BIPOC and other underrepresented populations.

The Task Force strongly believes that moving forward, ASHP will benefit greatly from drawing on the full breadth of its members to find highly qualified and diverse individuals to serve on the Committee on Nominations.

Upon the recommendation of the Task Force, the Board of Directors voted to propose that the ASHP bylaws be amended to have the Immediate Past President of ASHP appoint the Committee on Nominations and to draw those appointments from the ASHP membership at large, thereby increasing the pool of highly qualified and diverse candidates.

The proposed amendment to the ASHP bylaws aligns with ASHP's broader diversity, equity, and inclusion initiatives and represents an important step in the journey toward a more diverse, equitable, and inclusive environment for all.

### **3. Why did the ASHP Task Force on Racial Diversity, Equity, and Inclusion and ASHP Board of Directors recommend having the Immediate Past President of ASHP select the members of the Committee on Nominations?**

Given the proposal to select Committee on Nominations members from the full active membership of ASHP, the Task Force and Board believed that the Immediate Past President would be in the best position to make those nominations given their engagement with a wide array of ASHP members in the course of their service as a presidential officer. Further, the Immediate Past President has no perceived personal conflicts of interest with appointing a Committee on Nominations that could in turn slate them for an elected position. An Immediate Past President is not eligible to run again for ASHP Board, President, or Chair of the House of Delegates.

### **4. What is the process for voting on ASHP Governing Documents amendments?**

Proposed amendments to the ASHP bylaws must be submitted to the ASHP Board of Directors for review and approval. When approved, the Board submits the amendments to the House of Delegates for approval by a majority of voting delegates then present and voting. Amendments made by the House to the ASHP bylaws must be approved by the Board of Directors. Please note that no amendments to the ASHP Charter are required by this proposed change in bylaws, so no vote by the entire ASHP membership is required.

### 5. How will the bylaws amendments be introduced and voted on at the ASHP House of Delegates?

The bylaws amendments will be introduced to the House of Delegates during the first meeting of the House by Dr. Paul C. Walker, who served as the Chair and ASHP Board Liaison to the ASHP Task Force on Racial Diversity, Equity, and Inclusion. The Chair of the House of Delegates will then request that the delegates vote to approve the amendments.

[Proposed amendments shown in red; ~~strikethrough~~ indicates deletion.]

# Governing Documents of the American Society of Health-System Pharmacists

## ASHP CHARTER

**First.** The undersigned, whose names and post office addresses are set forth at the end of this document, each being at least 18 years of age, do hereby form a corporation under the general laws of the state of Maryland.

**Second.** The name of the corporation is American Society of Health-System Pharmacists, Inc. (ASHP).

**Third.** The purposes for which ASHP is formed are as follows:

1. To advance public health by promoting the professional interests of pharmacists practicing in hospitals and other organized health care settings through:
  - a. Fostering pharmaceutical services aimed at drug-use control and rational drug therapy.
  - b. Developing professional standards for pharmaceutical services.
  - c. Fostering an adequate supply of well-trained, competent pharmacists and associated personnel.
  - d. Developing and conducting programs for maintaining and improving the competence of pharmacists and associated personnel.
  - e. Disseminating information about pharmaceutical services and rational drug use.
  - f. Improving communication among pharmacists, other members of the health care industry, and the public.
  - g. Promoting research in the health and pharmaceutical sciences and in pharmaceutical services.
  - h. Promoting the economic welfare of pharmacists and associated personnel.
2. To foster rational drug use in society such as through advocating appropriate public policies toward that end.
3. To pursue any other lawful activity that may be authorized by ASHP's Board of Directors.

**Fourth.** The post office address of the principal office of ASHP in Maryland is 7272 Wisconsin Avenue, Bethesda (Montgomery County), Maryland 20814. The name and post office address of the resident agent of ASHP in Maryland is C.T. Corporation Systems, Inc., 32 South Street, Baltimore, Maryland 21202. The resident agent of ASHP is a Maryland corporation.

**Fifth.** ASHP shall be a not-for-profit corporation and shall not be authorized to issue capital stock. No part of the net earnings of ASHP, current or accumulated, shall inure to the benefit of any private individual, nor shall ASHP be operated for the primary purpose of carrying on a trade or business for profit. ASHP intends to avail itself of any and all tax benefits or exemptions to which it may be entitled under Section 501 of the Internal Revenue Code of 1954, and it shall not operate or engage in any activity nor shall it possess or exercise any power that would substantially risk the loss of such benefits under that Code.

**Sixth.** The number of Directors of ASHP shall be 12, which number may be increased or decreased only by amendment to this Charter. The Board of Directors shall consist of six Directors who shall be elected at large by a majority of votes cast by active members; the Chair of the House of Delegates; and the officers of ASHP, to wit, the President, the President-elect, the Immediate Past President, the Treasurer, and the Secretary. The Directors, who shall act until the first annual meeting or until their successors are duly chosen and qualified, as set forth in the Bylaws, are Roger W. Anderson, John A. Gans, Thomas J. Garrison, Clifford E. Hynniman, Marianne F. Ivey, Herman L. Lazarus, Harland E. Lee, Arthur G. Lipman, Joseph A. Oddis, Judith A. Patrick, Paul G. Pierpaoli, and Marilyn L. Slotfeldt. The Directors of ASHP shall manage its business affairs. All Directors shall be active members of ASHP.

**Seventh.** The following provisions are hereby adopted for the purposes of defining, limiting, and regulating the internal affairs of ASHP:

1. The membership of ASHP shall consist of active members, associate members, honorary members, and such other categories as may be established in the Bylaws. Active members shall be licensed pharmacists who support the purposes of ASHP as stated in the Article Third of this Charter; the other requirements for active membership shall be stated in the Bylaws. Only active members may (a) vote as individual members on amendment to this Charter as provided in Charter item 11, (b) serve as state delegates to the House of Delegates, (c) elect the Directors of ASHP, and (d) serve as a Director of ASHP. The definition, rights, powers, and obligations of each class of members not set forth herein shall be established and limited by the Bylaws.
2. ASHP shall have a House of Delegates that shall meet yearly to review, consider, and ultimately approve or disapprove the professional policies recommended to it by its Directors and to review the affairs of ASHP; voting delegates in the House of Delegates shall consist of the following classes: state delegates, who shall be active members and shall be deemed to represent the aliquot portion of the active membership of ASHP, plus Directors, plus eligible Past Presidents of ASHP, plus fraternal delegates, plus the chair of each Section and Forum created by the Board pursuant to Article 6.1.6 of the bylaws.
  - 2.1. The House of Delegates shall have at least two state delegates from each state.
  - 2.2. The House of Delegates shall elect a Chair to preside at all of its meetings.
3. ASHP may establish and shall try to promote and strengthen ongoing cooperative relationships with other domestic and international organizations when such relationships further the purposes of ASHP.

4. ASHP shall try to formally recognize, promote, and strengthen relationships with groups of pharmacists in the various states and possessions of the United States when such groups promote and foster the purposes of ASHP.

**Eighth.** Upon termination, dissolution, or winding up of ASHP, any assets that remain after payment or provision for payment of all of its liabilities, debts, and obligations shall be distributed by the Board of Directors only to one or more organized charitable, educational, scientific, or philanthropic organizations duly qualified as exempt under Section 501(c)(3) of the Internal Revenue Code of 1954 (or under such successor provision of the Internal Revenue Code as may be in effect at the time of termination, dissolution, or winding up of ASHP). Under no circumstances shall any assets be distributed to any member of ASHP.

**Ninth.** The private property of the members, officers, Directors, and employees of ASHP shall not be subject to payment of any debts or obligations of ASHP.

**Tenth.** The Bylaws shall delineate the authority of the Board of Directors and govern the internal affairs of ASHP. The Bylaws may be amended as provided therein.

**Eleventh.** Any proposed amendment to this Charter must first be submitted to the Board of Directors. Upon review, the Board shall submit the proposed amendment to the House of Delegates. Upon approval of a majority of the voting delegates of the House of Delegates then present and voting, it shall be submitted to the entire active membership for vote by mail ballot in the same manner as in the election of officers as provided in the Bylaws and shall be sent out as part of the ballot for officers.

**Twelfth.** The duration of ASHP shall be perpetual.

## BYLAWS

### Article 1. Name and Seal

- 1.1. The name of the corporation shall be the “American Society of Health-System Pharmacists, Inc.,” which will be referred to as ASHP.
  - 1.1.1. The official corporate seal of ASHP, which shall be used as needed to authenticate documents of ASHP, shall consist of the word “Seal” as authorized by Section 1-304 of the Corporations and Associations Article of the Code of Maryland.
- 1.2. ASHP may adopt and use such trade names, trademarks, service names, and service marks as, in its judgment, are necessary or appropriate to identify or designate its products and services and to carry on its business.
  - 1.2.1. No member, chapter, organizational component, or third party may use any name or mark of the ASHP unless such use conforms to the standards established by the Board of Directors and unless the Board has specifically approved such use in writing.

### Article 2. Offices and Agent

- 2.1. ASHP shall continuously maintain, in the state of Maryland, a registered office at such place as may be established by the Board of Directors. The Board of Directors may establish ASHP’s principal place of business and other offices and places of business either inside or outside the state.
- 2.2. ASHP shall continuously maintain a registered agent within the state of Maryland, which shall be designated, from time to time, by the Board of Directors.

### Article 3. Membership

- 3.1. The classifications of membership in ASHP are as follows:
  - 3.1.1. *Active Members*: Pharmacists licensed by any state, district, or territory of the United States who have paid dues as established by ASHP; practice in the jurisdictions of the United States, the District of Columbia, or Puerto Rico; and who support the purposes of ASHP as stated in the Article Third of the ASHP Charter.
    - 3.1.1.1. Only active members may vote on amendment to the Charter, serve as state delegates, and elect or serve as a Director of ASHP.
  - 3.1.2. *Associate Members*: Persons who have paid the dues as established by ASHP and who, by virtue of vocation, training, education, and interest, wish to further the purposes of ASHP. Associate members shall consist of the following categories:
    - 3.1.2.1. *Supporting*: Individuals, other than those who qualify as active members, who by working in the health services, teaching prospective pharmacists, or otherwise contributing to pharmacy services provided in organized health care systems, make themselves eligible for membership.



