



# House of Delegates Session—2023

June 11 and 13, 2023

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Proceedings of the 75th annual session  
of the ASHP House of Delegates,  
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### **Paul W. Abramowitz, Secretary**

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

### **First meeting**

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

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

The roll of official delegates was called. A quorum was present, including 208 delegates representing 49 states and the District of Columbia, as well as the federal services, chairs of ASHP sections and forums, ASHP officers, members of the Board of Directors, and ASHP

past presidents (see Appendix I for a complete roster of delegates).

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

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

**Report of the Committee on Nominations.** Chair Dodd called on Donald Kishi, Chair of the Committee on Nominations, for the report of the Committee on Nominations (Appendix IV).<sup>a</sup> Nominees were presented as follows:

### *President 2023-2024*

**Leigh A. Briscoe-Dwyer, PharmD, BSPHarm, BCPS, FASHP**, System Director of Pharmacy, UHS Hospitals, Johnson City, NY

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

### *Board of Directors, 2023-2026*

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

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

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

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

### *Board of Directors, 2023-2025*

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

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

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

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

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

Chair Dodd also announced that delegates could suggest minor wording changes (without introducing a formal amendment) that did not

affect the substance of a policy proposal, and that the Board of Directors would consider these suggestions and report its decisions on them at the second meeting of the House. *(Note: The following reports on House action on policy committee recommendations give the language adopted at the first meeting of the House. The titles of policies amended by the House are preceded by an asterisk [\*]. Amendments are noted as follows: underlined type indicates material added; ~~strikethrough~~ marks indicate material deleted. If no amendments are noted, the policy as proposed was adopted by the House. For purposes of this report, no distinction has been made between formal amendments and wording suggestions made by delegates.*

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

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

### **\*1. Emergency Medical Kits**

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

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

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

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

### **\*2. Raising Awareness of the Risks Associated with the Misuse of Medications**

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

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

### **\*3. Standardization of Medication Concentrations**

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

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

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

*Note: This policy would supersede ASHP policy 1306.*

### **\*4. Pharmacoequity**

To ~~recognize~~ raise awareness that disparities in ~~standards of care~~ clinical practice negatively impact healthcare outcomes and compromise

~~pharmacoequity in marginalized and underserved populations; further,~~

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

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

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

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

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

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

### **\*5. Medication Administration by the Pharmacy Workforce**

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

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

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

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

*Note: This policy would supersede ASHP policy 9820.*

### **6. Reducing Healthcare Sector Carbon Emissions to Promote Public Health**

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

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

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

#### **\*1. Availability and Use of Fentanyl Test Strips**

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

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

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

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

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

### **2. Manipulation of Drug Products for Alternate Routes of Administration**

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

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

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

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

### **\*3. DEA Scheduling of Controlled Substances**

To advocate that the Drug Enforcement Administration (DEA) establish clear,

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

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

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

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

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

*Note: This policy would supersede ASHP policy 1315.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*Note: This policy would supersede ASHP policy 2229.*

### **\*6. Nonprescription Availability of Self-Administered Influenza Antivirals** **Osetamivir**

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

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

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

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

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

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

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

*Note: This policy would supersede ASHP policy 2116.*

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

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

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

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

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

*Note: This policy would supersede ASHP policy 1410.*

### **8. Responsible Medication-Related Clinical Testing and Monitoring**

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

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

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

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

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

*Note: This policy would supersede ASHP policy 1823.*

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

To recognize the role of gender-affirming care in achieving health equity and reducing health disparities; further,

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

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

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

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

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

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

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

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

*Note: This policy would supersede ASHP policy 1718.*

### **\*10. Removal of Injectable Promethazine from Hospital Formularies**

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



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

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

*Note: This policy would supersede ASHP policy 1831.*

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

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

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

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

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

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

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

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

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

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

*Note: This policy would supersede ASHP policy 1825.*

The meeting adjourned at 5:30 p.m.

### **Second meeting**

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

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

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

### **Board of Directors duly considered matters.**

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

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

### **Council on Therapeutics 4. Pharmacist Prescribing Authority for Antiretroviral Therapy for the Prevention of HIV/AIDS**

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

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

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

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

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

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

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

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

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

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

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

#### *Motion:*

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

#### *Background:*

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

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

*Suggested Outcomes:*

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

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

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

*Compensation for pharmacist cognitive services*

*Motion:*

To adopt the following as a new ASHP policy:

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

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

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

To advocate for the development of consistent, transparent billing, reimbursement, and alternative payment model policies and

practices by both government and commercial payers.

*Background:*

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

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

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

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

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

Additional rationale from the ASHP Statement on Primary Care:  
Billing and reimbursement for primary care pharmacy services  
The National Academy of Sciences recommends that payers, including Medicaid, Medicare, commercial insurers, and self-insured employers, should shift payments toward a

hybrid model that includes fee-for-service and capitated payments, and that these models should pay prospectively for interprofessional, integrated, team-based care.<sup>6</sup> Financial sustainability for services provided by primary care pharmacists may be achieved using a variety of models. Due to lack of federal provider status for pharmacists and subsequent inability to directly bill Medicare as primary care providers, organizations and practices have become creative in maintaining financial sustainability of primary care pharmacist services. Some settings utilize indirect funding, while others take advantage of some of the limited direct insurance billing opportunities to fund pharmacists in primary care settings. Direct billing opportunities will vary based on the setting, hospital-based versus physician-based practices, as well as state-specific laws and regulations. Medicare, Medicaid, and commercial health plans may reimburse pharmacists for certain services, while some will require direct contracting with the health plan. Several states have passed pharmacist state provider status laws and/or reimbursement parity laws allowing for reimbursement for direct patient care pharmacist services by state Medicaid and/or commercial plans.<sup>4</sup>

### *References:*

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

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

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

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

### *Barcodes with Lot and Expiration Date Needs and Impacts*

#### *Motion:*

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

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

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

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

#### *Background:*

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

containing additional characters needed to code lot number, expiration date and NDC on labels of inner packages. As a result, the 1D barcodes required on inner packages only contain the NDC number.

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

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

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

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

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

Current 2D scanners can read 1D and 2D barcodes. Past arguments 19 years ago that hospitals do not have the barcode readers to read 2D barcodes are no longer valid. Many products dispensed are saleable packages that only contain 2D barcodes. In addition, 2D barcode readers are significantly less expensive

and more reliable than the 1D laser scanners used in the past.

GS1, the barcode standards organization that defines medication barcode standards has invited stakeholders to provide input on how GS1 can better support industry needs. This is a call-out to organizations such as ASHP to communicate the need for lot, expiration and on immediate products and to work with GS1 to assure the resulting barcodes meet the need in health systems. Such communication with GS1 should include the barcoding of repackaged products and investigational medications. This is the invite statement from GS1: “Manufacturers should be moving toward 2D to support forward movement in adoption and use. Downstream trading partners should focus on scanning and consuming - the time is now to move in this direction. As stakeholders across the healthcare supply chain begin to adopt scanning and consuming of data from GS1 DataMatrix barcodes further detail may be needed to support this industry.

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

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

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

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

*Suggested Outcomes:*

- 1) That ASHP adopt the proposed policy.

