House of Delegates Session—2025

June 11 and 13, 2023

Proceedings of the 77th annual session of the ASHP House of Delegates, June 8 and 10, 2025

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Paul W. Abramowitz, Secretary

The 77th annual session of the ASHP House of Delegates was held at the Charlotte Convention Center, in Charlotte, North Carolina in conjunction with Pharmacy Futures 2025.

First meeting

The first meeting was convened at 1:00 p.m. Sunday, June 8, by Chair of the House of Delegates Jesse H. Hogue. Chair Hogue introduced the persons seated at the head table: Nishaminy (Nish) Kasbekar, Immediate Past President of ASHP and Vice Chair of the House of Delegates; Leigh A. Briscoe-Dwyer, President of ASHP and Chair of the Board of Directors; Melanie A. Dodd, President-elect of ASHP and Vice Chair of the Board of Directors; Paul W. Abramowitz, Chief Executive Officer of ASHP and Secretary of the House of Delegates; and Susan Eads Role, Parliamentarian.

Chair Hogue welcomed the delegates and 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. A quorum was present, including 197 delegates representing 49 states and the District of Columbia, as well as the federal services, chairs of ASHP sections and forums, ASHP officers, members of the Board of Directors, and ASHP past presidents (see Appendix I for a complete roster of delegates).

Chair Hogue reminded delegates that the report of the 76th annual session of the ASHP House of Delegates was published on the ASHP website distributed to all delegates. Delegates were earlier advised to review this report. The proceedings of the 76th House of Delegates session were received without objection.

Ratification of Previous Actions. The House ratified its actions taken in November, 2024 and March 2025 (Appendices II-III).

Report of the Committee on Nominations. Chair Hogue called on Tyler Vest, Chair of the Committee on Nominations, for the report of the Committee on Nominations (Appendix IV). Nominees were presented as follows:

President 2026-2027

Kim W. Benner, PharmD, BCPS, FALSHP, FASHP, FPPA, Professor of Pharmacy Practice, Samford University McWhorter School of Pharmacy, and Pediatric Clinical Specialist at Children's of Alabama, Birmingham, AL

Vivian B. Johnson, BS, PharmD, RPh, MBA, FASHP, Senior Vice President of Community Health Services, and Senior Pharmacy Advisor, Parkland Health in Dallas, TX

Board of Directors, 2025-2028
Marie A. Chisholm-Burns, PharmD, PhD, MPH, MBA, FACHE, FASHP, FAST, Executive Vice President and Provost, Oregon Health & Science University, Portland, OR

Davey P. Legendre, PharmD, MBA, BCPS, BCIDP, FASHP, Vice President of Pharmacy Management, PharmD on Demand, Watkinsville, GA

Christy M. Norman, PharmD, MS, BCPS, CPEL, FASHP, Senior Vice President of Pharmacy, Emory Healthcare, Atlanta, GA

Christopher M. Scott, PharmD, BCPS, FASHP, FCCM, Chief Clinical Operating Officer, Eskenazi Health, Indianapolis, IN

Martin J. Torres, PharmD, FCSHP, Director of Pharmacy, UC Irvine Medical Center Pharmacy Department, Orange, CA

Report of the Board on Treasurer Nominations. Chair Hogue called on Kristi Gullickson, Chair of the Board of Directors Committee on Nominations for ASHP Treasurer, for the report of the Board Committee on Treasurer Nominations (Appendix V). Nominees were presented as follows:

Treasurer 2026-2027
John A. Armitstead, MS, RPh, CPEL, FASHP, Vice President**,** Pharmacy Services, Lee Health, Fort Myers, FL

Lisa M. Gersema, BSPharm, PharmD, MHA, BCPS, CPEL, FASHP, System Director of Clinical Pharmacy Services for Allina Health, Minneapolis, MN

A "Meet the Candidates" session to be held on Monday, June 10, was announced. The candidates for the executive committees of the sections of ASHP were then presented to the House.

Report of the Committee on Resolutions. Chair Hogue called on Leigh A. Briscoe-Dwyer, Chair of the Committee on Resolutions, for the report of the Committee on Resolutions (Appendix VI). Two Resolutions were presented, "Advanced Trauma Life Support (ATLS) Certification for Pharmacists" and "Revision of ASHP State Affiliation Guidelines."

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

Chair Hogue 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.)

Kristi Gullickson, Board Liaison to the **Council on Public Policy**, presented the Council's Policy Recommendations 1 through 5.

1. Funding, Expertise, and Oversight of State Boards of Pharmacy
To advocate appropriate oversight of pharmacy practice and the pharmaceutical supply chain through coordination and cooperation of state boards of pharmacy and related ~~other state and federal~~ agencies whose mission it is to protect the public health; further,

To advocate adequate representation on state boards of pharmacy and related agencies by pharmacists and pharmacy technicians representing hospitals and health systems ~~pharmacists and pharmacy technicians~~; further,

~~To advocate hospitals and health systems are adequately represented on state boards of pharmacy; further,~~

To advocate for the dedicated funds for the exclusive use by state boards of pharmacy and related agencies to carry out expected duties; further,

To advocate for consistent application ~~established training~~ of state board of pharmacy regulations by pharmacy inspectors with demonstrated competency in diverse pharmacy practice areas and the implementation of adequate inspection schedules to ensure the effective oversight and regulation of pharmacy practice~~, the integrity of the pharmaceutical supply chain, the protection of the public, and to establish variances from any documented rule by the board of pharmacy~~; further,

~~To advocate that inspections be performed only by individuals with demonstrated competency in the applicable area of practice.~~

To advocate that state boards of pharmacy develop quality assurance processes for evaluating the performance of inspectors to ensure consistency.
Note: This policy would supersede ASHP policy 2021.

2. Payment Parity for Pharmacists' Services
To advocate that pharmacists, as healthcare providers, should receive payment that is commensurate with services provided within their scope of practice.

~~To advocate that any physician or non-physician practitioner be reimbursed in accordance with services provided within their scope of practice; further,~~
~~To recognize that pharmacists, as healthcare providers, provide patient care and bridge existing gaps in healthcare as members of the healthcare team.~~

Note: This policy would supersede ASHP policy 1502.

3. Pharmacists Cross-State Licensure*
To advocate for the improved timeliness of pharmacist ~~that state boards of pharmacy collaborate to streamline the~~ licensure application approval ~~process through standardization and improve the timeliness of application approval across state lines~~; further,

To advocate for interstate pharmacist licensure ~~that state boards of pharmacy collaborate with third-party vendors to streamline the licensure transfer or reciprocity process~~; further,

To support streamlined reciprocity processes, including ~~advocate that boards of pharmacy grant licensed pharmacists in good standing~~ temporary licensure mechanisms, as progress toward interstate licensure. ~~permitting them to engage in practice, while their application for licensure transfer or reciprocity is being processed~~.

Note: This policy would supersede ASHP policy 1621.

4. Patient's Right to Choose
~~To support the patient's right, or that of their~~

~~representative, as allowed under state law, to~~

~~make informed decisions as part of their overall plan of care; further,~~

To acknowledge that patients or their representative have the right to be fully informed about their medication options ~~including benefits, risks, costs, and alternatives,~~ and to be involved in the decision-making process; further,

To support the right of patients or their representative to ~~request specific medications, and to~~ have their preferences considered respectfully, within the limits of clinical appropriateness, ~~evidence-based practice,~~ formulary considerations, safety, ~~restrictions,~~ and legal requirements.~~; further,~~

To recognize the right of the patient or their representative to refuse care and have those decisions respected.

~~To recognize the right of patients to refuse medications or request changes in their prescribed therapy after being informed of the potential consequences of such decisions.~~

Note: This policy would supersede ASHP policy 0013.

5. Support of Global Health Organizations

To strongly support the mission and work of global health organizations in their role in public health preparedness, prevention, and control to improve the health and well-being of people globally.

Note: This policy would supersede ASHP policy 2037.

Vivian Bradley Johnson, Board Liaison to the **Council on Pharmacy Management**, presented the Council's Policy Recommendations 1 through 3.

1. Recovery and Assistance Programs for Healthcare Workers with Substance Use Disorder

To advocate that hospitals and health systems support and promote ~~establish~~ recovery and assistance programs for healthcare personnel ~~workers~~ with substance use disorders, including those who have diverted controlled substances to support their own drug addiction; further,

To encourage state licensing boards to support structured rehabilitation programs that demonstrate a clear pathway for recovery and hospitals and health systems to support the return to practice upon successful completion of the program.

2. Cellular and Gene Therapies

To affirm that the pharmacy workforce ~~pharmacists~~ serve key roles in the use of cellular and gene therapies (CGTs), spanning supply chain management, operational oversight, and clinical consultation on individual patients; further,

To recognize that CGTs ~~are therapeutics that~~ are managed ~~as such~~ in the medication-use process; further,

To assert that health-system decisions on the selection, use, and management of CGTs are made through the formulary system; further,

To advocate for payment models that facilitate patient access, coverage, and reimbursement for CGTs with consideration of total cost of care; further, ~~outcomes-based innovative payment models that facilitate patient access to CGTs, including full coverage of approved indications and full reimbursement for CGTs.~~ To advocate for manufacturer processes that decrease the burden and resources required for hospitals and health systems to use CGTs.

Note: This policy would supersede ASHP policy 1802.

3. Interstate Pharmacist Licensure
To discontinue ASHP policy 2030, Interstate Pharmacist Licensure, which reads:

To advocate for interstate pharmacist licensure to expand the mobility of pharmacists and their ability to practice.

Vickie L. Powell, Board Liaison to the **Council on Pharmacy Practice**, presented the Policy Recommendations 1 through 3.

1. Safe and Secure Transfer of Controlled Substances
To advocate for the standardization of policies, procedures, and practices in the handling of controlled substance medications throughout the care process, including transfers ~~between~~ involving emergency medical services and during interfacility transport; further,

To promote closed loop communication and chain of custody documentation processes related to controlled substance medication management during patient transfers; further,

To collaborate with emergency medical services and other stakeholders involved in pre- and post-hospital and interfacility transfers of controlled substances to improve patient safety, increase standardization, ~~minimize variation,~~ and ensure compliance.

2. Addressing and Preventing Moral Distress and Injury in the Healthcare Workforce*
To acknowledge the acute and chronic exposure of the healthcare workforce to potentially morally injurious events across the continuum of care; further,

To recognize the risk of moral distress and moral injury when a healthcare worker is unable to provide ethical, safe, and effective care ~~due to system-level constraints~~; further,

To advocate for consistent support for ~~and~~ equitable and transparent allocation of resources across care teams and health systems to ensure that healthcare workers can provide safe and comprehensive patient care services; further,

To advocate that ~~for proactive and corrective approaches within~~ organizations ~~that are co-designed with members of the healthcare team to~~ prevent and address moral distress and moral injury among healthcare workers.

3. Pharmacy Services to Optimize Patient Throughput
To support the integration of pharmacy services ~~as systems are optimized~~ to improve safe and efficient throughput and patient flow throughout the health system~~-wide patient throughput~~; further,

To advocate for pharmacists to serve as key decision-makers for improving medication management to optimize patient flow throughout the continuum of care ~~health system.; further,~~

~~To develop resources related to incorporating pharmacy services into patient throughput action plans and process maps; further,~~

~~To identify measures and tracking systems that demonstrate the impact of pharmacy-driven services to optimize patient throughput.~~

Douglas Slain, Board Liaison to the **Council on Therapeutics**, presented the Council's Policy Recommendations 1 through 5.

1. Accurate and Timely Height and Weight Measurements
To encourage the pharmacy workforce ~~pharmacists~~ to participate in interprofessional efforts to ensure accurate and timely patient height and weight measurements are recorded in the patient medical record to provide safe and effective drug therapy; further,

~~To encourage drug product manufacturers to conduct and publicly report pharmacokinetic and pharmacodynamic research in pediatric, adult, and geriatric patients at the extremes of weight and weight changes to facilitate safe and effective dosing of drugs in these patient populations, especially for drugs most likely to be affected by weight; further,~~

~~To encourage independent research on the clinical significance of extremes of weight and weight changes on drug use, as well as the reporting and dissemination of this information via published literature, patient registries, and other mechanisms; further,~~

To advocate that clinical decision support systems and other information technologies be structured to facilitate prescribing, dispensing, and monitoring of drugs which utilize height and/or weight to calculate safe and effective

dosing ~~most likely to be affected by extremes of weight and weight changes~~; further,

To advocate for ~~federal and~~ ~~state~~ laws and regulations that prescribers ~~to~~ include weight, height, and date obtained as a required component of prescriptions for medications that are dosed based on height and/or weight.

Note: This policy would supersede ASHP policy 1721.

2. Clinical and Safety Considerations of Naming Drug Moieties and Complexes
To encourage regulatory agencies to ~~consider~~ incorporate pharmacists when considering clinical, operational, access, and safety factors when approving and classifying medications with different moieties or complexes that are used to deliver the active drug; further,
[MOVED FROM BELOW AND AMENDED]

To oppose the consolidation of existing drug classes that include drugs that have distinct pharmacologic effects and pharmacokinetic/pharmacodynamic profiles; further,

~~To encourage regulatory agencies to consider clinical, operational, access, and safety factors when approving and classifying medications with different moieties or complexes that are used to deliver the active drug; further,~~
[MOVED ABOVE AND AMENDED]

~~To advocate for the pharmacist's active role in these processes; further,~~

To foster increased ~~pharmacist, provider, and~~ public notification ~~awareness~~ when changes in approved drug products with therapeutic equivalence occur.

3. Clinical, Operational, and Safe Use of Manipulated Drug Products and Alternate Administration Routes
To support clinically appropriate, evidence-based use of manipulated drug-products or alternate drug administration routes when it supports optimal patient care; further,

To promote research that includes ~~further delineates the~~ pharmaceutics, pharmacokinetics, pharmacodynamics, ~~pharmacokinetic and pharmacodynamic properties as well as~~ safety, and efficacy of drugs when manipulated or when given through alternate administration routes ~~and investigate the interrelationship between drug exposure and safety and efficacy outcomes including the potential role of artificial intelligence in advancing model development and validation~~; further,

To encourage manufacturers to develop drug products in ready-to-use devices and diverse formulations; further,

To foster pharmacist-led interdisciplinary teams to provide institutional guidance, best practices, and safety recommendations regarding drug products that are manipulated or administered through alternative routes.

Note: This policy would supersede ASHP policies 2041, 2242, and 2314.

4. Expedited Partner Therapy
To affirm that the pharmacy workforce improves patient access to therapies that prevent and treat sexually transmitted infections in all settings; further,

To support legislation that authorizes pharmacists to provide ~~promotes~~ expedited partner therapy (EPT) while addressing barriers; further,

To encourage dispensing pharmacy entities and payers to adopt internal policies that facilitate dispensing of EPT medications in alignment with public health guidance; further,

~~To affirm that interpreting test results, prescribing, dosing, and dispensing therapies as clinically indicated is within pharmacists' scope of practice; further,~~

To advocate and affirm that drug products for EPT should be provided to individuals in a manner that ensures safe and appropriate use; further,

To encourage surveillance of EPT as a public health effort.

5. Quality Consumer Medication Information
To support efforts by the Food and Drug Administration (FDA) and other stakeholders to improve the quality, consistency, accessibility, targeting, and simplicity of consumer medication information (CMI); further,

To encourage the FDA to work in collaboration with patient advocates and other stakeholders to create evidence-based models and standards, including establishment of a universal literacy level and standardized, patient-focused templates for CMI; further,

To advocate that research be conducted to validate these models in actual-use studies in pertinent patient populations; further,

To advocate that the FDA explore alternative models of CMI content development and maintenance that will ensure the highest level of accuracy, consistency, currency, and conformity with health literacy requirements; further,

To advocate that the FDA maintain a highly structured, publicly and easily accessible central repository of CMI in a format that is suitable for ready export; further,

To advocate for laws and regulations that would require all dispensers of medications to comply with FDA-established standards for ~~unalterable~~ content, format, and distribution of CMI.
Note: This policy would supersede ASHP policy 2005.

Jennifer Tryon, Board Liaison to the **Council on Education and Workforce Development**, presented the Council's Policy Recommendations 1 through 2.

1. Support for Caregiving Responsibilities in the Pharmacy Workforce
To affirm that an individual's life circumstances can change and influence their workplace needs; further,

To foster psychologically safe environments that promote dialogue around individual workplace needs; further,

To advocate for organizational policies and resources that reduce disparities caused by caregiving responsibilities such as ~~including~~ eldercare, ~~and~~ lactation support, and other life circumstances; further,

To empower individuals to advocate for their own needs related to work-life integration.

2. Support for Caregiving Responsibilities in the Pharmacy Workforce
To foster the ongoing development of cultural humility and competency within the pharmacy workforce and promote a whole-person-health approach to care; further,

To educate the pharmacy workforce on how to interact with patients, caregivers, and other healthcare professionals in a manner that demonstrates respect for and responsiveness to all; further,

To educate healthcare providers on the importance of providing culturally congruent and trauma-informed care to achieve quality care and patient engagement.

Note: This policy would supersede ASHP policy 2231.

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

Recommendations. Chair Hogue called on members of the House of Delegates for Recommendations. See Appendix IX for a complete listing of all Recommendations.

The meeting adjourned at 5:30 p.m.

Second meeting
The second and final meeting of the House of Delegates session convened on Tuesday, June 10 at 4:00 p.m. A quorum was present.

Report of the Committee on Resolutions. Committee on Resolutions Chair Briscoe-Dwyer presented the Resolution, "Advanced Trauma Life Support (ATLS) Certification for Pharmacists." The House voted to adopt the Committee's recommendation that the resolution be referred to council for further study and action.

Report of the President and the Chief Executive Officer. President Briscoe-Dwyer updated and elaborated upon various ASHP initiatives. There was no discussion, and the delegates voted to accept the report (Appendix X).

Board of Directors duly considered matters. Pursuant to Bylaws section 7.3.1.1, the Board met on the morning of June 9 to "duly consider" the policies amended at the first meeting. Three policy recommendations were approved without amendment. Fifteen policy recommendations were amended or edited by the House of Delegates. The Board agreed with the House's amendments and editorial changes to 15 policy recommendations, with nonsubstantive editorial changes to eight of those 15 policy recommendations. The Board offered revised language for those policy recommendations, as noted below (amendments made by the House are delineated as follows: words added are underlined; words deleted are ~~stricken~~. Text added by the Board is indicated in **bold double underline;** text deleted by the Board is indicated in ~~**bold double strikethrough**~~):

Council on Public Policy
1. Funding, Expertise, and Oversight of State Boards of Pharmacy
To advocate appropriate oversight of pharmacy practice and the pharmaceutical supply chain through coordination and cooperation of state boards of pharmacy and related ~~other state and federal~~ agencies whose mission it is to protect the public health; further,

To advocate adequate representation on state boards of pharmacy and related agencies by pharmacists and pharmacy technicians representing hospitals and health systems ~~pharmacists and pharmacy technicians~~; further,

~~To advocate hospitals and health systems are adequately represented on state boards of pharmacy; further,~~

To advocate for the dedicated funds for the exclusive use by state boards of pharmacy and related agencies to carry out expected duties; further,

To advocate for consistent application ~~established training~~ of state board**s** of pharmacy regulations by ~~**pharmacy**~~ inspectors with demonstrated competency in diverse pharmacy practice areas and the implementation of adequate inspection schedules to ensure the effective oversight and regulation of pharmacy practice~~, the integrity of the pharmaceutical supply chain, the protection of the public, and to establish variances from any documented rule by the board of pharmacy~~; further,
~~To advocate that inspections be performed only by individuals with demonstrated competency in the applicable area of practice.~~

To advocate ~~**that**~~ state boards of pharmacy develop quality assurance processes for evaluating the performance of inspectors to ensure consistency.

Note: This policy would supersede ASHP policy 2021.

2. Payment Parity for Pharmacists' Services
To advocate ~~**that**~~ pharmacists, as healthcare providers, ~~**should**~~ receive payment that is commensurate with services provided within their scope of practice.

~~To advocate that any physician or non-physician practitioner be reimbursed in accordance with services provided within their scope of practice; further,~~

~~To recognize that pharmacists, as healthcare providers, provide patient care and bridge existing gaps in healthcare as members of the healthcare team.~~

Note: This policy would supersede ASHP policy 1502.

3. Pharmacists Cross-State Licensure
To advocate for ~~**the**~~ improved timeliness of **the** pharmacist ~~that state boards of pharmacy collaborate to streamline the~~ licensure application approval **process** ~~process through standardization and improve the timeliness of application approval across state lines~~; further,

To advocate for interstate pharmacist licensure ~~that state boards of pharmacy collaborate with third-party vendors to streamline the licensure transfer or reciprocity process~~; further,

To support streamlined reciprocity processes, including ~~advocate that boards of pharmacy grant licensed pharmacists in good standing~~ temporary licensure mechanisms, as progress toward interstate licensure. ~~permitting them to engage in practice, while their application for licensure transfer or reciprocity is being processed~~.

Note: This policy would supersede ASHP policy 1621.

4. Patient's Right to Choose
~~To support the patient's right, or that of their representative, as allowed under state law, to make informed decisions as part of their overall plan of care; further,~~

To acknowledge that patients or their representative have the right to be fully informed about their medication options ~~including benefits, risks, costs, and alternatives,~~ and to be involved in the decision-making process; further,

To support the right of patients or their representative to ~~request specific medications, and to~~ have their preferences considered respectfully, within the limits of clinical appropriateness, ~~evidence-based practice,~~ formulary considerations, safety, ~~restrictions,~~ and legal requirements**; further,**~~; further,~~

To recognize the right of the patient or their representative to refuse care and have those decisions respected.

~~To recognize the right of patients to refuse medications or request changes in their prescribed therapy after being informed of the potential consequences of such decisions.~~

Note: This policy would supersede ASHP policy 0013.

Council on Pharmacy Management
1. Recovery and Assistance Programs for Healthcare Workers with Substance Use Disorder
To advocate that hospitals and health systems support and promote ~~establish~~ recovery and assistance programs for healthcare personnel ~~workers~~ with substance use disorders, including those who have diverted controlled substances to support their own drug addiction; further,

To encourage state licensing boards to support structured rehabilitation programs that demonstrate a clear pathway for recovery and hospitals and health systems to support the return to practice upon successful completion of the program.

2. Cellular and Gene Therapies
To affirm that the pharmacy workforce ~~pharmacists~~ serve key roles in the use of cellular and gene therapies (CGTs), spanning supply chain management, operational oversight, and clinical consultation on individual patients; further,

To recognize that CGTs ~~are therapeutics that~~ are managed ~~as such~~ in the medication-use process; further,

To assert that health-system decisions on the selection, use, and management of CGTs are made through the formulary system; further,

To advocate for payment models that facilitate patient access, coverage, and reimbursement for CGTs with consideration of total cost of care; further, ~~outcomes-based innovative payment models that facilitate patient access to CGTs, including full coverage of approved indications and full reimbursement for CGTs.~~

To advocate for manufacturer processes that decrease the burden and resources required for hospitals and health systems to use CGTs.

Note: This policy would supersede ASHP policy 1802.

Council on Pharmacy Management
1. Safe and Secure Transfer of Controlled Substances
To advocate for the standardization of policies, procedures, and practices in the handling of controlled substance medications throughout the care process, including transfers ~~between~~ involving emergency medical services and during interfacility transport; further,

To promote closed loop communication and chain of custody documentation processes related to controlled substance medication management during patient transfers; further,

To collaborate with emergency medical services and other stakeholders involved in pre- and post-hospital and interfacility transfers of controlled substances to improve patient safety, increase standardization, ~~minimize variation,~~ and ensure compliance.

2. Addressing and Preventing Moral Distress and Moral Injury in the Healthcare Workforce
To acknowledge the acute and chronic exposure of the healthcare workforce to potentially morally injurious events across the continuum of care; further,

To recognize the risk of moral distress and moral injury when a healthcare worker is unable to provide ethical, safe, and effective care ~~due to system-level constraints~~; further,

To advocate for consistent support for ~~and~~ equitable and transparent allocation of resources across care teams and health systems to ensure that healthcare workers can provide safe and comprehensive patient care services; further,

To advocate ~~**that** for proactive and corrective approaches within~~ organizations ~~that are co-designed with members of the healthcare team to~~ prevent and address moral distress and moral injury among healthcare workers.

3. Pharmacy Services to Optimize Patient Throughput

To support the integration of pharmacy services ~~as systems are optimized~~ to improve safe and efficient throughput and patient flow throughout the health system~~-wide patient throughput~~; further,

To advocate for pharmacists to serve as key decision-makers **in** ~~**for**~~ improving medication management to optimize patient flow throughout the continuum of care ~~health system.; further,~~

~~To develop resources related to incorporating pharmacy services into patient throughput action plans and process maps; further,~~

~~To identify measures and tracking systems that demonstrate the impact of pharmacy-driven services to optimize patient throughput.~~

Council on Therapeutics

1. Accurate and Timely Height and Weight Measurements

To encourage the pharmacy workforce ~~pharmacists~~ to participate in interprofessional efforts to ensure accurate and timely patient height and weight measurements are recorded in the patient medical record to provide safe and effective drug therapy; further,

~~To encourage drug product manufacturers to conduct and publicly report pharmacokinetic and pharmacodynamic research in pediatric, adult, and geriatric patients at the extremes of weight and weight changes to facilitate safe and effective dosing of drugs in these patient populations, especially for drugs most likely to be affected by weight; further,~~

~~To encourage independent research on the clinical significance of extremes of weight and weight changes on drug use, as well as the reporting and dissemination of this information via published literature, patient registries, and other mechanisms; further,~~

To advocate that clinical decision support systems and other information technologies be structured to **incorporate height and weight to** facilitate prescribing, dispensing, and monitoring of drugs ~~**which utilize height and/or weight to calculate**~~ **for** safe and effective dosing ~~most likely to be affected by extremes of weight and weight changes~~; further,

To advocate for ~~federal and state~~ laws and regulations that prescribers ~~to~~ include **either height and weight or weight alone** ~~weight, height~~, and date obtained, as a required component of prescriptions for medications that are dosed based on **that information** ~~height and/or weight~~**.**

Note: This policy would supersede ASHP policy 1721.

2. Clinical and Safety Considerations of Naming Drug Moieties and Complexes

To encourage regulatory agencies to ~~consider~~ incorporate pharmacists when considering clinical, operational, access, and safety factors when approving and classifying medications with different moieties or complexes that are used to deliver the active drug; further,

[MOVED FROM BELOW AND AMENDED]

To oppose the consolidation of existing drug classes that include drugs that have distinct pharmacologic effects and

pharmacokinetic/pharmacodynamic profiles; further,

~~To encourage regulatory agencies to consider clinical, operational, access, and safety factors when approving and classifying medications with different moieties or complexes that are used to deliver the active drug; further,~~
[MOVED ABOVE AND AMENDED]

~~To advocate for the pharmacist's active role in these processes; further,~~

To foster increased ~~pharmacist, provider, and~~ public notification ~~awareness~~ when changes in approved drug products with therapeutic equivalence occur.

3. Clinical, Operational, and Safe Use of Manipulated Drug Products and Alternate Administration Routes
To support clinically appropriate, evidence-based use of manipulated drug-products or alternate drug administration routes when it supports optimal patient care; further,

To promote research that includes ~~further delineates the~~ pharmaceutics, pharmacokinetics, pharmacodynamics, ~~pharmacokinetic and pharmacodynamic properties as well as~~ safety, and efficacy of drugs when manipulated or when given through alternate administration routes ~~and investigate the interrelationship between drug exposure and safety and efficacy outcomes including the potential role of artificial intelligence in advancing model development and validation~~; further,

To encourage manufacturers to develop drug products in ready-to-use devices and diverse formulations; further,

To foster pharmacist-led interdisciplinary teams to provide institutional guidance, best practices, and safety recommendations regarding drug products that are manipulated or administered through alternative routes.

Note: This policy would supersede ASHP policies 2041, 2242, and 2314.

4. Quality Consumer Medication Information
To support efforts by the Food and Drug Administration (FDA) and other stakeholders to improve the quality, consistency, accessibility, targeting, and simplicity of consumer medication information (CMI); further,

To encourage the FDA to work in collaboration with patient advocates and other stakeholders to create evidence-based models and standards, including establishment of a universal literacy level and standardized, patient-focused templates for CMI; further,

To advocate that research be conducted to validate these models in actual-use studies in pertinent patient populations; further,

To advocate that the FDA explore alternative models of CMI content development and maintenance that will ensure the highest level of accuracy, consistency, currency, and conformity with health literacy requirements; further,

To advocate that the FDA maintain a highly structured, publicly and easily accessible central repository of CMI in a format that is suitable for ready export; further,

To advocate for laws and regulations that would require all dispensers of medications to comply with FDA-established standards for ~~unalterable~~ content, format, and distribution of CMI.

Note: This policy would supersede ASHP policy 2005.

Council on Education and Workforce Development

1. Support for Caregiving Responsibilities in the Pharmacy Workforce
To affirm that an individual's life circumstances can change and influence their workplace needs; further,

To foster psychologically safe environments that promote dialogue around individual workplace needs; further,

To advocate for organizational policies and resources that reduce disparities caused by caregiving responsibilities such as ~~including~~ eldercare, ~~and~~ lactation support, and other life circumstances; further,

To empower individuals to advocate for their own needs related to work-life integration.

No further action was required by the House on these policies.

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2 ~~**Pharmacy Technician Education Requirements**~~ **Additional Education Requirements for Pharmacy Technicians in Advanced Roles**
To recognize that highly trained and skilled pharmacy technicians working in advanced roles regularly perform complex and critical medication-use procedures, and that a safe and effective medication-use process depends significantly on the skills, knowledge, and competency of those pharmacy technicians to perform those tasks; further,

~~To reaffirm that all pharmacy technicians should complete an ASHP-accredited training program, be certified by the Pharmacy Technician Certification Board and be licensed by state boards of pharmacy; further,~~

To reaffirm that all pharmacy technicians should complete an ASHP-accredited training program, be certified by the Pharmacy Technician Certification Board and be licensed by state boards of pharmacy; further,

To advocate that ~~beyond those requirements,~~ pharmacy technicians working in advanced roles ~~should complete at a minimum an~~ have additional training, such as an associate ~~of science~~ degree, and demonstrate ongoing competencies specific to the tasks to be performed, to ensure patient safety~~; further,~~

~~To advocate that expansion of pharmacy technician duties into expanded, advanced roles should include consideration of potential risk to patients and that ongoing quality assurance metrics should be established to assure patient safety~~.

Note: This policy supersedes ASHP policy 1203.

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

New Business. Chair Hogue announced that, in accordance with Article 7 of the Bylaws, there were three items of New Business to be considered. Chair Hogue called on Christopher Crank (IL), Katrina Derry (CA), and Sarah M. Panella (SACP) to introduce the New Business (Appendix XI).

Integrity of Pharmacist Provided Health Information

Motion:
To oppose any governmental restrictions on pharmacists' ability to provide evidence-based health information to patients; further

To urge policymakers to protect pharmacists' professional autonomy in educating patients on

medications, public health issues, and emerging scientific developments; further

To oppose the elimination, suppression, manipulation, or politicization of evidence-based public health data and drug safety information by any entity; further

To advocate for legislation that protects scientific integrity and ensures transparency in the dissemination of public health information; further

To affirm that pharmacists have the professional responsibility to disseminate evidence-based, health information to patients and communities.

Background:
Protecting the Integrity of Pharmacist-Provided Health Information

Pharmacists play a vital role in public health, serving as accessible and trusted sources of evidence-based medical information for patients and communities. As experts in medication therapy, pharmacists ensure individuals have the knowledge and information they need to make informed decisions about their care. However, in recent years, pharmacists have faced growing challenges in their ability to share accurate, evidence-based health information due to restrictions, the politicization of drug safety data, and the suppression of public health findings.

