



# House of Delegates

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## Consolidated Documents: June 2023 ASHP House of Delegates

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### Contents

1. House of Delegates Agenda
2. House of Delegates Roster (as of May 31)
3. Report on the 2022 House of Delegates
4. Report on the March Virtual House of Delegates
5. Report on the May Virtual House of Delegates
6. Report of the Committee on Nominations
7. Board Report on Policy Recommendations
8. Treasurer's Report
9. House of Delegates Meetings-at-Glance
10. First Delegate Caucus Agenda
11. Second Delegate Caucus Agenda
12. Open Forum Agenda
13. June 2023 House of Delegates Antitrust Statement
14. June 2023 House of Delegates Seating Chart
15. Parliamentary Terms Often Used in the ASHP House of Delegates

*<click on title to go to page>*

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# House of Delegates

## AGENDA

**ASHP House of Delegates  
Baltimore, Maryland**

**Presiding – Melanie A. Dodd  
Chair, House of Delegates**

### FIRST MEETING

**Baltimore Convention Center  
Sunday, June 11, 2023  
1:00 – 5:00 p.m.**

1. CALL TO ORDER
2. ROLL CALL OF DELEGATES
3. REPORT ON PREVIOUS SESSION
4. RATIFICATION OF PREVIOUS ACTIONS
5. REPORT OF COMMITTEE ON NOMINATIONS
6. BOARD OF DIRECTORS REPORTS
  - a. COUNCIL ON PHARMACY PRACTICE  
Vivian Bradley Johnson, Board Liaison
  - b. COUNCIL ON THERAPEUTICS  
Pamela K. Phelps, Board Liaison
  - c. COUNCIL ON EDUCATION AND WORKFORCE DEVELOPMENT  
Kim W. Benner, Board Liaison
  - d. SECTION OF PHARMACY EDUCATORS  
Linda S. Tyler, Immediate Past President
7. REPORT OF THE TREASURER
8. RECOMMENDATIONS OF DELEGATES
9. ANNOUNCEMENTS
10. ADJOURNMENT OF FIRST MEETING

## SECOND MEETING

Baltimore Convention Center  
Tuesday, June 13, 2023  
4:00 – 6:00 p.m.

1. CALL TO ORDER
2. QUORUM CALL
3. REPORT OF THE PRESIDENT AND THE CEO  
Paul C. Walker
4. UNFINISHED AND NEW BUSINESS
5. RECOMMENDATIONS OF DELEGATES
6. INSTALLATION OF OFFICERS AND DIRECTORS
7. ANNOUNCEMENTS
8. ADJOURNMENT OF SECOND MEETING



## HOUSE OF DELEGATES

Melanie A. Dodd, Chair

Linda S. Tyler, Vice Chair

As of May 31, 2023

OFFICERS AND BOARD OF DIRECTORS			
Paul C. Walker, President			
Nishaminy Kasbekar, President-Elect			
Linda S. Tyler, Immediate Past President			
Christene M. Jolowsky, Treasurer			
Paul W. Abramowitz, Chief Executive Officer			
Kim W. Benner, Board Liaison, Council on Education and Workforce Development			
Leigh A. Briscoe-Dwyer, Board Liaison, Council on Pharmacy Management			
Samuel V. Calabrese, Board Liaison, Council on Public Policy			
Vivian Bradley Johnson, Board Liaison, Council on Pharmacy Practice			
Pamela K. Phelps, Board Liaison, Council on Therapeutics			
Jamie S. Sinclair, Board Liaison, Commission on Affiliate Relations			
Melanie A. Dodd, Chair of the House			
PAST PRESIDENTS			
Roger Anderson	Rebecca Finley	Lynnae Mahaney	Thomas Thielke
John Armitstead	Lisa Gersema	Gerald Meyer	Sara White
Daniel Ashby	Diane Ginsburg	John Murphy	T. Mark Woods
Paul Baumgartner	Harold Godwin	Cynthia Raehl	David Zilz
Jill Martin Boone	Mick Hunt	Philip Schneider	
Cynthia Brennan	Clifford Hynniman	Kathryn Schultz	
Bruce Canaday	Marianne Ivey	Bruce Scott	
Kevin Colgan	Thomas Johnson	Steven Sheaffer	
Debra Devereaux	Stan Kent	Janet Silvester	
Fred Eckel	Robert Lantos	Kelly Smith	
STATE	DELEGATES		ALTERNATES
<b>Alabama (3)</b>	Nancy Bailey Laura Matthews Megan Roberts		Joshua Settle
<b>Alaska (2)</b>	Shawna King Laura Lampasone		
<b>Arizona (3)</b>	Janelle Duran Christopher Edwards Danielle Kamm		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	Tala Ataya
<b>Colorado (3)</b>	Clint Hinman Lance Ray Tara Vlasimsky	Sarah Anderson
<b>Connecticut (3)</b>	Osama Abdelghany 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 Mark Mierzwa	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 Jenna Rose	Emmeline Paintsil Melanie Ryan Marisa Zweifel
<b>Kansas (3)</b>	Brian Gilbert Joanna Robinson Katie Wilson	
<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>	Monica Mahoney Francesca Mernick Marla O'Shea-Bulman Russel Roberts	Jacqueline Gagnon
<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>	Lindsey Firman 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>	Amy Buesing Nick Crozier	Lisa Anselmo
<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