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

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

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

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

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**Installation of Section Chairs.** Chair Dodd then installed the chairs of ASHP's sections: Brody J. Maack, Section of Ambulatory Care Practitioners; Nancy MacDonald, Section of

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

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**ASHP-PAC Fundraising Competition.**

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

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

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

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

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

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# Appendix I



## ROSTER - HOUSE OF DELEGATES Baltimore, Maryland June 11-13, 2023

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

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

<b>OFFICERS AND BOARD OF DIRECTORS</b>			
Paul C. Walker, President			
Nishaminy Kasbekar, President-Elect			
Linda S. Tyler, Immediate Past President			
Christene M. Jolowsky, Treasurer			
Paul W. Abramowitz, Chief Executive Officer			
Kim W. Benner, Board Liaison, Council on Education and Workforce Development			
Leigh A. Briscoe-Dwyer, Board Liaison, Council on Pharmacy Management			
Samuel V. Calabrese, Board Liaison, Council on Public Policy			
Vivian Bradley Johnson, Board Liaison, Council on Pharmacy Practice			
Pamela K. Phelps, Board Liaison, Council on Therapeutics			
Jamie S. Sinclair, Board Liaison, Commission on Affiliate Relations			
Melanie A. Dodd, Chair of the House			
<b>PAST PRESIDENTS</b>			
Roger Anderson	Diane Ginsburg	Lynnae Mahaney	Kelly Smith
Daniel Ashby	Harold Godwin	Philip Schneider	Thomas Thielke
Debra Devereaux	Marianne Ivey	Kathryn Schultz	Sara White
Rebecca Finley	Thomas Johnson	Steven Sheaffer	T. Mark Woods
Lisa Gersema	Stan Kent	Janet Silvester	
<b>STATE</b>	<b>DELEGATES</b>	<b>ALTERNATES</b>	
<b>Alabama (3)</b>	Nancy Bailey Laura Matthews Megan Roberts	Joshua Settle	
<b>Alaska (2)</b>			
<b>Arizona (3)</b>	Janelle Duran Christopher Edwards Danielle Kamm <sup>1</sup> Lindsey Kelley <sup>2</sup>	Melinda Burnworth	
<b>Arkansas (2)</b>	Jeff Cook Jama Huntley	Josh Maloney	



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

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

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

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

<sup>1</sup>Seated in Sunday meeting only.<sup>2</sup>Seated in Tuesday meeting only.

# House of Delegates

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## REPORT ON THE VIRTUAL HOUSE OF DELEGATES

March 17-24, 2023

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### RESULTS OF THE VOTING

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

### POLICY RECOMMENDATIONS APPROVED

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

#### **Education and Training in Digital Health (96%)**

*Source: Council on Education and Workforce Development*

To acknowledge that digital health is a growing modality that supports the pharmacy workforce in providing patient care; further,

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

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

#### **Education and Training in Telehealth (97%)**

*Source: Council on Education and Workforce Development*

To discontinue ASHP policy 2117, Education and Training in Telehealth, which reads:

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

in providing direct patient care; further,

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

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

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

### **Digital Therapeutics Products (94%)**

*Source: Council on Pharmacy Management*

To affirm the essential role of the pharmacist in the team-based evaluation, implementation, use, and ongoing assessment of digital therapeutic products to ensure the safety, effectiveness, and efficiency of medication use; further,

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

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

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

### **Interoperability of Patient-Care Technologies (98%)**

*Source: Council on Pharmacy Management*

To encourage interdisciplinary development and implementation of standards that foster foundational, structural, semantic, and organizational interoperability of health information technology (HIT); further,

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

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

*Note: This policy supersedes ASHP policy 1302.*

### **Patient Medication Delivery Systems (98%)**

*Source: Council on Pharmacy Practice*

To foster the clinical and technical expertise of the pharmacy workforce in the use of medication delivery systems; further,

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

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

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

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

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

### **Education About Performance-Enhancing Substances (86%)**

*Source: Council on Pharmacy Practice*

To encourage pharmacists to engage in and advise community outreach efforts informing the public on the risks associated with the use of performance-enhancing substances, including but not limited to medications; further,

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

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

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

*Note: This policy supersedes ASHP policy 1305.*

### **Support for FDA Expanded Access (Compassionate Use) Program (95%)**

*Source: Council on Public Policy*

To advocate that the Food and Drug Administration (FDA) Expanded Access (Compassionate Use) Program be the primary mechanism for patient access to drugs for which an

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

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

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

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

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

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

*Note: This policy supersedes ASHP policy 1508.*

### **Biosimilar Medications (97%)**

*Source: Council on Public Policy*

To encourage the development of safe and effective biosimilar medications in order to make such medications more affordable and accessible; further,

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

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

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

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

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



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

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

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

*Note: This policy supersedes ASHP policy 1816.*

### **Licensure of Pharmacy Graduates (85%)**

*Source: Council on Public Policy*

To support state licensure eligibility of a pharmacist who has graduated from a foreign or domestic pharmacy program accredited by the Accreditation Council for Pharmacy Education (ACPE) or accredited by an ACPE-recognized accreditation program.

*Note: This policy supersedes ASHP policy 0323.*

### **Pharmacogenomics (95%)**

*Source: Council on Therapeutics*

To advocate that pharmacists take a leadership role in pharmacogenomics-related patient testing, based on current or anticipated medication therapy; further,

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

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

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

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

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

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

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

*Note: This policy supersedes ASHP policy 2113.*

## **POLICY RECOMMENDATIONS NOT APPROVED**

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

### **Well-Being and Resilience of the Pharmacy Workforce (84%)**

*Source: Council on Education and Workforce Development*

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

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

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

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

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

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

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

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

*Note: This policy supersedes ASHP policy 1825.*

### **Emergency Medical Kits (74%)**

*Source: Council on Pharmacy Practice*

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

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

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

### **Raising Awareness of the Risks Associated with the Misuse of Medications (67%)**

*Source: Council on Pharmacy Practice*

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

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

### **Standardization of Medication Concentrations (81%)**

*Source: Council on Pharmacy Practice*

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

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

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

*Note: This policy supersedes ASHP policy 1306.*

### **Availability and Use of Fentanyl Test Strips (77%)**

*Source: Council on Therapeutics*

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

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

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

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

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

### **Manipulation of Drug Products for Alternate Routes of Administration (83%)**

*Source: Council on Therapeutics*

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

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

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

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

### **DEA Scheduling of Controlled Substances (72%)**

*Source: Council on Therapeutics*

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

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

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

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

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

*Note: This policy supersedes ASHP policy 1315.*

## **NOTES ON VOTING**

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

**HOUSE OF DELEGATES****Melanie A. Dodd, Chair****Linda S. Tyler, Vice Chair****As of March 24, 2023**

<b>OFFICERS AND BOARD OF DIRECTORS</b>			
Paul C. Walker, President			
Nishaminy Kasbekar, President-Elect			
Linda S. Tyler, Immediate Past President			
Christene M. Jolowsky, Treasurer			
Paul W. Abramowitz, Chief Executive Officer			
Kim W. Benner, Board Liaison, Council on Education and Workforce Development			
Leigh A. Briscoe-Dwyer, Board Liaison, Council on Pharmacy Management			
Samuel V. Calabrese, Board Liaison, Council on Public Policy			
Vivian Bradley Johnson, Board Liaison, Council on Pharmacy Practice			
Pam Phelps, Board Liaison, Council on Therapeutics			
Jamie S. Sinclair, Board Liaison, Commission on Affiliate Relations			
Melanie A. Dodd, Chair of the House			
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R. David Anderson	Debra Devereaux	Stan Kent	Janet Silvester
Roger Anderson	Fred Eckel	Robert Lantos	Kelly Smith
John Armitstead	Rebecca Finley	Herman Lazarus	Thomas Thielke
Daniel Ashby	Lisa Gersema	Gerald Meyer	Sara White
Paul Baumgartner	Diane Ginsburg	John Murphy	T. Mark Woods
Jill Martin Boone	Harold Godwin	Cynthia Raehl	David Zilz
Cynthia Brennan	Mick Hunt	Philip Schneider	
Bruce Canaday	Clifford Hynniman	Kathryn Schultz	
Jannet Carmichael	Marianne Ivey	Bruce Scott	
Kevin Colgan	Thomas Johnson	Steven Sheaffer	
<b>STATE</b>	<b>DELEGATES</b>		<b>ALTERNATES</b>
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<b>Alaska (2)</b>	Shawna King Laura Lampasone		
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<b>New York (5)</b>	Travis Dick Robert DiGregorio Frank Sosnowski Lisa Voigt Kim Zammit	Charrai Byrd Lijian Cai Heide Christensen Russ Lazzaro Daryl Schiller Steven Tuckman