The American Society of Health-System Pharmacists (ASHP) is committed to safeguarding the professional autonomy of pharmacists, advocating against any efforts that restrict their ability to provide evidence-based health education. In an era where misinformation can spread rapidly, it is more important than ever to uphold integrity and transparency. The suppression or manipulation of data can have serious consequences, potentially jeopardizing patient safety and undermining trust in healthcare professionals. ASHP stands firm in its position that pharmacists have a professional duty to disseminate accurate and reliable health information. ASHP seeks to ensure that pharmacists remain empowered to educate patients on medications, emerging scientific advancements, and critical public health concerns.

Suggested Outcomes:
The ASHP House of Delegate evaluate the proposed language and consider it for a new policy statement.

Chair Hogue then called on Katrina Derry (CA) to introduce the next item of New Business (Appendix XII), "Decriminalization of the interdisciplinary workforce involved with medical events." Following discussion, the item was approved for action by ASHP. It reads as follows:

Decriminalization of the interdisciplinary workforce involved with medical events

Motion:
To advocate that healthcare interdisciplinary workforce involved in medical error shall be immune from criminal liability for any harm or damages alleged to arise from an act or omission relating to the provision of health services;

Further, the immunity would not limit liability for any gross negligence or wanton, willful, malicious, or intentional misconduct and does not protect healthcare professionals from civil litigation.

Further, to advocate that each state enacts legislation to decriminalize medical errors.

Background:
Kentucky House Bill 159 was signed into law on March 26, 2024. The law shields healthcare providers from criminal liability for inadvertent

errors, aiming to encourage reporting and improve patient safety. It does not protect against gross negligence, wanton, willful, malicious, or intentional misconduct.
By removing the fear of criminal prosecution, the law will encourage healthcare professional to report errors, leading to better learning and system improvements.

Medical events will include preventable medical errors and non-preventable medical events. There have been several cases of healthcare workforce members being criminally prosecuted, convicted, and/or imprisoned due to involvement in tragic medical or medication errors.

ASHP Professional Policy catalogue has existing policy related to this topic, but not specific to the topic of decriminalization. ASHP Policy 1021 is related to just culture and reporting of medication errors. ASHP Policy 1505 related to statutory protection for medication error reporting. ASHP 0504 pertaining to pharmacy staff fatigue and medication errors.

Suggested Outcomes:
Refer to the Council on Public Policy for further review and consideration as a new policy topic. This topic might be considered as a new policy recommendation, an amendment to existing policy, or addressed through other available actions. The submitters are seeking statutory protection for the healthcare workforce due to medical errors.

Chair Hogue called on Sarah M. Panella (SACP) to introduce the next item of New Business (Appendix XIII), "Pharmacist's Role in Value-Based Care Models." Following discussion, the item was approved for action by ASHP. It reads as follows:

Pharmacist's Role in Value-Based Care Models

Motion:
To affirm the role of the pharmacy workforce in advancing value-based care through the optimization of medication use, improvement of clinical outcomes, and reduction of total cost of care; further,
To promote pharmacist leadership in value-based care models; further,

To advocate for the inclusion of pharmacists in the development, implementation, and evaluation of value-based care models and alternative payment arrangements; further,

To support the use of performance metrics that demonstrate the impact of the pharmacy workforce in value-based care.

Background:
While ASHP policy 1523 (Pharmacist's Role in Population Health Management, 2019) remains appropriate, a new, distinct policy is warranted to reflect the rapid evolution of value-based care (VBC) models in which pharmacists play an increasingly vital role. Population health management is a broad discipline focused on preventive care, risk stratification, and care coordination, whereas VBC directly ties reimbursement to outcomes, cost-efficiency, and performance metrics, often through payer-provider contracts. Merging the two may dilute the specificity and urgency required to support the role of pharmacists in VBC models such as accountable care organizations (ACOs), the Medicare Shared Savings Program (MSSP), Medicare Advantage (MA) Star Ratings, and bundled payments.

Pharmacists are now accountable for outcomes linked to HEDIS measures, CMS Star Ratings, and risk-adjusted quality metrics. Evidence supports their effectiveness in managing chronic conditions, optimizing medication use, and reducing healthcare costs. For example, pharmacist-led comprehensive medication management (CMM) services in primary care

and ACO settings have significantly improved control of diabetes and hypertension while reducing emergency department visits and hospital admissions.

Pharmacy leaders are increasingly involved in benefit design, cost containment, and financial performance within value-based contracts. Pharmacists contribute directly to meeting payer-aligned targets, such as statin use in diabetes, blood pressure and A1C control, and medication adherence. Additionally, they lead population-level initiatives using risk-stratification tools, clinical data, and targeted interventions to reduce total cost of care.

Pharmacists must also be equipped to lead and sustain their role in VBC. National organizations, such as the Pharmacy Quality Alliance, emphasize the need for training in healthcare quality, informatics, population health, and interprofessional collaboration to ensure the pharmacy workforce is prepared for payer-driven care transformation.

A dedicated ASHP policy on value-based care will define the profession's direction, elevate pharmacy's contributions to payer-aligned care, and guide integration, education, and performance measurement efforts that support continued pharmacy success in value-driven healthcare.

Suggested Outcomes:
Referral to Council on Pharmacy Management.

Recommendations. Chair Hogue called on members of the House of Delegates for any remaining recommendations. (See Appendix IX for a complete listing of all Recommendations.)

Recognition. Chair Hogue recognized members of the Board who were continuing in office (Appendix XIV). He also introduced members of the Board who were completing their terms of office.

As a token of appreciation on behalf of the Board of Directors and members of ASHP, Chair Hogue presented President Briscoe-Dwyer with an inscribed gavel commemorating her term of office.

Chair Hogue then installed the chairs of ASHP's sections and forums who were present: Ashley Parrott, Section of Ambulatory Care Practitioners; Amanda Place, Section of Community Pharmacy Practitioners; Molly Leber, Section of Inpatient Care Practitioners; Timothy Brown, Section of Pharmacy Educators; and Anthony Scott, Section of Pharmacy Practice Leaders.

Chair Hogue then recognized the remaining members of the executive committees of sections and forums.

Installation. Chair Hogue then installed Melanie Dodd as President of ASHP and incoming Board members, Marie Chisolm-Burns and Todd Nesbit (Appendix IV). (See Appendix XV) for the Inaugural Address of the Incoming President.)

Adjournment. The 77th annual June meeting of the House of Delegates adjourned at 6:00 p.m.

ASHP HOUSE OF DELEGATES

Jesse H. Hogue, Chair
Nishaminy Kasbekar, Vice Chair

As of May 28, 2025

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

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

STATE	DELEGATES	ALTERNATES
Alabama (3)	Nancy Bailey Sarah Blackwell Danna Nelson	Laura Matthews
Alaska (2)	Shawna King Karina Rauenhorst Stark	Aly Noble
Arizona (3)	Christopher Edwards Kelly Erdos Mary Manning	Janelle Duran Jake Schwarz Sarah Stephens
Arkansas (3)	Jamalee Huntley Phillip Jackson Kim Young	Brandy Hubbard

California (7)	Gary Besinque Katrina Derry Emily Do Kathy Ghomeshi Jaclyn Jaskowiak Elaine Law Caroline Sierra	Steve Gray Stacey Raff Keith Yoshizuka
Colorado (3)	Ashley Ramp Lance Ray Bridger Singer	Clint Hinman
Connecticut (3)	Sam Abdelghany Shannon Giddens Colleen Teevan	Chandra Cooper Jason Zybert
Delaware (2)	Cheri Briggs Pooja Dogra	
Florida (6)	Madeline Camejo Venessa Goodnow Dave Lacknauth Dionis Malo Heather Petrie Elaina Rosario	Luis Alfonso Jessica Bianco
Georgia (3)	Davey Legendre Meredith Lopez Samantha Roberts	Darren Evans Derek Gaul
Hawaii (2)	Shelley Kikuchi Mark Mierzwa	
Idaho (2)	Paul Driver Victoria Wallace	
Illinois (5)	Megan Corrigan Andy Donnelly Bernice Man Jennifer Phillips Matthew Rim	Chris Crank Jim Dorociak Sharon Karina Jason Orr Samantha Rimas
Indiana (3)	Rachael Kruer Andrew Lodolo Tate Trujillo	Jennifer Reiter
Iowa (3)	John Hamiel Jessica Nesheim Jennifer Williams	Arinze Nkemdirim Okere
Kansas (3)	Christina Crowley Megan Ohrlund Katie Wilson	Matt Bilhimer Jeff Little
Kentucky (3)	Dale English Scott Hayes Elizabeth Schlosser	Brandy Brown Rachel Swope

Louisiana (3)	Neil Hunter Heather Maturin Heather Savage	Myra Thomas Renesha Yarbrough
Maine (2)	Brian McCullough	
Maryland (4)	Justin Hare John Hill Terri Jorgenson Molly Wascher	Courtney Henry Marybeth Kazanas
Massachusetts (4)	Erica Housman Jason Lancaster Frankie Mernick Russel Roberts	Marla O'Shea-Bulman
Michigan (4)	Rox Gatia Lama Hsaiky Amber Lanae Martirosov Rebecca Maynard	Jessica Jones Ed Szandzik
Minnesota (3)	Lance Oyen Rachel Root Cassie Schmitt	Benjamin Anderson Ryan Hannan Paul Morales
Mississippi (2)	Joshua Fleming Andrew Mays	Wesley Pitts
Missouri (3)	Tony Huke Amy Sipe Mel Smith	Zach Gunter Cassie Heffern Sayo Weihs
Montana (2)	JoEllen Maurer Logan Tinsen	Elizabeth Klein
Nebraska (3)	Fred Massoomi Katie Reisbig David Schmidt	Jolyn Merry
Nevada (2)	Adam Porath Judy Mattorano	Kate Ward
New Hampshire (2)	Melanie McGuire Marilyn Hill	Jessica Marx
New Jersey (4)	Rich Artymowicz Julie Kalabalik-Hoganson Deb Sadowski Craig Sastic	Barbara Giacomelli Agnieszka Pasternak Jennifer Sternbach
New Mexico (2)	Nick Crozier John Rafi	
New York (5)	Amisha Arya Charrai Byrd Nicole Cieri Hutcherson Travis Dick Leila Tibi-Scherl	Paul Green Russ Lazzaro Michael Ott Sammy Yafai

North Carolina (4)	Leslie Barefoot Nick Gazda Jeffrey Reichard Andy Warren	Tyler Vest
North Dakota (2)	Maari Loy Saidee Oberlander	Katie Evans
Ohio (5)	Ashley Duty Indrani Kar Julie Kennerly-Shah Cynthia King Dan Lewis	Beth Krause Joshua Musch
Oklahoma (3)	Christopher Pack Deidra Williams Jimmy Williams	
Oregon (3)	Michael Lanning Edward Saito Ryan Wargo	Kristy Butler Stacey Olstad
Pennsylvania (4)	Scott Bolesta Lauren Finoli Arpit Mehta Cassandra Redmond	Jennifer Belavic Sejal Patel-Francis Jill Rebuck Joseph Stavish Evan Williams
Puerto Rico (2)	Carlos Méndez Bauza Idaliz Rodriguez Escudero	Mirza Martínez Giselle Rivera
Rhode Island (2)	Nelson Caetano Karen Nolan	Martha Roberts
South Carolina (3)	Thomas Achey Abigail Bouknight Sarah Steinert	Reagan Barfield
South Dakota (2)	Betsy Karli Laura Stoebner	Anne Morstad Ryan Waybright
Tennessee (4)	Don Branam Justin Griner Grayson Peek Jennifer Robertson	Meredith Gilbert Erin Neal
Texas (6)	Joshua Blackwell Linda Haines Phuoc Anne Nguyen Binita Patel Aaron Reich Jeffrey Wagner	Bradi Frei Stephanie Stramel
Utah (3)	Conor Hanrahan Shannon Inglet Krystal Moorman-Bishir	
Vermont (2)	Stacey Dalpoas Kevin Marvin	Jennifer Burrier Emily Piehl

Virginia (4)	Matt Jenkins Kathy Koehl Amy Schultz Rodney Stiltner	Ian Orensky
Washington, D.C. (2)	Sue Carr Kelly Mullican	Joann Lee
Washington State (3)	Chris Greer Laura Hanson Karen White	Kevin Anderson
West Virginia (2)	Chris Fitzpatrick Derek Grimm	
Wisconsin (4)	Monica Bogenschutz Matt Carleton John Muchka Sarah Peppard	Girish Kaimal David Reeb Terri Wallner Jordan Wulz
Wyoming (2)	Jonathan Beattie Channa Richardson	
SECTIONS AND FORUMS	**DELEGATES**	**ALTERNATES**
Ambulatory Care Practitioners	Sara Panella	Ashley Parrott
Clinical Specialists and Scientists	Megan Musselman	Angela Colella
Community Pharmacy Practitioners	Courtney Isom	Amanda Place
Digital and Telehealth Practitioners	Lisa Stump	
Inpatient Care Practitioners	Lucas Schulz	Molly Billstein Leber
Pharmacy Educators	Jennifer Arnoldi	Tim Brown
Pharmacy Informatics and Technology	Jeffrey Chalmers	David Agüero
Pharmacy Practice Leaders	Katherine Miller	Anthony Scott
Specialty Pharmacy Practitioners	Erica Diamantides	Karen Thomas
New Practitioners Forum	Alfred Awuah	Luning Shi
Pharmacy Student Forum	Katy Xia	
The Pharmacy Technician Society	Daniel Nyakundi	
FRATERNAL	**DELEGATES**	**ALTERNATES**
U.S. Air Force	Elizabeth Tesch	Rohin Kasudia
U.S. Army	Daniel Zsido	Gregory Hare
U.S. Navy	Terence Cusack	Chirag Patel
U.S. Public Health Service	Russ Gunter	Jeffrey Gildow Chenoa Shelton
Veterans Affairs	Julie Groppi	Heather Ourth

House of Delegates

REPORT ON THE VIRTUAL HOUSE OF DELEGATES

November 8-15, 2024

RESULTS OF THE VOTING

Between November 8 and 15, the ASHP House of Delegates (roster attached as Appendix A) voted on six policy recommendations. Delegates approved four policy recommendations including two discontinuations by 85% or more, the threshold for final approval. Two policy recommendations did not reach the threshold for approval, Clinical Significance of Accurate and Timely Height and Weight Measurements and Safety of Intranasal Route as an Alternative Route of Administration, and will be considered by the House of Delegates in 2025.

POLICY RECOMMENDATIONS APPROVED

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

Pharmacist's Leadership Role in Anticoagulation Therapy Management (93.0%)
Source: Council on Pharmacy Practice
To discontinue ASHP policy 2006, Pharmacist's Leadership Role in Anticoagulation Therapy Management, which reads:

> To advocate that pharmacists provide leadership in caring for patients receiving drug products for anticoagulant therapy management; further,
>
> To advocate that pharmacists be responsible for coordinating the individualized care of patients receiving drug products for anticoagulation therapy management; further,
>
> To encourage pharmacists who participate in anticoagulation therapy management to educate patients, caregivers, prescribers, and other members of the interprofessional healthcare team about anticoagulant drug product uses, drug interactions, reversal

therapies and strategies, adverse effects, the importance of adhering to therapy, access to care, and recommended laboratory testing and other monitoring.

Use of Two Patient Identifiers in the Provision of Patient Care (93.0%)
Source: Council on Pharmacy Practice
To encourage the use of two unique identifiers during the provision of patient care.

Pharmacy Drug Theft (93.9%)
Source: Council on Pharmacy Management
To discontinue ASHP policy 0303, Pharmacy Drug Theft, which reads:

> To support the development of policies and guidelines for health-system pharmacists designed to deter drug product theft and thereby enhance both the integrity of the drug distribution chain and the safety of the workplace; further,
>
> To encourage the development of systems that limit the diversion and abuse potential of medications, including high-cost drugs and controlled substances, and thereby reduce the likelihood that these products will be targets of theft.

ASHP Statement on Artificial Intelligence in Pharmacy (94.4%)
Source: Section of Pharmacy Informatics and Technology
To approve the ASHP Statement on Artificial Intelligence in Pharmacy (Appendix B).

POLICY RECOMMENDATIONS NOT APPROVED

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

Clinical Significance of Accurate and Timely Height and Weight Measurements (75.5%)
Source: Council on Therapeutics

To encourage pharmacists to participate in interprofessional efforts to ensure accurate and timely patient height and weight measurements are recorded in the patient medical record to provide safe and effective drug therapy; further,

To encourage drug product manufacturers to conduct and publicly report pharmacokinetic and pharmacodynamic research in pediatric, adult, and geriatric patients at the extremes of weight and weight changes to facilitate safe and effective dosing of drugs in these patient populations, especially for drugs most likely to be affected by weight; further,

To encourage independent research on the clinical significance of extremes of weight and weight changes on drug use, as well as the reporting and dissemination of this information via published literature, patient registries, and other mechanisms; further,

To advocate that clinical decision support systems and other information technologies be structured to facilitate prescribing and dispensing of drugs most likely to be affected by extremes of weight and weight changes; further,

To advocate for federal and state laws and regulations to include weight, height, and date obtained as a required component of prescriptions for medications that are dosed based on height and weight.

Safety of Intranasal Route as an Alternative Route of Administration (76.0%)
Source: Council on Therapeutics

To encourage research on the pharmacokinetic and pharmacodynamic characteristics of drugs not approved for intranasal administration; further,

To encourage the development of institutional guidance and resources on the safe and effective use of drugs not approved for intranasal administration; further,

To encourage manufacturers to develop intranasal formulations in accordance with current regulatory standards to minimize the risk of medication errors, including ready-to-use devices.

NOTES ON VOTING

Over 91% (202) of delegates to the virtual House of Delegates participated in the voting.

Appendix A

ASHP HOUSE OF DELEGATES

Jesse H. Hogue, Chair
Nishaminy Kasbekar, Vice Chair

As of November 8, 2024

OFFICERS AND BOARD OF DIRECTORS
Leigh A. Briscoe-Dwyer, President
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Vickie L. Powell, Board Liaison, Council on Pharmacy Practice
Douglas C. Slain, Board Liaison, Council on Therapeutics
Jennifer E. Tryon, Board Liaison, Council on Education and Workforce Development

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

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

California (7)	Gary Besinque Katrina Derry Daniel Kudo Elaine Law Sarah McBane Caroline Sierra Steven Thompson	Kethen So
Colorado (3)	Clint Hinman Lance Ray Tara Vlasimsky	Bridger Singer
Connecticut (3)	Sam Abdelghany Christina Hatfield Colleen Teevan	Jason Zyber
Delaware (2)	Cheri Briggs Pooja Dogra	
Florida (6)	Jeffrey Bush Andrew Kaplan Dionis Malo Farima Raof Heather Petrie William Terneus	Margareth Larose Pierre
Georgia (3)	Davey Legendre Christy Norman Samantha Roberts	Matthew Hurd Kunal Patel
Hawaii (2)	Shelley Kikuchi Mark Mierzwa	Wesley Sumida
Idaho (2)	Paul Driver Victoria Wallace	Jessica Bowen
Illinois (5)	Andy Donnelly Bernice Man Jennifer Phillips Radhika Polisetty Matthew Rim	Chris Crank Sharon Karina Nikola Markoski Samantha Rimas
Indiana (3)	Andrew Lodolo Christopher Scott Tate Trujillo	
Iowa (3)	John Hamiel Lisa Mascardo Jessica Nesheim	Emmeline Paintsil Jenna Rose Jennifer Williams

Kansas (3)	Christina Crowley Brian Gilbert Katie Wilson	Jeff Little Katherine Miller Zahra Nasrazadani Megan Ohrlund
Kentucky (3)	Dale English Scott Hayes Thomas Platt	Kortney Brown Stephanie Justice Chelsea Maier
Louisiana (3)	Tara Montgomery Heather Maturin Heather Savage	Jason Lafitte
Maine (2)	Brian McCullough Megan Rusby	Kathryn Sawicki
Maryland (4)	John Hill Terri Jorgenson Marybeth Kazanas Janet Lee	Justin Hare Molly Wascher
Massachusetts (4)	Jason Lancaster Frankie Mernick Marla O'Shea-Bulman Russel Roberts	Monica Mahoney
Michigan (4)	Rox Gatia Lama Hsaiky Jessica Jones Rebecca Maynard	Ed Szandzik
Minnesota (3)	Lance Oyen John Pastor Rachel Root	Paul Morales Scott Nei Cassie Schmitt
Mississippi (2)	Caroline Bobinger Andrew Mays	Joshua Fleming
Missouri (3)	Joel Hennenfent Amy Sipe Mel Smith	Nathan Hanson Cassie Heffern Sayo Weihs
Montana (2)	Julie Neuman Logan Tinsen	JoEllen Maurer
Nebraska (3)	Tiffany Goeller Katie Reisbig David Schmidt	Jolyn Merry
Nevada (2)	Adam Porath Kate Ward	
New Hampshire (2)	Melanie McGuire Elizabeth Wade	Marilyn Hill

New Jersey (4)	Rich Artymowicz Julie Kalabalik-Hoganson Deb Sadowski Craig Sastic	Barbara Giacomelli Agnieszka Pasternak Jennifer Sternbach
New Mexico (2)	Lisa Anselmo Nick Crozier	
New York (5)	Travis Dick Paul Green Mark Sinnet Leila Tibi-Scherl Kimberly Zammit	Amisha Arya Brendan Begnoch Charrai Byrd Angela Cheng Carline Fevry Courtney Jarka Christine Nguyen
North Carolina (4)	Leslie Barefoot Angela Livingood Mary Parker Jeffrey Reichard	Mollie Scott Tyler Vest
North Dakota (2)	Maari Loy Katrina Rehak	Elizabeth Monson Saidee Oberlander
Ohio (5)	Ashley Duty Cynthia King Dan Lewis Kellie Musch Kembral Nelson	Ben Lopez Joshua Musch Jerry Siegel
Oklahoma (3)	Corey Guidry Jeremy Johnson Andrea Rai	
Oregon (3)	Ryan Gibbard Edward Saito Ryan Wargo	Michael Lanning
Pennsylvania (4)	Arpit Mehta Kimberly Mehta Cassandra Redmond Christine Roussel	Jennifer Belavic Scott Bolesta Larry Jones Joseph Stavish Evan Williams
Puerto Rico (2)	Carlos Méndez Bauza Idaliz Rodriguez Escudero	Mirza Martínez Giselle Rivera
Rhode Island (2)	Nelson Caetano Martha Roberts	Ray Iannuccillo Karen Nolan
South Carolina (3)	Thomas Achey Lisa Gibbs Sarah Steinert	Harrison Jozefczyk

South Dakota (2)	Betsy Karli Anne Morstad	Joseph Berendse Laura Stoebner
Tennessee (4)	Kelly Bobo Don Branam Erin Neal Grayson Peek	Jennifer Robertson
Texas (6)	Latresa Billings Joshua Blackwell Todd Canada Rodney Cox Binita Patel Jeffrey Wagner	Abimbola Farinde Jerry James
Utah (3)	Conor Hanrahan Elyse MacDonald Krystal Moorman-Bishir	Shannon Inglet Whitney Mortensen
Vermont (2)	Jeffrey Gonzalez Emily Piehl	Julie MacDougall Kevin Marvin
Virginia (4)	Kathy Koehl Amy Schultz Brian Spoelhof Rodney Stiltner	June Javier
Washington, D.C. (2)	Sue Carr Kelly Mullican	Joann Lee
Washington State (3)	Lauren Bristow Chris Greer Karen White	
West Virginia (2)	Chris Fitzpatrick Derek Grimm	
Wisconsin (4)	John Muchka Sarah Peppard William Peppard Kate Schaafsma	Monica Bogenschutz Edward Conlin Carmen Gust David Reeb
Wyoming (2)	Linda Gore Martin Jessica Papke	
SECTIONS AND FORUMS	**DELEGATES**	**ALTERNATES**
Ambulatory Care Practitioners	Sara Panella	Ashley Parrott
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Specialty Pharmacy Practitioners	Erica Diamantides	Karen Thomas
New Practitioners Forum	Alfred Awuah	Luning Shi
Pharmacy Student Forum	Charbel Aoun	Katy Xia
The Pharmacy Technician Society	Daniel Nyakundi	
FRATERNAL	**DELEGATES**	**ALTERNATES**
U.S. Air Force	Elizabeth Tesch	Rohin Kasudia
U.S. Army	Victoria O'Shea	Danielle Zsido
U.S. Navy	Terence Cusack	Chirag Patel
U.S. Public Health Service	Russ Gunter	Andrew Glatz Chenoa Shelton
Veterans Affairs	Julie Groppi	Heather Ourth

Appendix B

ASHP Statement on Artificial Intelligence in Pharmacy

Position

Artificial intelligence (AI) has the potential to improve patient care and the medication-use process by offering innovative methods to gather clinical, operational, and economic knowledge; assist end users; enhance educational experiences; and streamline administrative processes within pharmacy practice.[1] The pharmacy workforce is uniquely positioned to serve as key contributors and domain experts in the advancement of AI in healthcare. They should lead in decision-making, design, validation, implementation, and ongoing evaluation of AI-related applications and technologies that affect medication-use processes and related tasks.[1] Pharmacy leaders should use scientific approaches to define appropriate medication-related use cases for AI-enabled technology and determine which aspects of the medication-use process are best handled by the pharmacy workforce, by AI, or by the pharmacy workforce who receive information or support from AI-based systems.

The pharmacy workforce must assist in validating AI for clinical and operational uses and identify strategies to mitigate unintended consequences of AI, especially recognizing the ethical considerations that must guide the development and use in pharmacy practice.[1] Pharmacists should engage in research efforts to generate data to support additional AI use cases and identify potential risks. At a minimum, AI should be evaluated for accuracy, transparency, and interpretability, with policies adopted for AI utilization and ongoing surveillance of AI-related applications.[1] Additionally, the pharmacy workforce should actively pursue ongoing education and training in AI, given its rapidly growing adoption.

Fully automated AI should be reserved for algorithmic tasks where AI performance is

comparable to that of its human counterpart. AI of proven value, particularly AI with proven safety and efficacy, should be adopted and used so that the pharmacy workforce can make informed and efficient decisions and focus their expertise on solving new and confounding problems for patients, families, and healthcare professionals and organizations.[1]

Background

In 2020, the American Society of Health-System Pharmacists (ASHP) released a statement on the use of AI in pharmacy.[2] Given the rapid advancements in AI technology,[3] this statement has been developed to expand the scope to include generative AI, large language models (LLMs), natural language processing (NLP), AI agents, and deep learning within the context of pharmacy practice.

AI is the theory and development of computer systems to perform tasks previously thought to require human intelligence, such as visual perception, language processing, learning, and problem solving, by using machine learning to extrapolate from large collections of data.[4] Deep learning, a form of machine learning, allows a network to understand concepts quickly, learning from examples, similar to the way the human brain does.[5] LLMs use deep-learning methods to process large data sets to construct natural-sounding text.[6] To put these concepts together, generative AI is a type of AI trained using deep learning that can create content such as text, images, and sound. As a result, text-based generative AI is a type of AI LLM that can generate human-like text responses to written or spoken prompts, based on identified patterns.[7]

AI-based technologies are being adopted by industries worldwide to improve efficiency

and outcomes. Healthcare has an opportunity to leverage AI to improve all aspects of the value equation – outcomes, cost, and access. By increasing automation and improving workflow efficiencies, AI has the potential to reduce time spent on manual and routine tasks, allowing healthcare practitioners to optimize their scope of practice and improving clinician satisfaction, both of which are vital in the context of ongoing clinician workforce shortages. AI adoption in the healthcare system can also create new roles for the pharmacy workforce and alter the scope of pharmacist patient care.[8] Therefore, pharmacy teams must be prepared to embrace and lead efforts in selecting, implementing, safely using, and assessing AI technology use in the medication-use process.

At its June 2024 meeting, the ASHP House of Delegates approved ASHP policy 2413, Role of Artificial Intelligence in Pharmacy Practice.[1] The policy recognizes the potential for AI to improve patient care, acknowledges the risks and ethical challenges associated with the use of AI in healthcare settings, and supports the adoption of policies and procedures related to the use of AI. This statement expands upon the ideals described in that policy and further defines the roles and positions of the pharmacy workforce in the advancement of AI in the care of patients. This statement was developed not simply to consider potential applications of AI within the current practice of pharmacy but also to plan for how this technology will need to be developed and implemented in coming years. Although this statement is similar to positions held by other organizations of health professionals, it is uniquely focused on identifying opportunities for AI to drive change specific to the practice of pharmacy. This statement is based on consensus opinion and professional judgment among experts on AI in pharmacy and is applicable to all pharmacy practice settings.

Role of the pharmacy workforce in AI

The pharmacy workforce serves in crucial roles in AI, including developing and validating models, ensuring data quality, educating about implementation and use, and identifying enhancement needs. As subject matter experts in medication-use processes, they bear significant responsibility to ensure that AI contributes to safe, effective, and efficient outcomes. In the same way they apply scientific rigor to medication formulary decision-making, they should evaluate the deployment of AI capabilities and contribute to experimental design when research gaps are identified.

The pharmacy workforce can support the development of new AI models or the implementation of prebuilt AI models, depending on the scope of the need. Pharmacy informaticists, operations pharmacists, and clinical pharmacists possess diverse clinical and technical skills, equipping them to collaborate with computer scientists to build or adjust existing models. They can ensure data used in AI models are accurate and minimize bias, which can impact outputs.[9] Among the 2023 ASHP Pharmacy Forecast panelists, 73% predicted that health systems will be required to validate the safety and effectiveness of AI tools, while only 37% reported that they were prepared to perform the validation.[10] The pharmacy workforce must be aware of pharmacy data sources, data classification, data quality and lineage, intellectual property, and privacy management during model development and validation stages. Once a model is established, the pharmacy workforce is responsible for testing it to ensure it serves its intended function without errors.[11] Because it is important to define the quality assurance and quality engineering processes that must occur to test AI accuracy as part

of the validation process, the pharmacy workforce will need to be trained on the evaluation and validation of AI solutions, including failure modes and effects analysis.

The pharmacy workforce must also educate AI users, informing them of the AI model's focus, scope, and boundaries. Generative AI models may require engineering to ensure that prompts are crafted with the optimal textual inputs (i.e., appropriate words, phrases, sentence structure, and punctuation). To be reliable and efficient, a generative AI tool will require a clearly defined problem with a formulated prompt. Prompts can be built and standardized for use. However, proper user education is required to ensure reliable outputs. Furthermore, superusers can be designated among the pharmacy workforce to build credibility and advocate for technology.

Role of pharmacy informaticists. Pharmacy informaticists play a vital role in creating, supporting, and interfacing clinical information and technology to improve medication safety, efficiency, and patient care.[12] Because that role typically includes oversight of data and analytics, pharmacy informaticists should also have a robust understanding of AI, especially as it pertains to medication-related applications. Pharmacy informaticists should have a deep understanding of AI model types and variables.[13] They should assess models to align with organizational policies to safeguard sensitive information, including protected health information, personally identifiable information, and financial data. These individuals should be responsible for ensuring models are trained, evaluated, corrected, and applied to data that match clinical practice prior to implementation. Additionally, pharmacy informaticists should also perform routine maintenance and monitoring of deployed AI models, as clinical practice, data inputs, or data distributions change over time.[14] Pharmacists who have knowledge and

experience in informatics are well-suited for designing, implementing, and researching AI applications in the future. As healthcare professionals, pharmacists can focus on AI and data science as a specialty, going beyond the supportive role with data scientists and industry.