<b>North Carolina (4)</b>	Angela Livingood Mary Parker Mollie Scott Tyler Vest	Stephen Eckel
<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 Christopher Pack Andrea Rai	Corey Guidry
<b>Oregon (3)</b>	Ryan Gibbard Michael Lanning Edward Saito	Ryan Wargo
<b>Pennsylvania (4)</b>	Paul Green Arpit Mehta Kim Mehta Christine Roussel	Jennifer Belavic Scott Bolesta Joseph Stavish
<b>Puerto Rico (2)</b>	Jennifer Rivera Idaliz Rodriguez Escudero	Mirza Martínez Giselle Rivera
<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 Todd Canada Rodney Cox Randy Martin Binita Patel	Todd Connor Bradi Frei Jerry James
<b>Utah (3)</b>	Elyse MacDonald Anthony Trovato David Young	Kavish Choudhary Whitney Mortensen 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	Sue Carr
<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 Jaime Bobinmyer Hornecker	
<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>	Charnae Ross	Justin Moore
<b>Pharmacy Student Forum</b>	Ma Emmanuelle (Ella) Domingo	Austen Werab
<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





# House of Delegates

## REPORT ON IMPLEMENTATION OF 2022

### ASHP HOUSE OF DELEGATES ACTIONS AND RECOMMENDATIONS

#### **Council on Education and Workforce Development 2201: State-Specific Requirements for Pharmacist and Pharmacy Technician Continuing Education**

To advocate for the standardization of state pharmacist and pharmacy technician continuing education requirements; further,

To advocate that state boards of pharmacy adopt continuing professional development as the preferred model to maintain competence.

*This policy supersedes ASHP policy 1111.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Education and Workforce Development 2202: ASHP Statement on Professionalism**

To approve the ASHP Statement on Professionalism.

*This statement supersedes the ASHP Statement on Professionalism dated June 26, 2007.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Education and Workforce Development 2203: Preceptor Skills and Abilities**

To collaborate with pharmacy organizations and colleges of pharmacy on the development of standards to enhance the quality of experiential education and pharmacy residency precepting; further,

To provide tools, education, and other resources to develop and evaluate preceptor skills.

*This policy supersedes ASHP policy 1201.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts. The ASHP Preceptor Competency Assessment Center was created to ensure faculty members or preceptors have the ongoing knowledge and skills needed to meet their responsibilities to the professional program. ASHP developed a four-part value of precepting mini-series to discover why becoming a pharmacy preceptor can offer benefits to pharmacy professionals, organizations, and their learners.

#### **Council on Pharmacy Management 2204: Mobile Health Tools, Clinical Apps, and Associated Devices**

To advocate that patients, pharmacists, and other healthcare professionals be involved in the selection, approval, and management of patient-centered mobile health tools, clinical software applications ("clinical apps"), and associated devices used by clinicians and patients for patient care; further,

To foster development of tools and resources to assist pharmacists in designing and assessing processes to ensure safe, accurate, supported, and secure use of mobile health tools, clinical apps, and associated devices; further,

To advocate that decisions regarding the selection, approval, and management of mobile health tools, clinical apps, and associated devices consider patient usability, acceptability, and usefulness and should further the goal of delivering safe and effective patient care that optimizes outcomes; further,

To advocate that mobile health tools, clinical apps, and associated devices that contain health information be interoperable and, if applicable, be structured to allow incorporation of health information into the patient's electronic health record and other essential clinical systems to facilitate optimal health outcomes; further,

To advocate that pharmacists be included in regulatory and other evaluation and approval of mobile health tools, clinical apps, and associated devices that involve medications or medication management; further,

To encourage patient education and assessment of competency in the use of mobile health technologies; further,

To enhance patient awareness on how to access and use validated sources of health information integrated with mobile health tools, clinical apps, and associated devices.

*This policy supersedes ASHP policy 1708.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts. The potential for Mobile Health Tools, Clinical Apps, and Associated Devices to improve healthcare is expansive as technology becomes more sophisticated and accessible. The tools allow for patients to become active in their own healthcare. The topic has been addressed in *AJHP* articles and ASHP podcasts.