- 3.1.2.2. *Student:*** Individuals enrolled full time in a pharmacy practice degree program (graduate or undergraduate) in an accredited college of pharmacy.
- 3.1.2.3. *International:*** Pharmacists who are engaged in practice outside the United States of America; individuals, other than pharmacists, who are interested in pharmacy as practiced in an organized health care system and reside outside the United States and its possessions.
- 3.1.2.4. *Pharmacy Support Personnel:*** Technicians and other individuals who are employed as support personnel in a health care system.
- 3.1.3. *Honorary Members:*** Persons who shall be elected for life by unanimous vote of the Board of Directors from among individuals who are or have been especially interested in, or who have made outstanding contributions to, pharmacy practice in organized health care systems. Honorary members may vote or hold office if otherwise eligible for active membership. No dues shall be required of honorary members.
- 3.2.** The Board of Directors shall establish dues and membership periods for all members.
- 3.2.1.** Persons seeking membership in ASHP shall complete the application form and enclose payment of dues for the classification of membership being sought.
- 3.2.2.** Payment of dues each year automatically renews membership in ASHP; failure to pay timely dues constitutes termination of membership. If dues are paid after membership has terminated, ASHP may treat such payment as a reinstatement of membership.
- 3.2.3.** A member may terminate membership, at any time, by submitting a signed, written statement to ASHP.
- 3.2.4.** Members shall, at the time of application or at renewal, be classified into the category of membership for which they qualify.
- 3.3.** Members of ASHP shall be entitled to receive such services and publications as the Board of Directors establishes.
- 3.3.1.** All active members of ASHP shall receive the *American Journal of Health-System Pharmacy* as part of dues. Other classifications or categories of members shall be provided the *American Journal of Health-System Pharmacy* as part of dues as determined by the Board of Directors.
- 3.3.2.** The Board of Directors may establish a service or publication as part of dues or for a separate fee and may establish different services and publications and, for various categories of members, different prices for the same service or publication.
- 3.3.3.** Upon termination of membership, a member's right to membership services shall cease.
- 3.3.4.** Nothing herein shall affect the rights of members to vote or attend the House of Delegates meeting, to the extent those rights are set forth in the Charter or Bylaws.

**Article 4. Officers**

- 4.1.** The officers of ASHP shall be the President, the President-elect, the Immediate Past President, the Treasurer, and the Secretary, all of whom shall be active members of ASHP. The Secretary shall also serve as Executive Vice President of ASHP.
- 4.1.1.** The President-elect shall be elected annually for a term of one year and shall succeed successively to the office of President and then to the office of Immediate Past President, serving for one year in each office.
- 4.1.2.** The Executive Vice President shall be chosen by the Board of Directors.
- 4.1.3.** The candidates for Treasurer shall be nominated by the Board of Directors and elected by the active members for a term of office of three years. No person shall serve more than two successive terms as Treasurer.
- 4.1.4.** The President, President-elect, Immediate Past President, and Treasurer are not charged with executive or administrative responsibility for the management or conduct of the internal affairs of ASHP.
- 4.2.** The President shall serve as the principal elected official of ASHP; serve as Chair of the Board of Directors; serve as Chair of the Committee on Resolutions; at the House of Delegates, communicate to the delegates on the actions of the Board of Directors and on important new activities that affect and further the purposes of ASHP; and communicate with members of ASHP, affiliated chapters, and the public on the activities and policies of ASHP.
- 4.2.1.** With the approval of the Board of Directors, the President shall annually appoint Chairs and members of the councils, commissions, committees, and other appropriate components set forth in Article 6 of these Bylaws and any ad hoc committee or groups that the Board of Directors establishes.
- 4.2.2.** The President shall be an ex-officio member of all councils and committees of the Board of Directors and all ad hoc committees.
- 4.2.3.** The President shall report to the Board of Directors on official activities and shall advise the Board of Directors on such matters as may further the purposes of ASHP.
- 4.3.** The President-elect shall perform the duties of the President in the President's absence; succeed to that office upon the death, resignation, or inability of the President to perform the duties of that office; serve as Vice Chair of the Board of Directors; and assist in communicating the policies and activities of ASHP to its affiliated chapters, members, and the public.
- 4.3.1.** The President-elect shall communicate to the House of Delegates and the membership on those issues and activities that may affect and further the purposes of ASHP.
- 4.3.2.** The President-elect shall report to the Board of Directors on official activities and shall advise the Board of Directors on such matters as may further the purposes of ASHP.
- 4.3.3.** A President-elect who succeeds to the office of President as provided in Section 4.3 shall serve out both the unfinished term to which he or she has succeeded and the term to which he or she would have succeeded in due course.

- 4.3.4.** The President-elect shall be nominated by the Committee on Nominations ~~of the House of Delegates~~ and elected by the active membership of ASHP as set forth in Article ~~7~~ 5 of these Bylaws.
- 4.4.** The Immediate Past President shall perform the duties of the President in the temporary absence of both the President and President-elect, serve as Vice Chair of the House of Delegates, and serve in such other capacity as may be designated by the Board of Directors.
- 4.4.1.** The Immediate Past President shall report to the Board of Directors on his or her activities and shall advise the Board of Directors on such matters as may further the purposes of ASHP.
- 4.5.** The Treasurer shall serve as the Chair of the Committee on Finance, as specified in Section 5.23; be responsible for overseeing conservation and prudent investment of the assets and funds of ASHP; assure expenditure of funds is in accord with the programs, priorities, and budget established by the Board of Directors; and regularly inform the Board of Directors, members, and House of Delegates on the financial strength and needs of ASHP.
- 4.5.1.** No monies shall be disbursed except upon signature of the Treasurer and the Executive Vice President. The Treasurer shall periodically review and approve internal controls designed to assure proper control of funds and disbursements and make sure that current and projected income and expenses meet the budget of ASHP.
- 4.5.2.** The Board of Directors may, at all times, inspect and verify the books and accounts of ASHP.
- 4.5.3.** The Treasurer shall review and report upon the long-term financial projections and plans of ASHP.
- 4.6.** The Executive Vice President shall serve as the chief executive officer and as Secretary of ASHP.
- 4.6.1.** The Executive Vice President shall be responsible for administration of ASHP; direction of all operations, programs, and activities of ASHP; and hiring, firing, and the compensation and benefits of staff, subject to establishment of general salary and benefit policies by the Board of Directors. The Executive Vice President shall, at all times, carry out the policy aims and programs as generally determined by the Board of Directors.
- 4.6.2.** As Secretary, the Executive Vice President shall keep and maintain an accurate record of the meetings of the Board of Directors, the House of Delegates, and such other activities of ASHP as the Board of Directors may direct. The Executive Vice President shall give all notices required by law. The Executive Vice President shall have authority to affix the corporate seal to any document requiring it and attest thereto by his or her signature.
- 4.6.3.** The Executive Vice President may appoint an Assistant Secretary to attest to documents.
- 4.6.4.** The Executive Vice President shall, by virtue of the office, be a nonvoting member of all councils, commissions, and committees of the Board of Directors; committees of the House of Delegates; and any other committee or component group established by the Board of Directors.

- 4.6.5. The Executive Vice President shall be chosen by and serve at the pleasure of the Board of Directors. The Board of Directors may, on behalf of ASHP, enter into a contract with the Executive Vice President with such terms and for such fixed period as the Board of Directors deems reasonable and in the best interests of ASHP. Failure of a person to continue in the office of Executive Vice President will not affect contract rights, except as the terms of that contract may so provide.
- 4.7. The manner of filling vacancies of any office shall be as follows:
- 4.7.1. The provision of Sections 4.3 and 4.3.3 shall apply.
- 4.7.2. If both the President and the President-elect shall become permanently unable to perform the duties of their offices, the Board of Directors shall appoint, from the Board of Directors, a President Pro Tempore to serve for the remaining portion of the unexpired term. ~~At~~ **Following** the next yearly meeting of ~~the House of Delegates,~~ the Committee on Nominations, ~~the Committee~~ shall present **to the ASHP membership** nominations for the offices of President and President-elect, and an election shall be conducted in accordance with the provisions of Article ~~7~~ **5** of these Bylaws.
- 4.7.3. If the Executive Vice President or the Treasurer becomes unable to perform the duties of his or her office, the Board of Directors is empowered to fill that vacancy.
- 4.7.4. If the Immediate Past President is permanently unable to perform the duties of that office, the Board of Directors shall appoint a Director of ASHP to perform the duties of that office.
- 4.8. The following miscellaneous provisions shall apply:
- 4.8.1. To the extent not prohibited by these Bylaws, the officers may also exercise the powers that, by statute or otherwise, are customarily exercised by officers holding such offices or that may be established by the Board of Directors. However, only the Executive Vice President or an individual appointed by the Executive Vice President may execute, on behalf of ASHP, contracts, leases, debt obligations, and all other forms of agreement. An officer of ASHP may sign an instrument that must be executed by the Executive Vice President and that other officer. The Board of Directors may authorize any two officers to jointly execute a specific document or instrument.
- 4.8.2. Except to the extent specifically authorized by the Board of Directors, no officer shall be entitled to any compensation for services. In accordance with policies established by the Board of Directors, officers may be reimbursed for reasonable expenses incurred in discharging the functions of the office.

## Article 5. Board of Directors

- 5.1. The Board of Directors shall consist of 12 persons: the officers of ASHP, the Chair of the House of Delegates, and six Directors at large.
- 5.1.1. The term of office for a Director, who also serves as an officer or as Chair of the House of Delegates, shall be the term for that office, and the manner of election and filling vacancies in such offices shall be as specified in the Bylaws dealing with those offices.

- 5.1.2.** Directors at large shall be nominated by the Committee on Nominations ~~of the House of Delegates~~ and elected as set forth in Section 5.27.4.
- 5.1.3.** Elected Directors shall serve for one term of three years beginning with installation at the yearly meeting of the House of Delegates following their election. Elected Directors may not serve more than one term as a member at large.
- 5.1.4.** If the office of an elected member of the Board of Directors shall become vacant between yearly meetings of ASHP because of resignation, death, or otherwise, the Board of Directors may fill the vacancy. ~~At~~ **Following** the next yearly meeting of ~~the House of Delegates~~, the Committee on Nominations, ~~the Committee~~ shall present **to the ASHP membership** candidates for election to serve for the remaining portion of the unexpired term.
- 5.2.** Election of Directors of ASHP shall be conducted by, or under the auspices of, the Committee on Nominations.
- 5.2.1.** The Treasurer shall be elected by written or electronic ballot of a majority vote of the active membership in the same manner as members at large as provided in Section 5.2.3.2 every third year before the term of that office begins. Only nominations for the office of Treasurer from the Board of Directors shall be accepted.
- 5.2.2.** The Chair of the House of Delegates shall be elected by written or electronic ballot of the House of Delegates as provided in Section 7.1.2.
- 5.2.3.** The ASHP Immediate Past President shall appoint a Committee on Nominations consisting of seven active members who shall have been members of ASHP in good standing for at least five consecutive years at the time of their appointment to serve as a Committee on Nominations. The Committee shall solicit names of possible candidates for office using such means as it determines to be appropriate.
- 5.2.3.1.** The Committee shall present to the ASHP membership one or more reports nominating two candidates for the office of President-elect, two candidates for each Director to be elected, and two candidates each for Chair of the House of Delegates. The reports of the Committee shall not be subject to amendment and shall be the exclusive source of nominations for these offices.
- 5.2.3.2.** The names of the candidates for President-elect, Treasurer, and Directors of ASHP shall be submitted by mail or electronic transmission to every active member of ASHP within 60 days after nomination. The active member shall indicate on the ballot a choice of candidates for the offices to be filled and return the same by mail or electronic transmission within 30 days of the date on the ballot.
- 5.2.3.3.** The ballots, postmarked or electronically transmitted within 30 days of the date printed on the ballot, will be submitted to the Board of Canvassers who shall oversee counting of the ballots. The Board of Canvassers shall certify the results of the election to the Executive Vice President. The Executive Vice President shall notify all candidates of

the results of the election, and the results of the election shall also be disseminated to the membership.