AI education and training

Education on AI is necessary across all pharmacy practice domains.[3,15] Pharmacy curricula should introduce students to the essential concepts of data science, including the fundamentals of AI, ethical use of generative AI, AI e-iatrogenesis, and AI model safety and efficacy validation.[16,17] The pharmacy workforce must also be given the chance to expand their understanding of AI through continuing education. Data science courses or pharmacy residencies with a focus on AI topics should be available to pharmacists seeking advanced training in these fields. Existing residencies could explore how to incorporate foundational AI concepts into their learning experiences (e.g., pharmacy administration or informatics electives).

Role of AI in pharmacy practice

Informatics. Pharmacy information systems, automation, and technology have been key sources of data and analytics within health systems. These data should not only be an output but should also be considered an agent to troubleshoot, enhance, and optimize pharmacy technology to better suit the needs of end users.[18] Given the differing levels of data complexity and organization, AI may aid pharmacy personnel in mining the vast amount of healthcare data for actionable trends or patterns. Informaticists must also partner with their medical

technology vendors, advocating for continual, ethical advancement of AI applications to provide the best possible patient outcomes.

Clinical applications. Historically, AI has been used in pharmacy to perform repetitive tasks and translate large quantities of data into easily digestible patterns or trends.[18] More recent literature has emerged describing clinical applications of AI. For example, AI has proven useful in interpreting diagnostic imaging,[19] conducting pharmacovigilance,[20] and designing treatment plans.[18] Generative AI has the potential to offer additional benefits, including clinical documentation, patient chart analysis, patient education, drug information, clinical protocol development, and publication support. Future clinical applications of AI may intersect with other growing fields in pharmacy, including pharmacogenomics, population health, drug development, and telehealth pharmacy practice. A common feature of current and future use cases is that they are designed to augment clinical pharmacy services, not replace the pharmacy workforce. Pharmacists should be open to changing traditional clinical workflows to include AI and AI-enabled clinical decision support systems that improve patient care. Pharmacy departments should support efforts to integrate emerging AI-enabled tools to evaluate models, improve care, improve access, lower costs, and provide comprehensive medication management for patients.

Pharmacy practice. From an operational standpoint, AI platforms can improve inventory management, facilitate product verification, assess medication adherence, and help pharmacists perform at the top of their skill set.[20,21] Generative AI can assist with pharmacy administration documentation requirements, such as staffing memos, human resource management tasks, and medication safety event analysis.[22,23] As AI becomes more reliable,

standard pharmacy operations will become increasingly automated, allowing pharmacists to focus more on high-value patient-care activities. Furthermore, it may also enable pharmacy technicians to assume operational tasks historically performed by pharmacists (e.g., medication optimization, medication safety and quality surveillance, and drug diversion monitoring), supporting pharmacists' ability to provide direct patient care.

Rather than just adopting AI, pharmacy executives should lead the effort to define the future of pharmacy and educate their healthcare colleagues and administrators on the role of the pharmacy workforce in an environment in which AI is pervasive.

Educational applications. Generative AI has been used in various settings to provide patient education.[7,24,25] Because pharmacists are often the most accessible healthcare professionals, they must be willing and able to address concerns and comprehension challenges when AI technologies are used for primary patient education. Ultimately, as technologies rapidly evolve, the pharmacy education system must remain agile to ensure our profession is equipped to steward these transformations of care, including educating patients on safe use of generative AI drug information.

In addition to patient education, AI capabilities may be leveraged to support education of the pharmacy workforce, including students and residents. AI applications have already been used in the pharmacy curriculum, including in skills-based courses, exam writing, and school admissions decision support, among other use cases.[26-28] These capabilities may allow for pharmacy instructors to streamline administrative tasks and optimize their time with pharmacy trainees. Pharmacy educators should evaluate AI capabilities to determine which are most appropriate to deploy within the classroom, skills laboratory, and experiential training

environments.

Ethical considerations and unintended consequences of AI

While AI is poised to bring significant benefits to patient care, it also has its limitations. An effective AI system relies on a repository of high-quality data. In the absence of high-quality data, AI systems can easily perpetuate bias due to limited training data, population size, or human bias. Medicine is vulnerable to those risks, as evidence-based clinical practice and measures are often based on data from study populations skewed towards certain groups.[29] Healthcare organizations must ensure that AI models are based on high-quality and expansive data sets that include other objective measures to minimize perpetuating biases.

Generative AI also poses the risk of creating content that is false or misleading. These models should be developed to minimize the probability of creating misleading content, such as setting constraints on possible responses.[30] Operating these tools with human oversight is crucial; AI should serve as a valuable aid to support the pharmacy workforce, rather than as a proxy for them.[31]

These risks have been well recognized nationally. Recently, an executive order outlined the risks, requirements, responsibilities, and accountability measures for the "safe, secure, and trustworthy development of artificial intelligence."[32] One outcome of this executive order was designating the National Institute of Standards and Technology (NIST) as the lead organization for development of guidelines, standards, and best practices for AI safety and security. NIST has already constructed an AI risk management framework, which includes guidelines on general AI risk management and a companion framework on generative AI risk management.[33] Within

these frameworks, NIST tackles many common unintended consequences of AI, including harmful bias, homogenization, data privacy, information integrity, and transparency.[33] Organizations should establish AI governance committees to evaluate and ensure compliance with these guidelines, standards, and best practices.

Having educated, competent staff using these models helps organizations mitigate potential liability. Generally, individuals or groups are not found liable when the standard of care is followed.[34] However, there are two scenarios in which liability may occur: when the AI tool makes a recommendation that aligns with the standard of care, or optimal care, but is dismissed, or when it erroneously makes a recommendation that is not the standard of care and is accepted. In both situations, staff using the AI model must be educated and competent, not only in the current subject in which AI is being applied, but also in the strengths and weaknesses of the model itself.

As with any technology used to assist the practice of pharmacy, contingency plans must be developed in the event of unexpected downtimes, breaches, or recalls.[35] Organizations should answer such questions as: How are patient safety risks identified and handled? If the model is unavailable, what processes should staff fall back to in its absence? Mitigation strategies for unintended consequences of AI must be proactively identified and included within an organization's AI policies and procedures.

In 2021, the World Health Organization published a set of ethical considerations that should be observed in the application of healthcare AI.[36] These considerations include the preservation of human autonomy within AI-supported medical decision-making and uses of protected health information, the avoidance of harm, and the responsibility to provide the

maximum possible unbiased benefit across diverse patient populations. Pharmacy leaders should address these considerations when AI is implemented.

AI regulation

Rapid expansion of AI use in health information technology has highlighted the need for federal agency standards and policy to support safe use, encourage responsible development, improve trust, and promote adoption. In January 2021, the FDA released its first AI/ML-Based Software as a Medical Device (SaMD) Action Plan, outlining the agency's plans to develop a SaMD regulatory framework for AI while also establishing best practices for development, implementation, and monitoring of AI capabilities.[37] In December 2023, the Office of the National Coordinator for Health Information Technology (ONC) issued the Health Data, Technology, and Interoperability: Certification Program Updates, Algorithm Transparency, and Information Sharing (HTI-1) Final Rule.[38] This rule established new standards for algorithm transparency and risk management expectations for AI-enabled decision support interventions. Additionally, it advanced interoperability standards designed to promote health equity and established interoperability-focused reporting metrics.

Interoperability and AI are uniquely related. A common barrier to health information exchange is the lack of standardized documentation or use of data standards. AI and machine learning can improve interoperability by allowing the use of streamlined data standards to provide for semantic exchange of health information. Given the fundamental role of data sets and LLMs in AI, improving health information exchange will be a key goal of AI technology development and optimization. In December 2023, the ONC also announced that the Trusted

Exchange Framework and Common Agreement (TEFCA) had become operational.[39] TEFCA is a new interoperability framework supporting nationwide exchange of health information that may support the facilitation of AI in healthcare due to simplification of connectivity and increased flexibility for the exchange of data[40].

As AI and interoperable exchange of information continue to rapidly evolve, pharmacy leaders are uniquely positioned to contribute to the regulatory efforts and ethical considerations for applications related to medication use. Pharmacy leaders must embed themselves in all arenas (organizational, regional, and national) of AI policymaking, governance, and data stewardship to promote personalized, continuous, and preventive care.[15]

Conclusion

Advances in AI technologies will continue at a rapid pace, as will the opportunities to leverage AI in all aspects of pharmacy practice. This evolving landscape presents pharmacy professionals with the opportunity to embed themselves in processes to investigate, implement, maintain, and optimize the use of AI technologies within their respective organizations. Pharmacy workforce engagement in these processes is necessary to ensure that the use of AI technologies results in safe and effective tools for improved patient care. To see this vision come to fruition, pharmacy leaders must ensure sufficient education regarding AI technologies is available to current and future pharmacy professionals. The incorporation of AI technologies within pharmacy practice is inevitable, and pharmacists have the potential to significantly impact patient care and the profession's future.

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Additional information
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March 25, 2025

MEMORANDUM

To: Board of Directors

From: Paul W. Abramowitz, Pharm.D., Sc.D. (Hon), FASHP
Chief Executive Officer

Subject: Results of March 2025 Virtual House of Delegates

Dear Board Members:

From March 14 to 21, the ASHP House of Delegates voted on fifteen policy recommendations. Per the attached report, delegates approved two policy recommendations and discontinued five policy recommendations by 85% or more, the threshold for final approval. The House approved the following policies:

- Professional Development as a Retention Tool (CEWD)
- Pharmacy Access to Payer Networks (CPM)

The House voted to discontinue the following policies:

- Care-Commensurate Reimbursement (CPuP)
- Patient Adherence Programs as Part of Health Insurance Coverage (CPuP)
- Nonproprietary Naming of Biological Products (CPuP)
- Employee Testing (CPuP)
- Generic Substitution of Narrow Therapeutic Index Drugs (COT)

The eight policy recommendations that **did not achieve the 85% threshold for approval** are below. These eight policy recommendations will be presented to the House of Delegates in June 2025.

- Safe and Secure Transfer of Controlled Substances (CPhP)
- Pharmacy Services to Optimize Patient Throughput (CPhP)
- Funding, Expertise, and Oversight of State Boards of Pharmacy (CPuP)
- Pharmacists Cross-State Licensure (CPuP)
- Clinical and Safety Considerations of Naming Drug Moieties and Complexes (COT)
- Clinical, Operational, and Safe Use of Manipulated Drug Products and Alternate Administration Routes (COT)
- Expedited Partner Directed Therapy (COT)

- Recovery and Assistance Programs for Healthcare Workers with Substance Use Disorder (CPM)

91 percent (211) of delegates to the virtual House of Delegates participated in the voting. Please join me in thanking Jesse for his leadership as Chair of the House of Delegates, and thanks to all of you for taking part.

Sincerely,
Paul

Attachment:
Report on the Virtual House of Delegates

House of Delegates

REPORT ON THE VIRTUAL HOUSE OF DELEGATES

March 14-21, 2025

RESULTS OF THE VOTING

Between March 14 and 21, the ASHP House of Delegates (roster attached as an Appendix) voted on 15 policy recommendations. Delegates approved seven policy recommendations by 85% or more, the threshold for final approval. Eight policy recommendations did not receive 85% of the votes and will be sent to the June House of Delegates.

POLICY RECOMMENDATIONS APPROVED

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

Care-Commensurate Reimbursement (98.5%)
Source: Council on Public Policy
To discontinue ASHP policy 2020, Care-Commensurate Reimbursement, which reads:

> To advocate that reimbursement for healthcare services be commensurate with the level of care provided, based on the needs of the patient.

Patient Adherence Programs as Part of Health Insurance Coverage (97.5%)
Source: Council on Public Policy
To discontinue policy 1504, Patient Adherence Programs as Part of Health Insurance Coverage, which reads:

> To advocate for the pharmacist's role in patient medication adherence programs that are part of health insurance plans; further,
>
> To advocate those programs that (1) maintain the direct patient pharmacist

relationship; (2) are based on the pharmacist's knowledge of the patient's medical history, indication for the prescribed medication, and expected therapeutic outcome; (3) use a communication method desired by the patient; (4) are consistent with federal and state regulations for patient confidentiality; and (5) permit dispensing of partial fills or overfills of prescription medications in order to synchronize medication refills and aid in medication adherence.

Nonproprietary Naming of Biological Products (98.0%)
Source: Council on Public Policy
To discontinue policy 1535, Nonproprietary Naming of Biologic Products, which reads:

> To advocate that originator biological products, related biological products, and biosimilar products share the same global nonproprietary name as defined by the United States Adopted Name Council, the World Health Organization Programme on International Nonproprietary Names, and United States Pharmacopeial Convention; further,
>
> To oppose unique nonproprietary naming for originator biological products, related biological products, and biosimilar products.

Employee Testing (97.0%)
Source: Council on Public Policy
To discontinue policy 9108, Employee Testing, which reads:

> To oppose the use of truth-verification testing such as polygraphs as routine employment practices because of the possible interference with the rights of individuals; further,
>
> To recognize the limited use of such testing during employment where such testing may protect the rights of individuals against false witness.

Generic Substitution of Narrow Therapeutic Index Drugs (99.5%)
Source: Council on Therapeutics
To discontinue ASHP policy 0817, Generic Substitution of Narrow Therapeutic Index Drugs, which reads:

> To support the current processes used by the Food and Drug Administration (FDA) to determine bioequivalence of generic drug products, including those with a narrow therapeutic index, and to recognize the authority of the FDA to decide if additional studies are necessary to determine equivalence; further,
>
> To oppose a blanket restriction on generic substitution for any medication or medication class without evidence from well-designed, independent studies that demonstrate inferior efficacy or safety of the generic drug product.

Professional Development as a Retention Tool (93.6%)
Source: Council on Education and Workforce Development
To recognize that pharmacy workforce development is an essential component of staff recruitment, retention, and well-being; further,

To recognize that pharmacy workforce development encompasses more than formal education programs and includes informal learning among colleagues, mentoring, participation in activities of professional organizations, and other types of learning; further,

To encourage healthcare executives to support pharmacy workforce development programs, including leadership succession planning, as an important benefit that aids in recruiting and retaining qualified staff; further,

To support healthcare executives with pharmacy workforce development by providing educational programs, services, and resources.

To encourage organizations to assess the effectiveness of professional development initiatives by evaluating their impact on recruitment and retention outcomes.

Note: This policy supersedes ASHP policy 2103.

Pharmacy Access to Payer Networks (86.8%)
Source: Council on Pharmacy Management
To oppose pharmacy access criteria that impose discriminatory requirements or qualifications on participation in insurance payer networks that interfere with patient continuity of care or patient site-of-care options; further,

To advocate for laws and regulations that require healthcare payers to disclose to pharmacies applying to participate in payer networks the criteria and the clinical and operational outcome data reporting requirements used to include, retain, or exclude pharmacies; further,

To encourage healthcare payers to standardize network access criteria and eliminate those reporting requirements already imposed by accrediting bodies or regulatory agencies.

Note: This policy supersedes ASHP policy 2031.

POLICY RECOMMENDATIONS NOT APPROVED

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

Safe and Secure Transfer of Controlled Substances (65.5%)
Source: Council on Pharmacy Practice

To advocate for the standardization of policies, procedures, and practices in the handling of controlled substance medications throughout the care process, including transfers between emergency medical services and during interfacility transport; further,

To promote closed-loop communication processes related to controlled substance medication management during patient transfers; further,

To collaborate with emergency medical services and other stakeholders involved in pre- and post-hospital and interfacility transfers of controlled substances to improve patient safety, minimize variation, and ensure compliance.

Pharmacy Services to Optimize Patient Throughput (79.7%)
Source: Council on Pharmacy Practice
To support the integration of pharmacy services as systems are optimized to improve health system-wide patient throughput; further,

To advocate for pharmacists to serve as key decision-makers for improving patient flow throughout the health system; further,

To develop resources related to incorporating pharmacy services into patient throughput action plans and process maps; further,

To identify measures and tracking systems that demonstrate the impact of pharmacy-driven services to optimize patient throughput.

Funding, Expertise, and Oversight of State Boards of Pharmacy (68.8%)
Source: Council on Public Policy
To advocate appropriate oversight of pharmacy practice and the pharmaceutical supply chain through coordination and cooperation of state boards of pharmacy and other state and federal agencies whose mission it is to protect the public health; further,

To advocate representation on state boards of pharmacy and related agencies by pharmacists and pharmacy technicians; further,

To advocate that hospitals and health systems are adequately represented on state boards of pharmacy; further,

To advocate for dedicated funds for the exclusive use by state boards of pharmacy and related agencies to carry out expected duties; further,

To advocate for established training of state board of pharmacy inspectors in diverse pharmacy practice areas and the implementation of adequate inspection schedules to ensure the effective oversight and regulation of pharmacy practice, the integrity of the pharmaceutical supply chain, the protection of the public, and to establish variances from any documented rule

by the board of pharmacy; further,

To advocate that inspections be performed only by individuals with demonstrated competency in the applicable area of practice.

Note: This policy would supersede ASHP policy 2021.

Pharmacists Cross-State Licensure (81.8%)
Source: Council on Public Policy
To advocate that state boards of pharmacy collaborate to streamline the licensure process through standardization and improve the timeliness of application approval across state lines; further,

To advocate that state boards of pharmacy collaborate with third-party vendors to streamline the licensure transfer or reciprocity process; further,

To advocate that boards of pharmacy grant licensed pharmacists in good standing temporary licensure, permitting them to engage in practice, while their application for licensure transfer or reciprocity is being processed.

Note: This policy would supersede ASHP policy 1621.

Clinical and Safety Considerations of Naming Drug Moieties and Complexes (71.5%)
Source: Council on Therapeutics
To oppose the consolidation of existing drug classes that include drugs that have distinct pharmacologic effects and pharmacokinetic/pharmacodynamic profiles; further,

To encourage regulatory agencies to consider clinical, operational, access, and safety factors when approving and classifying medications with different moieties or complexes that are used to deliver the active drug; further,

To advocate for the pharmacist's active role in these processes; further,
to foster increased pharmacist, provider, and public awareness when changes in approved drug products with therapeutic equivalence occur.

Clinical, Operational, and Safe Use of Manipulated Drug Products and Alternate Administration Routes (64.2%)
Source: Council on Therapeutics
To support clinically appropriate, evidence-based use of manipulated drug-products or alternate drug administration routes when it supports optimal patient care; further,

To promote research that further delineates the pharmacokinetic and pharmacodynamic properties of drugs when manipulated or when given through alternate administration routes and investigate the interrelationship between drug exposure and safety and efficacy outcomes

including the potential role of artificial intelligence in advancing model development and validation; further,

To encourage manufacturers to develop drug products in ready-to-use devices and diverse formulations; further,

To foster pharmacist-led interdisciplinary teams to provide institutional guidance, best practices, and safety recommendations regarding drug products that are manipulated or administered through alternative routes.

Note: This policy would supersede ASHP policies 2041, 2242, and 2314.

Expedited Partner Directed Therapy (78.8%)
Source: Council on Therapeutics
To affirm that the pharmacy workforce improves patient access to therapies that prevent and treat sexually transmitted infections in all settings; further,

To support legislation that promotes expedited partner therapy (EPT); further,

To affirm that interpreting test results, prescribing, dosing, and dispensing therapies as clinically indicated is within pharmacists' scope of practice; further,

To affirm that drug products for EPT should be provided to individuals in a manner that ensures safe and appropriate use; further,

To encourage surveillance of EPT as a public health effort.

Recovery and Assistance Programs for Healthcare Workers with Substance Use Disorder (51.7%)
Source: Council on Pharmacy Management
To advocate that hospitals and health systems establish recovery and assistance programs for healthcare workers with substance use disorders, including those who have diverted controlled substances to support their own drug addiction; further,

To encourage state licensing boards to support structured rehabilitation programs that demonstrate a clear pathway for recovery and return to practice upon successful completion of the program.

NOTES ON VOTING

91 percent (211) of delegates to the virtual House of Delegates participated in the voting.

ASHP HOUSE OF DELEGATES

Jesse H. Hogue, Chair

Nishaminy Kasbekar, Vice Chair

As of March 14, 2025

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

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

STATE	DELEGATES	ALTERNATES
Alabama (3)	Nancy Bailey Danna Nelson Sarah Blackwell	Laura Matthews
Alaska (2)	Shawna King Karina Rauenhorst Stark	Aly Noble
Arizona (3)	Christopher Edwards Kelly Erdos Mary Manning	Janelle Duran Jake Schwarz Sarah Stephens
Arkansas (3)	Jamalee Huntley Phillip Jackson Kim Young	Brandy Hubbard

California (7)	Gary Besinque Katrina Derry Emily Do Jaclyn Jaskowiak Elaine Law Stacey Raff Caroline Sierra	Steve Gray Keith Yoshizuka
Colorado (3)	Lance Ray Tara Vlasimsky Bridger Singer	Ashley Ramp
Connecticut (3)	Sam Abdelghany Shannon Giddens Colleen Teevan	Chandra Cooper Jason Zybert
Delaware (2)	Cheri Briggs Pooja Dogra	
Florida (6)	Madeline Camejo Venessa Goodnow Dave Lacknauth Dionis Malo Heather Petrie Elaina Rosario	Luis Alfonso Jessica Bianco
Georgia (3)	Davey Legendre Meredith Lopez Samantha Roberts	Darren Evans Derek Gaul
Hawaii (2)	Shelley Kikuchi Mark Mierzwa	
Idaho (2)	Paul Driver Victoria Wallace	
Illinois (5)	Megan Corrigan Andy Donnelly Bernice Man Jennifer Phillips Matthew Rim	Chris Crank Jim Dorociak Sharon Karina Jason Orr Samantha Rimas
Indiana (3)	Rachael Kruer Andrew Lodolo Tate Trujillo	Jennifer Reiter
Iowa (3)	John Hamiel Jessica Nesheim Arinze Nkemdirim Okere	Jennifer Williams
Kansas (3)	Christina Crowley Megan Ohrlund Katie Wilson	Matt Bilhimer Jeff Little
Kentucky (3)	Dale English Scott Hayes Elizabeth Schlosser	Brandy Brown Rachel Swope

Louisiana (3)	Neil Hunter Heather Maturin Heather Savage	Myra Thomas Renesha Yarbrough
Maine (2)	Brian McCullough	
Maryland (4)	Justin Hare John Hill Terri Jorgenson Molly Wascher	Courtney Henry Marybeth Kazanas
Massachusetts (4)	Erica Housman Jason Lancaster Frankie Mernick Russel Roberts	Marla O'Shea-Bulman
Michigan (4)	Rox Gatia Lama Hsaiky Amber Lanae Martirosov Rebecca Maynard	Jessica Jones Ed Szandzik
Minnesota (3)	Lance Oyen Rachel Root Cassie Schmitt	Benjamin Anderson Ryan Hannan Paul Morales
Mississippi (2)	Joshua Fleming Andrew Mays	Wesley Pitts
Missouri (3)	Tony Huke Amy Sipe Mel Smith	Zach Gunter Cassie Heffern Sayo Weihs
Montana (2)	JoEllen Maurer Logan Tinsen	
Nebraska (3)	Fred Massoomi Katie Reisbig David Schmidt	Jolyn Merry
Nevada (2)	Adam Porath Judy Mattorano	Kate Ward
New Hampshire (2)	Melanie McGuire Marilyn Hill	Jessica Marx
New Jersey (4)	Rich Artymowicz Julie Kalabalik-Hoganson Deb Sadowski Craig Sastic	Barbara Giacomelli Agnieszka Pasternak Jennifer Sternbach
New Mexico (2)	Nick Crozier John Rafi	
New York (5)	Amisha Arya Charrai Byrd Nicole Cieri Hutcherson Travis Dick Leila Tibi-Scherl	Paul Green Russ Lazzaro Michael Ott Sammy Yafai

North Carolina (4)	Leslie Barefoot Nick Gazda Jeffrey Reichard Andy Warren	Tyler Vest
North Dakota (2)	Maari Loy Saidee Oberlander	Katie Evans
Ohio (5)	Ashley Duty Indrani Kar Julie Kennerly-Shah Cynthia King Dan Lewis	Beth Krause Joshua Musch
Oklahoma (3)	Christopher Pack Deidra Williams Jimmy Williams	
Oregon (3)	Michael Lanning Edward Saito Ryan Wargo	Kristy Butler Stacey Olstad
Pennsylvania (4)	Scott Bolesta Lauren Finoli Arpit Mehta Cassandra Redmond	Jennifer Belavic Sejal Patel-Francis Jill Rebuck Joseph Stavish Evan Williams
Puerto Rico (2)	Carlos Méndez Bauza Idaliz Rodriguez Escudero	Mirza Martínez Giselle Rivera
Rhode Island (2)	Nelson Caetano Karen Nolan	Martha Roberts
South Carolina (3)	Thomas Achey Lisa Gibbs Sarah Steinert	Reagan Barfield
South Dakota (2)	Betsy Karli Laura Stoebner	Anne Morstad Ryan Waybright
Tennessee (4)	Don Branam Justin Griner Grayson Peek Jennifer Robertson	Meredith Gilbert Erin Neal
Texas (6)	Joshua Blackwell Linda Haines Phuoc Anne Nguyen Binita Patel Aaron Reich Jeffrey Wagner	Bradi Frei Stephanie Stramel
Utah (3)	Conor Hanrahan Shannon Inglet Krystal Moorman-Bishir	
Vermont (2)	Stacey Dalpoas Kevin Marvin	Jennifer Burrier Emily Piehl

Virginia (4)	Matt Jenkins Kathy Koehl Amy Schultz Rodney Stiltner	Ian Orensky
Washington, D.C. (2)	Sue Carr Kelly Mullican	Joann Lee
Washington State (3)	Chris Greer Laura Hanson Karen White	Kevin Anderson
West Virginia (2)	Chris Fitzpatrick Derek Grimm	
Wisconsin (4)	Monica Bogenschutz Matt Carleton John Muchka Sarah Peppard	Girish Kaimal David Reeb Terri Wallner Jordan Wulz
Wyoming (2)	Jonathan Beattie Channa Richardson	
SECTIONS AND FORUMS	**DELEGATES**	**ALTERNATES**
Ambulatory Care Practitioners	Sara Panella	Ashley Parrott
Clinical Specialists and Scientists	Megan Musselman	Angela Colella
Community Pharmacy Practitioners	Courtney Isom	Amanda Place
Digital and Telehealth Practitioners	Lisa Stump	
Inpatient Care Practitioners	Lucas Schulz	Molly Billstein Leber
Pharmacy Educators	Jennifer Arnoldi	Tim Brown
Pharmacy Informatics and Technology	Jeffrey Chalmers	David Agüero
Pharmacy Practice Leaders	Katherine Miller	Anthony Scott
Specialty Pharmacy Practitioners	Erica Diamantides	Karen Thomas
New Practitioners Forum	Alfred Awuah	Luning Shi
Pharmacy Student Forum	Katy Xia	
The Pharmacy Technician Society	Daniel Nyakundi	
FRATERNAL	**DELEGATES**	**ALTERNATES**
U.S. Air Force	Elizabeth Tesch	Rohin Kasudia
U.S. Army	Daniel Zsido	Gregory Hare
U.S. Navy	Terence Cusack	Chirag Patel
U.S. Public Health Service	Russ Gunter	Jeffrey Gildow Chenoa Shelton
Veterans Affairs	Julie Groppi	Heather Ourth

House of Delegates

REPORT OF THE

COMMITTEE ON NOMINATIONS

June 8, 2025

Charlotte, North Carolina

Tyler Vest, Chair, Vermont
Paul Walker, Vice Chair, Michigan
Amy Gutierrez, Colorado
Trisha Jordan, Ohio
Arpit Mehta, Pennsylvania
Michael Nnadi, Texas
Kuldip Patel, North Carolina
Jason Wong (1st Alternate), California
Trinh Le (2nd Alternate), North Carolina

ASHP COMMITTEE ON NOMINATIONS

Mister Chair, Fellow Delegates:

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

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

First, the Committee must determine that a prospective nominee for office is an active member as required in the Charter. This is generally the easiest and most straightforward part of the Committee's work. The Committee must ascertain that each prospective nominee can perform the duties required of the office or offices to which he or she has been nominated. All nominees must be able to perform the duties of a Director, set forth in article 5 of the Bylaws. Presidential nominees must also be able to perform the duties of that office, set forth in article 4 of the Bylaws.

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

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

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

The Committee’s year-long process of receiving nominations and screening candidates is designed to solicit extensive membership input and, ultimately, to permit the Committee to candidly and confidentially assess which candidates best fit ASHP’s needs. The Committee has met three times since the last session of the House of Delegates: on December 12, 2024, at the ASHP Midyear Clinical Meeting; on February 13, 2025, via teleconference; and in person on April 16, 2025, at ASHP Headquarters. Review of nominees’ materials was conducted continuously between February and April 2025 solely via secure electronic transmissions. This process has been reviewed for quality improvement and will be repeated for the 2025–2026 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 903 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: 5 accepted
BOARD OF DIRECTORS: 8 accepted
A list of candidates that were slated was provided to delegates following the Committee's meeting on April 16, 2025.

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 (2026-2027)

Kim W. Benner, PharmD, BCPS, FALSHP, FASHP, FPPA (Birmingham, AL)
Vivian B. Johnson, BS, PharmD, RPh, MBA, FASHP (Dallas, TX)

Board of Directors (2026-2029)

Davey P. Legendre, PharmD, MBA, BCPS, BCIDP, FASHP, (Watkinsville, GA)
Christy M. Norman, PharmD, MS, BCPS, CPEL, FASHP (Atlanta, GA)
Christopher M. Scott, PharmD, BCPS, FASHP, FCCM (Indianapolis, IN)
Martin J. Torres, PharmD, FCSHP (Orange, CA)

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

CANDIDATES FOR PRESIDENT-ELECT 2026–2027

Kim W. Benner, PharmD, BCPS, FALSHP, FASHP, FPPA (kwbenner@samford.edu) is a professor of pharmacy practice at the Samford University McWhorter School of Pharmacy, and pediatric clinical specialist at Children's of Alabama (COA). Upon graduating from Samford, she completed a residency and then pursued a joint pediatric/academic role. Benner has both didactic (i.e., pediatrics, health-system pharmacy, medical missions) and experiential teaching experience with many medical learners. Practice experience includes 25+ years providing direct patient care in pediatric intensive care and pulmonary units working with multidisciplinary teams. She precepts PGY1 and PGY2 residents, participates in the resident mentoring program, and has served on numerous practice site interdisciplinary committees. At Samford, she is SSHP faculty advisor, admissions committee chair, serves on mentoring and recruiting cores, coordinates a teaching and learning program for local residents, and directs pharmacy camp. Advocacy efforts include 340B transparency, PBM reform, step therapy, and provider status. Her research centers around pediatrics and pharmacy education.

Benner's current ASHP service includes: participation in section and ASHP Foundation committees and advisory groups, Clinical Skills Competition (CSC) judge, student leadership award selection committee, CV reviewer, and guided mentorship program. Past ASHP activities include Board of Directors (2021-24), Section of Clinical Specialists and Scientists chair, CSC coordinator, and chair of Committee on Nominations and Council of Therapeutics. ASHP state affiliate (ALSHP) activities currently include student affairs committee. She also served ALSHP as delegate, president, and council director. Benner has authored an ASHP guideline and therapeutic position statement and has earned service awards. She is a fellow of ALSHP and ASHP.

Statement of Philosophy

ASHP has been my professional home for 30 years, from the time I was a pharmacy student and founded Samford's ASHP student chapter. I have actively participated in ASHP via the board of directors, section and council work, delegate, and my state affiliate, including serving as past president. These activities help me fulfill ASHP's mission of supporting our members to achieve optimal patient health outcomes.

My career as a pharmacist has focused on providing direct pediatric patient care. Therefore, I envision a pharmacy practice that delivers patient-centered team care inclusive of pharmacists deployed in all areas of the health system, technicians with advanced roles, and pharmacy support staff. We should continue developing this workforce, with enhanced emphasis on well-being initiatives. Pharmacy services within new or unique models of care should be strengthened. Recruiting for our profession and mentoring others is crucial for the future of pharmacy. Advocacy efforts should continue to focus on improving patient access, seeking pharmacist provider status, and protecting 340B programs for health systems, such as the hospital where I practice.