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<b>Pennsylvania (4)</b>	Paul Green Arpit Mehta Kim Mehta Christine Roussel	Jennifer Belavic Scott Bolesta Joseph Stavish
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<b>West Virginia (2)</b>	Chris Fitzpatrick Derek Grimm	
<b>Wisconsin (4)</b>	Tom Dilworth John Muchka William Peppard Kate Schaafsma	Monica Bogenschutz Tara Feller Courtney Morris Tahmeena Siddiqui
<b>Wyoming (2)</b>	Jonathan Beattie Jaime Bobinmyer Hornecker	
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<b>FRATERNAL</b>	<b>DELEGATES</b>	<b>ALTERNATES</b>
<b>U.S. Air Force</b>	Lt Col Rohin Kasudia	Lt Col Jin Kim
<b>U.S. Army</b>	LTC Joe Taylor	MAJ Ryan Constantino
<b>U.S. Navy</b>	LT Staci Jones	LT Chirag Patel
<b>U.S. Public Health Service</b>	LCDR Kali Autrey	LCDR Bryan "Russ" Gunter CDR Christopher McKnight (Coast Guard)
<b>Veterans Affairs</b>	Heather Ourth	Anthony Morreale Virginia "Ginny" Torrise



# House of Delegates

## REPORT ON THE VIRTUAL HOUSE OF DELEGATES

May 12-18, 2023

### RESULTS OF THE VOTING

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

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

#### **Payer-Directed Drug Distribution Models (90.9%)**

*Source: Council on Pharmacy Management*

To advocate that insurers and pharmacy benefit managers be prohibited from mandating drug distribution models that introduce patient safety and supply chain risks or limit patient choice.

*Note: This policy supersedes ASHP policy 2248.*

#### **Use of Social Determinants of Health Data in Pharmacy Practice (88.1%)**

*Source: Council on Pharmacy Management*

To encourage the use of patient and community social determinants of health (SDoH) data in pharmacy practice to optimize patient care services, reduce healthcare disparities, and improve healthcare access and equity; further,

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

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

*Note: This policy supersedes ASHP policy 2249.*

**Pharmacy Accreditations, Certifications, and Licenses (86.7%)**

*Source: Council on Pharmacy Management*

To advocate that healthcare accreditation, certification, and licensing organizations adopt consistent standards for the medication-use process, based on established evidence-based principles of patient safety and quality of care; further,

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

*Note: This policy supersedes ASHP policy 1810.*

**ASHP Statement on Leadership as a Professional Obligation (98.1%)**

*Source: Council on Pharmacy Management*

To approve the ASHP Statement on Leadership as a Professional Obligation.

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

**ASHP Statement on Criteria for an Intermediate Category of Drugs (90.9%)**

*Source: Council on Therapeutics*

To discontinue the ASHP Statement on Criteria for an Intermediate Category of Drugs.

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

**Reducing Healthcare Sector Carbon Emissions to Promote Public Health (81.9%)**

*Source: Council on Pharmacy Practice*

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

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

**ASHP Statement on Precepting as a Professional Obligation (83.4%)**

*Source: Section of Pharmacy Educators*

To approve the ASHP Statement on Precepting as a Professional Obligation.

**NOTES ON VOTING**

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



## HOUSE OF DELEGATES

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

<b>OFFICERS AND BOARD OF DIRECTORS</b>			
Paul C. Walker, President			
Nishaminy Kasbekar, President-Elect			
Linda S. Tyler, Immediate Past President			
Christene M. Jolowsky, Treasurer			
Paul W. Abramowitz, Chief Executive Officer			
Kim W. Benner, Board Liaison, Council on Education and Workforce Development			
Leigh A. Briscoe-Dwyer, Board Liaison, Council on Pharmacy Management			
Samuel V. Calabrese, Board Liaison, Council on Public Policy			
Vivian Bradley Johnson, Board Liaison, Council on Pharmacy Practice			
Pam Phelps, Board Liaison, Council on Therapeutics			
Jamie S. Sinclair, Board Liaison, Commission on Affiliate Relations			
Melanie A. Dodd, Chair of the House			
<b>PAST PRESIDENTS</b>			
Roger Anderson	Fred Eckel	Robert Lantos	Kelly Smith
John Armitstead	Rebecca Finley	Herman Lazarus	Thomas Thielke
Daniel Ashby	Lisa Gersema	Gerald Meyer	Sara White
Paul Baumgartner	Diane Ginsburg	John Murphy	T. Mark Woods
Jill Martin Boone	Harold Godwin	Cynthia Raehl	David Zilz
Cynthia Brennan	Mick Hunt	Philip Schneider	
Bruce Canaday	Clifford Hynniman	Kathryn Schultz	
Jannet Carmichael	Marianne Ivey	Bruce Scott	
Kevin Colgan	Thomas Johnson	Steven Sheaffer	
Debra Devereaux	Stan Kent	Janet Silvester	
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<b>U.S. Air Force</b>	Lt Col Rohin Kasudia	Lt Col Jin Kim
<b>U.S. Army</b>	LTC Joe Taylor	MAJ Ryan Constantino
<b>U.S. Navy</b>	LT Staci Jones	LT Chirag Patel
<b>U.S. Public Health Service</b>	LCDR Kali Autrey	LCDR Bryan "Russ" Gunter CDR Christopher McKnight (Coast Guard)
<b>Veterans Affairs</b>	Heather Ourth	Anthony Morreale Virginia "Ginny" Torrise



# House of Delegates

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## **HOUSE OF DELEGATES**

### **REPORT OF THE**

### **COMMITTEE ON NOMINATIONS**

June 11, 2023

Baltimore, Maryland

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

## ASHP COMMITTEE ON NOMINATIONS

Madam Chair, Fellow Delegates:

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

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

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

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

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

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

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

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

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

PRESIDENT-ELECT: 4 accepted

BOARD OF DIRECTORS: 17 accepted

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

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

#### **President-Elect**

Leigh A. Briscoe-Dwyer, PharmD, BSPHarm, BCPS, FASHP (Johnson City, NY)

Kristina (Kristy) L. Butler, PharmD, BSPHarm, BCACP, FASHP, FOSHP (Portland, OR)

#### **Board of Directors, 2024-2027**

Jeffrey J. Cook, PharmD, MS, MBA, CHFP (Little Rock, AR)

Dawn M. Moore, PharmD, MS, CPEL, FACHE (Indianapolis, IN)

Douglas C. Slain, PharmD, BCPS, FASHP (Morgantown, WV)

Majid-Theodore R. Tanas, PharmD, MHA, MS, FASHP (Portland, OR)

#### **Board of Directors, 2023-2025**

Marie A. Chisholm-Burns, PharmD, PhD, MPH, MBA, FACHE, FASHP, FAST (Portland, OR)

Kristine (Kristi) K. Gullickson, PharmD, MBA, DPLA, FASHP, FMSHP (Minneapolis, MN)