***AJHP articles:***

- [Implementation and evaluation of an EHR-integrated mobile dispense tracking technology in a large academic tertiary hospital](#)
- [Exploring the effects of a smartphone-based meditation app on stress, mindfulness, well-being, and resilience in pharmacy students](#)
- [ASHP Statement on Telehealth Pharmacy Practice](#)

***ASHP podcasts:***

- [Impact of Telehealth Services on Outcomes and the Future of Healthcare Delivery](#)
- [Implementing Digital Health & Health Information Technology in Pharmacy](#)

This policy is included in our communications with policymakers and healthcare stakeholders regarding policy, practice, and regulatory considerations for pharmacist leadership, patient experience, and considerations related to effective system design for safe medication use and patient safety.

**Council on Pharmacy Management 2205: Transitions of Care**

To encourage the pharmacy workforce to assume responsibility for medication-related aspects of ensuring the continuity of care as patients move from one care setting to another; further,

To encourage the development, optimization, and implementation of technologies that facilitate sharing of patient-care data across care settings and interprofessional care teams; further,

To advocate that health systems provide sufficient resources to support the important roles of the pharmacy workforce in supporting transitions of care; further,

To encourage payers to provide reimbursement for transitions of care services; further,

To encourage the development of strategies to address the gaps in continuity of pharmacist patient care services, including effective patient engagement.

*This policy supersedes ASHP policy 1208.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts. The topic has been addressed in *AJHP* articles and an ASHP podcast.

**ASHP podcast:**

- [Getting Started with Transitions of Care Pharmacy Services](#)

**AJHP articles:**

- [Impact of a pharmacist-driven transitions of care clinic for a multisite integrated delivery network](#)
- [Pharmacist involvement in a comprehensive remote monitoring and telemanagement program](#)

This policy is included in our communications with policymakers and healthcare stakeholders regarding policy, practice, and regulatory considerations for pharmacist leadership, patient experience, continuity of care, and considerations related to effective system design for safe medication use and patient safety.

### Council on Pharmacy Management 2206: Continuous Performance Improvement

To encourage the pharmacy workforce to establish multidisciplinary continuous performance improvement (CPI) processes within their practice settings to assess the effectiveness and safety of patient care services, adherence to standards, and quality and integrity of practice; further,

To encourage the pharmacy workforce to use contemporary CPI techniques and methods for ongoing improvement in their services; further,

To support the pharmacy workforce in their development and implementation of CPI processes.

*This policy supersedes ASHP policy 0202.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts. The topic has been addressed in *AJHP* articles and ASHP webinars.

**AJHP articles:**

- [Virtual clinical pharmacy services: A model of care to improve medication safety in rural and remote Australian health services](#)
- [Protected professional practice evaluation: A continuous quality-improvement process](#)

**ASHP webinars:**

- [Quality Measurement for Health-System Specialty Pharmacy Practice: Current and Future Trends](#)
- [Quality Measurement for Community Pharmacy Practice: Current and Future Trends](#)

This policy is included in our communications with policymakers and healthcare stakeholders regarding policy, practice, and regulatory considerations for pharmacist leadership, continuity of care, and considerations related to effective system design for safe medication use and patient safety.

**Council on Pharmacy Practice 2207: Institutional Review Board and Investigational Use of Drugs**

To support mandatory education and training on human subject protections and research bioethics for members of institutional review boards (IRBs), principal investigators, and all others involved in clinical research; further,

To advocate that principal investigators discuss their proposed clinical drug research with representatives of the pharmacy department before submitting a proposal to the IRB; further,

To advocate for the pharmacist's roles in ethical clinical research, including but not limited to serving as a principal investigator, developing protocols, executing research, determining rational-use decisions for the off-label use of drug products, and publishing research findings, and for adequately resourced, sustainable models for filling those roles; further,

To advocate that IRBs include pharmacists as voting members; further,

To advocate that IRBs inform pharmacy of all approved clinical research involving drugs within the hospital or health system; further,

To advocate that pharmacists act as liaisons between IRBs and pharmacy and therapeutics committees in the management and conduct of clinical drug research studies; further,

To support pharmacists' management of drug products used in clinical research.