I value the opportunity to care for patients while practicing what I teach to pharmacy and medical learners. I am proud to have participated in key pharmacy health-system initiatives that have strengthened our profession during my career and time in ASHP leadership. Serving as president to continue working with the board of directors, maintaining our forward momentum, and striving for excellence in care for the patients we serve, would be my greatest professional honor.

Vivian B. Johnson, BS, PharmD, RPh, MBA, FASHP (Vivian.Johnson@phhs.org) is the senior vice president of Community Health Services and senior pharmacy advisor for Parkland Health in Dallas, Texas. Johnson provides executive oversight of Parkland's Community Health Needs Assessment Program (CHNA), value-based payment programs, community health workers, and serves as the senior pharmacy advisor and authorizing officer for the 340B Program.

Prior to accepting the role as overseer of the CNHA Program, Johnson served as the senior vice president of clinical services at Parkland Health overseeing pharmacy, radiology, respiratory, clinical dietary, physical medicine & rehabilitation and laboratory services.

She has spent over 39 years providing healthcare services to the underserved in Dallas County. Under Johnson's leadership, many pharmacy programs have been developed including the 340B program. She served as a subject matter expert on COVID-19 vaccines for the Dallas community and congressional constituents.

Johnson attended Florida Agricultural & Mechanical University, School of Pharmacy. She attained her Doctor of Pharmacy degree from Mercer University in Atlanta, Georgia and an MBA from University of Dallas.

Johnson has been the recipient of many awards, including the 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 and a fellow of ASHP. Johnson has served on the ASHP Residency Excellence Awards Committee, the Council on Pharmacy Management and Taskforce. She was appointed to the Pharmacy Executive Leadership Alliance Advisory Panel and the ASHP Forecast 2022 Advisory Committee. Johnson serves on the ASHP Board of Directors.

Statement of Philosophy

Three fundamental philosophies shape and drive my personal and professional decisions:

1. *I firmly believe in recognizing the inherent worth of every individual, irrespective of their role or position. Our shared humanity makes us equal, and each of us has the capacity to contribute positively to society. I am deeply committed to living my life to the fullest while empowering others to do the same.*
2. *I have never been content with maintaining the status quo. My choice of pharmacy as a profession was guided by my desire to make a meaningful difference in the lives of others. I am dedicated to improving processes and conditions that yield beneficial outcomes and advocate for collaboration—both within and beyond the field of pharmacy—to drive collective success.*
3. *I embrace the philosophy of servant leadership, finding fulfillment in assisting others in realizing their potential. Great leadership, to me, lies in uplifting and inspiring others to reach their personal and professional aspirations. This mindset has enabled me to guide, encourage, and empower individuals.*

CANDIDATES FOR BOARD OF DIRECTORS 2026-2029

Davey P. Legendre, PharmD, MBA, BCPS, BCIDP, FASHP (legendred@pharmdondemand.com) is the vice president of pharmacy management for PharmD on Demand in Watkinsville, GA. In this role, he operates 45 hospital and outpatient pharmacies in four states, largely in rural settings, and focuses on bringing the highest quality of care to this population.

Legendre earned his PharmD from the University of Louisiana at Monroe and completed a pharmacy practice residency at West Virginia University. He completed his infectious diseases residency at The University of Mississippi and his Master of Business Administration from Western Governors University. He is also designated a Fellow of ASHP.

Legendre's service to ASHP includes the Council on Pharmacy Management (2022-2025), chair of the Section Advisory Group on Value, Quality, and Compliance (2022-2025, Chair 2024-2025), and Georgia representative in the House of Delegates (2023-2025). He has served on the board of directors of the Georgia Society of Health-System Pharmacists (GSHP) for ten years, including chair of the board (2024), president (2023), president elect (2022), treasurer (2025), and co-chair of Organizational Affairs (2016-2021). Legendre is the recipient of numerous awards, including the Hirschman Award for pharmacy excellence, the Clinician of the Year as a clinical pharmacist, and the Co-Chair of the Year for GSHP.

Statement of Philosophy

Patients have access to an unprecedented amount of information and advice about their healthcare, and the pharmacist role as a trusted advisor to the patient and to the public is as important as ever. For the patient, the pharmacist is uniquely positioned to optimize care through appropriate selection, dosing, initiation, and de-escalation of therapy as well as throughout transitions of care. For the public, the practice of pharmacy serves as a crucial extension of access to healthcare and trusted information, and with continued advocacy, we can use our unique expertise and perspective to improve public health as providers.

Provider status for pharmacists will allow for reimbursing and staffing for cognitive abilities as well as extend the reach of healthcare. Outpatient pharmacists are reimbursed based on prescription volume while inpatient pharmacists are commonly staffed on models such as doses dispensed. Pharmacy practice is at its best when medication is optimized for the patient, and provider status will encourage a patient-centered model with an extended footprint.

Pharmacists also serve as trusted advisors to our legislators and government agencies, and our advocacy efforts remain a cornerstone of our organization. As a highly regulated industry, it is important that pharmacists tell our story of how our practice impacts the lives of our patients and our communities. Continued advocacy is necessary to maintain pharmacist autonomy and discourage unfair business practices that limit patient access, increase costs, and destabilize important programs.

Christy M. Norman, PharmD, MS, BCPS, CPEL, FASHP (Christy.norman@emoryhealthcare.org) serves as senior vice president of pharmacy at Emory Healthcare. In her role as the senior executive, she leads the strategic direction for practice across the continuum of care, promoting best practices and innovative solutions. Norman is also committed to pharmaceutical education, acting as a preceptor and mentor to pharmacy students and residents, as well as contributing as a guest lecturer on medication effectiveness and safety.

Norman earned her PharmD from the University of Georgia and obtained an MS degree in health system pharmacy administration during her PGY1/PGY2 health-system pharmacy administration residency at The Ohio State University/Wexner Medical Center. She furthered her professional development in leadership through participation in the Emory University Woodruff Leadership Academy.

An active member of the ASHP state affiliate, Norman holds the position of past-president and currently co-chairs the legislative committee. Her engagement with ASHP includes various leadership roles, including chair of the Pharmacy Executive Leadership Alliance (PELA) advisory committee, member of the Pharmacy Practice Accreditation Commission, past chair of the Council on Pharmacy Practice Management, past chair of the Multi-Hospital Pharmacy Executives Committee, and Georgia representative to the House of Delegates. Norman has been recognized as a fellow and earned the designation of Certified Pharmacy Executive Leader.

Norman has received numerous accolades for her contributions to the pharmacy profession, including being named a UGA College of Pharmacy Distinguished Alumni and recipient of the William T. Robie Inclusive Excellence Award.

Statement of Philosophy

The landscape and dynamics for healthcare delivery are continually evolving, with pharmacy playing an essential role in developing adaptive solutions. Addressing current challenges while anticipating future opportunities requires leadership, agility, and a proactive approach. A pharmacy colleague once described the profession as being "multilingual" because we must possess expertise in operations, finance, technology, care delivery, and quality/safety, among other areas. Furthermore, pharmacists collaborate with patients, providers, nurses, clinical support professionals, administrative/financial teams, and payors across the continuum of care, always prioritizing patient-centered outcomes. This multidisciplinary perspective has consistently earned the pharmacy profession a trusted position within healthcare.

The moment demands an invigorated and connected workforce that values contributions from all team members, including students, residents, technicians, pharmacists, and support staff. The experience of seasoned practitioners combined with the fresh perspectives of eager new practitioners creates an ideal balance to reconcile past successful practices with future needs.

National statistics predict a shortfall of over 17,000 pharmacists by 2037. ASHP launched the "We're Your Pharmacist" campaign to spread awareness about the crucial role of pharmacists in delivering safe, effective, and accessible medications. Additionally, the quality of care we provide is strengthened by the positive contributions of a well-trained pharmacy technician workforce. Whether it be navigating costly novel therapeutics, drug shortages, new healthcare policies, or advancements in

technology, our patients and communities will be seeking the expertise of our teams. They are counting on us. This is our calling, our mission, and our time.

Christopher M. Scott, PharmD, BCPS, FASHP, FCCM (Christopher.Scott@eskenazihealth.edu) serves as the chief clinical operating officer at Eskenazi Health, Indianapolis, IN. Scott earned his BS and PharmD from Purdue University and completed a PGY1 pharmacy residency and a PGY2 critical care residency at Indiana University Health. He is board-certified in pharmacotherapy and recognized as a fellow with the American College of Critical Care Medicine and ASHP (American Society of Health-System Pharmacists).

Additionally, Scott holds an adjunct clinical faculty appointment at Purdue University College of Pharmacy and Indiana University School of Medicine. Before his executive roles, he practiced as a clinical pharmacy specialist in trauma/surgical critical care and directed PGY1 and PGY2 residency programs at Eskenazi Health. His professional interests include postgraduate pharmacy training, patient safety, clinical service advancement, promoting healthcare equity, and growing future leaders.

He has a longstanding record of service to ASHP, including roles on the Council on Pharmacy Management, as an ASHP Forecast Advisory Committee member and chapter author, on the Commission on Credentialing, in the House of Delegates, with the International Accreditation Commission, and on the Pharmacists in the C-Suite Advisory Panel. He has also served as a practitioner surveyor for over 50 residency programs nationwide.

Statement of Philosophy
I'm a "focus on the fix, get out of our own way" leader who believes pharmacy's future depends on empowering people, acting authentically, and removing barriers limiting our potential. Throughout my career—from bedside clinician to classroom instructor to executive leader—I have witnessed the transformative impact of the pharmacy workforce when we are trusted, supported, and equipped to lead.

My leadership philosophy is grounded in empathy, efficiency, accountability, and altruism. Whether I am developing residency programs, expanding clinical services, or mentoring future leaders, my focus has always been clear: put people first, concentrate on meaningful action, and propel pharmacy forward with purpose.

I envision a future where pharmacy practice is inclusive, technologically advanced, and centered on equitable access to care. Building a thriving workforce culture where every pharmacist, learner, and technician can contribute and succeed is critical to achieving that vision. We must prioritize innovation, workforce well-being, and breaking down the regulatory and cultural barriers that slow our progress.

I am committed to leading with integrity, collaboration, and a relentless drive to elevate pharmacy's role in healthcare. Most importantly, I am committed to working alongside you to shape a future where pharmacy propels healthcare forward. I am honored to offer my experience, passion, and voice to the ASHP Board of Directors candidate pool to help shape our profession's bold, inclusive, and action-driven future.

Martin J. Torres, PharmD, FCSHP (martit3@hs.uci.edu) is a director of pharmacy at UC Irvine (UCI) in Orange, California with administrative oversight of quality, safety, education, and research. Torres provides executive leadership in strategic planning, medication safety, regulatory compliance, formulary review, preceptor development, PGY1/2 residency programs, and investigational drug trials in addition to serving on the UC Irvine Health Council on Diversity, Equity, and Inclusion.

Torres is also an adjunct professor of pharmacology and pharmacology curriculum coordinator at the Southern California College of Optometry in Fullerton and on faculty at the UCI School of Pharmacy and Pharmaceutical Sciences.

Torres received his PharmD from the USC School of Pharmacy, completed a residency at LAC/USC Medical Center, and while providing direct patient care, established clinical programs in several community hospitals. In leadership roles in academic and hospital medical centers with increasing responsibilities, Torres was privileged to lead teams in acute care and outpatient settings in developing patient care services across multiple transitions of care.

Torres has been an active member of ASHP for 40 years with his most recent service including the Commission on Affiliate Relations (2022-current), member, meeting with legislators during Policy Week, and California delegate to the ASHP House of Delegates (2018-2021). He has been very active with the 4,000 member California Society of Health System Pharmacists (CSHP) as chair House of Delegates (2018-2021), co-chair/member Committee on Professional Affairs (2014-2017), president, Orange County Society of Health System Pharmacists (2017-2018), frequent speaker at state meetings, member of state conference planning committees, and being recognized as a fellow of CSHP.

Statement of Philosophy

Join with me as we control the narrative on our profession and reinforce our identity as medication management experts with an expertise in patient safety! ASHP's leadership has provided a platform for telling our story, but do all pharmacy organizations articulate our value with the same sharp focus? We must continue our leadership role on how our profession is promoted to the patients we serve and the policy makers who determine payment. It is imperative we drive unified messaging across all pharmacy organizations highlighting "taking care of patients is what we do" and avoid confusing terminology which diminishes our role in patient care.

We must use our training as clinical scientists with patient care experience to develop healthcare leaders not only for the pharmacy enterprise, but as CEOs, COOs, vice presidents of quality, patient safety, and population health management (PHM). If not a pharmacist, then who?

Let's further standardize the pharmacist's role in medication histories in all settings, TOC within and between health systems with handoffs to community pharmacies, telepharmacy, and promote research which provides statistically significant evidence for the value of pharmacy on outcomes and not solely cost reduction.

We must establish an unequivocal role for pharmacy in PHM, independent of medication dispensing, based on medication and medical history/lab reviews at every patient interaction.

Additionally, we need to define our responsibilities in pharmacogenomics, gene and cellular therapies, and artificial intelligence.

Together we can do this! Please send me a note to share your thoughts.

House of Delegates

REPORT OF THE

BOARD OF DIRECTORS

ON

NOMINATIONS FOR ASHP TREASURER

June 8, 2025

Charlotte, North Carolina

This year, our Treasurer, Ms. Christene Jolowsky, will complete her term in that office. Accordingly, and pursuant to section 4.1.3 of the Bylaws, the Board hereby submits two names as nominees to the office of Treasurer. As provided in section 5.2.1 of the Bylaws, ASHP members will elect by majority vote a Treasurer to a three-year term of office.

Through announcements in various ASHP communications, the entire membership was advised of the forthcoming opening in the Treasurer's office and recommendations and expressions of interest were solicited. That solicitation outlined the formal duties of the Treasurer and summarized other qualities that the Board would consider in selecting the most qualified nominees.

To facilitate selection of the nominees, the Board formed a committee consisting of Kristine K. Gullickson (Chair), Melanie A. Dodd, Nishaminy Kasbekar, Vickie L. Powell, Jennifer E. Tryon, John R. Heberlein, and Paul W. Abramowitz. The committee met on March 21, 2025, via teleconference and reviewed the qualifications of members who had agreed to be considered as candidates and selected two candidates. The Board of Directors approved the slated candidates on April 10.

The role of the Treasurer is unique among the Board members and selection of these nominees involved special consideration of these unique responsibilities. In addition to serving as a member of the Board and providing leadership to the profession, the Treasurer is specifically charged with significant and specific fiduciary responsibilities for financial oversight of ASHP and, thereby, the ability of this organization to serve the needs of the profession.

The Treasurer must be an active member and able to perform the duties of a Director, as set forth in article 5 of the Bylaws. Therefore, it is important that a nominee possess those qualities of commitment, leadership, vision, professional awareness, and intellect necessary for being a member of the Board, including:

- professional experience, involvement, vision, and perspective;
- communication and motivational skills; and
- involvement in ASHP and affiliated state societies.

Because of the uniqueness of the Treasurer's position in the governance process, additional assessments must be made. The Treasurer serves as the financial planner and overseer of ASHP under the obligations set forth in section 4.5 of the Bylaws. Under the Bylaws, the Treasurer must be able to:

- oversee conservation and prudent investment of ASHP assets;
- assure that expenditures are in accord with program priorities;
- approve internal controls relative to management and handling of funds;
- inform the Board and membership about ASHP's financial needs and projections;
- oversee ASHP activities to assure budget objectives are met; and
- serve as Chair of the Committee on Finance and Audit.

The Treasurer of ASHP also serves as Treasurer of the ASHP Foundation.

Finally, the Board assessed those intangibles that would permit the Treasurer to balance technical financial capabilities with professional vision, so as to permit this person to serve as a cornerstone of the Board. Among the qualities are:

- credibility with members, Board, and staff;
- ability to interrelate substantive ASHP policy, goals, objectives, and financial issues;
- willingness to commit the time to do the job;
- a sensitivity to membership needs and wants, and to practice; and
- ability to assess and evaluate the details of financial management of ASHP.

The Board's job was a difficult one because selection of the nominees involved matters of degree, not the mechanistic application of a formula. We are confident that our nominees are outstanding; both have the capacity to provide financially responsible and responsive leadership.

Your Board is pleased to place in formal nomination two members for election as the Treasurer of ASHP, John A. Armitstead and Lisa M. Gersema.

CANDIDATES FOR ASHP TREASURER

John A. Armitstead, MS, RPh, CPEL, FASHP, (john.armitstead@leehealth.org) is vice president - pharmacy services, Lee Health, Fort Myers, Florida. He is responsible for practice advancement, strategic planning, financial management and coordination of pharmacy care provision in a five hospital, three skilled nursing facility and county-wide ambulatory health system with a $330 million budget, including a workforce of 440 team members. Over 250 new pharmacy practice positions have been initiated at Lee Health under approved, innovative business plans.

John obtained a master's degree in hospital/clinical pharmacy from The Ohio State University and completed a pharmacy residency at Riverside Methodist Hospitals in Columbus, Ohio. He received a Bachelor of Science in pharmacy from Ohio Northern University, Ada, Ohio. He earned the Certified Pharmacy Executive Leader credential from ASHP in 2023. John has directly precepted 250 pharmacy residents and 100 Doctor of Pharmacy students throughout his career. He also serves as a residency program director for the Lee Health PGY2 program in health services pharmacy administration and has written two financial management book chapters among over 50 publications.

As an active member of ASHP for over 40 years, John is a past president and board member of the ASHP, the Ohio Society of Health System Pharmacists, and the Kentucky Society of Health System Pharmacists (KSHP). He has served as board member and chair of the House of Delegates for the Florida Society of Health-System Pharmacists (FSHP). Armitstead is a Fellow of the ASHP, FSHP, and KSHP.

Statement of Philosophy

John's professional philosophy emphasizes alignment with the ASHP vision, strategic plan, policies, and statements with a commitment to patient care, advocacy for pharmacy practice advancement, workforce development for our future, and a focus on an individual's pursuit of excellence.

- *Optimizing patient outcomes through interdisciplinary medication management.*
- *Advance, expand and promote pharmacy services in an enthusiastic, innovative and consistent manner, in which pharmacy is recognized as a leader, advancing practice, and care to patients where continuity of care from the patient's perspective is expected and delivered.*
- *Develop and expand pharmacy training programs for pharmacy residents, student pharmacists, and pharmacy technician students, demonstrating professionalism, competency, and excellence while providing a highly trained pharmacy workforce for future challenges in optimizing care for patients.*
- *Contribute to providing an environment and culture for personal and professional growth for pharmacists and pharmacy technicians through encouragement, continuous professional development, recognition and utilization of the skills, talents and strengths of the individual.*

Lisa M. Gersema, BSPharm, PharmD, MHA, BCPS, CPEL, FASHP (lisa.gersema@allina.com) is the system director of clinical pharmacy services for Allina Health, Minneapolis, Minnesota. She completed her BSPharm, PharmD., and a one-year fellowship in clinical pharmacology at the University of Iowa. She received her MHA from Simmons College located in Boston. She has maintained her BCPS since 1993 and became a Certified Pharmacy Executive Leader in 2022.

In her current role, she provides leadership of clinical pharmacy services to develop, advance, and optimize system practice standards. This is inclusive of formulary management, cost-savings initiatives, policy harmonization, EMR clinical decision support, development of practice standards and outcomes, and clinical workload metrics for use at 10 hospitals in the health system. Prior to this position, Gersema was director of pharmacy and clinical manager at United Hospital, part of Allina Health, for more than 25 years. As director, she advanced a decentralized and integrated pharmacy practice model emphasizing accountability, collaboration, and team-based care.

Gersema's service to ASHP includes serving as president and on the board of directors, chair of the International Accreditation Commission, chair of the Council on Pharmacy Practice, member of the Commission on Therapeutics, chair of the ASHP Task Force on Opioids, served in the House of Delegates representing Minnesota, and was a member of several other ASHP committees and advisory groups. She also served as president and treasurer of the Minnesota ASHP affiliate (MSHP). She received MSHP's Hallie Bruce Award (highest honor bestowed by MSHP) and the Hugh F. Kabot Award (leadership and innovation).

Statement of Philosophy:
We live in a chaotic and challenging time. It can be daunting to demonstrate positive outcomes and the value of our professional services while evaluating practice advancements, implementing innovative technologies, and managing unprecedented financial challenges in this environment. Collaboration between ASHP leadership, staff, and members is essential to remain nimble and effectively engaged, and to capture and disseminate the extensive knowledge, wisdom, creativity, and aspirations of ASHP members. These efforts must include:

- *Providing leadership and developing best practices on the safe and effective use of artificial intelligence and other innovations to advance efficient pharmacy practice*
- *Assertively advocating with legislators and regulatory bodies to recognize pharmacists as providers, advance the role of technicians, and ensure safe medication use and supply*
- *Supporting research and programs that enhance well-being in our pharmacy environments and workforce*
- *Promoting collaboration with the interdisciplinary healthcare team to quantify pharmacists' unique and irreplaceable contributions to positive clinical and fiscal outcomes*

I have witnessed the vital role of the ASHP treasurer in providing oversight and communication regarding ASHP's financial status to the board and ASHP members. The treasurer's role to ensure resources are available to sustain ASHP's rich history to advance pharmacy initiatives is a critical one. The treasurer's previous board experience also positions them to provide insight, context, and mentorship regarding historical Board activities or decisions.

Through our collective wisdom, I am confident we can be successful in advancing our agenda in these challenging times. I would be honored to serve as treasurer to contribute to this success.

Resolutions Submitted to the 2025 ASHP House of Delegates

Contents:

Appendix A: Resolution for the 2025 ASHP House of Delegates: Advanced Trauma Life Support (ATLS) Certification for Pharmacists

Submitted by:
Justin Griner, PharmD, MBA, BCEMP, BCPS (jgriner1@gmail.com)
Memphis, TN

Paula Hogrefe, PharmD, BCEMP, BCPS (plhogrefe@gmail.com)
Memphis, TN

Subject: Advanced Trauma Life Support (ATLS) Certification for Pharmacists

Received: February 20, 2025

Motion

To advocate that Advanced Trauma Life Support (ATLS) certification be made available to pharmacists.

Background

ATLS training and certification was developed in the 1980s by the American College of Surgeons (ACS) to uniformly assess and treat seriously injured trauma patients. It is designed for physicians, but a modified version of this training is also available for nurses.

The 2020 ASHP Guidelines on Emergency Medicine Pharmacist (EMP) Services reference the important role EMPs play in "all critical and acute resuscitative efforts in the Emergency Department." The guidelines specifically reference pharmacists' involvement in the resuscitation of trauma patients. The guidelines also recommend that EMPs seek out training and certification in the conditions applicable to their practice settings, such as Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), and Pediatric Advanced Life Support

(PALS) from the American Heart Association (AHA), as well as ATLS from ACS. Currently, pharmacists can obtain certification in all these except ATLS. Pharmacists can audit the course but cannot become certified in ATLS.

To advance the training and the role of EMPs in traumatic resuscitations, pharmacists should be incorporated into the existing ATLS certification, or a new training/certification specific to pharmacists should be developed as one was for nurses. If ACS is unwilling to do this, ASHP should collaborate with other organizations such as AHA to create a pharmacist-appropriate trauma resuscitation training certificate.

Suggested Outcome

ATLS certification (or equivalent) would become available to pharmacists, either through the ACS or another certifying body such as AHA.

Appendix B: Related ASHP Policy

ASHP Policy 1527, Pharmacist's Role in Urgent and Emergency Situations
Source: Council on Pharmacy Practice

To affirm that pharmacists should participate in planning and providing emergency treatment team services; further,

To advocate that pharmacists participate in decision-making about the medications and supplies used in medical emergencies; further,

To advocate that pharmacists serve in all emergency responses, and that those pharmacists receive appropriate training and maintain appropriate certifications.

This policy was reviewed in 2025 by the Council on Pharmacy Practice and by the Board of Directors and was found to still be appropriate.

Rationale
Pharmacists have a leadership role in many hospitals in planning for emergency treatment team services. Data from the 2021 ASHP National Survey indicates that approximately 70% of hospitals have pharmacist participation in cardiopulmonary resuscitation (CPR), or code, teams and 36% have pharmacist participation on rapid response teams. This role includes developing policy on the contents of code carts and other supplies as well as establishing the role of the pharmacist in supporting these services. The literature demonstrates that pharmacists can make significant contributions to CPR and other emergency response teams as medication-use leaders and as participants, and there is evidence that better patient outcomes result when pharmacists participate. Pharmacists participating in this role should receive appropriate training and certification (e.g., Basic Life Support, Advanced Cardiopulmonary Life support, and Pediatric Acute Life Support). The ASHP Guidelines on Emergency Medicine Pharmacist Services reference many of the patient care services that pharmacists provide during urgent and emergency situations including but not limited to direct patient care activities, medication information, resuscitation, high-alert medication handling procedures, medication selection and preparation, medication order review and medication therapy monitoring, patient and caregiver education, and medication reconciliation.

Appendix C: Resolution for the 2025 ASHP House of Delegates: Revision of ASHP State Affiliation Guidelines Appendix C to Permit Special Accommodation Models for Unified State Pharmacy Associations

Submitted by:
Chris Greer, RPh (christopher.greer@providence.org)
Spokane, WA

John Muchka, PharmD, BCPS (jpmuchka@yahoo.com)
Nashotah, WI

Subject: Revision of ASHP State Affiliation Guidelines Appendix C to Permit Special Accommodation Models for Unified State Pharmacy Associations

Received: March 10, 2025

Motion
The American Society of Health-System Pharmacists (ASHP) should revise Appendix C of the ASHP Guidelines for Affiliation with State Organizations to permit special accommodation models for affiliating with unified state pharmacy associations that align with the ASHP mission and represent health-system pharmacists. It is the intention that qualified unified state pharmacy organizations may serve as the primary entities for state-level representation and collaboration with ASHP as an affiliate.

Background
ASHP has a long-standing commitment to supporting health-system pharmacists through structured state affiliations that align with ASHP's mission, vision, and strategic priorities. ASHP's Guidelines for Affiliation with State Organizations currently prioritize affiliations with state-level health-system pharmacy organizations, ensuring that ASHP's advocacy and professional development efforts remain focused on pharmacists practicing in hospitals, health systems, and ambulatory care settings. Further, the Board approved Appendix C on September 15, 2022 that stated "ASHP will not consider additional Special Accommodations Models for affiliation" which means they will not consider new affiliations with unified state pharmacy organizations.

ASHP Currently Affiliates with these Unified State Pharmacy Organizations include Colorado Pharmacists Society, Hawaii Pharmacists Association, Indiana Pharmacy Association, Iowa Pharmacy Association, North Carolina Association of Pharmacists, and Pharmacy Society of Wisconsin. Other unified state pharmacy associations have requested ASHP to revise its affiliation model to allow full affiliation with their pharmacy organizations, rather than requiring affiliation through only health-system-specific group.

Unified state pharmacy associations bring together pharmacists, residents, student pharmacists and pharmacy technicians from various practice settings, including hospitals, long-term care, specialty, community pharmacy, and academia, often within health systems, to create a stronger, more cohesive voice for the profession. These broad areas of practice overlap with multiple ASHP Special Advisory Groups and member interests. Currently some ASHP members who are not part of the health system subgroups of unified state affiliates are excluded (i.e. technicians, ambulatory pharmacists) because they are better represented by other subgroups. Affiliating with the unified state associations is more inclusive of diverse member voices from across the state.

Potential benefits of broadening the definition of affiliation to include unified state pharmacy organizations include:

- A unified voice for pharmacy professionals at the state level;
- Enhanced collaboration and resource sharing across practice settings;
- More effective state-level legislative and regulatory advocacy; and
- Stronger engagement and representation for health-system pharmacists within the broader pharmacy community.

Suggested Outcome

The ASHP Board of Directors update the Guidelines for Affiliation with State Organizations Appendix C to permit consideration of affiliating with unified state pharmacy organizations which align with the ASHP Mission and represent health system pharmacists. In doing so, ASHP will include all ASHP members in unified states, and enhance collaboration and resource sharing with unified state pharmacy organizations.

Appendix D: Related ASHP Materials

ASHP Guidelines for Affiliation with State Organizations- Appendix C

Mission, Scope, and Membership Focus of ASHP and Its Affiliates

ASHP Board policy—September 15, 2022

Pharmacy practice in hospitals and health systems is a distinct area of the profession and practitioners in this area have unique interests and needs; further,

ASHP's membership mission is to serve the interests and needs of the pharmacy workforce in hospitals and health systems; further,

ASHP collaborates with state affiliates to improve patient care and advance pharmacy practice; further,

ASHP has no interest in merging with other pharmacy organizations; further,

ASHP formally affiliates with state organizations whose purposes and priorities are aligned with ASHP's membership mission, scope, and focus consistent with the ASHP Guidelines for Affiliation with State Organizations; further,

ASHP will only approve state affiliates in independent and umbrella structures that meet the ASHP Guidelines for Affiliation with State Organizations; further,

ASHP will not consider additional Special Accommodations Models for affiliation.

Note: This action supersedes a Board action of April 16, 2004.

pharmacists advancing healthcare®

House of Delegates

Board of Directors Report: Policy Recommendations for the June 2025 House of Delegates

ashp

COUNCIL ON PUBLIC POLICY
POLICY RECOMMENDATIONS

The Council on Public Policy is concerned with ASHP professional policies related to laws and regulations that have a bearing on pharmacy practice. Within the Council's purview are (1) federal laws and regulations, (2) state laws and regulations, (3) analysis of public policy proposals that are designed to address important health issues, (4) professional liability as defined by the courts, and (5) related matters.

Kristi Gullickson, Board Liaison

1. Funding, Expertise, and Oversight of State Boards of Pharmacy

To advocate appropriate oversight of pharmacy practice and the pharmaceutical supply chain through coordination and cooperation of state boards of pharmacy and other state and federal agencies whose mission it is to protect the public health; further,

To advocate representation on state boards of pharmacy and related agencies by pharmacists and pharmacy technicians; further,

To advocate that hospitals and health systems are adequately represented on state boards of pharmacy; further,

To advocate for dedicated funds for the exclusive use by state boards of pharmacy and related agencies to carry out expected duties; further,

To advocate for established training of state board of pharmacy inspectors in diverse pharmacy practice areas and the implementation of adequate inspection schedules to ensure the effective oversight and regulation of pharmacy practice, the integrity of the

pharmaceutical supply chain, the protection of the public, and to establish variances from any documented rule by the board of pharmacy; further,

To advocate that inspections be performed only by individuals with demonstrated competency in the applicable area of practice.

Note: This policy would supersede ASHP policy 2021.

Rationale

In recent years, the regulatory scope of boards of pharmacy has grown to address new and expanded scopes of practice and healthcare while fulfilling their mission of protecting the public health. In addition, coordination with federal agencies (e.g., Food and Drug Administration, Drug Enforcement Administration) and related state agencies adds to the complexity of a state board's mission. With this expanded scope and mission comes the need for additional resources, both financial and human. Specific knowledge acquired by pharmacists and pharmacy technicians is essential to the safe regulation of practice. Thus, inspectors need to have demonstrated competency in the applicable area of practice in order to assure the health and safety of the public. Further, inspectors should provide evidence for variance to established BOP rules to ensure that rules are applied as objectively and consistently as possible.