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

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

## CANDIDATES FOR PRESIDENT 2024–2025

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

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

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

### **Statement:**

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

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

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

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

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

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

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

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

**Statement:**

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

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

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

## CANDIDATES FOR BOARD OF DIRECTORS 2024–2027

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

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

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

### **Statement:**

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

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

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

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

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

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

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

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

**Statement:**

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

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

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

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



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

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

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

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

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

**Statement:**

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

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

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

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

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

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

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

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

**Statement:**

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

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

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

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

*We are better together.*

## CANDIDATES FOR BOARD OF DIRECTORS 2023–2025

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

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

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

### **Statement:**

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

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

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

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

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

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

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

**Statement:**

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

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



# House of Delegates

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

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# COUNCIL ON PHARMACY PRACTICE

## POLICY RECOMMENDATIONS

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

Vivian Johnson, *Board Liaison*

### **Council Members**

Kuldip Patel, *Chair* (North Carolina)  
Jennifer Morris, *Vice Chair* (Texas)  
Earnest Alexander (Florida)  
Jason Babby (New York)  
Michelle Chu (California)  
Angela Colella (Wisconsin)  
Kailee Fretland (Minnesota)  
Clarissa Garcia, *Student* (California)  
Terri Jorgenson (Maryland)  
Christopher Pack (Oklahoma)  
Josie Quick (North Dakota)  
Aaron Steffenhagen (Wisconsin)  
Amanda Wollitz (Florida)  
Anna Legreid Dopp, *Secretary*

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### **1. Emergency Medical Kits**

- 1 To recognize the importance of immediate, readily accessible emergency medical kits
- 2 (EMKs) in locations inaccessible to emergency medical services; further,
  
- 3 To advocate for the inclusion of pharmacist expertise in the interprofessional decisions
- 4 related to stocking and maintaining medications in EMKs; further,
  
- 5 To collaborate with other professions and stakeholders to determine appropriate
- 6 locations for EMKs.

### **Rationale**

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

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

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

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

### **Background**

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

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

- 1 To encourage pharmacists to engage in community outreach efforts to provide
- 2 education on the risks associated with use of medications for nonmedical purposes or
- 3 from nonmedical sources; further,
- 4 To encourage pharmacists to advise authorities, patients, and the community on the
- 5 dangers of using medications for nonmedical purposes.



**Rationale**

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

**Background**

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

**3. Standardization of Medication Concentrations**

- 1 To support adoption of nationally standardized drug concentrations and dosing units for
- 2 medications administered to adult and pediatric patients, and to limit those
- 3 standardized concentrations and dosing units to one concentration and one dosing unit
- 4 when possible; further,
  
- 5 To encourage interprofessional collaboration on the adoption and implementation of
- 6 standardized drug concentrations and dosing units across the continuum of care;
- 7 further,
  
- 8 To encourage manufacturers and outsourcing facilities to provide medications in those
- 9 standardized concentrations when it is clinically appropriate and feasible.

*Note: This policy would supersede ASHP policy 1306.*

**Rationale**

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

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

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

### **Background**

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

To ~~develop~~ support adoption of nationally standardized drug concentrations and dosing units for ~~commonly used high-risk drugs that are given as continuous infusions~~ medications administered to adult and pediatric patients, and to limit those standardized concentrations and dosing units to one concentration and one dosing unit when possible; further,

~~To encourage all hospitals and health systems to use infusion devices that interface with their information systems and include standardized drug libraries with dosing limits, clinical advisories, and other patient safety enhancing capabilities~~; further,

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

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

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

#### 4. Pharmacoequity

- 1 To recognize that disparities in standards of care negatively impact healthcare
- 2 outcomes and compromise pharmacoequity in marginalized and underserved
- 3 populations; further,
  
- 4 To recognize the impact of social determinants of health on pharmacoequity and
- 5 patient outcomes; further,
  
- 6 To advocate that the pharmacy workforce identify and address threats and patient
- 7 vulnerabilities to pharmacoequity as part of comprehensive medication management
- 8 services; further,
  
- 9 To advocate for resources, including technology, that improve access to care for
- 10 underserved populations where pharmacy access is limited; further,
  
- 11 To raise awareness about implicit and unconscious bias in healthcare decision-making
- 12 that may compromise pharmacoequity; further,
  
- 13 To advocate for drug availability, drug pricing structures, and insurance coverage
- 14 determinations that promote pharmacoequity.

#### **Rationale**

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

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

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

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

### **Background**

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

## **5. Medication Administration by the Pharmacy Workforce**

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

*Note: This policy would supersede ASHP policy 9820.*

### **Rationale**

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

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

### **Background**

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

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

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

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

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

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

## **6. Reducing Healthcare Sector Carbon Emissions to Promote Public Health**

- 1 To promote reducing carbon emissions from the healthcare sector through
- 2 collaboration with other stakeholders; further,
- 3 To encourage members of the pharmacy workforce to seek out opportunities to engage
- 4 in efforts to reduce carbon emissions in their workplaces and communities.

### **Rationale**

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

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

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

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

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

### **Background**

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

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

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

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# COUNCIL ON THERAPEUTICS POLICY RECOMMENDATIONS

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

Pamela K. Phelps, *Board Liaison*

## **Council Members**

Kelly Bobo, *Chair* (Tennessee)  
Russel Roberts, *Vice Chair* (Massachusetts)  
Scott Bolesta (Pennsylvania)  
Rachel Bubik (Minnesota)  
Rachel Chandra (Ohio)  
Jerika Lam (California)  
Zahra Nasrazadani (Kansas)  
Kristy Nguyen (Oregon)  
David Silva (Connecticut)  
Thomas Szymanski (West Virginia)  
Erica Um, *Student* (Missouri)  
Kate Ward (Nevada)  
Vicki Basalyga, *Secretary*

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## **1. Availability and Use of Fentanyl Test Strips**

- 1 To affirm that fentanyl test strips (FTS) have a place in harm reduction strategies for
- 2 people who use drugs; further,
- 3 To support legislation that declassifies FTS as drug paraphernalia; further,
- 4 To promote continued widespread availability of and access to FTS at limited to no cost
- 5 to the public; further,
- 6 To foster research, education, training, and the development of resources to assist the
- 7 pharmacy workforce, other healthcare workers, patients, and caregivers in the use and
- 8 utility of FTS; further,
- 9 To support the pharmacy workforce in their roles as essential members of the
- 10 healthcare team in educating the public and healthcare providers about the role of FTS
- 11 in public health efforts.

## **Rationale**

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



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

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

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

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

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

### **Background**

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

## 2. Manipulation of Drug Products for Alternate Routes of Administration

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

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

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

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

### **Rationale**

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

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

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

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

### **Background**

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

### **3. DEA Scheduling of Controlled Substances**

- 1 To advocate that the Drug Enforcement Administration (DEA) establish clear,
- 2 measurable criteria and a transparent process for scheduling determinations; further,
  
- 3 To urge the DEA to use such a process to re-evaluate existing schedules for all
- 4 substances regulated under the Controlled Substances Act to ensure consistency and
- 5 incorporate current science-based evidence concerning scheduling criteria; further,
  
- 6 To advocate that the United States Congress define the terms *potential for abuse*,
- 7 *currently accepted medical use*, and *accepted safety for use* in the Controlled
- 8 Substances Act; further,
  
- 9 To monitor the effect of DEA scheduling of products under the Controlled Substances
- 10 Act and other abuse-prevention efforts (e.g., prescription drug monitoring programs) to

- 11 assess the impact on patient access to these medications and on the practice burden of  
12 healthcare providers; further,
- 13 To advocate for the alignment of federal and state laws to eliminate barriers to research  
14 on and therapeutic use of Schedule I substances.

*Note: This policy would supersede ASHP policy 1315.*

### **Rationale**

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

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

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

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

reporting.