*This policy supersedes ASHP policy 0711.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts. The ASHP policy is reflected in the following activities:

- [ASHP Guidelines for the Management of Investigational Drug Products](#) falls in line with pharmacists properly managing and documenting the use of investigational products especially on reception, storage, dispensing, returns, and final disposition. The pharmacist ensures the research participant's safety as well as protect the integrity of clinical study data. Training of research pharmacist includes IRB training and standard operating procedures when being approved for the clinical study.
- The ASHP Foundation advocates for pharmacy, practice-based research with eLearning free to the public: [Essentials of Practice-Based Research for Pharmacists](#). The focus is with pharmacy residents and to provide a foundation for clinical research. The ASHP Foundation also has a [Research Advisory Council](#) whose function is to "enhance the capacity to do research, including developing the researchers, resources, and innovative research models."
- ASHP offers an [Investigational Drug Services Certificate](#) and [Research Skills Certificate](#) for both pharmacist and pharmacy technicians.

This policy is included in our communications with policymakers and healthcare stakeholders regarding policy, practice, and regulatory considerations for pharmacist leadership, research, and considerations related to effective healthcare system-design for safe medication use and patient safety.

#### **Council on Pharmacy Practice 2208: Pharmacist's Role in Team-Based Care**

To recognize that pharmacists, as core members and medication-use experts on interprofessional healthcare teams, increase the capacity and efficiency of teams for delivering evidence-based, safe, high-quality, and cost-effective patient-centered care; further,

To advocate to policymakers, payers, and other stakeholders for the inclusion of pharmacists as care providers within team-based care and as the provider of comprehensive medication management services; further,

To assert that all members of the interprofessional care team have a shared responsibility in coordinating the care they provide and are accountable to the patient and each other for the outcomes of that care; further,

To urge pharmacists on healthcare teams to collaborate with other team members in establishing and implementing quality and outcome measures for care provided by those teams.

*This policy supersedes ASHP policy 1215*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts. The ASHP policy is reflected in the ASHP [Interprofessional Practice & Education Toolkit](#), which provides robust resources for the establishment of pharmacy as a part of the multidisciplinary healthcare team.

#### **AJHP articles:**

- [Interdisciplinary relationship dynamics](#)
- [Publication rates of pharmacy residents involved in a team-based research program](#)
- [Impact of pharmacist participation in the patient care team on value-based health measures](#)
- [Call for pharmacists to join vascular safety teams](#)
- [Team science, layered learning, and mentorship networks: The trifecta for maximizing scholastic achievement for clinical pharmacists](#)

#### **ASHP podcast:**

- [Candid conversations: Developing integrated interprofessional teams that embrace pharmacy learners and improve patient outcomes](#)

This policy is included in our communications with policymakers and healthcare stakeholders regarding policy, practice, and regulatory considerations for pharmacist leadership, multidisciplinary collaboration, and considerations related to effective healthcare system-design for safe medication use and patient safety.

#### **Council on Public Policy 2209: Drug Testing as Part of Diversion Prevention Programs**

To advocate for the use of pre-employment and random or for-cause drug testing during employment based on defined criteria and with appropriate testing validation procedures; further,

To support employer- or government-sponsored drug diversion prevention programs that include a policy and process that promote the recovery of impaired individuals; further,

To advocate that employers use validated testing panels that have demonstrated effectiveness detecting commonly abused or illegally used substances.

*This policy supersedes ASHP policy 1717.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Public Policy 2210: Drug Samples**

To oppose drug sampling or similar drug marketing programs that circumvent appropriate pharmacy oversight or control.

*This policy supersedes ASHP policy 9702.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Therapeutics 2211: Naloxone Availability**

To recognize the public health benefits of naloxone for opioid reversal; further,

To support efforts to safely expand patient and public access to naloxone through independent pharmacist prescribing authority, encouraging pharmacies to stock naloxone, supporting availability of affordable formulations of naloxone (including zero-cost options), and other appropriate means; further,

To advocate for statewide naloxone standing orders to serve as a prescription for individuals who may require opioid reversal or those in a position to aid a person requiring opioid reversal; further,

To support and foster standardized education and training on the role of naloxone in opioid reversal and its proper administration, safe use, and appropriate follow-up care, and dispelling common misconceptions to the pharmacy workforce and other healthcare professionals; further,

To support the use of objective clinical data, including leveraging state prescription drug monitoring programs and clinical decision-making tools, to facilitate pharmacist-initiated screenings to identify patients who may most benefit from naloxone prescribing; further,

To encourage the co-prescribing of naloxone with all opioid prescriptions; further,

To support legislation that provides protections for those seeking or providing medical help for overdose victims.

*This policy supersedes ASHP policy 2014.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Therapeutics 2212: Safe and Effective Therapeutic Use of Invertebrates**

To recognize use of medical invertebrates (e.g., maggots and leeches) as an alternative treatment in limited clinical circumstances; further,

To educate pharmacists, other providers, patients, and the public about the risks and benefits of medical invertebrates use and about best practices for use; further,

To advocate that pharmacy departments, in cooperation with other departments, provide oversight of medical invertebrates to assure appropriate formulary consideration and safe procurement, storage, use, and disposal; further,

To encourage independent research and reporting on the therapeutic use of medical invertebrates.