Background

The Council reviewed 2021, Funding, Expertise, and Oversight of State Boards of Pharmacy, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

To advocate appropriate oversight of pharmacy practice and the pharmaceutical supply chain through coordination and cooperation of state boards of pharmacy and other state and federal agencies whose mission it is to protect the public health; further,

To advocate representation on state boards of pharmacy and related agencies by pharmacists and pharmacy technicians; further,

To advocate that hospitals and health systems are adequately represented on state boards of pharmacy; further,

To advocate for dedicated funds for the exclusive use by state boards of pharmacy and related agencies to carry out expected duties, ~~including funding for the training of state board of pharmacy inspectors and the implementation of adequate inspection schedules to ensure the effective oversight and regulation of pharmacy practice, the integrity of the pharmaceutical supply chain, and protection of the public~~; further,

To advocate for established training of state board of pharmacy inspectors in diverse pharmacy practice areas and the implementation of adequate inspection schedules to ensure the effective oversight and regulation of pharmacy practice, the integrity of the

pharmaceutical supply chain, the protection of the public, and to establish variances from any documented rule by the board of pharmacy; further,

To advocate that inspections be performed only by individuals with demonstrated competency in the applicable area of practice.

The Council felt that the policy needed updating to reflect the need for additional training for board of pharmacy inspectors, especially for setting-specific training. Discussion focused heavily on problems from inspectors applying the same standards to every inspection, even when those standards might not be relevant to certain settings.

2. Payment Parity for Pharmacists' Services

To advocate that any physician or non-physician practitioner be reimbursed in accordance with services provided within their scope of practice; further,

To recognize that pharmacists, as healthcare providers, provide patient care and bridge existing gaps in healthcare as members of the healthcare team.

Note: This policy would supersede ASHP policy 1502.

Rationale

Recognition of pharmacists as healthcare providers is emerging and is being codified in state law as well as in current federal legislative proposals (e.g., H.R. 592, S. 314). In some cases, this recognition also includes specified compensation through existing payment mechanisms (e.g., federal Medicare Part B or state Medicaid programs). With recognition, pharmacists should be sustainably compensated for their patient-care services by all public and private payers using standardized billing processes.

Background

The Council reviewed ASHP policy 1502, Pharmacist Recognition as a Healthcare Provider, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

~~To advocate for changes in federal (e.g., Social Security Act), state, and third-party payment programs to define pharmacists as healthcare providers; further,~~

~~To affirm that pharmacists, as medication-use experts, provide safe, accessible, high-quality care that is cost-effective, resulting in improved patient outcomes; further,~~

~~To recognize that pharmacists, as healthcare providers, improve access to patient care and bridge existing gaps in healthcare; further,~~

~~To collaborate with key stakeholders to describe the covered direct patient-care services provided by pharmacists; further,~~

~~To advocate for sustainable compensation and standardized billing processes used by payers for pharmacist services by all available payment programs.~~

The Council opted to revise the policy completely without maintaining verbiage from the previous version, including a change of title. During the Council's extended discussion on this issue, there was consensus that the current focus on pharmacist status is becoming counterproductive because it invites opposition from physicians' groups due to scope creep concerns. The Council agreed that this should remain a priority issue for ASHP, but that a focus on payment for our services commensurate with what other providers receive might provide a refresh for the issue and prove a more productive strategy. The Council felt that this strategy has worked well in states and would translate well to federal advocacy.

3. Pharmacists Cross-State Licensure

To advocate that state boards of pharmacy collaborate to streamline the licensure process through standardization and improve the timeliness of application approval across state lines; further,

To advocate that state boards of pharmacy collaborate with third-party vendors to streamline the licensure transfer or reciprocity process; further,

To advocate that boards of pharmacy grant licensed pharmacists in good standing temporary licensure, permitting them to engage in practice, while their application for licensure transfer or reciprocity is being processed.

Note: This policy would supersede ASHP policy 1621.

Rationale

Pharmacists sometimes face challenges from delays in obtaining licensure by transfer or reciprocity when moving their practice from one jurisdiction to another. Such delay may be due to the need for boards to review pharmacists' licensure records in all jurisdictions in which they are licensed, administer a state pharmacy law exam, complete a criminal background check, and, in some cases, schedule an interview with the board. To address these challenges, boards of pharmacy should allow pharmacists in good standing to immediately practice in a different jurisdiction when they change employment or enter a residency program. Granting pharmacists a temporary license for a period of up to six months while the board completes its review would help meet workforce demands while continuing to safeguard the public health. In some cases, pharmacists who are unable to obtain a license in a timely manner are unable to fully use

the skills in which they have been trained. Without a license, the pharmacist may temporarily have to function as a technician or perform other tasks. For pharmacists participating in residency programs outside their jurisdiction of licensure, several months of their residency program can elapse before they receive licensure transfer or reciprocity. Upon completion of a year-long residency program, many residents move to another jurisdiction to practice and have to start the transfer or reciprocity process again.

Members in several states have reported that in recent years boards of pharmacy have been slow to issue pharmacy licenses. This delay is especially problematic for pharmacy residents from another jurisdiction who rely on boards to grant them a license prior to performing in a clinical capacity. Given that the licensing period can take several months, this delay has presented a problem for pharmacy residents who have a limited timeframe to successfully complete their duties, typically one year. In some cases, state boards are urging residents to obtain a pharmacy technician license; however, this is inappropriate given the expertise and education residents have and the level of practice they're expected to engage in. Given its national scope, NABP is well-positioned to explore a broad solution to this problem rather than the current, incremental, state-by-state approach.

Background

The Council considered the issue of cross-state licensure, particularly the difficulty of quickly transferring licensure and/or maintaining licenses in multiple states. The discussion focused on the inconsistency of state requirements, including the elimination of the Multistate Pharmacy Jurisprudence Examination in some states and regional compacts or agreements in others. While there is a National Association Boards of Pharmacy (NABP) process for quickly attaining licensure, it is pricey and again, can be dependent on state requirements. Further, servicemembers and spouses continue to face hurdles to license transfer/multistate licensure despite the passage of the Servicemembers Relief Act, which streamlined professional licensure requirements for those groups.

The Council discussed whether to draft new policy, but felt that it made more sense to review policy 1621, Timely Board of Pharmacy Licensing, which is a CPuP policy. Specifically, the Council recommended revising the policy 1621 as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To advocate that ~~the National Association of Boards of Pharmacy (NABP)~~ state boards of pharmacy collaborate ~~with boards of pharmacy~~ to streamline the licensure process through standardization and improve the timeliness of application approval across state lines; further
>
> To advocate that ~~NABP collaborate with~~ state boards of pharmacy collaborate with third-party vendors to streamline the licensure transfer or reciprocity process; further,
>
> To advocate that boards of pharmacy grant licensed pharmacists in good standing temporary licensure, permitting them to engage in practice, while their application for licensure transfer or reciprocity is being processed.

4. Patient's Right to Choose

To support the patient's right, or that of their representative, as allowed under state law, to make informed decisions as part of their overall plan of care; further,

To acknowledge that patients have the right to be fully informed about their medication options, including benefits, risks, costs, and alternatives, and to be involved in the decision-making process; further,

To support the right of patients to request specific medications, and to have their preferences considered, within the limits of clinical appropriateness, evidence-based practice, formulary restrictions, and legal requirements; further,

To recognize the right of patients to refuse medications or request changes in their prescribed therapy after being informed of the potential consequences of such decisions.

Note: This policy would supersede ASHP policy 0013.

Rationale

ASHP supports the right of the patient, or their representative as allowed under law to make informed decisions regarding the patient's care plan. The patient's right to choose includes being entitled to be informed of their health status, involved with care and treatment, allowed to request or refuse treatment, execute advance directives, and have healthcare practitioners adhere to those directives.

Background

The Council reviewed 0013, Patient's Right to Choose, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To support ~~the right of the patient or his or her representative~~ the patient's right, or that of their representative as allowed under state law, to ~~develop, implement, and~~ make informed decisions ~~regarding his or her~~ as part of their overall plan of care; further,
>
> To acknowledge that ~~the patient's rights include being informed of his or her health status~~ that patients have the right to be fully informed about their medication options, ~~being involved in care planning and treatment, and being able to request or refuse treatment~~ including benefits, risks, costs, and alternatives, and to be involved in the decision-making process; further,

To support the right of patients to request specific medications, and to have their preferences considered, within the limits of clinical appropriateness ~~the patient in accord with state laws to (a) formulate advance directives and (b) have health care practitioners who comply with those directives.~~, evidence-based practice, formulary restrictions, and legal requirements; further,

To recognize the right of patients to refuse medications or request changes in their prescribed therapy after being informed of the potential consequences of such decisions.

The Council felt that the policy needed updating to focus more generally on informed consent generally, rather than focusing on informed consent for more controversial issues, such as end-of-life directives. The Council felt those issues were already addressed in policy, so they could be moved into the rationale to make it clear this policy would apply in those situations, while remaining flexible enough to apply to other situations as well.

5. Support of Global Health Organizations

To strongly support the mission and work of global health organizations in their role in public health preparedness, prevention, and control to improve the health and well-being of people globally.

Note: This policy would supersede ASHP policy 2037.

Rationale

In an age of global travel between and among countries, efforts to prevent, control, treat, and eradicate diseases and conditions that decrease health and well-being are critical to all countries, regardless of factors such as income and education. New vectors of disease transmission and behavioral conditions related to lifestyle and environmental conditions continue to provide challenges that need to be addressed. Domestic and international organizations that provide evidence-based warnings, guidelines, education, research, and advocacy, and that collect data to help countries prepare their public health infrastructure, are essential in providing people around the world with the tools and resources needed to address critical health issues globally.

Background

During Policy Week 2024, the Council discussed ASHP policy 2037, Support of the World Health Organization, as part of sunset review. At that time, the Council recommended discontinuation of the policy. When the Board considered CPuP's 2024 policy discontinuations, it recommended that CPuP reconsider the discontinuation. During the 2025 winter call, the Council felt that

discontinuing the policy could create the perception that ASHP does not support public health organizations, including domestic agencies. At the April 2025 Board of Directors meeting, the Board decided to edit the policy language to support broader global health efforts as follows (underscore indicates new April Board text; ~~strikethrough~~ indicates April Board deletions):

> To strongly support the mission and work of ~~the World Health Organization~~ global health organizations in ~~its~~ their role in public health preparedness, prevention, and control to improve the health and well-being of people globally.

The Council slated a discussion of policy indicating broad support for public health organizations, including FDA, CDC, and NIH for a future Council meeting.

COUNCIL ON PHARMACY MANAGEMENT POLICY RECOMMENDATIONS

The Council on Pharmacy Management is concerned with ASHP professional policies related to the leadership and management of pharmacy practice. Within the Council's purview are (1) development and deployment of resources, (2) fostering cost- effective use of medicines, (3) payment for services and products, (4) applications of technology in the medication-use process, (5) efficiency and safety of medication-use systems, (6) continuity of care, and (7) related matters.

Vivian Bradley Johnson, Board Liaison

1. Recovery and Assistance Programs for Healthcare Workers with Substance Use Disorder

To advocate that hospitals and health systems establish recovery and assistance programs for healthcare workers with substance use disorders, including those who have diverted controlled substances to support their own drug addiction; further,

To encourage state licensing boards to support structured rehabilitation programs that demonstrate a clear pathway for recovery and return to practice upon successful completion of the program.

Rationale

At least one in every 100 healthcare workers (HCWs) is estimated to have diverted medication. Because most drug diversion goes undetected, the true number is likely much higher. Moreover, an estimated 10-15% of HCWs will misuse substances within their career. Due to the physical demands of the job, increasing levels of burnout, and ease of access to controlled substances (CS), occupational risk factors contribute to substance misuse in the healthcare setting. Substance use disorders (SUDs) are formally recognized by *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, with decades of research linking these disorders to changes in brain chemistry. Historically, the stigma associated with such diagnoses and the fear of license revocation have prevented HCWs from seeking treatment. Many

hospitals and health systems have begun to offer confidential faculty and staff assistance programs; however, these resources continue to be underutilized. Even after diverters have been caught, many will not admit to any wrongdoing for fear of loss of employment. These situations can lead to the diverter resigning and seeking employment elsewhere. Often, the behavior will continue, putting patients and co-workers at risk for safety events. Furthermore, the risk of suicide is high after personnel are confronted about diversion.

To prevent poorer overall health and financial instability, HCWs need to retain their healthcare insurance and access treatment on while on leave of absence or disability, with return to work after completing state board-mandated protocols. ASHP supports employer-sponsored drug programs that promote the recovery of impaired individuals (see ASHP Statement on the Pharmacist's Role in Substance Abuse Prevention, Education, and Assistance). Less punitive approaches are recommended in the ASHP Guidelines on Preventing Diversion of Controlled Substances, which state that sanctions should take into account whether the HCW is supporting his or her own substance use disorder (or that of an associate) or there has been theft of CS for sale and financial gain. The guidelines further recommend that when an HCW is diverting to support a substance use disorder, the diversion should be reported to applicable licensing boards, and the HCW should be referred to a substance abuse program. The guidelines encourage healthcare organizations to establish a process to support recovery for HCWs who are diverting CS for an active substance abuse problem (i.e., an employee assistance program process, which may include mandatory program referral, reporting to the relevant state board or professional assistance program, and a contract for the HCW's return to work). Also known as alternatives to discipline programs (APDs), APDs are non-punitive monitoring programs that allow HCWs to return to work after receiving treatment for an SUD.

The intent of these programs is to support decriminalization of SUDs to avoid interfering with an empathetic approach to employee substance use disorders. However, this must be balanced with other priorities, including patient safety, legal and regulatory compliance, and employee protection. A 2021 ASHP survey found that 83% of surveyed healthcare organizations supported employee substance use recovery programs, and 65% had return-to-work policies for employees who wanted to re-enter the workforce following recovery. SAMHSA defines recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. State boards of pharmacy have embraced employee substance use recovery programs and return-to-work policies. Given their essential role in enabling HCWs to return to practice, ASHP encourages all state bodies responsible for licensing HCWs to support accessible, affordable, and structured rehabilitation programs for HCWs with substance use disorders that lead to return to practice upon successful completion.

Background

An ASHP Committee on Resolutions submission during the 2024 ASHP House of Delegates meetings was referred to Council for further review. The resolution led to this policy recommendation, which expresses a nuanced stance on the issue. Since ASHP policy 2042, Controlled Substances Diversion Prevention was slated for sunset review, the Council considered this discussion an opportunity to amend the policy. However, the council decided this topic should be treated as a new policy recommendation versus amending ASHP policy

2042. The existing policy is focused on diversion prevention, and the resolution discussion focused on recovery after an episode of diversion has already occurred. The Council was generally not in favor of including the term “alternatives to discipline programs” in the proposed policy clauses, as they felt it may provoke an emotional response that would interfere with the utility of the policy position. Specifically, when considering whether 1) an HCW is supporting their own substance use disorder, or 2) there has been criminal intent for financial gain; there may be punitive consequences in both cases. One may include a pathway to recovery and return to practice but is still subject to civil penalties; whereas, the other may lead to immediate termination with associated criminal and civil penalties. The Council suggested that ASHP could help members by promoting knowledge of these recovery and assistance programs through education and resources to gain support from hospitals and health systems (e.g., equity and access considerations for licensed and unlicensed personnel) and boards of pharmacy (e.g., clear pathway to re-licensure and return to practice, intra/interstate communication about known or suspected diverters).

2. Cellular and Gene Therapies

To affirm that pharmacists serve key roles in the use of cellular and gene therapies (CGTs), spanning supply chain management, operational oversight, and clinical consultation on individual patients; further,

To recognize that CGTs are therapeutics that are managed as such in the medication-use process; further,

To assert that health-system decisions on the selection, use, and management of CGTs are part of the formulary system; further,

To advocate for outcomes-based innovative payment models that facilitate patient access to CGTs, including full coverage of approved indications and full reimbursement for CGTs.

Note: This policy would supersede ASHP policy 1802.

Rationale

Currently, cellular and gene therapies (CGTs) are defined as "Advanced Therapy Medicinal Products", comprising a large group of cellular types that are either alone or in combination with gene and tissue engineering technology. The U.S. Food and Drug Administration (FDA) recognizes cellular therapy products as cellular immunotherapies, cancer vaccines, and other types of both autologous and allogeneic cells for certain therapeutic indications, including hematopoietic stem cells and adult and embryonic stem cells. The FDA regulates CGTs as biological products, meaning they are considered therapeutics subject to standard drug regulations. The FDA recognizes human gene therapy seeks to modify or manipulate the

expression of a gene or to alter the biological properties of living cells for therapeutic use. Together, CGTs are a rapidly growing and important area of medicine. The 2023 *AJHP* article Role of Pharmacy in Cellular-Based Therapy cites the need for pharmacists to take a leadership role in managing CGTs and delineates three major areas for pharmacy leadership: biologic drug management, multidisciplinary team coordination, and supportive care management. Additionally, the pharmacist, working collaboratively with the interdisciplinary team, should take the lead in ensuring successful use of CGTs (e.g., patient navigation, care coordination lead, proactive review, and assessment for eligibility and reimbursement, measuring and monitoring outcomes). Like other therapeutics, CGT agents should be managed as a part of the formulary system. As described in more detail in the ASHP Guidelines on the Pharmacy and Therapeutics Committee and the Formulary System, a fundamental characteristic of the formulary system is that all decisions are made based on evidence-based clinical, ethical, legal, social, logistical, philosophical, quality-of-life, safety, and economic factors that result in optimal patient care; include the active and direct involvement of physicians, pharmacists, and other appropriate healthcare professionals, as well representatives with expertise in finance, law, and informatics; and are not based solely on economic factors.

However, as reported in the ASHP/ASHP Foundation Pharmacy Forecast 2024, the ultra-high expense of these therapies, coupled with uncertain reimbursement, warrants careful financial, service-line, and external partnership analyses. Pharmacy leadership, service-line stakeholders, and the pharmacy and therapeutics committee should collaborate with health-system finance experts to gauge budget impact and measure financial risk associated with the provision of CGTs. Pharmacy should be integral in the development of procedures regarding storage, prescribing, dosing, preparation, labeling, dispensing, transport, safe and compliant administration, clinical decision support tools, and disposal when working with CGTs. To ensure the accuracy of the dose, product, and labeling, pharmacists should have the ability to verify the product when it's prepared in the pharmacy and should be involved when order sets or labeling procedures are developed. Well-known challenges are presented by the use of these agents in structuring clinical decision support tools. These agents are often measured in volumetric dosing (e.g., vector genomes per kilogram), and their documentation often requires use of exponents. Therefore, ASHP recognizes, as part of the medication-use process, the need for innovation in electronic health records and pharmacy workflow systems so that these doses can be displayed accurately while avoiding the use of free text in the electronic health record, which may lead to dosing and entry errors. Safety checks, including robust double check systems, should be in place to avoid errors due to compounding and order entry. Finally, advocacy for patient access to, full coverage of, and reimbursement for CGTs is necessary to develop new capabilities and enable pharmacy services to adapt to these new ultra-high-cost therapeutic innovations.

Public and private payers lack coverage policies and restrictions for CGTs. Many payers use traditional pricing models, such as fee-for-service or utilization management tools, to manage CGT but these models are not suitable for ultra-high-cost therapies. Some hospitals may lack economies of scale to support CGTs and may choose to opt-out of providing them to patients due to insufficient reimbursement. For instance, many hospitals consistently lose revenue on CAR T-cell therapy due to the high readmission rates within 72 hours that are then tied to the diagnostic related groups. CGTs are time intensive therapies, requiring hospitals to

take on financial risk. Hospitals should be paid at cost plus and reimbursement, which should not be dependent on readmission factors due to CGT drug-related events. Several payers plan to leverage reinsurance (e.g., annuity payments) as well as increase their use of value- and outcomes-based contracting. However, legal and regulatory barriers currently prevent or limit the use of innovative, value-based payment models. One value-based agreement under consideration ties reimbursement to value and durability, such as CGT developers reimbursing payers when therapy does not provide sufficient benefit. This approach has the potential to incentivize manufacturers to develop effective therapies, while also ensuring patients receive the best possible treatment. Reimbursement and pricing challenges faced by CGT are complex and require innovative solutions. Value-based arrangements and reinsurance are potential models that could help address these challenges.

Background

The Council previously reviewed ASHP policy 1802, Gene Therapy, in response to an intercouncil referral from the Council on Therapeutics, during its January 31, 2024 winter call. Due to the subject of the joint topic session, a decision was made by Council to revisit the Board-approved CGT policy recommendation to consider for further study. The Council voted to recommend amending the Board-approved amendments to policy 1802 as follows (underscore indicates new June Board text; ~~strikethrough~~ indicates June Board deletions; double underscore indicates new Policy Week Council text; ~~double strikethrough~~ indicates Policy Week Council deletions):

> To affirm that pharmacists serve key roles in the use of cellular and gene therapies (CGTs), spanning supply chain management, operational oversight, and clinical consultation on individual patients; further,
>
> To recognize that ~~cellular and gene therapies (~~CGTs~~)~~ are ~~biologic drugs~~ therapeutics that ~~should be~~ are managed as such in the medication-use process; further,
>
> To assert that health-system decisions on the selection, use, and management of ~~gene therapy agents~~ CGTs ~~should be managed as~~ are part of the ~~medication~~ formulary system ~~in that (1) decisions are based on clinical, ethical, legal, social, philosophical, quality-of-life, safety, comparative effectiveness, and pharmacoeconomic factors that result in optimal patient care; and (2) such decisions must include the active and direct involvement of physicians, pharmacists, and other appropriate healthcare professionals~~; further,
>
> ~~To advocate that electronic health record and pharmacy workflow systems be designed to ensure accurate documentation of CGTs; further~~
>
> ~~To advocate that gene therapy be documented in the permanent patient health record; further~~,
>
> ~~To advocate that documentation of gene therapy in the permanent patient health~~

~~record accommodate documentation by all healthcare team members, including pharmacists.~~

To advocate for outcomes-based innovative payment models that facilitate patient access to CGTs, including full coverage of approved indications and full reimbursement for CGTs.

The Council generally agreed with amendments approved by the Board and proposed adding the role of the pharmacist in the successful utilization of CGTs (e.g., patient navigation, care coordination lead, proactive review and assessment for eligibility and reimbursement). The Council stressed this does not mean that pharmacists should execute all functions of process but rather play a significant role and collaborate with other disciplines. Secondly, the Council recommended striking the clause related to electronic health record documentation and including this content in the rationale. The Council suggested documentation is part of the medication-use process which is captured in the proposed second clause. Finally, the Council reviewed the ASHP House of Delegates recommendation "Cellular Therapy Products" to determine if content might be considered for a policy, statement, guidelines, or other action. Council members recommended ASHP consider creating a drafting team to evaluate and guide the application of CGTs for use in pharmacy practice. ASHP's guidance document could advise the development of safe and appropriate manipulation, dispensing, and handling of cellular and gene therapeutics (investigational and commercial) for health systems. The guidance could also help establish pharmacy leadership in this field and identify opportunities for pharmacy practice that lead to an improved patient care experience. Additional practice needs and considerations for the guidance are:

- Regulatory regime and compliance, including provider knowledge of changes and/or recent FDA drug approval processes (e.g., FDA accelerated approval, CMS Cell and Gene Therapy Access Model).
- Infrastructure and facilities requirements, including those for biosafety.
- Hospital and health-system management of CGTs.
- Patient engagement and communication.
- Technology integration.
- Creating sustainable models for CGT research and development.
- Ethical framework considerations and concerns (e.g., rationing due to high costs, germ line manipulation, benefit-risk determination, use of human fetal tissue to source embryonic stem cells).
- Advanced training and education of students and current practitioners.
- Education of the pharmacy profession on innovative practice models with an associated resource center that is responsive to rapid changes in CGT.

The Council acknowledged that ASHP must help prepare the pharmacy workforce for CGTs by providing education and training. This effort should address the future impact CGTs will have on pharmacy resource allocation and traditional pharmacy roles as well as CGTs role in providing opportunities for a safer medication-use process, improved patient access to care,

and advocacy for fiscally solvent payment models.

3. Interstate Pharmacist Licensure

To discontinue ASHP policy 2030, Interstate Pharmacist Licensure, which reads:

To advocate for interstate pharmacist licensure to expand the mobility of pharmacists and their ability to practice.

Background

The Council recognizes this topic is still a profession-focused priority but suggests that the policy be discontinued with an opportunity to consolidate the central point within existing ASHP policy. The Council suggests the Council on Public Policy or Council on Education and Workforce Development consider reviewing ASHP policy position(s) 0909, Regulation of Interstate Pharmacy Practice; 1621, Timely Board of Pharmacy Licensing; 2201, State-Specific Requirements for Pharmacist and Pharmacy Technician Continuing Education; or 2420, Opposition to Pharmacy Jurisprudence Examination Requirement at a future meeting to determine if consolidating with ASHP policy 2030, Interstate Pharmacist Licensure, is a possibility.

COUNCIL ON PHARMACY PRACTICE
POLICY RECOMMENDATIONS

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

1. Safe and Secure Transfer of Controlled Substances

To advocate for the standardization of policies, procedures, and practices in the handling of controlled substance medications throughout the care process, including transfers between emergency medical services and during interfacility transport; further,

To promote closed-loop communication processes related to controlled substance medication management during patient transfers; further,

To collaborate with emergency medical services and other stakeholders involved in pre- and post-hospital and interfacility transfers of controlled substances to improve patient safety, minimize variation, and ensure compliance.

Rationale

Compliance with Drug Enforcement Administration (DEA) regulations and applicable state laws and regulations is crucial for protecting public health and preventing misuse and diversion of controlled substances (CS). Health systems are required to provide leadership and oversight of handling and storage of CS. They are also required to comply with laws and regulations in the transfer of CS between institutions and other DEA registrants. This can be a complex process, particularly in the absence of clear federal and state policies.

There is a lack of uniformity and clarity in allowances and processes for the transfer of CS from a hospital or health system to nonhospital-based emergency medical services (EMS) (e.g., state or local government-owned agencies) and vice versa. To address this, the Protecting Patient Access to Emergency Medications Act of 2017 (PPAEMA) authorized the DEA to amend the Controlled Substances Act to clarify the receipt, movement, and storage of CS for an EMS agency.[4,5] PPAEMA states that CS can be stored in the DEA-registered EMS agency location, in EMS vehicles used by the agency, and in unregistered locations as long as the US Attorney General is notified of the location at least 30 days before the CS is initially delivered for storage. In addition, hospitals may restock CS for an EMS agency following an emergency response. However, the DEA has not finalized regulations as authorized by PPAEMA, creating challenges for states and hospitals to interpret federal regulations while implementing systems and solutions for the safe and lawful transfer of CS to EMS. A uniform approach or standard development may assure accountability and prevent diversion while meeting patient care needs.

Background

The Council examined this topic in response to a recommendation from Council members who observed practice challenges with ambiguous state and federal regulations related to the transfer of controlled substances between healthcare settings and emergency medical services agencies. Council members expressed concern over patient safety and risks of worsening outcomes after changing administration methods during patient transfers, which are due to compliance issues and the need for more standardization. Council members suggested that future revisions to the ASHP Guidelines on Preventing Diversion of Controlled Substances include content related to safely and securely transferring CS.

2. Addressing and Preventing Moral Distress and Injury in the Healthcare Workforce

To acknowledge the acute and chronic exposure of the healthcare workforce to potentially morally injurious events across the continuum of care; further,

To recognize the risk of moral distress and moral injury when a healthcare worker is unable to provide ethical, safe, and effective care due to system-level constraints; further,

To advocate for consistent and equitable allocation of resources across care teams and health systems to ensure that healthcare workers can provide safe and comprehensive patient care services; further,

To advocate for proactive and corrective approaches within organizations that are co-designed with members of the healthcare team to prevent and address moral distress and injury among healthcare workers.

Rationale

Moral injury is defined as the "perceived betrayal by a legitimate authority in a high stakes situation, which leads one, through action or inaction, to deeply transgress held moral beliefs and expectations." It is considered to be a syndrome associated with clinical symptoms such as psychological distress, increased thoughts of self-harm and various mental illnesses. Moral injury occurs when workers begin to question the moral framework of the system and their own moral framework for continuing to work within that system. It is increasingly being included in discussions with occupational burnout, as a differentiating factor for healthcare workers from other professional fields struggling with occupational burnout in their workforces and due to exposures to potentially morally injurious events that occur in healthcare environments. It provides an important insight for healthcare workers who believe that occupational burnout, a syndrome of emotional exhaustion, depersonalization, and a low sense of accomplishment, is a symptom of a larger problem, beyond individual well-being and resilience.

Moral injury has been described as a process, or continuum, in which an individual progresses through a range of experiences from moral dilemma, to moral distress, and then to moral injury. The Workforce Change Collaborative advanced a National Framework for Addressing Burnout and Moral Injury in the Health and Public Safety Workforce which overlays the continuum of moral injury and burnout and depicts environmental, relational, and operational drivers and outcomes impacting workers and learners, patients and community, organizations, and society. Left unresolved, moral injury has not only consequences for the individuals experiencing it, but also for patients who are impacted by increased risk of errors, threats to safety, and diminished quality of service. Organizations may experience significant employee turnover and declines in quality and patient satisfaction ratings.

Moral injury was originally a military term used to describe a soldier's response to serving during times of conflict depicted as a "deep soul wound that pierces a person's identity, sense of morality, and relationship to society." In the context of healthcare, moral injury is not comparable to a soldier's actions taken during a war; however, it occurs when a healthcare worker feels unable to provide high-quality care due to ethical dilemmas experienced in their workplace. Calls for action include commitments from leadership and organizations to be proactive and corrective in addressing patterns that lead to moral distress and moral injury and ensuring equitable allocation of resources for healthcare workers to perform their jobs in an ethical, safe, and effective manner.

Background

The Council examined this topic as a response to a recommendation from Council members who felt moral injury was not addressed in current ASHP policy positions. The Council felt the policy should recognize the existence and impact of exposure to potentially morally injurious events throughout the careers of healthcare professionals and advocate for organizational and leadership decisions that equitably allocate scarce resources without increasing the risk of patient harm. Council members also spoke to experiences in their work environment where safety and quality was compromised for the sake of financial performance.

3. Pharmacy Services to Optimize Patient Throughput

To support the integration of pharmacy services as systems are optimized to improve health system-wide patient throughput; further,

To advocate for pharmacists to serve as key decision-makers for improving patient flow throughout the health system; further,

To develop resources related to incorporating pharmacy services into patient throughput action plans and process maps; further,

To identify measures and tracking systems that demonstrate the impact of pharmacy-driven services to optimize patient throughput.

Rationale

Efficient patient throughput, or hospital-wide patient flow, is important for care outcomes and organizational productivity. Increases in patient demand for healthcare services, high-acuity patient needs, healthcare worker staffing shortages, and constraints on organizational capacity create tensions in the flow of a patient's hospital stay from admission through discharge (*Health Policy*. 2022;126:87-98).

Barriers to patient throughput in emergency departments is also a hospital-wide problem as it leads to long wait times and crowding, compromises quality of care, decreases patient and healthcare worker satisfaction, and increases costs. Root causes identified as contributors to these barriers are lack of staff, lack of standards and routines, insufficient operational planning, lack of technology functions, insufficient discharge routines, insufficient facilities and layout, insufficient communication, insufficient transfer coordination, random internal disturbances, unpredictable patient problems, lack of beds, medical quality priorities, lack of ancillary services, increased demand, and lack of separate tracks (*Health Policy*. 2022;126:87-98).

The Institute for Healthcare Improvement white paper, "Achieving Hospital-wide Patient Flow" identifies the following principles to achieve optimal patient throughput:

- System-wide approach to patient flow,
- Hospital-wide learning system,
- Integration of various approaches,
- Utilization of advanced data analytics, and
- Focus on reducing and shaping demand.

The white paper also suggests following three rules for clinicians and staff as a means for ensuring patients receive the right care, in the right place, at the right time:

1. Right Care, Right Place: Patients are placed on the appropriate clinical unit with the clinical team that has disease- or condition-specific expertise.