**5.2.3.4.** The Board of Directors shall fill all vacancies in the list of candidates that may occur by death or resignation after the adjournment of the annual meeting of the Committee on Nominations and before the issuance of ballots.

- 5.3.** The Committee on Finance shall report to the Board and shall consist of the President, the President-elect, the Immediate Past President, the Executive Vice President, and the Treasurer; the Treasurer shall be its Chair. The Committee on Finance shall prepare a budget for the forthcoming year and submit it to the Board of Directors for approval; review, assess, and monitor operations of ASHP to assure that budget objectives are met or that appropriate changes thereto are made; review and assess performance of investments and assets of ASHP; review all investment policies and financial policies of ASHP; oversee the responsibilities of the Treasurer set forth in Section 4.5; and oversee the financial operations of ASHP.
- 5.4.** The Board of Directors shall meet annually, in conjunction with the yearly meeting of the House of Delegates, and at such other times as the Board may determine. A special meeting shall be held upon written application of any three Directors or of the President.
- 5.4.1.** The Secretary shall establish the time and place of scheduled and special meetings and shall give the Directors reasonable advance notice thereof by mail or other mode of transmittal.
- 5.4.2.** No Director shall be entitled to any compensation for services. Pursuant to policies adopted by the Board, Directors may be reimbursed for reasonable expenses incurred in attending meetings of the Board of Directors and in discharging functions at the direction of the Board.
- 5.5.** The Board of Directors shall manage the affairs of ASHP, establish policies within the limits of the Bylaws, actively pursue the purposes of ASHP, and have discretion in the control, management, investment, and disbursement of its funds. The Board of Directors, through its Committee on Finance, shall develop and approve an annual budget, establish financial goals for ASHP, and oversee the financial operations of ASHP. The Board of Directors shall establish and review long-term objectives of ASHP and establish the priority of all programs and activities. The Board may establish whatever rules and regulations for the conduct of its business it deems advisable and may appoint whatever agents it considers necessary to carry out its powers.
- 5.5.1.** The Board of Directors may establish committees and task forces and designate representatives to other organizations.
- 5.5.2.** The Board of Directors may make contributions of ASHP assets to other organizations for research and education activities of benefit to pharmacists practicing in organized health care systems. The Board may also accept grants, contributions, gifts, bequests, or devices to further the purposes of ASHP.
- 5.5.3.** The Board of Directors shall create, review, and modify the professional policies of ASHP and submit those policies to the House of Delegates for such action as the House of Delegates may choose to take under Article 7. The Board

of Directors shall approve or disapprove all recommendations of the components of ASHP set forth in Article 6 and any committee or group created by, or which reports to, the Board of Directors. Further, the Board of Directors shall report annually to the House of Delegates how it has handled such recommendations so that the House of Delegates can take final action as required or appropriate under Article 7.

- 5.5.4.** The Board of Directors shall approve all nominations to all committees, councils, and commissions, except as membership is specified in Article 6.
- 5.5.5.** The Board of Directors may establish and modify administrative policies, not inconsistent with these Bylaws, for the conduct of its business and for the conduct of the business of ASHP and its components, except for the House of Delegates, which may establish its own regulations.
- 5.5.6.** The Board of Directors and the officers shall tender reports at such times and in such manner as are required by law.

## **Article 6. Components**

**6.1.** The Board of Directors may establish councils, commissions, committees, joint committees, sections, forums and other appropriate component groups of ASHP, and such components shall operate to further the purposes of ASHP. The Board of Directors may modify, change, or eliminate components based on the needs of ASHP and its membership.

**6.1.1.** The Commission on Credentialing shall consist of a Chair and as many ASHP members and individuals from other disciplines as may be deemed necessary. The Commission shall formulate and recommend standards for accreditation of pharmacy personnel training programs, administer programs for accreditation of pharmacy personnel training programs, and perform such other functions as related to the development and recognition of pharmacy personnel and areas of pharmacy practice as may be assigned by the Board of Directors.

**6.1.1.1.** One or more members shall be appointed from the public sector.

**6.1.1.2.** The term of appointment shall not exceed three years. Commission members may be appointed to subsequent terms.

**6.1.2.** ASHP shall have councils that report to the Board of Directors and recommend professional policy positions within their areas of concern. Councils may also review ongoing activities of ASHP and recommend new programs within their areas of interest. The councils shall consist of a Chair and those members appointed by the President, with the approval of the Board of Directors. The President shall appoint a Director to each council who shall attend all meetings of the council as an observer and present council recommendations to the Board of Directors.

**6.1.3.** The President, with the approval of the Board of Directors, may establish and appoint joint committees with other organizations. Joint committees shall meet to discuss and recommend to each parent organization solutions to problems of mutual interest.

**6.1.4.** Sections and Forums are components of ASHP established by the Board of Directors. The Board of Directors may also establish rules and criteria (including financial criteria) to join and maintain enrollment in a Section or Forum for the administration of the affairs of the Section or Forum. ASHP members who meet the criteria may be members of the Section or Forum.

**6.1.4.1.** Sections and Forums shall be operated to further the purposes of ASHP by fostering the development, enhancement, and recognition of pharmacy practice as represented by the Section or Forum.

**6.2.** The components of ASHP established pursuant to this Article 6 shall have only those powers granted herein. The Board of Directors may establish administrative guidelines for the scope and operation of these components.

**6.2.1.** In no case shall a component independently contact other organizations, seek or attempt to secure funds from outside ASHP, or commit any funds of ASHP without prior authorization from the ASHP Board of Directors.

## **Article 7. House of Delegates**

**7.1.** The House of Delegates shall consist of 163 voting state delegates, who shall represent a proportionate number of active members in each state; plus all Directors of ASHP; plus Past Presidents (if active members) after completing the term of office of Immediate Past President; plus five (voting) fraternal delegates; plus the (voting) chair of each Section and Forum. Each delegate shall have one vote, and no delegate may have more than one vote by virtue of any dual capacity in the House of Delegates.

**7.1.1.** Delegates shall be chosen as follows:

**7.1.1.1.** As soon as convenient after July 1 in every fourth year beginning with the year 1983, the Board of Directors shall apportion 163 delegates among the states in proportion, as nearly as can be, to the total of active ASHP members in each state as recorded. Each state shall have at least two delegates. For the purpose of computing the reapportionment, the Board of Directors shall use the total number of active members during the immediately preceding year. This apportionment shall prevail until the next quadrennial apportionment, whether the ASHP membership from a particular state increases or decreases.

**7.1.1.2.** Affiliated state chapters shall administer the election of voting state delegates for the House of Delegates. The chapter shall conduct an election to elect voting state delegates from among the active members of ASHP within that state; only active members shall vote in that election. Each state shall certify and transmit, to the Executive Vice President of ASHP, the names and addresses of the elected delegates, and such delegates shall be deemed thereupon to be duly qualified. Delegates shall continue in office until the next election and certification. Any issue or question relating to qualification or eligibility of any delegate or alternate shall be referred to and resolved by the ASHP Board of Directors.



- 7.1.1.3. In those states where no affiliated state chapter exists, the President of ASHP shall appoint, from among the active members of ASHP in the state, a committee of three, designating a Chair and a Secretary, for the purpose of conducting an election for delegates and alternates from active members in the state.
- 7.1.1.4. The United States Army, Navy, Air Force, Public Health Service, and Veterans Administration shall each be entitled to designate one voting fraternal delegate.
- 7.1.1.5. Alternates for voting state delegates shall be chosen in the same manner as that designated for choosing voting state delegates. Alternates shall not be entitled to any of the rights or privileges for delegates until, pursuant to the Rules of Procedure of the House of Delegates, the alternate replaces a voting state delegate.
- 7.1.2. The House of Delegates shall elect a Chair who shall be installed immediately upon election and serve a three-year term.
  - 7.1.2.1. The Chair shall be elected by written or electronic ballot of a majority vote of the delegates present and voting in the House of Delegates. The Chair may not serve for more than one three-year term.
  - 7.1.2.2. The Chair shall serve as liaison between the submitter of resolutions for consideration by the House of Delegates and the Committee on Resolutions.
- 7.1.3. The Immediate Past President shall serve as Vice Chair of the House of Delegates.
- 7.1.4. The Executive Vice President of ASHP shall serve as Secretary of the House of Delegates.
- 7.1.5. Members of ASHP shall have no right to vote in the House of Delegates except by virtue of status hereunder.
- 7.2. A yearly session (consisting of at least two meetings) of the ASHP House of Delegates shall be held at such time and place as may be established; the House of Delegates shall conduct such business as may come before it. Special online sessions of the House of Delegates may be called by the Board of Directors or by the Chair of the House of Delegates, provided that such request contains the specific topic or topics to be considered at that meeting.
  - 7.2.1. The Secretary shall notify each member selected as a delegate to the House of Delegates at least 30 days in advance of its yearly session and any special session.
  - 7.2.2. ASHP shall use reasonable means to notify the membership of yearly and special sessions and to encourage their participation therein, to the extent authorized by these Bylaws.
  - 7.2.3. A majority of voting members of the House of Delegates who have enrolled for that session shall constitute a quorum at any session or meeting duly convened. In the absence of a quorum, the Chair may recess any session or meeting until such time as a quorum is present.
- 7.3. The House of Delegates shall conduct its business at its yearly or special online session.

- 7.3.1.** The House of Delegates shall review and oversee the professional affairs of ASHP to further its purposes.
- 7.3.1.1.** ASHP professional policy, as approved by the Board of Directors, shall be submitted to the House of Delegates for its review, consideration, modification, approval, or disapproval. In the event the House of Delegates fails to approve a matter as submitted to it, the House shall note the reason in its proceedings and return the matter to the Board of Directors for review, modification, or other action. The Board of Directors shall consider, during its interim meeting between meetings of a House of Delegates session, actions of the House of Delegates that resulted in amendment or modification of an issue presented in the first House meeting. The Board shall report its recommendations pertaining to these amendments or modifications during its report in the second meeting of the House session. If, after Board reconsideration, the House disagrees with the Board recommendation pertaining to disposal of an issue, the House may, by two-thirds vote of certified and registered delegates, reconsider the issue for approval. If, on reconsideration, the House fails to approve the matter as previously amended or modified, the House shall note the reason in its proceedings and return the matter to the Board of Directors for review, modification, or other action. The Board of Directors shall then duly report its action thereon at the next session of the House of Delegates.
- 7.3.1.2.** Individual delegates may make recommendations to the Board of Directors on such matters as each delegate deems appropriate.
- 7.3.1.3.** As to any resolution or item of business presented to the House, the Board shall normally certify that it has duly considered the matter. However, if the House of Delegates should debate a matter that the Board of Directors has not so considered, action taken by the House will be by vote to refer the proposed matter to the Board of Directors for review before the House of Delegates takes action on that matter or to reject the issue. The Board shall report on that matter for consideration by the House at the next session of the House of Delegates. If the Board of Directors rules that bona fide, extraordinary circumstances require immediate action and if a majority of the delegates present and voting concur, the House of Delegates may exercise extraordinary authority and amend, modify, or substitute any matter placed before it.
- 7.3.2.** By majority vote, the House of Delegates may establish its Rules of Procedure, to be effective at the next meeting of the House.
- 7.3.3.** The House of Delegates shall, except as is otherwise specifically provided for in these Bylaws, have no authority over the financial affairs of ASHP.
- 7.3.4.** The Chair of the House of Delegates shall preside at all sessions and meetings of the House of Delegates, shall be a member of the Board of Directors, and shall represent the House of Delegates at all Board meetings.