*This policy supersedes ASHP policy 1724.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Therapeutics 2213: Criteria for Medication Use in Geriatric Patients**

To support comprehensive medication management, including assessment of physiologic and pharmacokinetic factors, as a central component of providing safe and effective medication therapy to geriatric patients; further,

To oppose use of the Beers criteria or similar criteria by the Centers for Medicare & Medicaid Services, other accreditation and quality improvement entities, and payers as the sole indicator to assess the appropriateness of prescribing for geriatric patients based on known limitations in the evidence evaluating the association between use of medications listed in such criteria and subsequent adverse drug events; further,

To advocate for the development, refinement, and validation of new criteria that consider drug-, disease-, and patient-specific factors, and criteria and quality measures that demonstrate the ability to decrease the occurrence of adverse drug events in geriatric patients; further,

To support research to assess the clinical application of existing and proposed criteria, including assessment of their correlation to patient outcomes and strategies for implementation; further,

To encourage inclusion of validated criteria in clinical decision support systems and other information technologies to facilitate prescribing and deprescribing for geriatric patients; further,

To acknowledge that such criteria are intended as a guide and should not replace the clinical judgment of pharmacists and other clinicians.

*This policy supersedes ASHP policy 1221.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Therapeutics 2214: Medication Adherence**

To recognize that medication adherence improves the quality and safety of patient care when the following elements are included: (1) assessment of the appropriateness of therapy, (2) provision of patient education, and (3) confirmation of patient comprehension of information necessary to support safe and appropriate use of prescribed therapies; further,

To advocate that the pharmacy workforce take a leadership role in interdisciplinary efforts to improve medication adherence; further,



To recognize that clinicians, patients, and caregivers share accountability for the outcomes of medication therapies, and that the central role patients and their caregivers have in disease management includes responsibility for following instructions for safe and effective medication use; further,

To encourage development, evaluation, and dissemination of models and tools that improve adherence, including those that combine existing strategies that have demonstrated effectiveness; further,

To oppose misinformation or disinformation that leads patients to decline education and clinical information regarding their medication therapy; further,

To support the development of mechanisms to document medication adherence interventions, including information technology solutions; further,

To advocate for payment models that facilitate an expanded role for the pharmacy workforce in and provide reimbursement for medication adherence efforts.

*This policy supersedes ASHP policy 1222.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Section of Pharmacy Informatics and Technology 2215: ASHP Statement on the Pharmacy Technician's Role in Pharmacy Informatics**

To approve the ASHP Statement on the Pharmacy Technician's Role in Pharmacy Informatics.

*This statement supersedes the ASHP Statement on the Pharmacy Technician's Role in Pharmacy Informatics dated June 3, 2013.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Education and Workforce Development 2216: Career Counseling**

To advocate that structured student-centered career counseling begin early and continue throughout college of pharmacy curricula; further,

To urge pharmacists to partner with colleges of pharmacy for participation in structured and unstructured student-centered career counseling; further,

To encourage colleges of pharmacy to provide professional development opportunities for faculty and other pharmacy professionals to promote equitable and inclusive student-centered career counseling approaches; further,

To urge colleges of pharmacy to develop an assessment process to evaluate the equity and inclusivity of their career counseling.

*This policy supersedes ASHP policy 8507.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts. ASHP's outreach to student pharmacists at colleges of pharmacy at Historically Black Colleges and Universities (HBCUs), Hispanic Serving Institutions (HSIs), and schools of pharmacy with high BIPOC enrollment increased by 267% in the 2022 academic year with 17 scheduled



outreach visits. In 2022, BIPOC participation grew by 77% from its initial offering of the ASHP Guided Mentorship program that pairs student pharmacists with seasoned practitioners for a six-month mentorship experience through structured, virtual one on one mentor and mentee relationships.

#### **Council on Education and Workforce Development 2217: Workforce Diversity**

To affirm that a diverse and inclusive workforce contributes to improved health equity and health outcomes; further,

To advocate for the development and retention of a workforce whose background, perspectives, and experiences reflect the diverse patients for whom care is provided; further,

To advocate that institutions incorporate diversity, equity, and inclusion initiatives into daily practices and strategic plans.