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

### **Background**

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

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

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

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

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

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

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

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

- 4 To oppose reclassification of currently available drugs used for PrEP and PEP to  
5 nonprescription status; further,
- 6 To advocate for legislation and regulation that expands pharmacist scope of practice to  
7 encompass initiation of PrEP and PEP therapy; further,
- 8 To advocate that the therapies and associated care for PrEP and PEP are available to  
9 patients with zero cost-sharing; further,
- 10 To support establishment of specific and structured criteria to guide comprehensive  
11 pharmacist interventions related to PrEP and PEP; further,
- 12 To support the research, education, and training of the pharmacy workforce on the  
13 therapeutic, psychosocial, and operationalization considerations of pharmacist-provided  
14 PrEP and PEP therapy; further,
- 15 To support educating the public regarding the public health benefits of PrEP and PEP.

### **Rationale**

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

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

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

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

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

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

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

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

### **Background**

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

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

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

- 1 To advocate for laws and regulations that would include performing point-of-care
- 2 testing (POCT) and associated diagnosis, referral, prescribing, dosing, and dispensing
- 3 clinically indicated by POCT in pharmacists' scope of practice; further,
  
- 4 To support the development of specific and structured criteria for pharmacist
- 5 diagnosis, referral, prescribing, dosing, and dispensing based on POCT; further,
  
- 6 To support the diagnosis and tracking of reportable diseases through pharmacist-
- 7 managed POCT and reporting to public health agencies when appropriate; further,
  
- 8 To foster research on patient access and public health improvements, cost savings, and
- 9 revenue streams associated with pharmacist-managed POCT and related patient care
- 10 services; further,
  
- 11 To promote training and education of the pharmacy workforce to competently engage
- 12 in POCT and related patient care services.

*Note: This policy would supersede ASHP policy 2229.*

### **Rationale**

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



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

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

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

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

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

### **Background**

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

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

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

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

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

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

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

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

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

## 6. Nonprescription Availability of Oseltamivir

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

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

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

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

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

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

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

*Note: This policy would supersede ASHP policy 2116.*

### **Rationale**

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

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

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

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

### **Background**

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

~~To support expanded access to oseltamivir through a proposed intermediate category of drug products, as described by ASHP policy, that would be available from all pharmacists and licensed healthcare professionals (including pharmacists) who are authorized to prescribe medications, rather than nonprescription designation; further,~~

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

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

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

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

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

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

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

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

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

## 7. Over-the-Counter Availability of Oral Contraceptives

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

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

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

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

*Note: This policy would supersede ASHP policy 1410.*

### **Rationale**

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

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

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

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

### **Background**

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

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

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

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

~~To support expanded access to these products through a proposed intermediate category of drug products, as described by ASHP policy, that would be available from all~~

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

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

## 8. Responsible Medication-Related Clinical Testing and Monitoring

- 1 To recognize that overuse of clinical testing leads to unnecessary costs, waste, and  
2 patient harm; further,
- 3 To encourage the development of standardized measures of appropriate clinical testing  
4 to better allow for appropriate comparisons for benchmarking purposes and use in  
5 research; further,
- 6 To promote pharmacist accountability and engagement in interprofessional efforts to  
7 promote judicious use of clinical testing and monitoring, including multi-faceted,  
8 organization-level approaches and educational efforts; further,
- 9 To promote research that evaluates pharmacists' contributions and identifies  
10 opportunities for the appropriate ordering of medication-related procedures and tests;  
11 further,
- 12 To promote the use of interoperable health information technology services and health  
13 information exchanges to decrease unnecessary testing.

*Note: This policy would supersede ASHP policy 1823.*

### **Rationale**

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

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

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

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

### **Background**

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

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

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

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



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

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

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

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

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

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

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

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

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

*Note: This policy would supersede ASHP policy 1718.*

#### **Rationale**

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

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

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

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

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

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

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

### **Background**

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

~~To support medication and disease management of transgender patients as a part of care unique to this population; further,~~

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

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

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

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

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

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

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

## **10. Removal of Injectable Promethazine from Hospital Formularies**

<sup>1</sup> To advocate that injectable promethazine be removed from hospital formularies; further,

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

*Note: This policy would supersede ASHP policy 1831.*

### **Rationale**

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

Promethazine is a known vesicant that can cause tissue damage and necrosis when extravasation occurs during IV administration, and it has negative effects on cardiac conduction. Although therapeutic alternatives are available for most indications, the alternative therapies are also not without risk and may not be as effective in some clinical situations. Processes to limit the potential for patient harm when IV administration of promethazine is indicated include but are not limited to use of therapeutic alternatives (e.g., 5-HT<sub>3</sub> receptor antagonists, antipsychotic agents, antihistamines); use of alternate routes and modalities of administration (e.g., oral, rectal); and restrictions on use (e.g., nonformulary, nonstocked status and removal from order sets and protocols). While prior guidance provided practice recommendations to mitigate the risk of injectable promethazine use (e.g., minimum drug dilution, continuous nurse monitoring of infusion, administration through a running IV line), a 2006 ISMP survey of hospitals revealed poor adherence to these recommendations, despite the well-documented risks of circumventing them. Although medication regimens for some specific patient populations may include injectable promethazine, many guidelines for management of disease states in which promethazine may have a role do not recommend injectable promethazine as an agent of initial choice, indicating it should be used as last line/salvage therapy. Often, these guidelines do not include injectable promethazine as a therapeutic option at all; given the number and variety of suitable alternatives, the risks of using this medication outweigh the benefits. Finally, since ISMP has recommended injectable promethazine’s removal from formularies, there is not much data on its safety and efficacy, as implementation of the recommendation has varied across the U.S., and what data is available has been mostly

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

### **Background**

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

To advocate that injectable intravenous promethazine be removed from hospital formularies used only when medically necessary; further,

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

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

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

To advocate that injectable promethazine be removed from hospital and health-system formularies; further,

To recommend that hospitals and health systems that continue to use injectable promethazine develop policies that strictly limit use to specific patient populations and utilize administration techniques that minimize risk of preventable harm; further,

To encourage the Food and Drug Administration to review the most current patient safety data and ~~consider withdrawing injectable promethazine from the market~~ re-evaluate injectable promethazine's market status.

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

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# COUNCIL ON EDUCATION AND WORKFORCE DEVELOPMENT POLICY RECOMMENDATION

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

Kim Benner, *Board Liaison*

## **Council Members**

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

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

- 1 To affirm that occupational burnout adversely affects an individual's well-being and  
2 healthcare outcomes; further,
- 3 To acknowledge that the healthcare workforce encounters unique stressors throughout  
4 their education, training, and careers that contribute to occupational burnout; further,
- 5 To declare that healthcare workforce well-being and resilience requires shared  
6 responsibility among healthcare team members and between individuals and  
7 organizations; further,
- 8 To encourage individuals to embrace well-being and resilience as a personal  
9 responsibility that should be supported by organizational culture; further,
- 10 To promote that pharmacy leadership collaborate with their institutions to assess the  
11 well-being and resilience of the pharmacy workforce and identify effective prevention  
12 and intervention strategies; further,

- 13 To encourage hospitals and health systems to invest in the development and  
14 assessment of programs aimed at prevention, recognition, and treatment of  
15 occupational burnout, and to support participation in these programs; further,
- 16 To encourage education, research and dissemination of findings on stress, burnout, and  
17 well-being; further,
- 18 To collaborate with other professions and stakeholders to identify effective prevention  
19 and intervention strategies that support well-being at an individual, organizational, and  
20 system level.