- ~~7.4. Election of Directors of ASHP shall be conducted by, or under the auspices of, the Committee on Nominations of the House of Delegates.~~
- ~~7.4.1. The Treasurer shall be elected by written or electronic ballot of a majority vote of the active membership in the same manner as members at large as provided in Section 7.4.3.2 every third year before the term of that office begins. Only nominations for the office of Treasurer from the Board of Directors shall be accepted.~~
- ~~7.4.2. The Chair of the House of Delegates shall be elected by written or electronic ballot of the House of Delegates as provided in Section 7.1.2.~~
- ~~7.4.3. The Chair shall appoint a Committee on Nominations consisting of seven active members who shall have been delegates to the House of Delegates within the last five years at the time of their appointment to serve as a Committee of the House. The Committee shall solicit names of possible candidates for office using such means as it determines to be appropriate.~~
- ~~7.4.3.1. The Committee shall submit to the House of Delegates one or more reports nominating two candidates for the office of President-elect, two candidates for each Director to be elected, and two candidates each for Chair of the House of Delegates. The reports of the Committee shall not be subject to amendment and shall be the exclusive source of nominations for these offices.~~
- ~~7.4.3.2. The names of the candidates for President-elect, Treasurer, and Directors of ASHP shall be submitted by mail or electronic transmission to every active member of ASHP within 60 days after nomination. The active member shall indicate on the ballot a choice of candidates for the offices to be filled and return the same by mail or electronic transmission within 30 days of the date on the ballot.~~
- ~~7.4.3.3. The ballots, postmarked or electronically transmitted within 30 days of the date printed on the ballot, will be submitted to the Board of Canvassers who shall oversee counting of the ballots. The Board of Canvassers shall certify the results of the election to the Executive Vice President. The Executive Vice President shall notify all candidates of the results of the election, and the results of the election shall also be disseminated to the membership.~~
- ~~7.4.3.4. The Board of Directors shall fill all vacancies in the list of candidates that may occur by death or resignation after the adjournment of the annual meeting of ASHP and before the issuance of mail ballots.~~
- 7.4. The Committee on Resolutions shall be composed of the Board of Directors and chaired by the President of the Society. The Committee shall review all resolutions. Once duly considered, the Committee shall submit them to the House of Delegates.

## **Article 8. Affiliated State Chapters**

- 8.1. ASHP shall recognize groups of pharmacists practicing in organized health care systems within the states when such groups promote the purposes of ASHP.
- 8.1.1. Only one group in each state (hereafter, affiliated state chapter) shall be affiliated with ASHP.

- 8.1.2.** ASHP shall establish standards and criteria that a state group must meet to be affiliated with ASHP.
- 8.2.** ASHP shall promote and strengthen affiliations with affiliated state chapters in order to support and fulfill the mission of ASHP and its affiliates.
- 8.2.1.** Affiliated state chapters shall promote the standards and policies of ASHP within the state.
- 8.2.2.** Affiliated state chapters may use the official Society logo and note its affiliation with ASHP under such terms and conditions as may be established by the Board of Directors.
- 8.2.3.** Within the limits of its resources, ASHP shall endeavor to provide services, benefits, and programs to assist affiliated state chapters in furthering the purposes of ASHP and in furthering the organizational strength of affiliated state chapters.
- 8.2.4.** Affiliated state chapters shall administer the election of voting state delegates to the House of Delegates.
- 8.2.5.** Affiliated state chapter involvement is critical to ASHP and should advance the best interests of the membership at the national and state levels, encourage and facilitate two-way information exchange and support between ASHP and the affiliate, and provide benefits to ASHP and the affiliate.
- 8.3.** Affiliation shall not limit the rights of ASHP or the affiliated state chapter.
- 8.3.1.** Affiliated state chapters may not adopt, publicize, promote, or otherwise convey any policy or principle in the name of the American Society of Health-System Pharmacists that has not been officially adopted by ASHP.
- 8.3.2.** Acts of affiliated state chapters shall in no way commit or bind ASHP.
- 8.3.3.** Dues in affiliated state chapters may be set at the discretion of the chapter. Dues in ASHP shall be established pursuant to these Bylaws.

## **Article 9. International Cooperation**

- 9.1.** ASHP shall endeavor to promote and foster relationships with pharmacy organizations from other countries and with international pharmacy and health organizations when such furthers the purposes of ASHP.

## **Article 10. Miscellaneous**

- 10.1.** The following terms used in these Bylaws shall mean the following:
- 10.1.1.** “Notice” shall be delivered personally, electronically, or by mail to the primary address of the person to receive such notice. If such notice is given by mail, it shall be deemed delivered when deposited in the United States mail properly addressed and with postage paid thereon.
- 10.1.2.** “State” shall mean the 50 jurisdictions of the United States customarily called states, plus the District of Columbia and Puerto Rico.
- 10.2.** At the direction of the Board of Directors, any officer or employee of ASHP shall furnish, at the expense of ASHP, a fidelity bond in such a sum as the Board shall provide.
- 10.3.** ASHP may indemnify each Director, officer, former Director, and former officer of ASHP against expenses (including attorneys’ fees), judgments, fines, penalties, and settlements actually and necessarily incurred by that person in connection with or

arising out of any proceeding in which that person may be involved as a party or otherwise by reason of being or having been such Director or officer.

**10.3.1.** No indemnification shall be made until the Board of Directors or ASHP shall have determined that indemnification is proper.

**10.3.2.** The procedure and standard for indemnification shall be governed by the applicable sections of the Corporations and Associations Article and the Annotated Code of Maryland.

**10.4.** If any provision of these Bylaws should, for any reason, be held to be invalid, the validity of any other provision is not thereby affected.

**10.5.** Whenever the Board of Directors is given authority with respect to any matter, that authority shall include the ability to modify, change, stop, or eliminate that matter at any time.

**10.6.** The business of the House of Delegates shall be conducted in accord with such Rules of Procedure as the House of Delegates may establish and, to the extent not covered therein, by the latest edition of Robert's Rules of Order. In no case shall any rule of the House conflict with the Charter or these Bylaws.

**10.7.** The fiscal year of ASHP shall be a 12-month period beginning on June 1 and ending on May 31.

**10.8.** The *American Journal of Health-System Pharmacy* shall be the official publication of ASHP. The proceedings of the House of Delegates and the Board of Directors and other official business of ASHP shall be published in the *American Journal of Health-System Pharmacy*.

**10.9.** ASHP will support a research and education foundation to further development of the profession and as a means to meet the purposes of ASHP; the research and education foundation will, at all times, be a separate and independent entity.

## **Article 11. Amendment**

**11.1.** Any proposed amendment to these Bylaws must first be submitted to the Board of Directors. Upon review, the Board shall submit the proposed amendment to the House of Delegates. Upon approval of a majority of the voting delegates of the House of Delegates then present and voting, the amendment shall become effective.

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The ASHP Charter and Bylaws were approved by the ASHP House of Delegates on June 6, 1984, and by active members of the Society in the 1984 mail ballot annual election. These documents, as subsequently amended, replace the Society's former Articles of Incorporation, Constitution, and Bylaws, effective January 1, 1985. The Regulations for the ASHP House of Delegates were not a part of the 1982–84 governing documents modernization project. These Bylaws and the Rules of Procedure for the House of Delegates were further revised by the ASHP Board of Directors and approved by the ASHP House of Delegates on June 3, 2014, and June 12, 2016; these versions supersede previous versions. The ASHP Charter was not amended in those revisions.

Revised 06/12/16

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# ASHP Rules of Procedure for the House of Delegates

## Article 1. Summary and Authority

- 1.1. *Summary:* These Rules of Procedure establish basic rules under which the ASHP House of Delegates operates and conducts its business. These Rules of Procedure are subject to the ASHP Charter and Bylaws but supersede any contrary or inconsistent rule in *Robert's Rules of Order*.
- 1.2. *Authority:* ASHP Bylaws, Section 7.3.2.

## Article 2. Rules of Order

- 2.1. The latest edition of *Robert's Rules of Order* shall govern proceedings of the House of Delegates when not inconsistent or in conflict with these ASHP rules; in such cases, these ASHP rules will govern.
  - 2.1.1. In order of precedence, the ASHP Charter and then the ASHP Bylaws, at all times, supersede these ASHP rules and *Robert's Rules of Order*.
  - 2.1.2. The House should be guided by formal interpretation of the governing documents as announced by its Chair and by precedent.

## Article 3. Seating of Delegates

- 3.1. Delegates and alternates duly certified and qualified under Section 7.1 of the Bylaws shall be enrolled by the Secretary in advance of a yearly or special session. After the first meeting of a yearly or special session has been called to order, the Secretary shall call the roll of enrolled delegates; those answering the roll shall be recognized as delegates.
  - 3.1.1. Any delegate who, at the first meeting of a House of Delegates session, is recognized and enrolled as a delegate of the House shall remain a delegate of the House until such time as replaced pursuant to this rule.
  - 3.1.2. The place of a recognized and enrolled delegate will not be taken by any other person, except that at the commencement of each meeting the House may, by majority vote, recognize and enroll an alternate delegate (in order of precedence, if designated by the state) if presented, who shall then remain a delegate (in place of the replaced delegate).
  - 3.1.3. In the event neither a delegate nor alternate from a state appears at the commencement of a session of the House, the Secretary shall enroll and the Chair shall recognize the first certified delegate or alternate appearing before the House as the enrolled and recognized delegate from such state.

## Article 4. Meetings

- 4.1. All meetings of the House of Delegates shall be open unless the House of Delegates, by a vote of two-thirds of the total House, as defined in Section 7.1 of the Bylaws, votes to go into executive session. When in executive session, the following only shall be admitted to the room in which the meeting is held: members of the House of

Delegates (as defined in Section 7.1 of the Bylaws), the parliamentarian, and others specifically authorized by a majority vote of the House of Delegates.