*This policy supersedes ASHP policy 1705.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts. The [ASHP Inclusion Center](#) showcases ASHP's longstanding commitment to nurturing the principles of diversity, equity, and inclusion in the pharmacy community. The site is a home for ASHP's collection of resources, including clinical and editorial content from *AJHP*, on-demand CE programs, and member spotlights. This ASHP policy is also reflected in the following activities:

- [Report of the ASHP Task Force on Racial Diversity, Equity, and Inclusion](#)
- ASHP's [Writing Inclusive Job Descriptions: Gender-Neutral Language Recommendations](#)

#### **AJHP articles:**

- [Leading diversity, equity, and inclusion efforts within the pharmacy department](#)
- [Walker calls for diverse and inclusive pharmacy workforce](#)

#### **ASHP podcasts:**

- [Speaking Clearly: Inclusive and Bias-Free Negotiations](#)
- [Implementing Diversity, Equity, and Inclusion Initiatives in Schools and Colleges of Pharmacy](#)
- [MCM 2021 DEI Feature: Integration and Advancement of Diversity, Equity, and Inclusion in the Pharmacy Workplace](#)
- [Sowing the Seeds for Sustainable Change in Diversity, Equity and Inclusion - Creation of a Pharmacy Diversity Council](#)
- [Draft Recommendations from the ASHP Task Force on Racial Diversity, Equity, and Inclusion](#)

#### **ASHP webinars:**

- [Speaking Clearly: Inclusive and Bias Free Negotiations in All Your Transactions](#)
- [Laying the Foundation \(Part 1\): How to Understand You and Your Role in Inclusive Conversations](#)

#### **Council on Pharmacy Management 2218: Pharmacy Executive Oversight of Areas Outside Pharmacy**

To advocate for opportunities for pharmacy leaders to assume healthcare executive leadership roles outside the pharmacy department; further,

To urge pharmacy leaders to seek out formal and informal opportunities to provide such leadership; further,

To encourage pharmacy leaders to use tools, resources, and credentialing identified by national pharmacy and professional healthcare organizations to demonstrate competence and readiness for healthcare executive leadership; further,

To encourage pharmacy leaders to support development of leaders with a broader scope of executive responsibilities by balancing generalization and service-line specialization in their career development and the career development of rising pharmacy leaders; further,

To advocate for healthcare organization structures that provide pharmacy leaders with opportunities to assume leadership responsibilities outside the pharmacy department; further,

To promote continuing professional development opportunities in executive leadership to provide pharmacy leaders with evidence of a commitment to lifelong learning and leadership excellence.

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts. The [Pharmacy Executive Leadership Alliance \(PELA\)](#) is an initiative from ASHP to elevate pharmacy executives into innovators, advocacy, and expanding networks outside the scope of pharmacy. The [ASHP Statement on the Roles and Responsibilities of the Pharmacy Executive](#) defines roles of top executive pharmacists and how they may qualify for higher positions beyond the scope of pharmacy.

**AJHP Article:**

- [Leveraging the pharmacy executive beyond the pharmacy enterprise: Opportunities for advocacy, senior leadership integration, and strategic positioning](#)

**ASHP podcasts:**

- [Pharmacy Leadership and Oversight of Additional Service Lines](#)
- [System Integration: Establishing Governance, Accountabilities, and Policies](#)

This policy is included in our communications with policymakers and healthcare stakeholders regarding policy, practice, and regulatory considerations for pharmacist leadership and continuity of care.

**Council on Pharmacy Practice 2219: Hospital-at-Home Care**

To affirm that patients treated in the hospital-at-home (HAH) setting are entitled to the same level of care as those treated in an inpatient hospital setting; further,

To support HAH care models that provide high-quality, patient-centered pharmacist care, including but not limited to: (1) clinical pharmacy services that are fully integrated with the care team; (2) a medication distribution model that is fully integrated with the providing organization's distribution model and in which the organization's pharmacy leader retains authority over the medication-use process; (3) information technology (IT) systems that are integrated or interoperable with the organization's IT systems and that allow patient access to pharmacy services, optimize medication management, and promote patient safety; and (4) ensuring the safety of the pharmacy workforce throughout the HAH care delivery process; further,

To advocate that pharmacists be included in the planning, implementation, and maintenance of HAH programs; further,

To advocate for legislation and regulations that would promote safe and effective medication use in the HAH care setting, and for adequate reimbursement for pharmacy services, including clinical pharmacy services, provided in the HAH care setting; further,

To provide education, training, and resources to empower the pharmacy workforce to care for patients in HAH care settings and to support the organizations providing that care; further,

To encourage research on HAH care models.

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts. The ASHP policy is reflected in the following activities:

- Initial analysis of the CMS Hospital at Home program was done in the [Issue Analysis of the CMS Hospital-at-Home Program](#). The article highlighted key areas for consideration of pharmacy involvement and the asked questions on the preparedness of health systems to adopt this novel care model.
- ASHP, in conjunction with the Mayo Clinic, has created the [Home Hospital Pharmacy Playbook](#) to have a guide for the medication management of acutely ill patients living in their residence. The playbook goes in depth of the clinical services and medication use process for pharmacists. The pharmacy model provided is an example to establish a home hospital practice for pharmacy.
- The November 2021 [ASHP Pharmacy Executive Leadership Alliance Virtual Conference](#) convened to discuss the future of hospital at home with integration of pharmacy services to “ensure optimal medication outcomes.”