2. Right Time: There are no delays greater than two hours in patient progression from one hospital unit or clinical area to another, based on medical readiness criteria.
3. Available Capacity: Ensure each unit or clinical area has some capacity at the beginning of each day.

There are numerous reports focused on improving throughput and efficiencies with processes within the pharmacy department; however, there is limited literature about pharmacy department contribution to hospital-wide patient throughput processes. One report suggests a framework for establishing pharmacy services to support a co-located long-term acute care hospital within a health system, which offers some insight. The suggested framework includes operationalizing processes, ensuring licensure and regulations compliance, enhancing information technology, aligning staffing models, managing pharmacy operations and distribution services, implementing clinical services, and demonstrating quality. Pharmacy service interventions included medication clarification, therapy optimization, discharge process support, antimicrobial stewardship, discontinuation of unnecessary or inappropriate medications, IV to oral medication conversion, dose adjustment, preventative care, and managing duplicate medications ordered as needed. The report identifies coordination with pharmacy team leaders and collaboration with other healthcare disciplines as instrumental for seamless integration.

Pharmacy services are highly innovative and process-driven; however, they are often siloed from systemwide interventions for improving patient throughput. Expertise from the pharmacy workforce would add value to action plans and process improvements aimed at improving patient throughput in emergency departments and acute and ambulatory care settings.

Background

The Council examined this new policy topic as it relates to the pharmacy workforce's role in improving patient throughput in emergency departments and acute care settings. Council members felt this topic was not covered in existing policy and that there is limited information on the integration and impact of pharmacy services on systemwide patient throughput. Council members reflected that pharmacy services are process-driven and innovative and that systemwide efforts to improve patient throughput would benefit from greater involvement.

COUNCIL ON THERAPEUTICS
POLICY RECOMMENDATIONS

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

1. Accurate and Timely Height and Weight Measurements

To encourage pharmacists to participate in interprofessional efforts to ensure accurate and timely patient height and weight measurements are recorded in the patient medical record to provide safe and effective drug therapy; further,

To encourage drug product manufacturers to conduct and publicly report pharmacokinetic and pharmacodynamic research in pediatric, adult, and geriatric patients at the extremes of weight and weight changes to facilitate safe and effective dosing of drugs in these patient populations, especially for drugs most likely to be affected by weight; further,

To encourage independent research on the clinical significance of extremes of weight and weight changes on drug use, as well as the reporting and dissemination of this information via published literature, patient registries, and other mechanisms; further,

To advocate that clinical decision support systems and other information technologies be structured to facilitate prescribing and dispensing of drugs most likely to be affected by extremes of weight and weight changes; further,

To advocate for federal and state laws and regulations to include weight, height, and date obtained as a required component of prescriptions for medications that are dosed based on height and weight.

Note: This policy would supersede ASHP policy 1721.

Rationale

Patients who have clinically significant changes in weight during an admission or between physician visits, or who are at an extreme high or low weight, have a higher risk of medication dosing errors that depend on weight body surface area. Accurate heights and weights in SI units (i.e., kilograms, grams, meters, and centimeters) are an integral part of a physical examination for pharmacists to ensure proper dosing of medications. Certain medications require dosing based on body surface area, and there is a need for healthcare organizations to consistently record patients' height, as estimation of height or weight can contribute to potential over- or underdosing.

Factors such as clinically significant changes in weight due to fluid overload and subsequent diuresis, patient growth, and weight changes due to changes in caloric consumption complicate the picture of an appropriate weight to record for dosing certain medications. Some healthcare organizations default to a dosing weight that is used for dosing medications alone, while other weight fluctuations recorded on a daily basis are not used to dose medications, whereas other organizations alert pharmacists to a clinically significant change in weight. Leveraging technology to ensure such safeguards are in place is essential, and providing interoperability between the patient's recorded dosing weight and smart pumps is ideal.

Pharmacists are also seeing an increase in the number of patients at both extremes of weight, and there is a lack of information regarding dosing medications for these populations. ASHP advocates that the Food and Drug Administration develop guidance for voluntary drug dosing studies in these populations, as the need for this guidance is supported by the complexity of drug dosing that can vary based on drug and patient characteristics. Drug product manufacturers should be encouraged to complete pharmacokinetic and pharmacodynamic dosing studies, and to publicly report the results, especially for drugs for which significant weight extremes may have clinical impact.

Dosing medications based on height and weight presents important concerns, particularly for pediatric patients, whose variables can change often, but also for oncology patients and aging populations, for whom toxicities or adverse events are a concern (Lubsch L et al. Patient Weight Should Be Included on All Medication Prescriptions. *J Pediatr Pharmacol Ther.* 2023;28:380–1). Therefore, regulations that mandate recording of height and weight on orders for medications that are dosed based on height and weight would enhance patient safety.

Background

The Council reviewed ASHP policy 1721, Clinical Significance of Accurate and Timely Height and Weight Measurements, as part of a discussion of mandatory recording of pediatric weights on

all prescriptions. The Council believed that while most weight-based dosing for medications is for the pediatric population, it is not the only population for which weight-based dosing is used. The Council therefore recommended amending policy 1721 with language that would include all patients for whom medication doses are based on height and weight, as follows (underscore indicates new text):

> To encourage pharmacists to participate in interprofessional efforts to ensure accurate and timely patient height and weight measurements are recorded in the patient medical record to provide safe and effective drug therapy; further,
>
> To encourage drug product manufacturers to conduct and publicly report pharmacokinetic and pharmacodynamic research in pediatric, adult, and geriatric patients at the extremes of weight and weight changes to facilitate safe and effective dosing of drugs in these patient populations, especially for drugs most likely to be affected by weight; further,
>
> To encourage independent research on the clinical significance of extremes of weight and weight changes on drug use, as well as the reporting and dissemination of this information via published literature, patient registries, and other mechanisms; further,
>
> To advocate that clinical decision support systems and other information technologies be structured to facilitate prescribing and dispensing of drugs most likely to be affected by extremes of weight and weight changes; further,
>
> To advocate for federal and state laws and regulations to include weight, height, and date obtained as a required component of prescriptions for medications that are dosed based on height and weight.

2. Clinical and Safety Considerations of Naming Drug Moieties and Complexes

To oppose the consolidation of existing drug classes that include drugs that have distinct pharmacologic effects and pharmacokinetic/pharmacodynamic profiles; further,

To encourage regulatory agencies to consider clinical, operational, access, and safety factors when approving and classifying medications with different moieties or complexes that are used to deliver the active drug; further,

To advocate for the pharmacist's active role in these processes; further,
to foster increased pharmacist, provider, and public awareness when changes in approved drug products with therapeutic equivalence occur.

Rationale

The Food and Drug Administration (FDA) publication *Approved Drug Products with Therapeutic Equivalence Evaluations*, commonly known as the Orange Book, identifies drug products approved by the Food and Drug Administration (FDA) under the Federal Food, Drug, and Cosmetic Act (the FD&C Act) and contains therapeutic equivalence evaluations for approved multisource prescription drug products.

In May of 2021, the FDA changed four iron-carbohydrate drugs with distinct, established, names with different dosing and administration practices and consolidated them under a singular active ingredient, ferric oxyhydroxide. The intravenous formulations of ferric oxyhydroxide, iron sucrose, sodium ferric gluconate, and iron dextran all have different dosing and administration requirements including test infusions, different infusion rates, doses spread out over multiple days and at different concentrations and different monitoring parameters and safety considerations (Iron dextran has a black box warning due to an increased rate of anaphylaxis than other IV iron therapies), Furthermore, the oral formulation is not used for the treatment of iron deficiency anemia, further complicating the clinical and operational picture.

Additionally, this consolidation introduces several areas of concern including risk for incorrect usage of these medications, formulary considerations, administration of the iron-carbohydrate drug, patient safety, and adverse drug event reporting.

This also creates the potential for the FDA to change labeling of drugs with the same active ingredient but different molecular delivery attributes, such as metoprolol tartrate and succinate which have different frequencies, or liposomal amphotericin B and amphotericin deoxycholate, which have different doses.

In general, the FDA considers an active ingredient to be the active moiety as "the molecule or ion, excluding those appended portions of the molecule that cause the drug to be an ester, salt (including a salt with hydrogen or coordination bonds), or other noncovalent derivative (such as a complex, chelate, or clathrate) of the molecule, responsible for the physiological or pharmacological action of the drug substance." However, because the dosing, administration and monitoring are distinct for different drugs-complexes, even if the active moiety is the same – they should be distinguished by name.

Further, this change was performed under the auspices of a response to a regulatory request in a citizen petition, and therefore did not follow the statue requirement delineated in the FD&C Act that includes an opportunity for comment on this change. While the goal of this consolidation appears to mitigate potential abuse of new chemical entity exclusivity, the negative safety and clinical implications necessitate an examination of this approach, particularly when it is retroactive in nature.

Background

The Council discussed the Food and Drug Administration's (FDA) Orange Book reclassification of four iron-carbohydrate drugs with distinct, established, names with different, dosing and administration practices to a singular entity, ferric oxyhydroxide. The Council discussed the risks associated with reclassifying these drug products including: safety concerns over drug mismatches; errors in ordering, dispensing, and administration; and confusion during patient access and insurance coverage. The Council appreciated the probable intent of the FDA which was to garner innovation and to avoid the over proliferation of patented drugs that contain the

same active ingredient. However, because chemical structures that deliver the drug can include different pharmacokinetic and pharmacodynamic properties as well as delivery mechanisms, consolidation of existing drug products should be avoided. The Council did acknowledge that if consolidation had been presented from the beginning, as what was done with amphotericin products, that it would have been amenable. Council members were most concerned that they were largely unaware of this consolidation and that the change was made without consideration for safety and could be retroactively applied to other drug classes with similar molecular drug delivery systems.

3. Clinical, Operational, and Safe Use of Manipulated Drug Products and Alternate Administration Routes

To support clinically appropriate, evidence-based use of manipulated drug-products or alternate drug administration routes when it supports optimal patient care; further,

To promote research that further delineates the pharmacokinetic and pharmacodynamic properties of drugs when manipulated or when given through alternate administration routes and investigate the interrelationship between drug exposure and safety and efficacy outcomes including the potential role of artificial intelligence in advancing model development and validation; further,

To encourage manufacturers to develop drug products in ready-to-use devices and diverse formulations; further,

To foster pharmacist-led interdisciplinary teams to provide institutional guidance, best practices, and safety recommendations regarding drug products that are manipulated or administered through alternative routes.

Note: This policy would supersede ASHP policies 2041, 2242, and 2314.

Rationale

Administration of drug products through alternative routes of administration including intranasal, nebulization, intrathecal, intraosseous, and enteral routes that deliver medications to alternate sites of absorption are increasingly more prominent in practice as patient needs evolve. For example, novel delivery mechanisms through the nebulization of antibiotics and antifungals that are formulated for intravenous (IV) administration are used adjunctively to treat pulmonary infections in critically ill patients. Intranasal administration is often the route of choice in the emergency department due to access issues, safety concerns, and the characteristics of specific patient populations (e.g., children). Soluble drugs such as naloxone can be converted for intranasal administration without altering the substance simply by use of an aerosolizer. The intranasal route is frequently used to treat pain when oral and intravenous routes are not available or optimal, and intranasal midazolam is often used for sedation in the

pediatric population, although that route of administration has not been approved by the Food and Drug Administration.

Manipulation of a drug product can include crushing, splitting, or suspending it in a solvent, which can alter the pharmaceutical properties of the original dosage form. These manipulations are often performed for various reasons including when a patient a) requires the medication administered enterally but is unable to take the medication by mouth, b) requires a dose that is not readily available and so a specific dose requires it to be compounded, or c) is unable to swallow or has a feeding tube placed necessitating manipulation. For patients who lose the ability to swallow easily (e.g., due to stroke or cancer), it is sometimes quite difficult to provide drugs as liquid formulations because they may not be available, thus necessitating crushing them.

Studies reveal that oral drug products pass through the stomach, exposing them to a specific set of pH conditions. The stomach may be bypassed when drug products are administered via feeding tube to organ systems in the body that may have a different pH, affecting the adsorption, metabolism, or distribution of the drug. In addition, the physical properties of the manipulated formulation may also cause obstruction and clogging of enteral tubes used for feeding and medication administration, leading to undesirable outcomes, including supra- or subtherapeutic concentrations in the body, which could lead for example to organ rejection in transplant patients, loss of viral suppression in HIV-positive patients, or toxicities when manipulating an extended-release tablet. When drug products are manipulated or administered through alternative sites or means, consideration for the properties of formulations, including but not limited to drug molecule size, viscosity, surface tension, solubility, stability, osmolality, tonicity, and pH must also be included as these can affect pharmacokinetics and pharmacodynamics.

It is important to recognize that the need to manipulate or administer drug products through an alternate route is because there is not a commercially available formulation and as such, need may require compounding with both sterile and nonsterile ingredients. Due to this variability and potential source for sterile compounding and administration errors, manufacturers should be encouraged to create commercially available formulations to meet clinical needs where there is evidence that supports the use of manipulated drug products or alternate administration methods.

There is also a lack of resources that provide guidance on how manipulation and alternative sites of drug administration may affect the bioavailability of the drug product or whether the manipulated drug product remains bioequivalent with the original dosage form. There is even less research or publicly available information on the clinical effects of manipulated drug products and those administered via alternate routes or delivery systems. ASHP encourages clinical and practice-based researchers to conduct studies on these subjects and to disseminate this information via journal articles and other easily accessible resources. ASHP also encourages education of the pharmacy workforce and other healthcare providers regarding the basic principles of drug dosing for manipulated drug products. Given that the frequency that some of these medications are manipulated or administered is often based on small case studies, consideration for the potential role of artificial intelligence in advancing model development and validation should also be explored.

Manipulation of drug products and alternate administration are also not without risk.

Nebulized drugs that are not commercially available may be compounded with both sterile and nonsterile ingredients and that, when possible, should be compounded with preservative- and additive-free formulations to improve patient tolerability and considerations for drug stability, safety for patient and personnel administering nebulized drug products, and methods for preparation and delivery. Drug products administered intranasally often vary in pharmacokinetic and pharmacodynamic properties due to the presence of preservatives and viscosity of the agents and efficacy may depend on the use of additional devices such as atomizers. There are also exposure risks to caregivers preparing or administering manipulated drug products that are carcinogenic or teratogenic. Medications compounded for administration in the epidural space or intrathecal administration also bear consideration for the presence of preservatives. To this end, ASHP strongly recommends that when medications are manipulated or being considered for alternative administration, a multidisciplinary team that includes a pharmacist is convened to assess clinical, safety and operational needs and provide institutional guidance.

Background

The Council discussed the expansion of how drug products are used in practice based on clinical need, drug shortages, and patient access for administration. The Council also discussed operational challenges, safety considerations when administering or manipulating medications outside of their original dispensed form or intended route of administration (e.g. intravenous medications being administered intranasally, crushing medications for tube administration, nebulized intravenous medications, intraosseous administration and more), as well as the lack of data surrounding these drug products that are manipulated or administered to meet patient need. Council members reviewed existing ASHP policies 2041, Safety of Intranasal Route as an Alternative Route of Administration, 2242, Use of Intravenous Drug Products for Inhalation, and 2314, Manipulation of Drug Products for Alternate Routes of Administration and determined that these policies all addressed similar needs. Instead of additional individualized policies for intrathecal, intraosseous and other non-traditional routes of administration, the Council consolidated the existing policies into one that includes provisions for manipulation of drug products and alternate methods for drug product delivery. The Council also considered consolidating policies 1804, Drug Dosing in Conditions That Modify Pharmacokinetics or Pharmacodynamics and 1725, Drug Dosing in Extracorporeal Therapies but decided that since these policies are changes in the way the patient affects the drug as opposed to changes to the drug-product, they are not appropriate for consolidation.

4. Expedited Partner Directed Therapy

To affirm that the pharmacy workforce improves patient access to therapies that prevent and treat sexually transmitted infections in all settings; further,

To support legislation that promotes expedited partner therapy (EPT); further,

To affirm that interpreting test results, prescribing, dosing, and dispensing therapies as clinically indicated is within pharmacists' scope of practice; further,

To affirm that drug products for EPT should be provided to individuals in a manner that ensures safe and appropriate use; further,

To encourage surveillance of EPT as a public health effort.

Rationale

Expedited Partner Directed Therapy (EPT) is an approach to treating sexual partners of patients who are seeking therapy for a sexually transmitted infection (STI). According to the Center for Disease Control and Prevention (CDC), chlamydia, gonorrhea, and syphilis are on the rise throughout the United States and are a source of significant morbidity and mortality. EPT has demonstrated to be an effective tool in combating the spread of STIs by treating the sex partners of patients with an STI by providing prescriptions or medications to the patient to take to their partner without the health care provider first examining the partner.

EPT is a generally accepted approach to treating certain STIs, but legislation across the United States varies from state to state with 47 states identifying EPT as permissible and three states that identify it as potentially allowable. "Permissible" is described as allowable for certain practitioners and conditions while "potentially allowable" means that EPT is potentially allowable subject to additional actions or policies. Relevant legal provisions include: existing statutes and regulations that specifically address the ability of authorized health care providers to provide a prescription for a patient's partner(s) without prior evaluation for certain STDs, specific judicial decisions concerning EPT, laws that incorporate via reference guidelines as acceptable practices, and statutory or regulatory provisions that relate to prescription drug laws in each jurisdiction – to the extent they may impact EPT.

Because the variety and complexity of these policies could present potential barriers to care, ASHP supports model legislation that articulates the authorization of a pharmacist to voluntarily offer preventative services, patient assessment, and patient care for sexual and reproductive health conditions, including EPT. When appropriate, pharmacists may recommend a referral to seek a higher level of care through the use of counseling and clinical decision-making tools. The proposed model legislation authorizes appropriately trained pharmacists to provide these services when consistent with the standard of care.

Finally, ASHP recognizes that any legislation should define these services, provide clear authority for pharmacists to provide person-centered health services independently and through collaboration, create a mechanism for state and commercial insurance companies to pay for these services, include federal preemption and severability language, and should remove any pre-existing state barriers to pharmacist provision of health services.

Background

The Council discussed the public health need to support EPT as well as the barriers to treatment with this approach to patient care including coverage of EPT by insurance companies, technology limitations, social stigmas, and cost. Some Council members also shared that while

they have laws that promote EPT, providers can often be a barrier to care as some may wish to see partners before providing prescriptions or may be unaware of nuances of the legislation that permits EPT.

5. Quality Consumer Medication Information

To support efforts by the Food and Drug Administration (FDA) and other stakeholders to improve the quality, consistency, accessibility, targeting, and simplicity of consumer medication information (CMI); further,

To encourage the FDA to work in collaboration with patient advocates and other stakeholders to create evidence-based models and standards, including establishment of a universal literacy level and standardized, patient-focused templates for CMI; further,

To advocate that research be conducted to validate these models in actual-use studies in pertinent patient populations; further,

To advocate that the FDA explore alternative models of CMI content development and maintenance that will ensure the highest level of accuracy, consistency, currency,and conformity with health literacy requirements; further,

To advocate that the FDA maintain a highly structured, publicly and easily accessible central repository of CMI in a format that is suitable for ready export; further,

To advocate for laws and regulations that would require all dispensers of medications to comply with FDA-established standards for unalterable content, format, and distribution of CMI.

Note: This policy would supersede ASHP policy 2005.

Rationale

Providing easy-to-read and accurate information to patients about medications is essential for ensuring their safety and efficacy. Nonadherence to and incorrect use of medications can lead to hospital admissions, treatment failures, and death. Multiple types of written information are provided to patients with prescription medications and biological products, but much of this information can be conflicting, confusing, and incomplete. Furthermore, only 12% of Americans have proficient health literacy skills according to the National Assessment of Adult Literacy, decreasing the likelihood that these patients will comprehend the provided information.

Consumer medication information (CMI) is written information for patients or caregivers about a prescription drug. CMI is developed by individuals or organizations; drug companies and the FDA do not review or approve CMI. Currently available patient labeling available in the United States include Medication Guides (MG), Patient Package Inserts (PPI), and Instructions for Use. Medication Guides are a type of labeling for patients or caregivers that

are required by the FDA if certain criteria are met, for example, when the medication has serious side effects or if following the directions is particularly important for effectiveness or avoiding serious side effects. PPIs provide patient information that can be a part of FDA-approved labeling and are developed by the manufacturer and approved by the FDA. PPI are required for estrogen-containing products and estrogens, but creation of PPI for other prescription medications is voluntary.

In 2023, the FDA proposed a rule that would create a new medication guide called "Patient Medication Information" (PMI) for prescription medications and biological products that are administered, dispensed, or used in an outpatient setting. These manufacturer-developed, FDA-approved, standardized, one-page documents will be provided in either paper or electronic format. PMI would replace the current MG and PPI and will be stored electronically in FDA's labeling repository. The FDA is in the process of reviewing comments and a final rule has not been issued.

The Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health's Healthy People 2030 initiative defines health literacy in two ways: personal health literacy is the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others; and organizational health literacy is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

Programs that support education and training around self-assessment of health literacy and general communication skills and methods for practitioner assessments of patient health literacy are needed to ensure full adoption and appropriate implementation. Barriers to health literacy include language barriers such as limited English proficiency and communication barriers such as those experienced by the deaf or hard of hearing community. Each of these barriers, along with disability, transportation, and cultural barriers require practice resources to accommodate patients with specific communication needs.

Use of plain-language and patient-centered formats of CMI is essential for optimal health-related outcomes of medication use. Design elements and interventions, however, lack high-quality evidence and are thus unable to be considered "best-practice." Incorporating new methods of providing CMI and innovative practices should be a focus of future investigations.

Background

The Council reviewed ASHP policy 2005, Quality Consumer Medication Information, as part of sunset review and voted to recommend amending it as follows as the FDA has assumed the responsibility for editorial control in CMI: (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To support efforts by the Food and Drug Administration (FDA) and other stakeholders to improve the quality, consistency, accessibility, targeting, and simplicity of consumer medication information (CMI); further,
>
> To encourage the FDA to work in collaboration with patient advocates and other stakeholders to create evidence-based models and standards, including establishment

of a universal literacy level and standardized, patient-focused templates, for CMI; further,

To advocate that research be conducted to validate these models in actual-use studies in pertinent patient populations; further,

To advocate that FDA explore alternative models of CMI content development and maintenance that will ensure the highest level of accuracy, consistency, currency, and
conformity with health literacy requirements; further,

To advocate that the FDA maintain ~~engage a single third-party author to provide editorial control~~ a highly structured, publicly and easily accessible central repository of CMI in a format that is suitable for ready export; further,

To advocate for laws and regulations that would require all dispensers of medications to comply with FDA-established standards for unalterable content, format, and distribution of CMI.

COUNCIL ON EDUCATION AND WORKFORCE DEVELOPMENT POLICY RECOMMENDATIONS

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

Jennifer Tryon, *Board Liaison*

Council Members
Michelle Estevez, *Chair* (Florida)
Kate Taucher, *Vice Chair* (Colorado)
Jaclyn Boyle (Ohio)
Aliyah Cruz (Wisconsin)
Katherine DeSanctis (Massachusetts)
Travis Dick (New York)
Johnnie Early II (Florida)
Ifeanyi Egbunike-Chukwuma (Maryland)
Daniel Kudo (California)
Donald Moore (North Carolina)
Kimberly Zammit (New York)
Rebecca Ohrmund (Illinois)
Travis Schubert, *Student* (Texas)
Sophia Chhay, *Secretary*

1. Support for Caregiving Responsibilities in the Pharmacy Workforce

To affirm that an individual's life circumstances can change and influence their workplace needs, further;

To foster psychologically safe environments that promote dialogue around individual workplace needs, further;

To advocate for organizational policies and resources that reduce disparities caused by caregiving responsibilities including eldercare and lactation support, further;

To empower individuals to advocate for their own needs related to work-life integration.

Rationale

Throughout an employee's career, work dynamics often shift in response to life changes such as caregiving and lactation responsibilities. These situations introduce unique challenges that can significantly impact an employee's ability to balance personal and professional demands. In the pharmacy profession, organizations and leaders have a critical role in addressing these needs by providing supportive resources, ensuring benefit options are clearly communicated, and

fostering an environment where employees feel comfortable discussing their circumstances.

Breastfeeding and lactation support are essential aspects of employee well-being, as breastmilk offers proven health benefits for both individuals and their children. Although the PUMP Act was enacted in 2022, pharmacy workplaces may still lack adequate, clean, and private spaces for expressing breastmilk. Variability in paid parental leave policies further complicates this issue, as many breastfeeding individuals return to work while still nursing and need support to maintain their breastfeeding relationships. Employers of pharmacy personnel must consider how to best support breastfeeding employees, promoting access to resources and lactation-friendly environments.

Eldercare is becoming an increasingly critical issue, particularly as the U.S. population over the age of 65 continues to grow. Unlike childcare, eldercare is not widely supported by current benefits policies, including FMLA. According to the 2022 National Pharmacist Workforce Study, women represent a majority of the pharmacy workforce and may face career disruptions due to caregiving responsibilities. By incorporating eldercare policies and benefits, employers of pharmacy personnel can improve employee retention, reduce absenteeism, and enhance productivity.

Supporting employees with caregiving and lactation needs requires employers of pharmacy personnel to advocate for policies that reduce disparities, ensure flexible work environments, and address the well-being of the workforce.

Background

The Council discussed lactation support and resources within the pharmacy workforce in response to a recommendation from the ASHP House of Delegates. The Council also discussed the topic of addressing eldercare to promote pharmacy workforce well-being. The Council determined that ASHP needs a broader policy to encompass support for caregiving responsibilities in the pharmacy workforce to include lactation, eldercare, and other work-life integration needs.

2. Cultural Competency and Trauma Informed Care

To foster the ongoing development of cultural humility and competency within the pharmacy workforce and promote a whole-person-health approach to care; further,

To educate the pharmacy workforce on how to interact with patients, caregivers, and other healthcare professionals in a manner that demonstrates respect for and responsiveness to all; further,

To educate healthcare providers on the importance of providing culturally congruent and trauma-informed care to achieve quality care and patient engagement.

Note: This policy would supersede ASHP policy 2231.

Rationale

Culture influences a patient's belief and behavior toward health and illness. Healthcare workers who demonstrate cultural humility and competence can improve clinical outcomes. Cultural humility is having an awareness of how a person's culture can impact health behaviors and then using this knowledge to approach the patient's treatment. Research has shown that overlooking cultural beliefs may lead to negative health consequences. Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations. According to the National Center for Cultural Competency, there are numerous examples of benefits derived from cultural competence on quality and effectiveness of care in relation to health outcomes and well-being. Further, pharmacists can contribute to providing "culturally congruent care," which can be described as "a process of effective interaction between the provider and patient," by recognizing that "[p]atients and families bring their own values, perceptions, and expectations to healthcare encounters."

Whole person health includes consideration of how biological, behavioral, environmental, and social factors impact a patient's health outcomes. When considering holistic approaches to patient care, clinicians should recognize and respond effectively to all personal and social identities. Spiritually congruent care may be expressed in prayer requests, in clinician-chaplain collaborations, and through health care organizations' religious accommodations for patients and staff. Numerous publications have outlined the role of spirituality in overall health, longevity, and quality of life, especially for patients with severe illness. The pharmacy workforce should be educated on the importance of individual patient spirituality and its impact on health and on ways to facilitate patient access to spiritual care services.

Trauma is a widespread public health issue that can stem from various sources, including abuse, neglect, poverty, and other emotionally harmful experiences. Trauma-informed care (TIC) is an essential healthcare approach that recognizes and responds to the impact of trauma on patients' physical and mental health. Increasing evidence shows that implementing TIC can improve patient outcomes, including engagement, satisfaction, and adherence, while addressing complex patient needs. For pharmacy professionals, integrating TIC is crucial to providing tailored care. Additionally, TIC can help healthcare workers, who face higher risks of trauma post-pandemic, recognize signs and symptoms of trauma thereby reducing burnout and turnover. Training healthcare providers to understand the effects of trauma at both the clinical and organizational levels is vital for improving patient care and outcomes.

Background

The Council reviewed ASHP policy 2231, Cultural Competency, in response to a recommendation from the ASHP House of Delegates on the role of the pharmacy workforce in trauma informed care voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

To foster the ongoing development of cultural humility and competency, and whole-person health within the pharmacy workforce; further,

To educate the pharmacy workforce on how to interact with patients, ~~and~~ caregivers, and other healthcare professionals in a manner that demonstrates respect for and responsiveness to personal and social identities; further,

To educate healthcare providers on the importance of providing culturally congruent and trauma-informed care to achieve quality care and patient engagement.

The council updated the rationale.

Report of the ASHP Treasurer

2025 Report of the ASHP Treasurer

Christene M. Jolowsky

The Treasurer has the responsibility to report annually on ASHP's financial condition to the membership. ASHP's fiscal year is from June 1 through May 31, coinciding with our policy development process and timetable. This report describes ASHP's actual financial performance for fiscal year FY2024, projected financial performance for FY2025, and an FY2026 budget status update.

Fiscal Year 2024 Ending May 31, 2024—Actual

ASHP's FY2024 financial statement audit for the year ending May 31, 2024, was performed by Aprio, LLP. The audit resulted in ASHP receiving the best opinion available, an unmodified opinion.

ASHP's core operations[1] remain strong. Core gross revenue was $61.5 million (Figure 1), up by $2.7 million compared to FY2023. The gross revenue increase was primarily attributable to the 2023 Midyear Clinical Meeting & Exhibition (MCM), Pharmacy Futures 2024, *American Journal of Health-System Pharmacy* (*AJHP*), special publishing, accreditation services, and consulting services. Core net income was a surplus of $4.0 million. Net program development, capital budget, and investments[2] were a gain of $1.9 million, which is primarily attributable to investment gains. In total, FY2024 resulted in a favorable $5.9 million net change in ASHP's reserves/net assets.

The building fund[3] had a gain of $1.8 million, primarily due to investment gains. 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 FY2024 were $142.3 million (Figure 2). Our year-end balance sheet remained strong, with an asset-to-liability ratio of 4.35:1. ASHP remains well-prepared for the future.

Fiscal Year 2025 Ending May 31, 2025—Projected

Fiscal year 2025 core operations are shaping up to have another strong year, with projected core gross revenue of $60.9 million. As of February 28, 2025, we anticipate that ASHP's FY2025 core net income will be in the range of $1.8 million (Figure 1). Assuming the financial markets

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

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

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

remain steady for the remainder of the fiscal year, we are projecting a deficit of $686,000 for program development expenses, capital budget, and investments. This deficit is primarily due to ASHP's current year $750,000 investment in a national public awareness campaign to educate the public about the roles of pharmacists and pharmacy personnel in hospitals, health systems, and clinics. This results in a projected positive net change in reserves/net assets of $1.1 million. Finally, we anticipate the building fund will have a surplus in the range of $323,000.

ASHP accomplished a great deal during FY2025, including maintaining a strong and active membership and nurturing The Pharmacy Technician Society (TPTS), which is in its second year of existence. Interest and engagement with TPTS continue to be strong. ASHP's national public awareness campaign has surpassed expectations, generating well over 70 million digital media impressions in its first year. Our new digital member engagement platform, ASHP Navigator, had a successful launch this past year with growing member usage, and expanding features and benefits. In addition, we have had strong attendance at our in-person meetings, remaining at the forefront of pharmacy training and education.

ASHP's engaged membership reflects our commitment to supporting pharmacy practitioners in addressing today's challenges and preparing for the future. As the largest and most influential professional pharmacy organization in the U.S., ASHP remains steadfast in addressing the evolving needs of our members across all practice settings and career stages.