*Note: This policy would supersede ASHP policy 1825.*

### **Rationale**

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

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

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



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

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

### **Background**

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

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

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

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

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

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

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

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

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

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## SECTION OF PHARMACY EDUCATORS POLICY RECOMMENDATION

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

Melanie A. Dodd, *Board Liaison*

### **Executive Committee**

James A. Trovato, *Chair* (Maryland)  
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### **1. ASHP Statement on Precepting as a Professional Obligation**

- <sup>1</sup> To approve the ASHP Statement on Precepting as a Professional Obligation (Appendix).

## Appendix:

### ASHP Statement on Precepting as a Professional Obligation

#### 1 **Position**

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

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

#### 19 **Background**

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

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

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

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

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

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

### **Value of precepting**

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

82 professional growth ensues, and institutional metrics improve.<sup>3,10</sup>

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

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

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

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

## 121 **Responsibilities of stakeholders**

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

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

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

#### 143 **Responsibilities of professional organizations**

144 Professional organizations play a pivotal role in the development of precepting standards and  
145 preceptor development resources. ASHP and ACPE provide guidance on the standards and  
146 requirements for preceptor training and development.<sup>6,8</sup> Professional organizations should  
147 collaborate with preceptors, healthcare institutions, and colleges of pharmacy to provide  
148 practical and contemporary preceptor development resources and programming to meet the  
149 standards. These organizations are equipped to spotlight best teaching practices and practice  
150 models of their diverse members.<sup>16</sup> Professional organizations are also positioned to advocate  
151 for the importance of precepting and preceptor development to pharmacists and healthcare  
152 institutions.

#### 153 **Responsibilities of colleges of pharmacy and postgraduate training programs**

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

#### 161 **Responsibilities of healthcare institutions**

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

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

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

### 188 **Responsibilities of preceptors**

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

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

### 208 **Incorporating precepting into practice**

209 Serving as a liaison between classroom education and practical application, preceptors are role  
210 models for the practice of pharmacy and share the art of the profession with learners.

211 Preceptors are vital to modeling professionalism, communication, and application of skills and  
212 knowledge when they advise, mentor, and provide feedback during thoughtfully designed  
213 experiential learning. Additionally, throughout postgraduate training, it is imperative that  
214 trainees not only learn to precept effectively, but also to employ those skills by becoming  
215 preceptors themselves following completion of postgraduate training. All pharmacists with  
216 practice experience, including those with and without postgraduate training, have a  
217 responsibility to be involved in the precepting process.

218 Preceptors have a responsibility to be involved not only in training learners, but also in  
219 the continuous quality improvement process of the training. Both colleges of pharmacy and  
220 postgraduate trainee programs have set standards for continuous quality improvement. ACPE  
221 2016 Standard 20 requires that colleges of pharmacy solicit preceptors for continuous quality  
222 improvement of educational programs, especially in experiential learning, and ASHP standards  
223 require that preceptors provide input related to continuous improvement and formal  
224 postgraduate trainee program evaluation.<sup>6,8</sup> These efforts ensure that experiential learning for  
225 both students and postgraduate trainees remain parallel with contemporary practice.  
226 Preceptors and learners are vital to these quality improvement processes to ensure patient care  
227 and outcomes and institutional metrics are optimized.

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

### 236 **Conclusion**

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



## References

1. American Association of Colleges of Pharmacy. Oath of a Pharmacist. <https://www.aacp.org/sites/default/files/2021-12/oath-of-a-pharmacist-pdf-2021.pdf> (accessed December 15, 2022).
2. Lyons K, McLaughlin JE, Khanova J et al. Cognitive apprenticeship in health sciences education: a qualitative review. *Adv in Health Sci Educ.* 2017; 22:723-739.
3. DeRemer CB, Gant KO, Ordonez ND et al. Precepting fundamentals. In: *Preceptor's Handbook for Pharmacists*, 4th ed. Bethesda, MD: American Society of Health-System Pharmacists; 2020:1-26.
4. Persky AM, Fuller KA, Cate OT. True entrustment decisions regarding entrustable professional activities happens in the workplace, not in the classroom setting. *Am J Pharm Educ.* 2021; 85:Article 8356.
5. American Association of Colleges of Pharmacy. Curriculum Outcomes and Entrustable Professional Activities (COEPA) 2022. Patient Care Provider Domains and Example Supporting Tasks. <https://www.aacp.org/sites/default/files/2022-11/coepa-document-final.pdf> (accessed December 15, 2022).
6. American Society of Health-System Pharmacists. ASHP Accreditation Standard for Postgraduate Residency Programs. <https://www.ashp.org/-/media/assets/professional-development/residencies/docs/examples/ASHP-Accreditation-Standard-for-Postgraduate-Residency-Programs-effective-July-2023.pdf> (accessed December 15, 2022).
7. Danielson J, Craddick K, Eccles D et al. A qualitative analysis of common concerns about challenges facing pharmacy experiential programs. *Am J Pharm Educ.* 2015; 79(1):Article 06.
8. Accreditation Council for Pharmacy Education. Accreditation Standards and Key Elements for the Professional Program in Pharmacy Leading the Doctor of Pharmacy Degree. Standards 2016. <https://www.acpe-accredit.org/pdf/Standards2016FINAL.pdf> (accessed December 15, 2022).
9. American Society of Health-System Pharmacists. ASHP Match Statistics. Natmatch.com. <https://natmatch.com/ashprmp/stats.html> (accessed December 15, 2022).
10. Mersfelder TL, Bouthilier MJ. Value of the student pharmacist to experiential practice sites: a review of the literature. *Ann Pharmacother.* 2012; 46:541-8.
11. Taylor CT, Adams AJ, Albert EL et al. AACP Reports. Report of the 2014-2015 Professional Affairs Standing Committee: producing practice-ready pharmacy graduates in an era of value-based health care. *Am J Pharm Educ.* 2015;79: Article s12.
12. Pinelli NR, Eckel SF, Vu MB et al. The layered learning practice model: Lessons learned from implementation. *Am J Health-Syst Pharm.* 2016; 73:2077-82.
13. Slack MK, Martin JM, Islam S. A systematic review of extramural presentations and publications from pharmacy student research programs. *Am J Pharm Educ.* 2016; 80:Article 100.
14. Delgado O, Kernan WP, Knoer SJ. Advancing the pharmacy practice model in a community teaching hospital by expanding student rotations. *Am J Health-Syst Pharm.* 2014; 71:1871-6.

15. Soric MM, GŁowczewski JE, Lerman RM. Economic and patient satisfaction outcomes of a layered learning model in a small community hospital. *Am J Health-Syst Pharm*. 2016; 73(7): 456-462.
16. Worrall CL, Chaira DS, Aistropeb EA et al. AACP Reports. Priming the preceptor pipeline: Collaboration, resources, and recognition: The Report of the 2015-2016 Professional Affairs Standing Committee. *Am J Pharm Educ*. 2016; 80: Article S19.
17. Walter S, Mulherin K, Cox CD. A preceptor competency framework for pharmacists. Part 2 of a 3-part series. *Curr Pharm Teach Learning*. 2018;10:402-410.
18. Larson S, Davis LE, Stevens AM et al. Development of a tool to assess and advance the effectiveness of preceptors: the habits of preceptors rubric. *Am J Health-Syst Pharm*. 2019; 76:1762-9.
19. Accreditation Council for Pharmacy Education. Accreditation Council for Pharmacy Education Guidance on Continuing Professional Development (CPD) for the Profession of Pharmacy. <https://www.acpe-accredit.org/pdf/CPDGuidance%20ProfessionPharmacyJan2015.pdf> (accessed December 15, 2022).
20. Tofade T, Kim J, Lebovitz L et al. Introduction of a continuing professional development tool for preceptors: lessons learned. *J Pharm Pract*. 2015; 28:212-219.
21. Eva KW, Regehr G. "I'll never play professional football" and other fallacies of self-assessment. *J Contin Educ Health Prof*. 2008; 28:14-19.
22. Davis LE, Pogge EK, Larson S, Storjohann T, Early N. Evaluating the change in preceptor habits while enrolled in a teaching and learning curriculum using the habits of preceptors rubric. *J Am Coll Clin Pharm*. 2021; 4:137-146.