### **Article 5. Open Hearing**

**5.1.** An open hearing shall be conducted, in conjunction with any in-person House of Delegates session, to provide a forum for members to express their opinions on matter of concern to them and on matters to be considered by the House of Delegates.

**5.1.1.** At the call of the Chair of the House of Delegates, and with approval of the Board of Directors, additional open hearings may be scheduled.

**5.1.2.** The Chair of the House of Delegates shall preside at any open hearing and may request assistance from members of the Board of Directors, officers of the Society, and council Chairs.

### **Article 6. Privilege of the Floor**

**6.1.** The privilege of the floor (which may include the right to participate in debate on a matter), during a meeting of the House of Delegates, may be extended by either the Chair or the House of Delegates.

### **Article 7. Conduct of Business of the House**

**7.1.** The Business of the House of Delegates shall be as follows, unless the Chair of the House of Delegates determines that the business or matters for the House require a different order or that additional items to the order are required:

- a. Call to order.
- b. Roll call of delegates.
- c. Reports of officers and the Board of Directors.
- d. Recommendations of delegates.
- e. Reports of councils and committees.
- f. Resolutions.
- g. Unfinished business.
- h. New business.
- i. Triennial Election of the Chair of the House of Delegates.
- j. Installation of officers and Directors.
- k. Adjournment.

**7.2.** Any matter upon which action is to be taken by the House of Delegates will be presented to delegates in writing and in advance. The Secretary will distribute copies of the proposed action to the House. Action of the House is, at all times, subject to Section 7.3 and, in particular, Section 7.3.1.3 of the Bylaws.

**7.2.1.** Any matter to be presented as new business shall be presented to the Chair of the House in writing no later than four o'clock in the evening before the day of the meeting in which new business is on the agenda. If any such matter will include the offering of a motion, the writing required by this rule shall state explicitly the motion to be offered.

**7.2.2.** Resolutions to be considered by the House of Delegates must be presented in writing to the Secretary of the House of Delegates at least 90 days in advance of the session and be signed by at least two active members of ASHP.



**7.2.2.1.** 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.

**7.2.2.2.** The House shall be informed of resolutions not presented to it and the reasons therefore.

**7.3.** Any item presented for action by the House of Delegates shall, unless the Bylaws or these rules specify to the contrary, require for passage the vote required by *Robert's Rules of Order*. Except for election of the Chair, no vote shall be by secret ballot.

**7.3.1.** Any matter not acted upon by the House of Delegates, upon adjournment of the session, shall die.

**7.4.** Matters of an emergent nature must be acted upon in accord with Section 7.3.1.3. of the Bylaws.

## Article 8. Nominations and-Elections

**8.1.** Nominations ~~of Directors of ASHP (including for the Chair of the House of Delegates)~~ shall be by the Committee on Nominations in accordance with Section ~~7.4~~ 5.2 of the Bylaws.

**8.1.1.** A written biography of each nominee shall be prepared and distributed at the appropriate meeting of the House of Delegates session.

**8.1.2.** The Chair shall appoint three delegates to serve as election tellers for elections conducted in the House of Delegates. Tellers shall supervise the election, count ballots, and report to the Chair the results thereof. The Chair shall share the election results with each nominee but shall announce only the name of the candidate receiving the majority of votes cast for Chair of the House of Delegates.

**8.1.3.** The Chair shall be elected by written or electronic secret ballot of the House of Delegates and need receive only a majority of votes cast.

~~**8.1.4.** The Committee on Nominations shall issue a separate report containing two nominees for each Director and the office of President elect.~~

## Article 9. Amendments

**9.1.** Every proposed amendment to the Rules of Procedure for the House of Delegates shall be submitted in writing at one meeting of the House of Delegates and may be acted upon at a subsequent meeting of the session, when upon receiving a majority of votes cast, it shall become a part of these rules, effective as of the following session of the House of Delegates.

Developed by the ASHP Council on Organizational Affairs. Approved by the ASHP Board of Directors, November 20–21, 1985, and by the ASHP House of Delegates, June 4, 1986. Supersedes the previous document, Regulations for the ASHP House of Delegates. Revised by the ASHP Board of Directors and approved by the ASHP House of Delegates, June 3, 2014. Supersedes previous versions of this document.

Revised: 06/03/14

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## 2021 Report of the ASHP Treasurer

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**Keywords:** assets, finance, operations

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ASHP has successfully navigated the financial challenges brought on by the COVID-19 pandemic and remains well-positioned for the future to continue to support its membership. We are proud of the accomplishments and the positive impact that ASHP has had on the profession of pharmacy, healthcare, and patient safety during the past year.



The Treasurer has the responsibility to report on ASHP's financial condition to the membership annually. 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) 2020, projected financial performance for FY2021, and an FY2022 budget status update.

### Fiscal Year 2020 Ending May 31, 2020—Actual

ASHP's FY2020 financial statement audit for the year ending May 31, 2020, was performed by RSM US LLP. The audit resulted in ASHP receiving the best opinion available, an unmodified opinion.

ASHP's core operations<sup>1</sup> had another successful year. Core gross revenue grew to a record \$56.8 million, or 5.1% over FY2019 (Figure 1), primarily due to strong membership growth, the continued success of the Midyear Clinical Meeting (MCM), and growth in professional certificates, certifications programs, residency accreditation services, and the Summer Meetings. Membership grew to nearly 53,500 as of December 31, 2019, which represents an 8.1% increase from the prior year. Core net income was a record \$5.7 million. Program development expenses,

capital budget, and investment gain/(loss)<sup>2</sup> had net expenses of \$1.5 million, and ASHP's pension plan realized a gain of \$126,000. In total, FY2020 resulted in a positive \$4.3 million net change in ASHP's reserves/net assets. Finally, the building fund<sup>3</sup> had a deficit of \$4.1 million, due to lower-than-budgeted investment returns. Even with this, 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 FY2020 were nearly \$129 million (Figure 2) and our year-end balance sheet remains strong, with an asset-to-liability ratio of 5.38:1.

### Fiscal Year 2021 Ending May 31, 2021—Projected

Fiscal year 2021 core operations are shaping up to be another solid year, with projected gross revenue of \$50.2 million. Gross revenue is projected to decrease by \$6.6 million as compared to FY2020, primarily due to holding a virtual MCM versus an in-person MCM as well as providing free educational content in place of in-person Summer Meetings. As of April 30, 2021, we anticipate that ASHP's FY2021 core net income will be in the range of \$3.0 million (Figure 1). This is remarkably strong performance, given the COVID-19 pandemic. We are

also projecting additional net income of \$8.3 million from net program development expenses, capital budget, and investment gains. During FY2021, ASHP terminated a frozen defined benefit pension plan. This has resulted in a projected charge of \$3.8 million. In total, this results in a projected positive \$7.5 million net change in ASHP's reserves/net assets. Finally, due to strong investment returns, we anticipate that the building fund will have net income of \$11.1 million.

A key reason ASHP's FY2021 core operations continue to be so strong is the growth of its membership. ASHP membership reached nearly 58,000 as of December 31, 2020, which is another membership record. This includes 4% growth in pharmacists and new practitioners and 20% growth in student memberships. In addition, the 2020 virtual MCM was the largest ever, with more than 27,000 attendees!

To support our members and the profession during the COVID-19 pandemic, ASHP unlocked numerous evidence-based resources and tools on ASHP.org, making them available free of charge to support the national response to the pandemic. The resources and tools that ASHP invested in included clinical information, advocacy updates, and materials for

Figure 1. ASHP condensed statement of activities (in thousands)

	Actual Fiscal Year 2019 Ended May 31, 2019	Actual Fiscal Year 2020 Ended May 31, 2020	Projection* Fiscal Year 2021 Ended May 31, 2021	Budget Fiscal Year 2022 Ended May 31, 2022
<b>CORE OPERATIONS</b>				
Gross Revenue	54,000	56,759	50,174	53,011
Total Expense	-53,029	-51,104	-47,180	(53,510)
<b>CORE NET INCOME</b>	971	5,655	2,994	(499)
<b>NET PROGRAM DEVELOPMENT EXPENSES, CAPITAL BUDGET, AND INVESTMENTS GAIN/(LOSS)</b>				
	-692	-1,453	8,290	599
Pension Plan Adjustment	1,093	126	(3,800)	-
<b>NET CHANGES IN RESERVES/NET ASSETS</b>	1,372	4,328	7,484	100
<b>BUILDING FUND</b>	-3,158	-4,140	11,086	149

\* Projection as of April 30, 2021.

Figure 2. ASHP statement of financial position (in thousands)

	Actual as of May 31, 2019	Actual as of May 31, 2020
<b>ASSETS</b>		
Current assets	11,573	12,887
Fixed assets	8,090	6,646
Investments	1,41,081	1,38,589
Other assets	224	268
<b>Total Assets</b>	<b>1,60,968</b>	<b>1,58,390</b>
<b>LIABILITIES</b>		
Current liabilities	22,036	19,493
Long-term liabilities	10,192	9,969
<b>Total Liabilities</b>	<b>32,228</b>	<b>29,462</b>
<b>RESERVES/NET ASSETS</b>		
Net assets	1,30,526	1,28,740
<b>Total Liabilities and Net Assets</b>	<b>1,60,968</b>	<b>1,58,390</b>

healthcare professionals about the pandemic. In addition, ASHP invested significant monies to take swift policy and advocacy actions, which included authorization of pharmacists and pharmacy personnel to “test-treat-immunize” for indicated populations, inclusion of ASHP’s drug shortage recommendations in federal COVID-19 relief law, streamlining of professional licensing allowances, Food and Drug Administration flexibilities for sterile compounding, and increased annual production quota allocations for Schedule II controlled substances. ASHP also devoted significant financial

resources to supporting national vaccination efforts by promoting broader authorizations for pharmacy staff to order and administer COVID-19 tests and vaccines, increased protection from COVID-19 exposure through personal protective equipment allocation and vaccine prioritization, reimbursement for vaccine administration, and alignment of the volunteer pharmacy workforce to support Federal Emergency Management Agency vaccine administration efforts. In addition to pandemic responses, ASHP also invested in and formed the following: Taskforce on Racial Diversity,

Equity, and Inclusion; Pharmacy Executive Leadership Alliance; Section of Pharmacy Educators; and Section of Community Pharmacy Practitioners.

**Fiscal Year 2022 Ending May 31, 2022 – Budget**

ASHP’s Board of Directors has thoughtfully considered the potential financial ramifications of the COVID-19 pandemic on ASHP’s FY2022 budget. This included potential impacts on the MCM, cancelling the 2021 Summer Meetings, and not increasing membership dues rates for a second consecutive year. The Board of Directors continues to focus on positioning ASHP for the future, including continued support of our members and the profession with timely, valuable resources, products, and services during these extraordinary times and acknowledging that although we did not need to use reserves in FY2021, we may ultimately need to do so in FY2022 if the economic recovery is slower than anticipated or if there is a COVID-19 resurgence.