Fiscal Year 2026 Ending May 31, 2026—Budget

In preparing the FY2026 budget, we continue to build on our successes, as we assess our financial performance. The budget includes expanding our Pharmacy Futures and Midyear Clinical meetings, growing our membership, and achieving new milestones as we invest in and enhance our publications, professional development offerings, accreditation services, and other initiatives. As the workforce and healthcare landscape evolves, the Board of Directors remains committed to positioning ASHP for the future, ensuring we provide our members and the profession with timely and valuable resources, products, and services.

Considering these and other factors, ASHP's FY2026 budgeted net change in reserves/net assets is a deficit of $282,000, with a record $61.8 million in core gross revenue. The deficit is attributable to ASHP's continued investment in the national public awareness campaign. The building fund, which is designed to pay for ASHP's headquarters office space, is budgeted to have a $250,000 surplus.

Conclusion

While the healthcare landscape is ever-changing, ASHP remains focused on maintaining strong financial stability so we can continue our important work supporting our members, the profession, and the patients we serve.

ASHP proudly reflects the professional diversity and growing contributions of pharmacists and pharmacy technicians across the continuum of care. Through sound financial stewardship, we are well-positioned to invest, collaborate, and innovate to ensure a robust offering of products, programs, and services that enhance practice, support career development, and, most

importantly, improve patient outcomes through safe, effective, and accessible medications. The Board of Directors, Chief Executive Officer, and staff remain fully committed to ASHP's mission, vision, and strategic plan, as well as to supporting our members. We look forward to another successful year, and I am honored to serve as your Treasurer!

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

	Actual Fiscal Year 2023 Ended May 31, 2023	Actual Fiscal Year 2024 Ended May 31, 2024	Projection* Fiscal Year 2025 Ended May 31, 2025	Budget Fiscal Year 2026 Ended May 31, 2026
CORE OPERATIONS				
Gross Revenue	58,775	61,499	60,873	61,816
Total Expense	(54,384)	(57,455)	(59,069)	(61,812)
CORE NET INCOME/(LOSS)	4,391	4,044	1,804	4
NET PROGRAM DEVELOPMENT EXPENSES, CAPITAL BUDGET, AND INVESTMENTS GAIN/(LOSS)	(1,929)	1,860	(686)	(286)
NET CHANGE IN RESERVES/NET ASSETS	2,462	5,904	1,118	(282)
BUILDING FUND	(4,867)	1,788	323	250

* Projection as of February 28, 2025

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

	Actual as of May 31, 2023	Actual as of May 31, 2024
ASSETS		
Current assets	22,204	20,590
Fixed assets	3,851	3,211
Investments	141,424	150,934
Other assets	12,850	10,108
Total Assets	180,329	184,843
LIABILITIES		
Current liabilities	27,783	28,267
Long-term liabilities	17,903	14,242
Total Liabilities	45,686	42,509
RESERVES/NET ASSETS		
Total Net Assets	134,643	142,334
Total Liabilities and Net Assets	180,329	184,843

Delegate Recommendations from the 2025 House of Delegates

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

	Recommendation Title/Text/Background	Sponsor(s)
1	**Mitigate impacts of alternative funding programs on patient care and health insurance integrity for specialty patients** **Background:** Submitter noted that more background information would be provided.	Phuoc Anne Nguyen (TX)
2	**No Need for Physical PAC Thank Yous** Eliminate "trinkets" provided to PAC contributors **Background:** Donating to PAC should not provide a need to give away "trinkets" back to those who donate. Just provide a name only for recognition and thanks.	Victoria Wallace (ID) and Paul Driver (ID)
3	**Complimentary access to public transportation** Provide meeting attendees with complimentary access to public transportation at all meetings. **Background:** At the 2024 Pharmacy Futures meeting all attendees were given the option to obtain a light rail pass for the duration of the meeting. This was highly valuable and allows attendees to see more of the cities we are visiting.	Jessica Nesheim (IA)
4	**Local affiliations and ASHP Futures Meetings** Planning committees for future Pharmacy Futures Meetings should collaborate with local state affiliates to organize small-group free time plans to foster sharing of cultures to visitors travelling in for the meetings. **Background:** One of the favorite activities of delegates and members attending meetings is to discover local treasures and cultural must-sees/experiences, so the suggestion is to plan small group gatherings of local affiliate members with visitors to see area sites, share an evening out. One idea is to partner with section and SAG chairs so those with similar interests can meet and network, or even hobby-based groups of interest. Idea is to explore local culture/businesses in a meaningful way with local ASHP members when there is meeting downtime, or after events. (I'll be with the foodie group(s)).	Jennifer Williams (IA)

5	**Encourage ASHP to have a written virtual backup plan/option for applicable meetings (e.g. RDC) to manage with travel issues** Virtual backup plan for meetings **Background:** RDCs!	Indrani Kar (OH)
6	**State affiliate delegate voting** Those that belong to more than one state affiliate organization should be allowed to vote for all applicable state delegates. **Background:** For those of us who belong to, say, ISHP and OSHP, we only get to vote for one organization's state delegates due to current voting platform.	Victoria Wallace (ID) and Paul Driver (ID)
7	**Paperless House of Delegates** We request that ASHP make all future House of Delegates sessions 100% paperless by making all HOD paperwork and forms available to all delegates via electronic means.	Dale English (KY)
8	**Reduction of materials printed onsite for House of Delegates sessions** Suggest providing electronic alternatives to printed materials for a number of House of Delegates documents **Background:** Delegates are instructed to download or print all materials in advance of June House of Delegates sessions. The number of copies provided onsite seems to waste a significant amount of paper, ink, staff time. Post materials provided well in advance (e.g., reports of committees/Board of Directors, delegate primer slides) to the appropriate session on the Pharmacy Futures site/app, and print only time sensitive materials (e.g., proposed amendments report)	Sarah Blackwell (AL)
9	**Request for ASHP to improve meeting spaces for House of Delegates caucus sessions to include tables and power supply** As we move to electronic resources for our House of Delegates documents and forms, it would be helpful to have tables for improved ergonomics for caucus sessions. **Background:** Although more complicated, it would also be great to have power supply back in the House of Delegates sessions too!	Ashley Duty (OH)
10	**Accessibility/Closed Captioning During Official ASHP Activities** To enact ASHP's mission of optimal care for all patients all the time, I propose that the education and activities of ASHP as an organization reflect meeting needs of audience members, specifically to use platforms for webinars that allow for closed-captioning functionality. **Background:** As an ASHP member with severe-profound classification of hearing loss, it is often difficult to follow live or recorded webinar proceedings, as well as discussion or comments	Jennifer Williams (IA)

	during live meeting venues (where acoustics or audience dynamics add difficulty in comprehension). Several virtual meeting platforms offer live captioning during meetings, but yet oftentimes the webinar platform used for ASHP's live webinars does not use the same functionality. Understanding that there are some concerns about accuracy or transcription (that HOH are well aware of and account for), would recommend adding a caveat statement that ASHP is not responsible for errors in use of captioning programs. Offering this would lessen the exclusion often felt by the HOH community. (HOH= hard of hearing).	
11	**Policy on Pharmacists Role in Advanced Therapeutics** Recommend reviewing policy/statement on pharmacogenomics and expanding to encompass all advanced therapeutics. **Background:** Emerging need for pharmacist involvement in all areas of advanced therapeutics as it applies to pharmaceutical care including biometrics, pharmacogenomics, wearables, etc.	Terri Jorgenson (MD) and Amy Sipe (MO)
12	**Industry to eliminate mailings to pharmacists** Decrease or eliminate the use of mail as a way to provide updated medication information to pharmacists **Background:** How many trees do we need to kill and waste on pharmaceutical data sheets and mailers to pharmacists who are now capturing updates on all medications virtually? Paper leaflets and circulars are a waste of resources and most often are gathered from a mailbox and placed directly into the trash or recycle bin.	Victoria Wallace (ID) and Paul Driver (ID)
13	**Home infusion engagement** Recommend to further collaborate with national home infusion organizations and bring insights to members	Jeff Reichard (NC)
14	**Policy development regarding research in extremes of weight and weight changes** Recommend development of a policy (or incorporation into an existing policy) regarding research surrounding safe and effective medication dosing in extremes of weight and/or weight changes. **Background:** Removal of previous clauses 2 and 3 from policy 1721 "Accurate and Timely Height and Weight Measurements" regarding research on medication dosing in extremes of weight and weight changes, while appropriate to remove from 1721, now leaves the issue unaddressed by an ASHP policy. With the pervasive nature of obesity, it is a critical issue that pharmacists are left with low quality or no evidence to guide decision making in these patients.	Sarah Blackwell (AL), Nancy Bailey (AL), Danna Nelson (AL)
15	**Development of Psychiatric Pharmacy Certificate** ASHP should pursue development of a psychiatric pharmacy certificate	Craig Sastic (NJ)

	Background: The growing mental health crisis in America and beyond has resulted in increased use of psychiatric medications, Board Certification and PGY-2 training is limited and difficult to obtain. A certificate program could meet the need of pharmacists that need a deeper understanding of these medications.	
16	**Mission, Vision, and Values Incorporation Across ASHP** A call to the councils, committees, Board, and ASHP collectively: to reinstate previously approved policies and work, to uphold the values of members and patients in regards to caring for all people all the time. The collective voice of ASHP membership values the vision of optimizing medication use and patient care for all people all the time, and feel this cannot happen without ongoing efforts in education, publications and programming of ASHP. Advocacy for patients remains a core value, and recent examples of changes made such as removal of the word "transgender" from ASHP publications, removing DEI policy supported and approved by the HOD, and the removal of specific programming and certificates are concerning and counter to membership core values. We call on ASHP to maintain the vision, we recognize the current climate may have ramifications, and we affirm the efforts of this organization to serve in the interests of patient care, which includes ongoing education in and advocacy for the underserved or disadvantaged. **Background:** The collective voice of ASHP membership values the vision of optimizing medication use and patient care for all people all the time, and feel this cannot happen without ongoing efforts in education, publications and programming of ASHP. Advocacy for patients remains a core value, and recent examples of changes made such as removal of the word "transgender" from ASHP publications, removing DEI policy supported and approved by the HOD, and the removal of specific programming and certificates are concerning and counter to membership core values. We call on ASHP to maintain the vision, we recognize the current climate may have ramifications, and we affirm the efforts of this organization to serve in the interests of patient care, which includes ongoing education in and advocacy for the underserved or disadvantaged.	Jennifer Williams (IA), Jessica Nesheim (IA), Krystal Moorman-Bishir (UT), Shannan Inglet (UT), Abigail Bouknight (SC), Rebecca Maynard (MI), Sarah Steinert (SC), Sarah Blackwell (AL)
17	**Expand and promote resources for programs and applicants related to visa sponsorship and application eligibility** Recommend that ASHP create, expand, and promote resources that would benefit residency programs and applicants that need visa sponsorship and have questions about their eligibility **Background:** Many residency program applicants have limited resources available to help them find programs that can entertain their application when they also need monetary sponsorship due to visa status, etc. Additionally, programs would benefit from	Justin Hare (MD) and Molly Wascher (MD)

	resources that could help them work with HR/compensation to allow for sponsorship of matched candidates.	
18	**Open Forum and First Caucus schedule optimization** Recommend consolidating open forum and first caucus to improve member input and travel schedule	Tate Trujillo (IN)
19	**Policy that comprehensively focuses on improving health equity** Recommend expanding advocacy for health equity through pharmacy practice **Background:** Underserved communities can have better access through pharmacy practice in alignment with the proposed legislation, Pharmacists and Medically Underserved Areas Enhancement Act. Currently this is partially covered in policy 2110 and should be more comprehensive.	Terri Jorgenson (MD)
20	**Prevention of States BOP Regulatory Accountability by Legislators** Stop the evaluation of state rulemaking to strengthen legislative oversight of pharmacy practice. **Background:** Several state legislatures are proposing to make all BOP rules and regulations statute. DOGE in action. This creates potential criminal action against pharmacy workforce if states are "broken."	Victoria Wallace (ID) and Paul Driver (ID)
21	**Merging ASHP Pharmacy Leadership Conference with ASHP Futures Meeting** Incorporate ASHP's Pharmacy Leadership Conference into ASHP Futures Meeting **Background:** Many pharmacy leaders already attend the Futures Meeting. Approval and funding to attend national meetings is becoming more difficult. This recommendation would streamline conferences to Futures in June and Midyear in December.	Karen Nolan (RI)
22	**Improved Pharmacy Technician Representation in the ASHP House of Delegates** Recommend ASHP examine options to increase pharmacy technician representation in the ASHP House of Delegates **Background:** Currently, one pharmacy technician sits in the ASHP House of Delegates. We believe increased representation of pharmacy technicians is warranted. An increase would better represent the important and unique perspectives of pharmacy technicians.	Jennifer Phillips (IL)
23	**Interstate License Renewal Standardization** To support a standardized pharmacist licensure renewal process such as timelines, CE requirements	Sarah Steinert (SC)
24	**Artificial Intelligence (AI) workforce report**	Justin Griner (TN)

	In light of the rapid advancement of artificial intelligence, I urge ASHP to conduct and release a report on the expected effect of artificial intelligence on the health systems pharmacy workforce over the next 5-10 years in order to better prepare for changes and disruptions to the workforce. **Background:** 1. AI technology is advancing at a remarkable rate, but integration of AI in healthcare is still in its infancy. 2. To better prepare both pharmacy and health systems administration and pharmacy professionals for disruptions due to AI, a comprehensive forecast on the realistic impact of AI should be conducted and released to ASHP membership. 3. This report should specifically address the impact on employment of pharmacy professionals over the next 5-10 years due to AI and explore ways to mitigate any negative impact. 4. ASHP should use this information to inform and adjust current AI policies and statements.	
25	**Specifically address 340B contract pharmacy restrictions and proposed rebate models in 340B policy 1908** Support and protect 340B covered entities from the anticipated overwhelming administrative burden of impending rebate models and continued contract pharmacy restrictions, as well as the financial impact and ability to stretch scarce federal resources caused by such policies. **Background:** 1. Current policy does not specifically address the burden placed on covered entities by policies imposed by drug manufacturers. 2. Not all states have enacted protection for covered entities from manufacturer-imposed restrictions. 3. There are multiple legislative and lawsuits pending that could cause significant administrative and financial burdens on hospitals and health systems.	Abigail Bouknight (SC)
26	**Increase visibility of the helpline on the ASHP website** For those in crisis seeking help, a hotline should be very visible on the ASHP website. **Background:** There is a pop-up on the ASHP website for a crisis helpline, but a lot of health-system firewalls block it. It should be easily accessible for anyone suffering from second victim syndrome or needing to talk to someone in time of need.	Heather Petrie (FL)
27	**Elimination of payer mandated biosimilar selection** Elimination of payer mandated biosimilar selection **Background:** When biosimilars entered the markets, pharmacists were restricted to substitution to preserve patient and provider preference. However, biosimilar selection is almost exclusively dictated by payers and their rebates. This causes an overly complex system with excessive denials and reduced access.	Davey Legendre (GA), Samantha Roberts (GA), Meredith Lopez (GA)

28	**ASHP exploration of residency training model reform to include flexible, scalable pathways** ASHP needs to explore solutions to residency supply/demand imbalance and increasing vacancies **Background:** There is growing professional frustration with the current antiquated residency models. Pharmacy students are changing and have expressed unique needs that aren't supported by our current model. This is evidenced by decreased application rates and increased PGY1 vacancies. The profession lacks flexible, scalable pathways (microresidencies / microcredentials, etc.) to meet the demands of the next generation of workforce.	John Muchka (WI)
29	**Reinstate a dedicated specialty pharmacy track at ASHP's Pharmacy Futures Meeting** We urge ASHP to seize the opportunity to reaffirm its leadership in the specialty pharmacy space by reinstating a specialty pharmacy track to retain and support health system specialty pharmacy (HSSP) professionals amid rapid change and increasing external competition. **Background:** The specialty pharmacy track previously served as a vital platform for HSSP professionals to share best practices, engage in focused learning, and build a strong professional network. HSSP practitioners are increasingly attending non-ASHP meetings due to a lack of relevant content. Regulatory changes and margin erosion are creating urgent needs for innovation in care delivery and training. A dedicated track would support the growth of community/specialty residency programs and provide a platform for networking and poster presentations. We urge ASHP to seize this opportunity to be not only thoughtful but also bold and relevant in fostering creative change on behalf of our HSSP membership.	Erica Diamantides (SSPP) and Sara Panella (SACP)
30	**Incorporation of the Global Harmonization Classification System into Package Inserts of Drugs** To advocate FDA add a new section within Full Prescribing Information Contents, Section 16. "How Supplied and Handling" of package inserts of drugs that harmonizes with a drug(s) chemical Safety Data Sheet (SDS) sections 2, "Hazards Identification" and 7, "Handling and Storage." **Background:** 1. OSHA requires the Global Harmonization System (GHS) for SDSS and labeling of all chemicals. 2. NIOSH has historically published an out-of-date hazardous drug list sample; latest 2024 for 2015 drugs. 3. Drug manufacturer package inserts are inconsistent and often lacking for safe handling. 4. Delays and downsizing of NIOSH, and lack of safe handling in package inserts	Fred Massoomi (NE), Katie Reisbig (NE), Mary Leick (NE), Ashley Duty (OH)

	puts providers at risk. 5. Immediacy and consistency of SDSs with the GHS hazard fills the safety gap of manufacturers.	
31	**Explore body size inclusivity in ASHP policies related to potential psychological harms or stigma** **Background:** Weight Science: evaluating the evidence for a paradigm shift in Nutrition Journal 24 Jan 2011	Kat Miller (SPPL) and Megan Musselman (SCSS)
32	**Reinstate and expand ambulatory care tracks into ASHP's Futures Meeting** SACP EC would like to recommend the reinstatement of the ambulatory care track into future ASHP Futures Meetings **Background:** SACP EC members have been receiving continued feedback that ASHP has lost focus on ambulatory care. It has been noted that the removal of the specialty tracks from what was previously known as the ASHP Summer Meeting, with focus on various areas including medication safety, specialty pharmacy, and ambulatory care. Although we continue to have a few programs within the Futures Meeting, the overall content on ambulatory care practice is a lot less than it has been in the past. With this, we are seeing lower engagement and attendance from this group of practitioners.	Erica Diamantides (SSPP) and Sara Panella (SACP)
33	**Appointment of appropriately qualified pharmacists to new ACIP** I recommend ASHP nominate qualified ASHP members to HHS and CDC for positions on the reconstituted CDC Advisory Committee on Immunization Practices to help ensure their future recommendations are based in science and consistent with best medical evidence. **Background:** The recent termination of the current ACIP raises concerns about recommendations related to critical vaccination practices. It will be critical the new ACIP be composed of appropriately qualified healthcare providers. ACIP recommendations may impact insurance companies reimbursement practices.	Mark Woods (PP)
34	**ASHP should take a more visible stance on recognizing the safety, efficacy, and importance of vaccination in public health and rise with other professional/medical organizations in opposition to the dismantling of our scientific community which may lead to further distrust of the healthcare system and ultimately put American lives at risk.** ASHP should take a more visible stance on recognizing the safety, efficacy, and importance of vaccination in public health and rise with other professional/medical organizations in opposition to the dismantling of our scientific community which may lead to further distrust of the healthcare system and ultimately put American lives at risk.	Karen White (WA) and Laura Hanson (WA)

	Background: In the past few weeks, a number of actions by the current administration have put the lives of Americans at risk including a lack of response to an ongoing measles outbreak, removal of recommendations for the COVID-19 vaccine for healthy children and pregnant individuals, and the dismantling of the Advisory Committee on Immunization Practices (ACIP). All of these actions sow further distrust in the community regarding vaccinations, their safety, and efficacy in preventing disease. Many organizations, including the American Academy of Pediatrics, the American Medical Association, and the American College of Obstetricians and Gynecologists have been outspoken in opposition to these changes on their public-facing media outlets. Pharmacists have long played a crucial role in vaccinating communities, providing education, and building trust as healthcare providers with their patients, yet have been noticeably silent on their stance on protecting access to vaccines. It is time for pharmacists and the ASHP to stand with these other professional organizations in opposition to this brazen attack on vaccines. Pharmacists need to know they have the support of their organizations to continue to provide evidence-based vaccinations to all appropriate patients.	
35	**Defending evidence-based immunization policies and safeguarding the integrity of scientific advisory committees in public health** To defend the core values of the pharmacy profession and immunization practices **Background:** Emphasize pharmacy's commitment to science-driven decision making, particularly in the area of immunizations where pharmacists play a direct role. Reinforce the importance of maintaining public trust in vaccine recommendations. Acknowledge the critical role expert advisory boards play in shaping national health policy. Consider joining with other pharmacy organizations or medical organizations to align in support of critical public health initiatives.	Amber Lanae Martirosov (MI)
36	**Recognition of Pharmacist Licensure in Non-Dispensing Telehealth Pharmacy Services** To enhance patient access to care and optimize medication management, all state boards of pharmacy and regulatory bodies should recognize and accept valid pharmacist licenses for the provision of non-dispensing telehealth pharmacy services across all 50 states. **Background:** "By advocating for the recognition of valid pharmacist licenses in the provision of non-dispensing telehealth pharmacy services, ASHP can empower pharmacists to optimize their contributions to patient care and address the evolving	Lisa Stump (SDTP)

	healthcare needs of diverse populations across the nation. This policy should address: 1. Recognition of Licensure: uniform recognition of pharmacist licensure that enables pharmacists to provide non-dispensing telehealth services without the impediment of state-specific regulations that may hinder their practice. 2. Scope of Practice: Pharmacists should be permitted to engage in telehealth services, including medication therapy management, patient consultations, and chronic disease management, irrespective of the state in which the patient resides, as long as the pharmacist holds a valid license in at least one state. 3. Patient-Centered Care: This recognition will support the delivery of patient-centered care by ensuring that qualified pharmacists can leverage telehealth technologies to enhance access to pharmaceutical care, improve health outcomes, and facilitate adherence to treatment regimens. 4. Interstate Collaboration: collaboration among state boards of pharmacy, telehealth organizations, and other stakeholders to establish best practices and frameworks that sustain the quality and integrity of non-dispensing telehealth pharmacy services while ensuring patient safety. 5. Advocacy for Legislative Measures: support of legislative efforts and policy initiatives that promote the recognition of pharmacist licensure and the establishment of a flexible regulatory environment conducive to telehealth practices."	
37	**Certifications for Students** To engage student members and enhance their member benefits, ASHP should develop and offer, at no cost to student members, certifications for professional development, such as Interprofessional Education. **Background:** The Section of Pharmacy Educators is developing IPE videos that would help in the development of a certificate or micro credential. We feel engaging student members will create a pathway for their continued involvement in ASHP.	Jen Arnoldi (SPE)

38	**Lifetime ASHP Membership** ASHP should evaluate the potential of granting members free lifetime membership once certain criteria are met. **Background:** APhA grants lifetime membership to individuals who have been members for 40 or more years. This is an excellent way to keep these individuals active in the organization, especially once retired when finances may be more of an issue. It is also a nice way to thank these individuals for supporting APhA throughout their careers. I know the ASHP annual membership for retired members is only $188 but for someone like me and others that I know who have been members for > 40 years and are not retired, the financial benefit would be greater. After listening to the Treasurer's report at the HOD on Sunday, it appears that ASHP has the financial means to do this.	Andrew Donnelly (IL)
39	**Incentivize Academic/Health System Partnerships for Workforce Pipeline Programs Starting in High School** ASHP advocates for the development and incentivization of academic health system partnerships that establish pharmacy career pipeline programs beginning in high school to expand and diversify the future pharmacy workforce. **Background:** There is a growing need to diversify and expand the pharmacy workforce, especially in underserved areas. Early exposure to health careers can improve recruitment into pharmacy pathways, but current ASHP policies lack guidance on proactive engagement with K-12 institutions.	Joshua Blackwell (TX)
40	**Recommendation to Improve Outpatient Medication Administration Documentation** Recommendation to partner with other professions to define the role of pharmacy practice in effective creation and use of outpatient documentation tools for medications administered in outpatient, non-infusion settings. **Background:** Documentation errors are common and there are many players involved. Health-system members could benefit from further guidance around roles and responsibilities of different professions in the process. Additionally, there are increasingly more long-acting injectable medications intended for in-clinic administration.	Marilyn Hill (NH)

41	**Increased use of smart phone technology to improve HOD efficiency** Encourage technology to text HOD amendments **Background:** Paper is old school - texting capabilities are omnipresent. The delegates should be able to text amendments for ease of HOD practices.	Kat Miller (SPPL), Megan Musselman (SCSS), Sarah Panella (SACP), Lucas Schulz (SICP), Jeff Chalmers (SOPIT), Courtney Isom (SCCP), Erica Diamantides (SSPP), Jen Arnoldi (SPE)
42	**Risk evaluation and mitigation strategies, policy 1002** Based on recent changes to the REMS process, would like the Council on Public Policy to review the current language for this policy and consider updates that focus on administrative burdens and electronic health record integration. **Background:** REMS has led to significant administrative burden among Authorized Representatives. REMS site administrators are not the same as the drug manufacturers and have more stringent requirements e.g., requiring REMS dispense auth. Codes. Each pharmacist must be registered to every single portal available and a national portal would be more efficient. Recommend integration of the REMS portals within the electronic health record. Increase awareness/education of the importance of the REMS requirements at ground level (i.e., sales and marketing).	Megan Musselman (SCSS), Kat Miller (SPPL), Lucas Schulz (SICP), Sara Panella (SACP), Jeff Chalmers (SOPIT)
43	**Unfunded mandates task force** ASHP create a task force to review evidence supporting the creation of unfunded mandates (e.g., DSCSA, USP 795, USP 797, etc.) as well as define metrics to measure their impact on patient safety and financial return on investment. **Background:** A number of unfunded mandates have been imposed on health systems with limited evidence such as USP standards and DSCSA. These mandates have significant impact on resources and may or may not impact patient/staff safety.	Travis Dick (NY), Adam Porath)NV), Leila Tibi-Scherl (NY), Nicole Cieri-Hutcherson (NY), Terri Jorgenson (MD), Rox Gatia (MI), Krystal Mooreman-Bishir (UT), Erica Housman (MA), Rebecca Maynard (MI), Kat Miller (SPPL), Christina Crowley (KS), Megan Ohrlund (KS), Katie Wilson (KS), Tyler Vest (NC), John Hill (MD), Shannon Inglet (UT), Conor Hanrahan (UT), Rachel Root (MN), Erica Diamantides (SSPP), Arpit Mehta (PA)

44	**Bojangles biscuits for House of Delegates** Keep HOD well fed with Bojangles biscuits	Jeff Reichard (NC)
45	**Section Advisory Group for industry pharmacists** As ASHP works to expand SAG and be more inclusive of the pharmacy workforce, it is important to include pharmacists in NSL or medical/educational affair roles as they support patient care within health systems. **Background:** Many active members within the profession transition into different areas of focus during their career. Additionally, as members of medical and/or educational affairs are in non-promotional roles with a focus on education and advancement of patient care within health systems and ambulatory settings.	Cindy King (OH)
46	**Consider Detroit, MI for an ASHP Futures Meeting** Consider Detroit, MI for an ASHP Futures Meeting	Rox Gatia (MI), Rebecca Maynard (MI), Amber Lanae Martirisov (MI), Lama Hsaiky (MI)

2025 Joint Address from the ASHP President and the Chief Executive Officer

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Innovation drives progress, and through collaboration and forward-thinking initiatives, ASHP is leading the way in shaping the future of pharmacy practice.

Editor's note: The following is adapted from comments delivered during the House of Delegates session of the ASHP Pharmacy Futures 2025 meeting, held in June in Charlotte, NC.

Each year in June, the CEO and the President of ASHP present an update to the House of Delegates on ASHP initiatives, activities, and accomplishments supporting our profession, members, and the patients they serve. The remarks are delivered as a prerecorded multimedia presentation to help bring this in-depth written version to life.[1]

A year ago in Portland, the theme for the inaugural address centered around the power of storytelling, a sentiment that underscores everything we do. From compelling patient care narratives to cautionary tales of workforce shortages, to inspiring accounts of pharmacists positively impacting their communities, stories from our members reinforce the importance of ASHP's critical work to advocate for our profession, support practice innovation, bolster the pharmacy workforce, and most importantly, improve health outcomes.

Throughout the past year, numerous success stories have exemplified ASHP's support of our 60,000 members and our dedication to enhancing healthcare delivery. As the largest professional pharmacy organization in the United States, we are committed to advocating for effective practices and innovative solutions that positively impact the quality of patient care.

We're Your Pharmacist

Storytelling is at the very heart of ASHP's successful national public awareness campaign, We're Your Pharmacist, which launched one year ago. Through compelling accounts of ASHP members and their interprofessional colleagues, we have taken the first steps to bring needed visibility to the critical patient care provided by pharmacists throughout hospitals, health systems, clinics, and many other patient settings.

As of this writing, our reach has exceeded expectations, with campaign content and messages creating more than 75 million media impressions and engaging more than 1.7 million people across social media channels. The reach and engagement of this initiative in just its first year is a testament to the power of storytelling and the inspirational narratives of our members.

Advocacy

ASHP is the leader in advocating for the pharmacy profession on Capitol Hill and supporting our affiliates in statehouses across the country. Over the past year, we have achieved a series of impressive advocacy wins that have advanced pharmacy practice and protected patient access to safe and affordable medications.

States continue to be a significant driver of advocacy wins. In 2024, three states granted pharmacists provider status, and 14 states expanded the scope of practice. ASHP released one of our most influential advocacy tools—model legislation—which states can use to expand scope of practice, protect 340B contract pharmacy arrangements, and empower pharmacy technicians to conduct final product verification.

On the federal level, one of our top priorities has been expanding the scope of pharmacist-provided patient care services in acute and primary

care settings. Key congressional committees continue to actively consider the Ensuring Community Access to Pharmacist Services Act,[2] which would help expand access to patient care services provided by pharmacists. We are working with Congress and the new administration to protect and expand pharmacy residency funding by supporting Rebuild America's Health Care Schools Act of 2025.[3]

We have also advocated for solutions to pharmacy workforce challenges and continue to urge Congress to pass the Dr. Lorna Breen Health Care Provider Protection Act.[4] This legislation would help mitigate ongoing mental health issues and burnout in the healthcare industry, allowing pharmacists to better serve their patients.

Protecting the 340B program remains a priority. Efforts include partnering with the American Hospital Association and 340B Health to support litigation protecting the program and working with our affiliates to secure protections at the state level. In 2024, six states passed 340B contract pharmacy laws aligned with ASHP's model legislation, and five states passed laws protecting 340B covered entities from discriminatory reimbursement by payers.

In addition, we have actively worked to oppose payment cuts for medication administration at hospital outpatient facilities which threaten to undermine fair reimbursement practices and the quality of patient care. While ASHP was recently successful in urging Congress not to include these so-called "site-neutral" provisions in any legislation, the threat remains. We will continue to advocate against site-neutral payment cuts and explain to stakeholders how they threaten patient safety.

Spearheading Innovation

Innovation drives progress, and through collaboration and forward-thinking initiatives, ASHP is leading the way in shaping the future of pharmacy practice. We aim to create a more efficient and effective healthcare landscape by prioritizing cutting-edge initiatives and embracing new technologies. These efforts facilitate professional growth for our members and ensure that patients receive the highest level of care.

The ASHP Innovation Center explores how emerging technologies enhance safe medication use, improve clinical outcomes, and streamline pharmacy operations. Our active partnerships extend our impact and foster new advancements, including ASHP Foundation grants supporting health information technology optimization and RFID adoption in medication-use systems.

In collaboration with the University of Minnesota College of Pharmacy, the Pharmacogenomics Accelerator program supported numerous institutions from 2022 to 2024 in establishing pharmacy-led pharmacogenomics services, leaving a lasting impact on patient care and laying the foundation for future innovation.