#### **AJHP articles:**

- [Executive summary of the meeting of the 2022 ASHP Commission on Goals: Optimizing Hospital at Home and Healthcare Transformation](#)
- [Hospital at home: Development of pharmacy services](#)
- [Developing pharmacy services in a home hospital program: The Mayo Clinic experience](#)
- [Health-system pharmacy executives discuss hospital-at-home model at ASHP’s third PELA event](#)

#### **ASHP podcasts:**

- [Hospital at Home: Operational Considerations](#)
- [Hospital at Home: Clinical Considerations](#)

#### **ASHP webinars:**

- [Acute Hospital Care at Home Program - Pharmacy Perspectives Operationalizing the CMS Initiative](#)
- [Hospital at Home: Integrating Pharmacy Clinical Services and Ensuring Proper Medication Oversight](#)

#### **ASHP News and Press Releases:**

- [Policy Week 2021 Kicks Off with Hospital-at-Home Event](#)

This policy is included in our communications with policymakers and healthcare stakeholders regarding policy, practice, and regulatory considerations for pharmacist leadership, patient experience, continuity of care, cost analysis, and considerations related to effective healthcare system-design for safe medication use and patient safety.

#### **Council on Pharmacy Practice 2220: Promoting Telehealth Pharmacy Services**

To advocate for innovative telehealth pharmacy practice models that (1) enable the pharmacy workforce to promote clinical patient care delivery, patient counseling and education, and efficient pharmacy operations; (2) improve access to pharmacist comprehensive medication management services; (3) advance patient-

centric care and the patient care experience; and (4) facilitate pharmacist-led population and public health services and outreach; further,

To advocate for removal of barriers to access to telehealth services; further,

To advocate for laws, regulations, and payment models for telehealth services that are equitable to similar services provided in person by health systems, with appropriate accountability and oversight; further,

To encourage comparative effectiveness and outcomes research on telehealth pharmacy services.

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts. The ASHP policy is reflected in the following activities:

- A new Section for Digital and Telehealth Practitioners was created in November 2022 with the goal of addressing the rapidly evolving advances in telehealth and virtual healthcare delivery, data utilization, and digital health technology. The section provides a unique new membership home within ASHP for pharmacists, student pharmacists, pharmacy residents, pharmacy technicians, and all who are currently practicing or aspire to practice in telehealth and virtual care settings where current and emerging digital healthcare technologies and data are being utilized for the betterment of patient care. As of April 2023, the Section has over 844 members and has launched a website with member resources and a new ASHP Connect community for Section members.
- The [ASHP Statement on Telehealth Pharmacy Practice](#) advocates for use of telehealth in pharmacy operations and patient care to improve patient outcomes, access to healthcare, cost, safety, and interprofessional collaboration. Technologies mentioned are videoconferencing, the internet, store-and-forward imaging, streaming media, and wireless communication. Pharmacists are encouraged to use mobile apps to educate patients with disease state and medication management.
- ASHP [Telehealth Resource Center](#) is a tool provided as hub for resources one could use learn more about Telehealth, especially for sources for advocacy of pharmacy in telehealth.
- [2021 PELA Virtual Health Telehealth Innovations Conference](#)

#### **AJHP articles:**

- [Executive summary of the meeting of the 2021 ASHP Commission on Goals: Optimizing Medication Outcomes Through Telehealth](#)
- [Pharmacists' impact on quality and financial metrics utilizing virtual care platforms during the coronavirus pandemic](#)
- [Impact of a pharmacist-led telehealth oral chemotherapy clinic](#)
- [Implementation of telehealth for first-dose device teaching within a health-system specialty pharmacy](#)
- [Effectiveness of telepharmacy diabetes services: A systematic review and meta-analysis](#)
- [Implementation and evaluation of an EHR-integrated mobile dispense tracking technology in a large academic tertiary hospital](#)
- [Exploring the effects of a smartphone-based meditation app on stress, mindfulness, well-being, and resilience in pharmacy students](#)

#### **ASHP podcasts:**

- [Impact of Telehealth Services on Outcomes and the Future of Healthcare Delivery](#)
- [Implementing Digital Health & Health Information Technology in Pharmacy](#)
- [Advocating for Impact: Deciphering CMS's Telehealth Changes](#)

**ASHP professional certificate:**

- [ASHP's Telehealth Certificate](#)

**ASHP webinar:**

- [COVID-19: Ambulatory Care Transition to Telehealth](#)

This policy is included in our communications with policymakers and healthcare stakeholders regarding policy, practice, and regulatory considerations for pharmacist leadership, patient experience, continuity of care, cost analysis, and considerations related to effective healthcare information system-design for safe medication use and patient safety.