Taking these and other factors into account, ASHP’s FY2022 budgeted net change in reserves/net assets is a surplus of \$100,000, with \$53.0 million in core gross revenue. The building fund, which is designed to pay for ASHP’s headquarters office space, has a budgeted surplus of \$149,000.

**Conclusion**

ASHP has successfully navigated the financial challenges brought on by the COVID-19 pandemic and remains well-positioned for the future to continue to support its membership. We are proud of the accomplishments and the positive impact that ASHP has had on the profession of pharmacy, healthcare, and patient safety during the past year. We are also proud that our membership has grown to nearly 58,000, which validates the value of the member benefits, programs, products, and services that ASHP offers. The Board of Directors, Chief Executive Officer, and staff remain fully committed to ASHP’s mission, vision, strategic plan, and supporting our

members and the profession of pharmacy. We look forward to another successful year, and I am proud to serve this organization as your Treasurer!

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<sup>1</sup>Represents the revenue and expense associated with the operations of ongoing ASHP programs, products, and services, as well as infrastructure and ASHP Foundation support.

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<sup>2</sup>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.

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<sup>3</sup>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.

# Reflections on an Unprecedented, Extraordinary, and Remarkable Year

## 2021 Report from the President and the Chief Executive Officer



THOMAS J. JOHNSON  
PHARM.D., M.B.A., BCCCP, BCPS,  
FASHP, FCCM  
PRESIDENT, ASHP

Unprecedented, extraordinary, and remarkable are words used frequently to describe the historic nature of the past 18 months and the impact of the COVID-19 global pandemic.

But we think you will agree that they are also words that describe the pharmacists, residents, student pharmacists, and technicians who have stepped up to meet the challenges of these times, doing amazing work on the front lines and behind the scenes to ensure the very best care for patients.



PAUL W. ABRAMOWITZ  
PHARM.D., SC.D. (HON), FASHP  
CHIEF EXECUTIVE OFFICER, ASHP

Reflection on the pandemic will always start with remembrance and acknowledging its societal and economic impact. The lives lost. But it must also focus on the tremendous response of the scientific community and healthcare professionals who worked tirelessly to get us to where we are today. With multiple vaccines now available and Americans aged 12 or older eligible for vaccination, the light at the end of the tunnel continues to grow brighter.

ASHP has played a key role in supporting our members and the entire healthcare community throughout the pandemic. From the early days of spring 2020, when we focused on knowledge-sharing and advocating for access to needed drugs and equipment, to today, as we support continued mass vaccination efforts, ASHP's commitment has never wavered.

In the spring and summer of 2020, ASHP made many important resources available to all pharmacy professionals and the healthcare community free of charge to ensure that essential tools were available to all who needed them. The value of these resources exceeded \$60 million dollars.

Knowledge and information sharing have remained focal points, and ASHP has developed and disseminated an incredible number of COVID-19 resources.

In a 12-month span, we produced 81 podcast episodes, downloaded over 81,000 times, and hosted 53 webinars with over 24,000 attendees.

We published and consistently updated critical tools like the evidence table for COVID-19-related treatments, which has been downloaded more than 57,000 times.

And we built on our position as a go-to organization for our medication use expertise, appearing in nearly 4,000 COVID-19 related articles that generated over 7 billion media impressions.

More recently, we supported broader authorizations for pharmacy staff to order and administer COVID-19 tests and vaccines; advocated for reimbursement for vaccine administration; and produced public-facing messaging to build vaccine confidence among the general public.

For example, a number of ASHP members were featured in a nationwide communications initiative to educate the American public and build vaccine confidence. The COVID-19 Vaccine Education Initiative, supported by the Ad Council and the COVID-19 Collaborative, featured ASHP members who recorded videos of themselves explaining a number of vaccine topics including herd immunity, vaccine research, and how vaccines work.



We also joined the Made to Save coalition as a founding partner to support a month-long vaccination campaign and collaborated with the Department of Health and Human Services and the We Can Do This campaign to advance credible information from pharmacists.

Collaborations and partnerships will be a critical driver in efforts to get all eligible Americans vaccinated and end the pandemic.



In April, Paul Abramowitz was named as a co-chair of an important national task force convened by GTMRx, the Get The Medications Right Institute. The “building vaccine confidence in the medical neighborhood” task force is a significant inter-professional effort designed to build partnerships among trusted healthcare providers, public health leaders, consumer health advocates, and community and social media influencers.

The task force members include leaders from across healthcare, academia, government, and industry who are united in the end goal to leverage the collective influence of these groups to increase vaccination rates and help the us achieve broad immunity against COVID-19.

Throughout the past year, we always kept the wide-ranging needs of our members in mind, creating and launching a wide range of strategic initiatives, products, and services to meet those needs.

## **Diversity, Equity, and Inclusion**



In June 2020, ASHP created the Task Force on Racial Diversity, Equity, and Inclusion to advise ASHP on actionable steps to further address and take inventory of matters of racial diversity, equity, and inclusion as they relate to issues facing Black Americans.

In January, the task force submitted 30 recommendations to the board of directors. The recommendations provide specific guidance to ASHP in several key areas, including ASHP governance and committees; education, training, research and publications; and advocacy, marketing, and communications. Further, the task force broadened its charge to focus on important efforts ASHP can undertake to support all black, indigenous, and people of color.

Immediate early steps taken by ASHP addressed recommendations related to ASHP governance and committees. Swift action was taken to update to our nominations process for board and committee members, and we are pleased to note that these changes resulted in the most diverse slate of candidates for board, officer, and section leadership positions in ASHP history.

In addition to these initial steps, ASHP has established work groups to support the implementation of each task force recommendation. We will regularly share updates with you on our progress.

Our organization has long been a leader in national efforts to eliminate racial and ethnic disparities in healthcare and advancing public health and social justice. Our work in support of diversity, equity, and inclusion at every level within our organization and our profession will always remain a focal point of everything we do.

## **Advocacy**

The past year has also been an extremely busy and productive one for ASHP's government relations team as we work to advance the interests of our members, our profession, and our patients.

Paul Abramowitz and government affairs staff have had several recent meetings with White House staff members and Department of Health and Human Services (HHS) officials across a range of issues, including the need for Medicare and Medicaid payment mechanisms to support pharmacist care; expansion of the role of pharmacists in COVID-19 and flu testing and treatment; opioid stewardship and the need to remove barriers to pharmacist provision of medications for opioid use disorder; and opportunities for pharmacists to address disparities in access to care.



ASHP has been at the forefront of the fight to protect the 340B drug pricing program, which is critical to ensuring that our most vulnerable populations have access to life saving-medications and the care they need.

ASHP's sustained efforts, in collaboration with our partners, including 340B health, the American Hospital Association, America's Essential Hospitals, the Association of American Medical Colleges, and others resulted in the announcement from the Health Resources and Services Administration (HRSA), which manages the 340B program, that it has directed six drug manufacturers to comply with 340B pricing requirements or risk financial penalties.

In support HRSA's decision, lawyers for ASHP and our partner organizations presented oral arguments in a court case between AstraZeneca and the HHS. This is another step in our ongoing work to aggressively protect this important program.

ASHP has also taken extensive action to address the issue of payer-mandated white bagging. In addition to directly lobbying the federal government to act, we are engaged with health systems, peer organizations, and state affiliates and are working on a number of resources for members including roundtable discussions with health-system pharmacy leaders, a self-assessment checklist tool, webinars, and podcasts on identifying solutions to minimize the impact of white bagging and supporting state advocacy efforts through engagement with our state affiliates. We also co-signed a letter to the Food and Drug Administration with more than 50 health systems outlining our concerns that white bagging threatens patient safety.

Most recently, ASHP has continued to lead the charge to support expanded access to pharmacist care at both the state and national levels. In late April, bi-partisan provider legislation was introduced in both the House and the Senate that would remove barriers preventing Medicare beneficiaries from accessing healthcare services from their pharmacist. The Pharmacy and Medically Underserved Areas Enhancement act (S. 1362, H.R. 2759) recognizes pharmacists as valuable members of the healthcare team and the integral role we can play in addressing the longstanding disparities faced by patients in medically underserved communities. Over 150 healthcare organizations, including every ASHP state affiliate, has joined ASHP in supporting the legislation.

In addition, HHS recently took an important step in recognizing pharmacists as patient care providers. Reflecting ASHP's recommendation to the White House COVID-19 testing team to create a payment mechanism for pharmacist services authorized under the Public Readiness and Emergency Preparedness (PREP) Act, HHS announced that pharmacists will qualify for reimbursement to cover provider costs for testing uninsured patients for COVID-19.

As the collective voice of pharmacists who serve in all healthcare settings spanning the full spectrum of medication use, ASHP remains committed to fighting for laws and policies that ensure the advancement of practice and the best possible outcomes for our patients.

## Meetings

Shifting gears a bit, we want to take a moment to reflect on the notable success of the first-ever virtual Midyear Clinical Meeting & Exhibition. The meeting's theme was “unstoppable,” which perfectly encapsulates the spirit of ASHP, our members, and our interprofessional community.

The largest annual gathering of pharmacists in the world, the Midyear meeting is always highly anticipated. The move to an all-virtual event was daunting, but ASHP staff and volunteers delivered a record-setting event with more than 27,000 attendees that featured exciting speakers, over 1,000 residency showcase booths, more than 4,000 posters, and our hallmark world-class educational programming.



## Innovation

Pivoting to create and implement a highly successful virtual Midyear meeting is just one example of ASHP's commitment to innovation, which was a focal point of the past year, including successful efforts to extend the reach and impact of the ASHP Innovation Center.

Highlights include partnership with the American Medical Association on a joint Pharmacogenomics Virtual Summit series promoting best practices for the clinical application of pharmacogenomics. Nearly 4,000 registrants, including pharmacist and physician leaders, attended the series.

In addition, the Innovation Center partnered with the ASHP Foundation to award the competitive “optimizing technology solutions” innovation grant to two member recipients in July 2020 and secured funding to offer the grant for a second consecutive year.

And ASHP is also preparing to open applications for our newest program that will recognize high-performing hospital and health-system pharmacy departments for excellence in medication-use safety and pharmacy practice. The awarded certification will be based on a new ASHP standard developed from highly regarded, contemporary best practices. Pharmacy departments that have achieved excellence under this standard may apply for and undergo a formal process to be considered for designation as an ASHP certified Center of Excellence.

## Growing strength of ASHP

Finally, we want to highlight ASHP's ongoing membership growth, fueled by our commitment to support the evolving pharmacy profession through the expansion of products, programs, and services. Over the past year, we launched the Section of Pharmacy Educators and the Section of Community Pharmacy Practitioners, two important new sections that provide enhanced engagement opportunities and resources for members.

In addition, the exciting work of ASHP's Pharmacy Executive Leadership Alliance, or PELA as we like to call it, kicked into high gear. Formed in early 2020, this group has provided extensive knowledge sharing over the past year and published an important white paper in February to advance COVID-19 response and recovery. Last month, PELA hosted an executive summit on telehealth and we look forward to sharing the report from that successful event with our members in the coming months.