Last year's reimagined summer meeting, Pharmacy Futures 2024, brought together forward-thinking pharmacy professionals and innovators to collaborate and shape the future of our practice. The inaugural Summit on Artificial Intelligence, held during Pharmacy Futures, resulted in a comprehensive roadmap that actively guides the safe and effective use of AI across health systems.

The ASHP Section of Digital and Telehealth Practitioners has made significant strides with a strategic plan focused on advancing patient care through digital health and telehealth, integrating digital solutions into pharmacy operations, preparing the workforce for a digital future, and leading pharmacy innovation. Its four dedicated working groups—assessing digital health value, exploring telehealth models, defining competencies for digital pharmacy professionals, and shaping pharmacists' roles in digital transformation—have developed vital resources, including ASHP's Digital Health and AI Resource Center, as well as educational webinars, podcasts, and guidance documents that help pharmacy professionals navigate and excel in the digital landscape.

In addition, the 2025 Commission on Goals addressed key challenges in our digital landscape such as AI's impact on patient care and the workforce, and cybersecurity as a patient safety issue, among others. These discussions inform our work as innovation continues to drive pharmacy transformation.

Leadership

ASHP values the development of pharmacy leaders at all levels, from students to healthcare executives. The ASHP Leadership Center offers professional growth opportunities for clinical and executive members, such as networking, mentorship, and verification of leadership competence and knowledge.

Our Certified Pharmacy Executive Leader program, or CPEL, celebrated its second anniversary in late 2024. To date, 146 pharmacy clinical and administrative executive leaders have achieved certification. CPELs represent more than 40 US states and 4 countries. It is a thriving community, and we look forward to the program's continued growth in 2025 and beyond.

The Pharmacists in C-Suites (PICS) membership home is a hub for pharmacists who have risen to executive roles beyond traditional pharmacy settings, including C-suite level positions. The PICS Advisory Panel met several times throughout the year and conducted multiple informative sessions and virtual roundtables, including a session at the 2024 Midyear Clinical Meeting titled "Leadership Heights: Pharmacists Specializing in the C-Suite." The group shared their perspectives on leveraging data to drive change for multihospital health systems by recording several episodes on the ASHP Official Podcast Channel.

ASHP's Pharmacy Executive Leadership Alliance, or PELA, provides opportunities for pharmacy executives and chief pharmacy officers to share insights on critical topics through exclusive events that help advance pharmacy leadership and practice with an

emphasis on the complexities of multihospital health-system pharmacy enterprises. PELA convened a virtual conference focused on how models that optimize pharmacist roles can make a significant impact on care by improving access, increasing patient throughput, and boosting capacity for hospitals and health systems.

The Pharmacy Administration and Leadership Residents' Collaborative (PALRC) is a home within ASHP that supports the pharmacy administration and leadership resident community. The PALRC Leadership Committee conducted its first in-person strategic planning meeting at the 2024 Conference for Pharmacy Leaders. The meeting focused on developing a PALRC strategic plan, which was finalized in February 2025. In the last year, PALRC appointed 71 resident members for the 2024-2025 volunteer term to three work groups: Pharmacy Administration and Leadership Resident Resources, Advocacy and Practice Advancement, and Student and Resident Engagement. PALRC organizes six events each year to connect and convene the nation's directors of pharmacy, resident pharmacy directors, and pharmacy administration and leadership residents.

ASHP's Section of Pharmacy Practice Leaders (SPPL) supported the execution of the 2024 Conference of Pharmacy Leaders, where they conducted the Managers Boot Camp and special networking sessions about the IV fluid crisis. Throughout the year, SPPL hosted live continuing education (CE) webinars and recorded episodes about pharmacy-related subjects for the ASHP Official Podcast Channel and hosted five networking roundtables during the 2024 ASHP Midyear Clinical Meeting on topics ranging from women in pharmacy leadership to AI implications.

Pharmacy Technicians

The pharmacy technician workforce is foundational to optimal patient care. In 2023, ASHP launched The Pharmacy Technician Society (TPTS), a national membership organization devoted exclusively to the needs of pharmacy technicians. TPTS supports the career advancement and professionalization of the pharmacy technician workforce through education, networking, policy development, and advocacy.

Now in its second year, TPTS is growing through traditional individual memberships and a robust group membership program. Recently, the TPTS Board of Directors, comprised of pharmacy technicians representing all practice settings, developed the organization's first strategic plan to guide the work of the organization moving forward. Key objectives include offering expansive professional development opportunities, enhancing professional standards and practice, and advocating for standardized technician education and training and elevated roles in patient care. The organization has also welcomed committee members to enhance pharmacy technician engagement and is currently conducting the first Board of Directors election.

To highlight the importance of recruiting, retaining, and continuous training of hospital and health-system pharmacy technicians, ASHP and the PELA Advisory Panel analyzed the vital contributions of hospital and health-system pharmacy technicians to patient care. The assessment found that pharmacy technicians provide 166 complex patient care functions, of which 37% were rated as highly complex. Pharmacy technicians' responsibilities were comparable to those of other healthcare technical staff. In addition, wage assessment and continuous training for technicians are imperative to better patient outcomes.

ASHP Member Engagement

In September 2024, we launched ASHP Navigator, a seamless, all-in-one online hub where members can easily manage their professional development activities, track their membership status, and personalize their experiences based on self-selected interests. ASHP Navigator provides an interactive dashboard that allows members to easily update their professional profile, monitor volunteer activities, track CE, and stay informed with relevant news and updates.

Since its launch, Navigator has been made available to all members—including students, active professionals, and more—helping them take control of their professional journey. This platform is just the beginning of a more connected and interactive membership experience, ensuring every member has the tools to grow, learn, and stay engaged with our ASHP community.

Education & Workforce Advancement

Leading the way in pharmacy education and training, ASHP produces and offers essential resources and content in multiple formats to aid professional growth and practice improvement. We offer a broad range of educational tools and resources to support clinical pharmacy practice, and we are one of the country's leading providers of pharmacy CE credits, issuing more than 700,000 CE hours in 2024. We continue to grow and enhance our professional certificates (now with nearly 50 titles), board certification resources (in partnership with ACCP), competency assessment products, publications, and more to meet the evolving needs of our members.

New in 2024, ASHP introduced a suite of product offerings to support different pharmacy career transitions, including transitioning from community practice to acute care, advancing from a clinical/staff pharmacist to pharmacy manager, and transitioning from acute care to oncology. These resources have been specially curated and tailored to help pharmacists prepare for new opportunities and successfully navigate career changes.

As a leader in providing timely and essential information to members, ASHP launched two new resource centers—the Measles Resource Center and

the Avian Flu Resource Center—to support pharmacists, pharmacy technicians, and healthcare professionals with up-to-date clinical guidance, immunization recommendations, and public health tools.

Our Certified Centers of Excellence in Medication-Use Safety and Pharmacy Practice program recognizes hospitals and health systems that demonstrate the highest levels of pharmacy practice. This certification signifies operational and practical excellence and bolsters the reputation and impact of pharmacy services within the institution. Seven hospitals and health systems, totaling 28 hospitals, have been recognized as ASHP-Certified Centers of Excellence. The City of Hope in Duarte, CA; Lee Health; and OSF HealthCare most recently earned this certification. Several additional organizations are currently in pursuit of this prestigious certification.

ASHP's Practice Advancement Initiative (PAI) 2030 is a nationally recognized set of recommendations to help pharmacists, health systems, and leaders in the pharmacy profession promote optimal, safe, and effective medication use, expand pharmacist and technician roles, and implement the latest technologies. Bringing PAI 2030 stories to life is one of the best ways to enable others to act. Whether it is the process used to mobilize the completion of the PAI 2030 Assessment Tool or modeling a path forward, amplifying successes inspires action to demonstrate progress with PAI 2030.

Examples of recent PAI 2030–focused efforts include Advocate Health's work on implementing a shared vision for their system by aligning patient-centered pharmacy practice standards that promote innovative models of clinical care delivery, transitions in care, and clinical decision support as top strategic priorities and Kaiser Permanente Northwest Region's use of ASHP's assessment tool to identify its pharmacy region's strengths and areas for improvement, resulting in the creation of a training committee focused on standardized department-wide education and training for technicians and pharmacists.

PAI 2030 action plans also helped the ASHP affiliates in Puerto Rico and North Dakota focus on areas to improve, such as pharmacy involvement with care transitions, patient education, and pharmacist scope of practice expansion.

At Pharmacy Futures 2025, ASHP continued to demonstrate its commitment to innovation and leadership in providing education for workforce advance. Now in its second year, this refocused annual meeting offers cutting-edge educational sessions and prepares participants to adapt to the future and actively participate in creating it, ensuring that pharmacy practice remains at the leading edge of patient care and technological progress. This year's meeting also included the Summit on Advanced Therapeutics, designed specifically for hospital and health-system leadership and pharmacy practitioners. This event is focused on the multifaceted challenges and opportunities of integrating advanced therapeutics into clinical and operational pharmacy practice.

The National Pharmacy Preceptors Conference returned to an in-person format this year and was held as part of Pharmacy Futures 2025. Tailored for preceptors, residency program directors, and educators, this experience equips participants with best practices in recruiting, teaching, mentoring, and assessing students and residents while fostering a supportive learning environment.

Expanding our Reach & Influence

ASHP remains a trusted and sought-after source for information on a full range of important issues impacting our patients and practices. Through the ASHP News Center, proactive media relations efforts, and a comprehensive presence on social media, ASHP continues to provide timely, relevant news and information and advance our thought leadership on a range of topics and issues. Over the past year, ASHP appeared in more than 4,500 media stories, generating an estimated 8 billion media impressions. Using multimedia to enhance the impact of our content and storytelling, we generated more than 3 million impressions across our social media platforms. In addition, our ASHP Official Podcast surpassed 1.4 million downloads across 1,100 episodes.

Conclusion

Earlier this year, ASHP announced Paul's plan to retire early in 2026. As we reflect on the successes of the past year, it's the perfect opportunity to also reflect on Paul's 14 years of dedicated service to ASHP, our members, and the pharmacy profession. Under his steady hand, ASHP has achieved tremendous growth, significantly expanding on the resources and tools that allow us to best support you and your patients. His vision and foresight have ensured that the organization is well positioned for great success well into the future.

As we move forward, ASHP will continue to innovate, transform, and adapt in our ever-evolving healthcare environment to empower our members, advance practice, and make a positive impact on health outcomes in communities nationwide. On behalf of ASHP, thank you for being members and for all you do for your patients and our profession.

Disclosures

The authors have declared no potential conflicts of interest.

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House of Delegates

2025 NEW BUSINESS SUBMISSION FORM

PLEASE RETURN BY 4PM ON MONDAY, JUNE 9, TO THE
EXECUTIVE OFFICE IN ROOM W204B, CHARLOTTE CONVENTION CENTER

Delegates may submit items of new business several ways. Delegates may submit a new business item online using the form on HOD Calls, Forms, and Rosters page of the ASHP House of Delegates website (https://www.ashp.org/house-of-delegates/hod-calls-forms-and-rosters) or by completing this form and submitting it by 4 p.m. to the Executive Office in Room W204B.

ASHP
HOUSE OF DELEGATES
JUNE 10, 2025
CHARLOTTE, NORTH CAROLINA

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

Date Submitted: 6/4/25

Time Submitted: **10:17 AM**

INTRODUCED BY (NAME):
Christopher Crank (IL), Bernice Mann (IL), Andy Donnelly (IL), Jennifer Phillips (IL), Matt Rim (IL), Megan Corrigan (IL), Jim Dorociak (IL), Sam Rimas (IL)

SUBJECT:
Integrity of Pharmacist Provided Health Information

MOTION:
To oppose any governmental restrictions on pharmacists' ability to provide evidence-based health information to patients; further

To urge policymakers to protect pharmacists' professional autonomy in educating patients on medications, public health issues, and emerging scientific developments; further

To oppose the elimination, suppression, manipulation, or politicization of evidence-based public health data and drug safety information by any entity; further

To advocate for legislation that protects scientific integrity and ensures transparency in the dissemination of public health information; further

To affirm that pharmacists have the professional responsibility to disseminate evidence-based, health information to patients and communities.

BACKGROUND: Protecting the Integrity of Pharmacist-Provided Health Information

Pharmacists play a vital role in public health, serving as accessible and trusted sources of evidence-based medical information for patients and communities. As experts in medication therapy, pharmacists ensure individuals have the knowledge and information they need to make informed decisions about their care. However, in recent years, pharmacists have faced growing challenges in their ability to share accurate, evidence-based health information due to restrictions, the politicization of drug safety data, and the suppression of public health findings.

The American Society of Health-System Pharmacists (ASHP) is committed to safeguarding the professional autonomy of pharmacists, advocating against any efforts that restrict their ability to provide evidence-based health education. In an era where misinformation can spread rapidly, it is more important than ever to uphold integrity and transparency. The suppression or manipulation of data can have serious consequences, potentially jeopardizing patient safety and undermining trust in healthcare professionals.

ASHP stands firm in its position that pharmacists have a professional duty to disseminate accurate and reliable health information. ASHP seeks to ensure that pharmacists remain empowered to educate patients on medications, emerging scientific advancements, and critical public health concerns.

SUGGESTED OUTCOMES:
Review and consider proposed policy language at the ASHP House of Delegates. This topic may be considered as a new policy position, an amendment of existing policy, or referred to an ASHP council for further consideration.

Q1.

ASHP HOUSE OF DELEGATES MEETINGS
June 2025

New Business
Please submit by 4:00 pm
Charlotte time (ET) on Monday, June 9

Q2. Please provide the information required below:

Name	Katrina Derry
State or Entity Represented	California
Email Address	katrina.derry@ucop.edu

Q9. If there are additional signers to this New Business Item, please provide names and state or entity represented.

Kathy Ghomeshi (CA), Gary Besinque (CA), Caroline Sierra (CA), Jaclyn Jaskowiak (CA), Elaine Law (CA), Emily Do (CA)

Q3. Subject:

Decriminalization of the interdisciplinary workforce involved with medical events.

Q4. Motion:

To advocate that healthcare interdisciplinary workforce involved in medical error shall be immune from criminal liability for any harm or damages alleged to arise from an act or omission relating to the provision of health services; Further, the immunity would not limit liability for any gross negligence or wanton, willful, malicious, or intentional misconduct and does not protect healthcare professionals from civil litigation. Further, to advocate that each state enacts legislation to decriminalize medical errors.

Q5. Background:

Kentucky House Bill 159 was signed into law on March 26, 2024. The law shields healthcare providers from criminal liability for inadvertent errors, aiming to encourage reporting and improve patient safety. It does not protect against gross negligence, wanton, willful, malicious, or intentional misconduct. By removing the fear of criminal prosecution, the law will encourage healthcare professional to report errors, leading to better learning and system improvements. Medical events will include preventable medical errors and non-preventable medical events. There have been several cases of healthcare workforce members being criminally prosecuted, convicted, and/or imprisoned due to involvement in tragic medical or medication errors ASHP Professional Policy catalogue has existing policy related to this topic, but not specific to the topic of decriminalization. ASHP Policy 1021 is related to just culture and reporting of medication errors. ASHP Policy 1505 related to statutory protection for medication error reporting. ASHP 0504 pertaining to pharmacy staff fatigue and medication errors.

Q6. Suggested Outcomes:

Statutory protections for the healthcare workforce from medical errors.

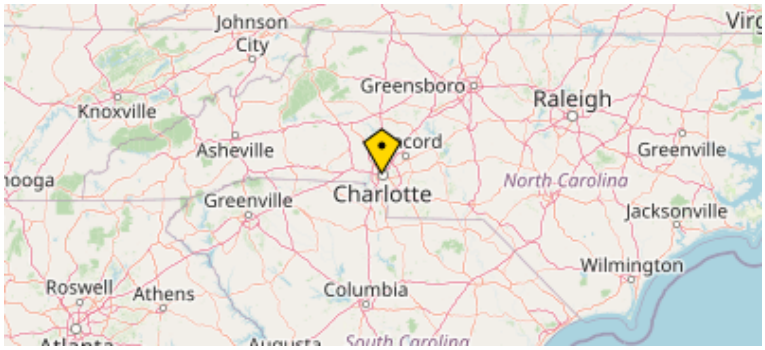
Q7. Please consider providing your phone number in the event ASHP staff need to follow up with you regarding your New Business Item.

Daytime Phone Number: 8582295664

Location Data

Location: (35.2296, -80.843)

Source: GeoIP Estimation



House of Delegates

2025 NEW BUSINESS SUBMISSION FORM

PLEASE RETURN BY 4PM ON MONDAY, JUNE 9, TO THE
EXECUTIVE OFFICE IN ROOM W204B, CHARLOTTE CONVENTION CENTER

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ASHP
HOUSE OF DELEGATES
JUNE 10, 2025
CHARLOTTE, NORTH CAROLINA

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

Date Submitted: June 9, 2025

Time Submitted: 1:42 p.m. ET

INTRODUCED BY (NAME):
Sarah M. Panella (SACP)

SUBJECT:
Pharmacist's Role in Value-Based Care Models

MOTION:
For ASHP to adopt the following Policy:

To affirm the role of the pharmacy workforce in advancing value-based care through the optimization of medication use, improvement of clinical outcomes, and reduction of total cost of care; further,

To promote pharmacist leadership in value-based care models; further,

To advocate for the inclusion of pharmacists in the development, implementation, and evaluation of value-based care models and alternative payment arrangements; further,

To support the use of performance metrics that demonstrate the impact of the pharmacy workforce in value-based care.

BACKGROUND:
While ASHP policy 1523 (Pharmacist's Role in Population Health Management, 2019) remains appropriate, a new, distinct policy is warranted to reflect the rapid evolution of value-based care (VBC) models in which

pharmacists play an increasingly vital role. Population health management is a broad discipline focused on preventive care, risk stratification, and care coordination, whereas VBC directly ties reimbursement to outcomes, cost-efficiency, and performance metrics, often through payer-provider contracts. Merging the two may dilute the specificity and urgency required to support the role of pharmacists in VBC models such as accountable care organizations (ACOs), the Medicare Shared Savings Program (MSSP), Medicare Advantage (MA) Star Ratings, and bundled payments.

Pharmacists are now accountable for outcomes linked to HEDIS measures, CMS Star Ratings, and risk-adjusted quality metrics. Evidence supports their effectiveness in managing chronic conditions, optimizing medication use, and reducing healthcare costs. For example, pharmacist-led comprehensive medication management (CMM) services in primary care and ACO settings have significantly improved control of diabetes and hypertension while reducing emergency department visits and hospital admissions.

Pharmacy leaders are increasingly involved in benefit design, cost containment, and financial performance within value-based contracts. Pharmacists contribute directly to meeting payer-aligned targets, such as statin use in diabetes, blood pressure and A1C control, and medication adherence. Additionally, they lead population-level initiatives using risk-stratification tools, clinical data, and targeted interventions to reduce total cost of care.

Pharmacists must also be equipped to lead and sustain their role in VBC. National organizations, such as the Pharmacy Quality Alliance, emphasize the need for training in healthcare quality, informatics, population health, and interprofessional collaboration to ensure the pharmacy workforce is prepared for payer-driven care transformation.

A dedicated ASHP policy on value-based care will define the profession's direction, elevate pharmacy's contributions to payer-aligned care, and guide integration, education, and performance measurement efforts that support continued pharmacy success in value-driven healthcare.

SUGGESTED OUTCOMES:
Referral to Council on Pharmacy Management

ASHP Board of Directors, 2024-2025

Am J Health-Syst Pharm.

2024;81:1208-1209

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BOARD-ELECT

Inaugural Address of the Incoming President: Drive the beat and let your rhythm move the world; the vital role of pharmacists, one note at a time

Am J Health-Syst Pharm. 2025;82:1290-1293

Melanie A. Dodd, PharmD, PhC, BCPS, FASHP, University of New Mexico College of Pharmacy, Albuquerque, NM, USA

Address correspondence to Dr. Dodd (prez@ashp.org)

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https://doi.org/10.1093/ajhp/zxaf207

Just as the jazz band leader sets the tempo and encourages each musician to find their voice, ASHP provides the guidance and vision for the pharmacy profession. ASHP fosters an environment where every member of the pharmacy workforce can shine.

Editor's note: The following is adapted from comments delivered by Dr. Dodd during the ASHP Pharmacy Futures 2025 meeting, held in June in Charlotte, NC.

Good morning! Colleagues, family, and friends, it is the honor of a lifetime to stand before you as your 82nd ASHP President and the first ASHP President from New Mexico. This is an incredible opportunity to continue serving you—ASHP—and our profession as we work together to advance pharmacy practice and healthcare.

Today as always, we remain committed to helping our patients achieve our shared vision: that medication use will be optimal, safe, and effective for all people all of the time.

The song you just heard was "Take Five"—by the Dave Brubeck Quartet—recorded in 1959. Brubeck, an American jazz pianist and composer, is known for unusual time signatures and superimposing contrasting rhythms, along with combining different styles and genres, like jazz, blues, and classical.

"Take Five" has become a jazz standard because it's both familiar and surprising. Its time signature, in 5/4 time, doesn't follow expected patterns—yet each note falls exactly where it needs to—in the same way that we, pharmacists and pharmacy technicians, find our place in the complex rhythm of healthcare.

Together we bring the balance and structure that patients need, and the expertise and precision that keep everything on track. But we're also ready to pivot, adapt, and listen to the unique needs of every individual to make each interaction meaningful.

As the medication experts, pharmacy professionals bring an artful blend of science, relationships, resiliency, and heart—and that's what I would like to talk to you about today: how our rhythm can move the world.

Music evokes emotions, heals the mind and body, and connects people across cultures. It strengthens relationships and transcends time to create a universal language. I know something of this language. I wasn't exposed to contemporary music until I reached my teen years. I grew up listening to and playing classical and jazz music. I began playing the piano and singing in choirs as a young girl. In late elementary school, it was time to pick an instrument and join the band. I picked the trumpet—the same instrument that my father plays. He had never met a girl who could play the trumpet well—and I was determined to prove him wrong.

I played the trumpet throughout high school and during pharmacy school at Purdue University, in both concert and jazz bands. During one of those jazz band rehearsals, I met a fellow trumpet player, Paul Dodd, who would become my best friend and, now, my husband of 31 years. I'd like now to take a moment to thank Paul. I would not be standing before you today without all these years of his friendship and love and support for me and our sons. He never wavers in his love and support for me.

My oldest son, Brian—with whom I was pregnant when I became President of the New Mexico Society of Health-System Pharmacists—and my son Kyle have been my longstanding cheerleaders. I thank you from the bottom of my heart. Thank you to all of my family and many friends, mentors, and colleagues who have believed in me and supported me throughout my life and career. I am grateful my parents, Marshall and Berdine Martin, raised me in a home surrounded in music and unfailing love. They taught me my core values and principles and encouraged me to be a leader, to make a difference in our communities, as they modeled and continue to lead to this day.

Career

Grounded by the steady rhythm of my family's love and values, I was drawn to a life of purpose and service in the healthcare setting. My career began as a volunteer candy striper at our community hospital, where later I was a pharmacy intern during pharmacy school. Having decided as a student to pursue a career in health systems providing direct patient care, I recognized early on the importance of professional organizations, and so I joined ASHP.

Immediately after graduating from Purdue, I moved with my husband to New Mexico, where I completed my doctor of pharmacy training at the University of New Mexico College of Pharmacy. Now as a faculty member for greater than 25 years at the UNM College of Pharmacy, I work as a pharmacist clinician in geriatric primary care—providing direct patient care, with very broad prescriptive authority, alongside an amazing interprofessional team.

Advocacy

The "Land of Enchantment" is largely a rural state—the fifth-largest state in land mass, with a population slightly greater than 2 million. Here is where I first made the connection between my work as a pharmacist and a patient's need for access to care. Those living in rural areas are less likely to have access to usual care and, on average, have poorer health compared with those in urban areas.[1] However, in rural areas there is a higher percentage of pharmacists compared with primary care physicians.[2]

Initially upon moving to New Mexico with Paul, I had no idea that for many years pharmacy leaders had been fighting hard for a new advanced practice pharmacist license—the pharmacist clinician license—which offered opportunities in healthcare deserts for broad prescriptive authority after completion of additional training, thereby opening up more avenues for patients to receive needed care.

The Pharmacist Prescriptive Authority Act arrived only after diligent lobbying by the pharmacy profession and collaboration with stakeholders.[3] Despite this amazing advocacy accomplishment, one of the barriers to expansion of these advanced practice pharmacist services was reimbursement for services and establishment of sustainable business models.

Several years later, in 2020, I was proud to be among the many pharmacy leaders, including our students, in New Mexico who advocated for the passage of the first state law allowing parity of reimbursement to physicians for pharmacists with prescriptive authority by New Mexico Medicaid and commercial insurance. This is an example of the power of advocacy breaking down the barriers of access to advanced pharmacy practice services.

I am committed to our collective advocacy efforts at the national and state levels here within ASHP. I'm excited that ASHP continues to advocate for the advanced role of pharmacists with the ability to prescribe under collaborative practice agreements or via a standard of care model in all 50 states.[4] And furthermore, all 50 states now allow pharmacists to prescribe vaccinations and assess and treat some other public health–driven needs such as tobacco cessation, hormonal contraception, and point-of-care testing for certain infectious diseases. In most states pharmacy technicians can now administer vaccinations. We have also made significant progress at the state level for continued reimbursement for pharmacist services.

Since 2022, we have increased from approximately 30% of US states to greater than 80% of states that have prescriptive authorities and reimbursement for pharmacist services at the state level. These changes . . . change . . . lives.

More pharmacists are now delivering healthcare that optimizes medication use, improves outcomes, reduces hospitalizations, and expands equitable access—especially in underserved areas. One embedded pharmacist full-time equivalent in an ambulatory clinic can open up greater than 1,900 primary care physician visit appointments per year.[5] In addition, with new opportunities for direct reimbursement, adding a pharmacist to chronic disease care can yield greater than an average $4 return for every $1 invested.[6] So, you see, our words and our actions are making a difference.

However, if we really want to beat it up, you and I need to do even more! ASHP remains committed to advocating for our members through direct action, professional policies, model state legislative language, and resource development in order to close our gaps in healthcare. As we all know, our work in advocacy is ongoing and crucial. The ongoing part is reflected in the work of ASHP's 2024 Commission on Goals, which highlighted key challenges and opportunities in primary care.[7] I envision a future where pharmacists universally play a central role as primary care providers, managing both chronic and acute conditions. And the advocacy is crucial at the federal level for achieving Medicare Part B provider status and managing issues impacting safe medication use.

Looking ahead, the ASHP 2025 Advocacy Agenda focuses on expanding pharmacist-provided patient care in primary and acute settings, securing payment for these services, addressing workforce challenges, promoting pharmacy technicians, ensuring access to affordable medications, and tackling societal barriers to care.[8]

Leadership

In a jazz band, each player relies on others to create a cohesive performance, but there are also solos where individual musicians shine, showcasing their unique skills. Similarly, pharmacists play a critical role in our healthcare system—working together as part of the interprofessional team while also stepping up as leaders. Recently one of my patients was considering switching their health insurance but before doing so ensured I

could continue to be one of their providers in their new network.

During the COVID-19 pandemic, pharmacists demonstrated exceptional leadership and resiliency. They quickly adapted, stepped into frontline roles, managed medication shortages, expanded services like testing and vaccinations, and ensured that patients could get what they needed and expanded access to care amid lockdowns. Working together, new roles for pharmacists were developed. During that time, I was able to utilize virtual technology to continue providing ambulatory primary patient care and mentor and teach the next generation of pharmacists. COVID-19 really placed an accelerando on our use of new technologies to deliver healthcare and education and work remotely, which continues today. During Hurricane Helene in September 2024, pharmacists across North Carolina demonstrated exceptional resilience and adaptability, ensuring continued access to essential medications and healthcare services despite widespread disruptions.

As I often tell my students, many of the pharmacy careers of the future have yet to be invented. However, we know they will be shaped by new advanced technologies, potential unexpected events, and the ongoing work and leadership of pharmacists. It is now essential that we prepare and position ourselves for not only today's opportunities but those of the future.

ASHP is instrumental in preparing pharmacists for evolving leadership roles. Just as the jazz band leader sets the tempo and encourages each musician to find their voice, ASHP provides the guidance and vision for the pharmacy profession. ASHP fosters an environment where every member of the pharmacy workforce can shine. Recently the ASHP Board of Directors has begun to develop a new strategic plan to advance practice and prepare for the future. This process involves contributions from nearly 200 members elected or appointed to key ASHP leadership groups to ensure that our plan reflects the diverse expertise of our entire membership. This new strategic plan will build upon our strengths while addressing emerging innovations in science, technology, healthcare economics, and the evolving needs of the pharmacy workforce. Stay tuned for our new strategic plan —to be released later this year.

Improvisation

As is the case with any good jazz combo, our strength as a pharmacy team lies in our collective improvisation. We are constantly writing our score—note by note, decision by decision. In a jazz ensemble, every instrument—every voice—is essential to the overall harmony. When one instrument is silenced, the music loses its richness. Jazz music thrives on improvisation, where the musicians lead and follow, responding to unexpected changes in rhythm, melody, or harmony.

Ms. Ella Fitzgerald, born in 1917, was considered the First Lady of Song, as the most popular female jazz singer in the United States for more than half a century.[9] She was a brilliant improviser and masterful scat singer. She broke down cultural barriers with grace, leading not by force but by the sheer power of her voice. Her leadership broke ground and broke expectations just like pharmacists do. She once said, "It isn't where you came from, it's where you're going that counts, and the only thing better than singing is more singing."[10]

As a pharmacy workforce, we all have opportunities to improvise by singing more and ensuring equitable access to optimal healthcare for all people through our leadership and innovation.

So, on that note, now it is time for us to join together in a little of our own scat singing and improvisation, à la Ella.

One of her most famous songs is "It Don't Mean a Thing (If It Ain't Got That Swing)." Take some time to scat along with Ella (https://www.youtube.com/watch?v=3y_d_aQg2xI).

Conclusion

As we move forward, may we continue to be like jazz musicians who don't just play the notes but who tell a story with each one. Every patient we help, every question we answer, and every life we touch builds on the rhythm of care and compassion that defines us. Just as each musical note contributes to a beautiful melody, we provide care one musical note at a time—each small act harmonizing to create a symphony of healing and hope. Let your rhythm move the world! Here's how:

- Increase your personal advocacy and let your harmony resonate by helping your team.
- Let the beat of your clinical expertise change patients' lives.
- Be a pharmacy leader that sets the tempo and helps each member find their voice, and don't be afraid to improvise.

All of these actions will increase access to care and improve the health of our communities.

We must remain committed to helping our patients achieve our shared vision: that medication use will be optimal, safe, and effective for all people all of the time. And that is how you can drive the beat and let your rhythm move the world.

Ella Fitzgerald's music soothed hearts and uplifted spirits across generations. Healthcare likewise brings a language of mission and care and connection. It transcends borders and cultures, offering healing where there is pain, comfort where there is fear, and dignity where there is suffering. In serving the health of others, we create a harmony as enduring and beautiful as Ella's song—a tribute to the soul of humanity.

Today, I ask you to join with me in committing to advancing the practice of pharmacy and the health of our communities through our leadership, our words, our actions, our advocacy,

our collaboration and relationships with others through melody and harmony, our response to unexpected changes in rhythm, and our improvisation as we listen, lead, and follow.

I stand before you now as a daughter, a sister, a wife, a mother, an aunt, an educator, an administrator, a pharmacist clinician, a lover of jazz music, and your 82nd ASHP President.

With the energy of a live jazz performance, we will ensure that every voice is heard through equitable access to care, and we will support our principles as the true bandleaders in this vibrant concert of life.

In the words of Ella, "Just don't give up trying to do what you really want to do. Where there is love and inspiration, I don't think you can go wrong."[10]

Disclosures

The authors have declared no potential conflicts of interest.

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