### Additional Information

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### Disclosures

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## 2023 Report of the ASHP Treasurer

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**Keywords:** assets, finance, operations

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

### Fiscal Year 2022 Ending May 31, 2022—Actual

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

ASHP's core operations<sup>1</sup> were impacted by the lingering effects of COVID-19. Core gross revenue was \$43.8 million (Figure 1), down by \$7.1 million compared to FY2021. The gross revenue decrease was primarily attributable to the Midyear Clinical Meeting & Exhibition (MCM) being held as a virtual meeting with significantly reduced registration pricing and a decrease in paid registration. This was favorably offset by successes in other areas. ASHP achieved a record number of members at 60,315 on December 31, 2021, with a related increase in membership

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



revenue. We also showed record revenue from our professional certificates, certifications programs, and accreditation services. In addition, ASHP was awarded a Health Resources and Services Administration grant to advance the well-being of the healthcare workforce. Core net income was a loss of \$4.15 million. Net program development, capital budget, and investments<sup>2</sup> were a net loss of \$4.2 million. In total, FY2022 resulted in a negative \$8.4 million net change in ASHP's reserves/net assets.

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

### Fiscal Year 2023 Ending May 31, 2023—Projected

FY2023 core operations are shaping up to be a record year, with projected core gross revenue of \$57.8 million. As of February 28, 2023, we anticipate that ASHP's FY2023 core net income will be in the range of \$2.2 million

(Figure 1). Assuming the financial markets stabilize for the remainder of the fiscal year, we are projecting a deficit of \$2.6 million for program development expenses, capital budget, and investments. This results in a negative net change in reserves/net assets of \$337,000. Finally, we anticipate the building fund will have a deficit of \$4.6 million.

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

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

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

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

\*Projection as of February 28, 2023.

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

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

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

**Fiscal Year 2024 Ending May 31, 2024 – Budget**

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

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

Considering these and other factors, ASHP’s FY2024 budgeted net change in reserves/net assets is a surplus of \$243,000, with \$59.7 million in core gross revenue. The building fund,

which is designed to pay for ASHP’s headquarters office space, is budgeted to break even.

**Conclusion**

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

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

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<sup>1</sup>Represents the revenue and expense associated with the operations of ongoing ASHP programs, products, and services,

as well as infrastructure and ASHP Foundation support.

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<sup>2</sup>Includes investments in ASHP's program development and capital budget, building sale reserve funds, reserves/net assets spending, and investment gains/(losses). The Board of Directors approves spending during ASHP's annual budget development process. Expenditures are typically (1) associated with new, enhanced, and expanded programs; (2) associated with time-limited programs;

(3) capital asset purchases; or (4) supplemental operating expenses. These expenditures are primarily funded by investment income from reserves/net assets and the building sale reserve funds.

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

## Joint address from the President and the Chief Executive Officer

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

**Am J Health-Syst Pharm.** 2023;XX:0-0

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

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

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

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

We are better together in every way that ASHP supports its members, our

profession, and the patients we serve. And we have accomplished much this past year through collaboration and a shared vision that the pharmacy profession, and ASHP, are leaders in meeting the demands of future pharmacy practice and patient care delivery models.

### Collaborations

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

Our collaborations span numerous efforts with government, non-profit, and industry partners. For example, our collaboration with the Future of Pharmacy Care Coalition, of which ASHP is an executive committee member, has generated extensive support for the Equitable

Community Access to Pharmacist Services Act,<sup>1</sup> which ensures patient access to pharmacist care.

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

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

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

## Advocacy

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

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

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

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

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

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

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

## Workforce

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

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

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

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

We are all well aware of the current challenges facing our workforce.

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

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

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

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



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

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

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

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

To further elevate ASHP's support for the nation's hospital and health-system leaders of tomorrow, the Pharmacy Administration and Leadership Residents' Collaborative (PALRC) serves as a home within ASHP for unique offerings for the Health-System Pharmacy Administration and Leadership (HSPAL) resident community. The PALRC is the advisory committee of HSPAL residents and

includes 3 workgroups: Student and Resident Engagement, Advocacy and Practice Advancement, and HSPAL Resident Resources. Over the past year, the PALRC has hosted multiple virtual roundtables and published several leadership-focused resources, including a podcast and infographic.

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

### Well-being

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

### Innovation

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

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

use, improve clinical outcomes, and streamline operations.

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

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

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

### Diversity, equity, and inclusion

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

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

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

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

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

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

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

### World-class education and content

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

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

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

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

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

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

I invite you all to listen to June's special Pride Series, a daily

5-minute podcast featuring ASHP members sharing reflections to inspire inclusivity, acceptance, and the celebration of diversity.

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

### Conclusion

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

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

### Disclosures

The authors have declared no potential conflicts of interest.

### References

1. American Society of Health-System Pharmacists. National pharmacist organizations applaud House introduction of provider status legislation. Published March 24, 2023. Accessed June 30, 2023. <https://www.ashp.org/news/2023/03/24/national-pharmacist-organizations-applaud-house-introduction-of-provider-status-legislation>
2. HR 1770, the Equitable Community Access to Pharmacist Services Act,

- 118th Cong (2023-2024). Accessed June 30, 2023. <https://www.congress.gov/bill/118th-congress/house-bill/1770/text>
- American Society of Health-System Pharmacists. Pharmacy technician shortage survey findings: executive summary. Accessed June 30, 2023. <https://www.ashp.org/-/media/assets/pharmacy-technician/docs/Technician-Shortage-Survey-Exec-Summary.pdf>
  - Pharmacy Technician Certification Board. PTCB releases 2022 pharmacy technician workforce survey results. Accessed June 30, 2023. <https://www.ptcb.org/news/ptcb-releases-2022-pharmacy-technician-workforce-survey-results>
  - American Society of Health-System Pharmacists. ASHP Task Force on Racial Diversity, Equity, and Inclusion: 2022 implementation report. Accessed June 30, 2023. <https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/Inclusion-Center/docs/DEI-Task-Force-2022-Update.pdf>
  - American Society of Health-System Pharmacists. Report of the ASHP Task Force on Racial Diversity, Equity, and Inclusion. *Am J Health-Syst Pharm*. 2021;78:903-906. doi:10.1093/ajhp/zxab078
  - American Society of Association Executives. ASAE announces 2023 Gold Circle Award winners. Published June 1, 2023. Accessed June 30, 2023. [https://www.asaecenter.org/about-us/news\\_releases/2023/asae-announces-2023-gold-circle-award-winners](https://www.asaecenter.org/about-us/news_releases/2023/asae-announces-2023-gold-circle-award-winners)



# House of Delegates

## **2023 NEW BUSINESS SUBMISSION FORM**

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

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

**ASHP  
HOUSE OF DELEGATES  
JUNE 13, 2023  
BALTIMORE, MARYLAND**

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

*Date Submitted: June 12, 2023*

*Time Submitted: 1:03 p.m.*

**INTRODUCED BY (NAME):**

Jodi Taylor (TN), Jesse Hogue (MI)

**SUBJECT:**

Discontinuing ASHP policy “Nonprescription Availability of Self-Administered Influenza Antivirals”