In what has certainly been a challenging year, ASHP has also continued to support the well-being and resilience of our members, including free access to headspace and other valuable resources.

ASHP's value and relevance to the profession has never been more evident. Total membership increased by 8% in 2020, including 4% growth in practitioner members, 7% growth in new practitioner members, and a nearly 20% increase in student membership. As of December 31, 2020, we stood at 58,000 total members. Our highest total ever. We are proud to say that ASHP is thriving!

### **Final Thoughts**

It's clear that what we have achieved together this past year is truly unprecedented, extraordinary, and remarkable.

And none of our achievements would have been possible without the strategic brilliance and passion of Joe Oddis.

Dr. Oddis, ASHP's longest-tenured CEO, passed away in February at the age of 92. His accomplishments and impact on global pharmacy practice are far too extensive to list here. But his legacy cannot be understated, and our ongoing success is directly attributable to his innovative spirit and vision. He will be forever remembered and greatly missed.

In closing thank you to all of you for your professionalism, dedication, and for all you do for our profession and our patients.



**Joseph A. Oddis**  
1928 - 2021

# House of Delegates

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## **Revised New Business Item: COVID-19 Vaccination Requirements to Advance Patient Safety and Public Health**

Sponsors: Bernice Man (IL), Karen McConnell (CO)

States or Entities Represented: Illinois, Colorado

Email Addresses: [bernice.man@nm.org](mailto:bernice.man@nm.org), [karenmcconnell@catholichealth.net](mailto:karenmcconnell@catholichealth.net)

Co-sponsors: Andrew Donnelly (IL), Ashley Ryther (UT), Laura Butkievich (MO), Matthew Rim (SSPP)

**Subject: COVID-19 Vaccination Requirements to Advance Patient Safety and Public Health**

**Motion:**

To support employers in establishing and implementing mandatory vaccine requirements for COVID-19 vaccines once approved by the Food and Drug Administration (FDA) and encouraging the use of COVID-19 vaccines under emergency use authorization; further

To advocate that healthcare organizations limit patient and staff risk of exposure to SARS-CoV-2 from individuals who are not immunized, which may include requiring unimmunized individuals to refrain from direct contact with patients and staff; further

To urge healthcare organizations to have policies that address additional infection prevention practices required for healthcare workers who remain unimmunized against SARS-CoV-2.

**Rationale:**

COVID-19 is a vaccine-preventable disease for which there are [safe and effective vaccines](#). The [evidence](#) is clear that the benefits of COVID-19 vaccines, as authorized by the Food and Drug Administration, far outweigh the risks associated with these medications. Universal vaccination against preventable infectious diseases among healthcare workers, including all members of the pharmacy workforce, is a safeguard to patients and public health. The Centers for Disease Control and Prevention (CDC) [recommends](#) that all healthcare personnel get vaccinated for COVID-19, and [several major health systems](#) have instituted mandatory COVID-19 vaccination policies for their employees as of May 2021. In its recommendation regarding influenza vaccination, the CDC considers healthcare workers to include (but not be limited to) physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental

personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual staff not employed by the healthcare facility, and persons (e.g., clerical, dietary, housekeeping, laundry, security, maintenance, administrative, billing, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from healthcare workers and patients.

Limiting patient exposure to unvaccinated staff is consistent with the Code of Ethics of the American Medical Association: “Physician practices and health care institutions have a further responsibility to limit patient and staff exposure to individuals who are not immunized, which may include requiring unimmunized individuals to refrain from direct patient contact.” ([AMA Code of Ethics Opinion 8.7](#))

**Suggested Outcomes:**

That ASHP advocate healthcare organizations adopt policies to reduce risk of SARS-CoV-2 transmission in all healthcare settings.

**Background:**

The sponsors of the proposed New Business wish to revise their motion in response to amendments made by the House to Council on Pharmacy Practice 6: Universal Immunization for Vaccine-Preventable Diseases in the Healthcare Workforce. Those changes are as follows:

~~To advocate that hospitals and health systems require healthcare workers to receive a COVID-19 vaccination except when (1) it is contraindicated, (2) the worker has religious objections, or (3) the worker signs an informed declination; further,~~

To support employers in establishing and implementing mandatory vaccine requirements for COVID-19 vaccines once approved by the Food and Drug Administration (FDA) and encouraging the use of COVID-19 vaccines under emergency use authorization; further,

To advocate that healthcare organizations ~~institutions~~ limit patient and staff risk of exposure to SARS-CoV-2 from individuals who are not immunized, which may include requiring unimmunized individuals to refrain from direct contact with patients and staff; further,

To urge healthcare organizations to have policies that address additional infection prevention practices required for healthcare workers who remain unimmunized against SARS-CoV-2.

# House of Delegates

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## Recommendations from the 2021 House of Delegates

The delegate[s] who introduced each Recommendation is [are] noted. Each Recommendation is forwarded to the appropriate body within ASHP for assessment and action as may be indicated.

### 1. Use of Derogatory Terms in Healthcare

Washington State delegation: Rena Gosser, Roger Woolf, Susan Teil Boyer, Karen White

We encourage the development of a statement rejecting the use of derogatory and/or stereotypical terms in healthcare.

**Background:** For example, “Red Man Syndrome” reinforce stereotypes and phrasing such as vancomycin induced flushing are more accurate and appropriate. The IDSA has come out with a policy statement requesting that this phrase not be used. We would like to see ASHP adopt this stance as well and ensure that terms such as these are not included in CE offerings, print materials, presentations, as well as encourage education on more appropriate terms.

### 2. Universal Removal of the Term "Red Man Syndrome"

Paul C. Walker, ASHP Board of Directors

ASHP should issue a position statement, alone or in collaboration with SIDP and/or other organizations, supporting universal removal of the term "Red Man Syndrome" from the healthcare lexicon and recommending replacement with a more suitable term that lacks discriminatory connotations.

**Background:** The term “red man” is a racial epithet used as a slur to derogatorily refer to persons of Native American descent. As ASHP seeks to make our profession, healthcare, and society more diverse, equitable and inclusive, removal of this offensive terminology from our lexicon will help us build trust with and improve care among Native Americans and help dismantle structural racism. The term "Red Man Syndrome" should be replaced with more appropriate terms that lack discriminatory connotations, such “vancomycin flushing syndrome,” “vancomycin histamine release syndrome,” or "vancomycin infusion reaction," as have been suggested by other professional associations.

### 3. Patient Access to Pharmacies within Provider Networks

Paul Driver, Idaho

With the HOD removing pharmacies from the policy adopted on 6/4/21 from the CPM, there is a need to develop a separate policy that addresses inclusion of pharmacies in networks.

**Background:** There was a perceived substantial difference between pharmacists and pharmacies in payer networks. As such, there appears to be a need for a separate policy to address this gap.

#### 4. Student Economic Impact

Ashley Duty, Missouri

ASHP should continue to evaluate the economic impact of ASHP managed and related activities (e.g. Midyear Clinical Meeting) on students.

**Background:** During the COVID-19 pandemic, ASHP offered the Midyear Clinical Meeting for free to students as many of them had been negatively impacted by the economy. There is a benefit to in-person meetings for networking and face time, but the economic burden of the registration and travel may prevent engagement from interested students with limited resources. With engagement from the Pharmacy Student Forum Executive Committee, ASHP should investigate virtual, meeting-lite, or discounted options for students.

#### 5. The Pharmacist's Role in Spiritual Care

To recognize that the spiritual dimension is an important aspect in the health of our patients and practitioners, further;

To encourage ASHP to explore the impact of current curriculums in U.S. Pharmacy Schools in addressing training needs for future pharmacists in the elements of spirituality recognizing the cultural diversity of our patients and pharmacy practitioners, further;

To encourage ASHP to evaluate ASHP Residency Accreditation Standards to address gaps in learning experiences to intentionally address spiritual needs (e.g. chaplaincy rotations), further;

To encourage ASHP to promote the well-being and resilience of the pharmacy workforce by addressing the spiritual health of pharmacy practitioners.

**Background:** Numerous publications have outlined the role of spirituality in health care. Some medical schools and pharmacy schools have developed curriculum with a consensus faculty group of the Association of American Medical Colleges developing goals and learning objectives for curriculum on spirituality in 1999.[1][2] Specific curriculums have been designed to address gaps among physician specialties.[3] The

Joint Commission (TJC) standards incorporate references to religious and spiritual beliefs in the elements of performance and TJC provides a Joint Commission Resource (JCR) that was updated in 2018; Cultural and Religious Sensitivity: A Pocket Guide for Health Care Professionals.[4] Although some pharmacy schools have developed curriculum which incorporate the spiritual health of the patient in the training of pharmacists, there is not a broad consensus of how or what training should be delivered and as the pharmacy professional assumes more responsibility for a patient's well-being, it is vital that the spiritual needs of the patient be addressed by every member of the healthcare team.

[1] Puvhalski, CM. The role of spirituality in health care. Baylor University Medical Center Proceedings, Volume 14, Number 4, pp. 352-357. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1305900/pdf/bumc0014-0352.pdf> accessed May 1, 2021.

[2] Sajja A., Puchalski C., Training Physicians as Healers, AMA Journal of Ethics, July 2018, Volume 20, Number 7: E6555-663. <https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-06/msoc1-1807.pdf> accessed May 1, 2021.

[3] Atkinson HG, Fleenor D, Lerner SM, Poliandro E, Truglio J. Teaching third-year medical students to address patients' spiritual needs in the surgery/anesthesiology clerkship. MedEdPORTAL. 2018;14:10784, [https://www.mededportal.org/doi/pdf/10.15766/mep\\_2374-8265.10784](https://www.mededportal.org/doi/pdf/10.15766/mep_2374-8265.10784), accessed May 1, 2021.

[4] Crittenden, P (Sr. Editor), The Increasing Need for Cultural and Religious Sensitivity, Dateline@TJC, June 20, 2018, <https://www.jointcommission.org/resources/news-and-multimedia/blogs/dateline-tjc/2018/06/the-increasing-need-for-cultural-and-religious-sensitivity/>, accessed May 1, 2021.

**6. Update to CPP 1909 Pharmacist Authority to Provide Medication-Assisted Treatment**  
Federal Pharmacy Caucus: Heather Ourth, Department of Veterans Affairs; LCDR Carl Coats, U.S. Public Health Service; Lt. Col. Rohin Kasudia, Air Force; LTC Joe Taylor, Army; Julie Groppi, ASHP Board of Directors and Department of Veterans Affairs

On behalf of the Federal Pharmacy Caucus, I would like to recommend the Council on Public Policy consider updating ASHP Policy 1909 with the following: 1. Replace the term "medication assisted treatment (MAT)" with the updated language "medications for opioid use disorder (MOUD)" 2. Add an additional clause which would advocate for states to authorize pharmacist prescribing of controlled substances including MOUD to their scopes of practice, 3. Update the rationale to include updated HHS guidelines for the administration of buprenorphine for treating OUD.