**MOTION:**

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

**BACKGROUND:**

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

**SUGGESTED OUTCOMES:**

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

# Appendix IX



# House of Delegates

## **NEW BUSINESS SUBMISSION FORM**

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

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

**ASHP  
HOUSE OF DELEGATES  
JUNE 13, 2023  
BALTIMORE, MARYLAND**

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

***Date Submitted: June 12, 2023***

***Time Submitted: 3:06 p.m.***

### **INTRODUCED BY (NAME):**

**Jaelyn Boyle - SACP**  
Ryan Gibbard – OR  
Monica Mahoney – MA  
Melissa Ortega – SCPP  
Sarah Stephens – SICP

### **SUBJECT:**

Compensation for pharmacist cognitive services

### **MOTION APPROVED:**

To adopt the following as a new ASHP policy:

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

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

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

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

**BACKGROUND:**

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

**Additional rationale from the ASHP Policy 2020, Care-Commensurate Reimbursement:**

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

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

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

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

**Additional rationale from the ASHP Statement on Primary Care:**

*Billing and reimbursement for primary care pharmacy services*

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

References:

<https://www.ashp.org/-/media/assets/policy-guidelines/docs/statements/pharmacists-role-primary-care.pdf>

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

ASHP Policies 2020, 2134, 2232

**SUGGESTED OUTCOMES:**

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



# Appendix X



# House of Delegates

## **2023 NEW BUSINESS SUBMISSION FORM**

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

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

**ASHP  
HOUSE OF DELEGATES  
JUNE 13, 2023  
BALTIMORE, MARYLAND**

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

***Date Submitted: June 12, 2023***

***Time Submitted: 3:20 p.m.***

### **INTRODUCED BY (NAME):**

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

### **SUBJECT:**

Barcodes with Lot and Expiration Date Needs and Impacts

### **MOTION APPROVED:**

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

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

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

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

**BACKGROUND:**

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

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

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

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

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

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

Current 2D scanners can read 1D and 2D barcodes. Past arguments 19 years ago that hospitals do not have the barcode readers to read 2D barcodes are no longer valid. Many products dispensed are saleable packages that only contain 2D barcodes. In addition, 2D barcode readers are significantly less expensive and more reliable than the 1D laser scanners used in the past.

GS1, the barcode standards organization that defines medication barcode standards has invited stakeholders to provide input on how GS1 can better support industry needs. This is a call-out to organizations such as ASHP to communicate the need for lot, expiration and on immediate products and to work with GS1 to assure the resulting barcodes meet the need in health systems. Such communication with GS1 should include the barcoding of repackaged products and investigational medications. This is the invite statement from GS1: “Manufacturers should be moving toward 2D to support forward movement in adoption and use. Downstream trading partners should focus on scanning and consuming - the time is now to move in this direction. As stakeholders across the healthcare supply chain begin to adopt scanning and consuming of data from GS1 DataMatrix barcodes further detail may be needed to support this industry.

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

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

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

**SUGGESTED OUTCOMES:**

That ASHP adopt the proposed policy.

## Recommendations from the 2023 House of Delegates

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

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

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

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

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

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



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

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

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

	<p>Motion that ASHP create a new policy regarding Independent Prescribing Authority or to revise/combine existing ASHP policies 2236, 2251, and 1822.</p> <p><b>Background:</b> ASHP has several policies related to independent prescriptive authority, however, the SACP would like to request that a review/revision of existing policies 2236, 2251, and 1822 be considered. Additionally, we recommend that additional clauses are added related to:</p> <ul style="list-style-type: none"> <li>- Access to a diagnosis related to prescribing a given medication</li> <li>- Ensuring access and the ability to document in the patient’s medical record</li> <li>- Ensuring access for pharmacists to order labs related to the prescribing/monitoring of a given medication</li> <li>- Establishing a credentialing and privileging process as well as a peer review process before independent prescribing authority be granted</li> </ul> <p>Several policies reference independent prescribing authority (ASHP Policies 2251, 2125, 2236, 2211, 2229, 2116, 1909, 1822) and there is likely an opportunity for policy to be streamlined or revised to be aspirational related to independent prescribing authority.</p>	<p>(TN), Melissa Ortega (SCPP)</p>
<p>27</p>	<p><b>Inclusion of Term “Red Flag” in the Controlled Substances Act</b>                  To advocate for the inclusion of the term “red flags” in the controlled substances act in 21 CFR 1306.</p> <p><b>Background:</b> Although the term “red flags” is used and considered apart, the term is not codified in the CSA. The lack of inclusion has presented severe issues when state regulatory agencies are challenged in drug diversion cases. The inclusion of this term in the CSA would establish consistent language to be followed by state CSAs, in addition to inclusion in the CSA, the term should also be included in the DEA’s Pharmacists’ (illegible text)</p>	<p>Diane Ginsburg (Past President)</p>
<p>28</p>	<p><b>Electronic maintenance and submission of the Academic and Professional Record</b>                  The SICP recommends ASHP establish an online form or database to facilitate the maintenance and submission of the Academic and Professional Record within Pharmacademic.</p> <p><b>Background:</b> Currently, the process for documenting the APR is cumbersome and inefficient both for Residency Program Directors and Preceptors. Optimization of this process to allow for online entry and maintenance is requested to ease administrative burden for all. Additionally, an online database has the ability to capture and collate information for multi-program site locations.</p>	<p>Sarah Stephens (SICP)</p>
<p>29</p>	<p><b>Measuring the Impact of Residency Training Programs</b>                  ASHP should compile and release metrics used by health systems to assess the impact of residency programs on patient and health-</p>	<p>Nancy MacDonald (SCSS), Chris Edwards (AZ), Christi Jen (SCSS), Andrew Mays (MS)</p>

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

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

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

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

Am J Health-Syst Pharm. 2023;XX:0-0

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

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

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

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

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

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innovative American spirit with Indian culture and traditions.

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

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

### Mentors and motivators

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

Thank you to many of you here in the audience, my “ASHP Pharmily,” for your wonderful support and guidance over the years. To my Penn Medicine and Penn Presbyterian Medical Center

Leadership—Kevin Mahoney, Michele Volpe, and Bob Russell—thank you for allowing me to live and share my passion for all things pharmacy for the last 27 years. Your support has allowed me to advance the role of pharmacists and technicians as essential to patient-centered care.

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

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

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

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

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

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

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

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

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

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

### The change imperative

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

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

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

### Tools and resources for driving change

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

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

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

These initiatives support our pharmacy leaders to drive innovation, drive

towards a better future, and drive to Be The Change.

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

### Pharmacy’s key role in shaping the digital future

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

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

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

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

in medication safety across the healthcare spectrum.

Adopting new technologies quickly allows us to create efficiencies, automate functions, and offer predictive solutions for our patients and our profession. Transactional tasks will be reduced, allowing us to do what we love to do and what we are good at, which is providing expertise with humanness. This future cannot be created without us, because we remain fundamental to patient care.

### How to be an agent of change

My commitment to these changes begins with me. During my term as your ASHP president, I am prepared to Be The Change and elevate the vital roles that health-system pharmacy

practitioners play as providers in new and emerging science, and to prepare the workforce for the digital future of pharmacy practice.

What role will you play in this pharmacy transformation? I have asked a few of my friends to help share some tips for how you can Be The Change. They said:

- Be the voice. Share your knowledge and stories to inspire others in our profession.
- Be more. Take deliberate and strategic steps to move your career to the next level.
- Be an advocate. Influence the advancement and growth of our profession.

- Be good. Balance your life by living well and being adaptable and resilient.
- Be brave. Immerse yourself in new technologies and drive healthcare transformation.

Did you hear what I heard? They said, “Be the voice. Be more. Be an advocate. Be good. Be brave.” I would like to see you be amazing and Be The Change in your organizations and in our profession.

Thank you so much.

### Disclosures

The author has declared no potential conflicts of interest.