**Background:** SAMHSA recommends replacing the term MAT with MOUD. The term "MAT" implies that medications are an adjuvant role to other treatment approaches, while the term "MOUD" supports the idea that medication is an independent treatment



for OUD. The DEA has stated that SAMHSA waivers and practice agreements cannot authorize a pharmacist practitioner to engage in MAT when state law, the Controlled Substances Act, or DEA regulations do not authorize such treatment. States need authorize prescriptive authority for controlled substances, including MOUD, within their state scope of practice regulations. In the 9 states where pharmacists are authorized to prescribe controlled substances, it is important to ensure the addition of MOUD to allow the ability of DEA to authorize SAMSHSA waivers and practice agreements. Additionally, the updated HHS practice guidelines for the administration of buprenorphine still excludes pharmacists as eligible providers due to the issues stated above. Current ASHP Policy, Pharmacist Authority to Provide Medication-Assisted Treatment (1909) Source: Council on Public Policy To advocate for the role of the pharmacist in medication-assisted treatment (MAT) for opioid use disorder, including patient assessment, education, prescribing, and monitoring of pharmacologic therapies; further, To pursue the development of federal and state laws and regulations that recognize pharmacists as providers of MAT for opioid use disorder; further, To foster additional research on clinical outcomes of pharmacist-driven MAT; further, To advocate for the removal of barriers for all providers to be able to provide MAT to patients.

## 7. Healthcare workers using their medical skills to harm patients intentionally

Tricia Meyer, Texas

With the recent conviction of a Wisconsin pharmacist who left COVID 19 vaccines out of refrigeration in hopes of tainting the vaccine, ASHP should provide awareness to members of incidences of misguided healthcare professionals/workers intentionally seeking to cause harm and possible death to patients (although it is assumed this is rare) and signs that may indicate this occurring.

**Background:** Not all patient harm is accidental. Although we were all shocked at the Wisconsin pharmacist's action, most of us assume that intentional harm is a rarity, however the literature and news reports cite patients experiencing a range of events from recoverable intentional harm to "mercy killings". In 2019 an ICU physician was reported to have given excessive doses of fentanyl to at least 27 near death patients. When these workers are finally unmasked, it becomes clear that many co-workers saw red flags but never thought the flags may have been intentional. The recent event highlights how trusted clinicians have access to patients or therapies and most stakeholders do not consider this can intentional action can occur. As co-workers, we are unaware and unknowing of this possibility. These events are difficult to prove and hospitals may be hesitant to report details or suspicions. This is thought to be rare but perhaps it is underreported just like in the past we thought med errors were not common but they were actually under reported.

# ASHP Board of Directors, 2020-2021

Am J Health-Syst Pharm. 2020;77:1807



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## INAUGURAL ADDRESS OF THE INCOMING PRESIDENT

## High Velocity

Am J Health-Syst Pharm. 2021; XX:0-0

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**Keywords:** advocacy, resiliency,  
transformation, well-being

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Change will continue to happen fast, at high velocity—and this can be the moment that defines a generation and our profession. The pandemic has amplified the value of the services we, as a pharmacy team, provide. Recent ASHP presidents have prepared us well for this moment by laying out some essential principles to guide us.



Thanks for joining me. While I was growing up, my family moved 18 times in 18 years. I learned to move fast and adapt. It has prepared me well for the role I accept as your new President.

As we enter this next year, our profession confronts 3 imperatives:

1. Take care of yourself, your family, and those with whom you work.
2. Transform your practice.
3. Shape the future of pharmacy and healthcare.

We'll return to these shortly.

### Gathering momentum

This moment in time is historic. It has been a wild race for all of us. We have been going nonstop to make it through this pandemic. Let's pause and reflect: When did *you* know the pandemic was going to be really bad? That this would transform our lives? We realized our lives would never be the same again. And that was when the race started: We needed to quickly understand how to keep each other safe, how to care for patients with COVID-19, and how to prevent transmission of this awful virus. We rallied with the rest of our healthcare teams to care for patients. We knew we could do this!

And then, disillusionment hit. It was clear this was going to be an endurance race, not a sprint. We knew the disruptions we faced would be much larger and last much longer than we initially imagined.

It has been a long year—both personally and professionally. We have been challenged in untold ways. We have experienced loss in small ways, in large ways, and—perhaps in more cases than we might yet understand—in irreversible ways.

As vaccines became available in record time, it gave us hope. Now, we are entering a Reconstruction Phase.<sup>1</sup> Setbacks will occur, but overall we are starting to come out of the pandemic.

Out of the chaos of the last year, many opportunities will be available for us as a profession, and we will create opportunities. How can we best take the lessons we have learned in this challenging time and apply them to the needs of our patients and the goals of our profession?

### Change at high velocity

Change will continue to happen fast, at high velocity—and this can be the moment that defines a generation and our profession. The pandemic has amplified the value of the services we, as a pharmacy team, provide. Recent

ASHP presidents have prepared us well for this moment by laying out some essential principles to guide us.

- Lisa Gersema<sup>2</sup> reminded us to remain true to our values.
- Paul Bush<sup>3</sup> advocated for a strong workforce and set the stage for ASHP's priority to emphasize a resilient workforce.
- Kelly Smith<sup>4</sup> asked if we were “all in” for pharmacy. And if ever there was a moment to be all in, it's now!
- Kathy Pawlicki<sup>5</sup> asked us to “never settle,” never settle for the sake of our patients and the profession.
- And last year, Tom Johnson<sup>6</sup> talked about transformation, emphasizing that we can't just “embrace change”—but rather, we must now be ready to transform what we do.

And today, I am asking you to do all of this, and at high velocity.

### The 3 imperatives

I believe we need to embrace 3 imperatives in the growth and development of our profession. The first is this: Take care of yourself, your family, and those with whom you work. Keeping pace with change, and the speed at which it occurs, is exhausting. And most days, it seems as though we are in a race.

I encourage us all to slow down to keep up. I know it seems a bit of an oxymoron. We are caregivers and this is not easy. Sometimes it's just a pause—15 seconds to take a deep breath. It is essential to rely on our values to guide and balance our home and family lives with our work lives. At work, let's take an extra moment to check in with each other. We are all starved for connection. We must care for both our teams and our patients.

ASHP's work has not slowed down during the pandemic. We are committed to supporting you in your practice. It has connected us to solve problems together. ASHP has emphasized well-being and resilience<sup>7</sup> for several years, especially this last year. The National Academy of Medicine<sup>8</sup> has an action collaborative on clinician resilience and well-being, and we are the only pharmacy organization that participates in it.

The second imperative is to transform your practice. We have adapted our practice at lightning speed to care for patients and deliver immunizations. We now have the chance to transform our practice. We need to ask: What do we want the lasting changes to be? First and foremost, we need to remember who we are. We are the medication experts. We want patients to get better faster. We are true, indispensable partners on the interprofessional care team. However, many of our organizations are struggling.

ASHP is here to give you the support you need to transform your practice by providing opportunities to share ideas. For almost 80 years, ASHP has been a champion for pharmacy practice advancement. Here are a few examples. We are stronger when we connect and collaborate with others who understand what we do. ASHP's sections and forums are invaluable: They lead practice change. During my term on the Board, ASHP created 3 new sections (Specialty Pharmacy, Pharmacy Educators, and Community Pharmacy Practitioners) and launched the Technician Forum to serve our members better and foster additional leadership. Our sections and forums facilitate the transformation of our practice.

A recent report from ASHP's Pharmacy Executive Leadership Alliance<sup>9-11</sup> captures the strategies we should consider at this time. It urges us to reassess all program offerings, retain patients in our system, identify ways to increase revenue, and support the pharmacy enterprise through innovations in care delivery. The title of this report,<sup>10</sup> "From Reconstruction to Reimagining," captures the theme of our work. I urge you to read it.

Another example of ASHP's leadership is the creation of the Task Force on Racial Diversity, Equity, and Inclusion.<sup>12</sup> It has developed 30 recommendations that provide specific guidance to ASHP. We are implementing the recommendations in a way that is enduring in everything we do. I am proud to lead us in implementing these changes.

The third imperative is: Shape the future of pharmacy and healthcare. An explosion of new opportunities will be created. The challenge is: Which opportunities should we pursue? We are fierce advocates for our patients and our profession as we lead healthcare change. Strong, impactful advocacy will be key.

I want to highlight our leadership in vaccine distribution. Tremendous strides occurred in developing COVID-19 vaccines. However, the pandemic has exposed many problems in our supply chain and in the equity of how we provide healthcare. ASHP anticipated these challenges and developed a set of principles<sup>13</sup> for vaccine access that served as the template for many national organizations and federal agencies.

The pandemic also highlighted that pharmacists should be recognized as providers for our expanded roles on healthcare teams. It is a landmark in our profession that bipartisan bills<sup>14,15</sup> recently introduced in the House and Senate would recognize pharmacists as providers, and critical primary caregivers, in the Medicare program. Our advocacy is critical to get these bills passed. Please, don't ignore those ASHP

Government Relations emails when you get them, especially right now!!

In addition, pharmacy technicians have embraced expanding roles and have opportunities to serve as providers in their own right. ASHP will continue to be the leader in advocating for the issues that matter most to us as health-system pharmacy teams.

## Conclusion

In conclusion, new challenges are coming at us at high velocity, and that's why the 3 imperatives are so important. To reiterate, the 3 imperatives are:

1. Take care of yourself, your family, and those with whom you work.
2. Transform your practice. This can happen by being engaged members and connecting with others.
3. Shape the future of pharmacy and healthcare. This can only happen through innovation and your advocacy efforts.

I'd like to thank some very generous people in my life. Thank you to the pharmacy team at the University of Utah Health. You are amazing, and this last year has shown how truly exceptional you are. I especially want to thank the leadership team I have had the honor to serve.

Thank you to the many residents with whom it has been my privilege to practice pharmacy. Residents challenge us and make us better. We would not be as strong as we are without our residents. I am so proud of you!

Thank you to the ASHP staff and to my colleagues and friends on the Board. We have the most talented staff and engaged board members. And, thanks to Amy and Tom for their help.

Thank you to my family—my two sisters, Sara and Cindy, my son and daughter, Ben and Katee, and their families. And thank you to my husband, Wayne, the most understanding, tolerant, generous, loving man on earth. We are all very close and have become even closer this last year. They are so encouraging and supportive.

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The recovery from the pandemic will be different for each of us. We face many changes both personally and in our practice. Our ability to shape our profession's future has never been greater if we can engage in this high-velocity transformation. I am honored to serve as your President for this next year. I promise you: We are ready! ASHP is ready and here to support each of you. We will shape our profession, we will transform, and we will prevail in our never-ending effort to improve care for all those we serve. Thank you!

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### Disclosures

The author has declared no potential conflicts of interest.

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