**Council on Pharmacy Practice 2221: Tamper-Evident Packaging on Multidose Products**

To support the standardization and requirement of tamper-evident packaging on all multidose prescription and nonprescription products; further,

To encourage proper safety controls be in place to prevent harm and ensure proper disposal of multidose products.

*This policy supersedes ASHP policy 9211.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts. The ASHP policy is reflected in the [ASHP Guidelines on Preventing Diversion of Controlled Substances](#), which includes recommendations on multi-dose products such as diversion of the overfill in those products.

This policy is included in our communications with policymakers and healthcare stakeholders regarding policy, practice, and regulatory considerations related to effective healthcare system-design for safe medication use and patient safety.

**Council on Pharmacy Practice 2222: Pharmacist's Role in Medication Procurement, Distribution, Surveillance and Control**

To affirm the pharmacist's expertise, responsibility, and oversight in the procurement, distribution, surveillance, and control of all medications used within health systems and affiliated services; further,

To assert that the pharmacy leader retains the authority to determine the safe and reliable sourcing of medications; further,

To assert that the pharmacy workforce is responsible for the coordination of medication-related care, including optimizing access, ensuring judicious stewardship of resources, and providing intended high-quality clinical care; further,

To encourage payers, manufacturers, wholesalers, accreditation bodies, and governmental entities to enhance patient safety by supporting the health-system pharmacy workforce's role in medication procurement, distribution, surveillance, and control.

*This policy supersedes ASHP policy 0232.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts. The ASHP policy is reflected in the following activities:

- The [Toolkit for Evaluating Complex Medication Therapies and Creating Customized Scopes of Service Based on Medication Therapy Considerations](#) provides the framework for health system specialty pharmacies to procure complex medications and safety associated with them.
- When the HHS declared the Monkeypox as a public health emergency, [ASHP called on HHS Secretary Becerra to issue a Public Readiness and Emergency Preparedness \(PREP\) Act declaration](#) to allow pharmacist to order and administer the monkeypox vaccines. This call to action is one of many that ASHP advocates to expand pharmacy's access to needed therapeutics and ensuring high-quality patient healthcare.
- [ASHP Guidelines on Preventing Diversion of Controlled Substances](#) provides a robust overview on the procurement, distribution, surveillance, and control of controlled medications. This reinforces pharmacy's oversight and accountability, especially when dealing with diversion of controlled substances.
- [ASHP alongside 93 other organizations joined the End Drug Shortages Alliance](#) to find solutions to minimize and prevent drug shortages. The alliance meets with key stakeholders such as purchasing organizations, manufacturers, and distributors to resolve supply chain disruptions of essential medications.

#### ASHP certificates:

- [Pharmacy Revenue Cycle Management Certificate](#)
- [Medication Safety Certificate](#)

This policy is included in our communications with policymakers and healthcare stakeholders regarding policy, practice, and regulatory considerations for pharmacist leadership, acquisition of medications, and considerations related to effective healthcare system-design for safe medication use and patient safety.

#### Council on Pharmacy Practice 2223: ASHP Statement on the Role of the Pharmacy Workforce in Emergency Preparedness

To approve the ASHP Statement on the Role of the Pharmacy Workforce in Emergency Preparedness.

*This statement supersedes the ASHP Statement on the Role of Health-System Pharmacists in Emergency Preparedness dated June 2, 2002.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts. The ASHP policy is reflected in the following activities:

- When the HHS declared the Monkeypox as a public health emergency, [ASHP called on HHS Secretary Becerra to issue a Public Readiness and Emergency Preparedness \(PREP\) Act declaration](#) to allow pharmacist to order and administer the monkeypox vaccines. This the call to action is one of many that ASHP advocates to expand pharmacy's access to needed therapeutics and ensuring appropriate response to a state of emergency.
- In the times near the end of the Public Health Emergency (PHE) from the COVID-19 epidemic, [ASHP provided an update in preparation for a post-PHE](#) and authorizations of pharmacy services under the PREP Act.

#### AJHP article:

- [Application of emergency preparedness principles to a pharmacy department's approach to a "black swan" event: The COVID-19 pandemic](#)

**ASHP podcasts:**

- [EM Pharmacist's Role in Disaster Preparedness](#)
- [Crisis and Pandemic Management - Where do Pharmacists Fit In?](#)

This policy is included in our communications with policymakers and healthcare stakeholders regarding policy, practice, and regulatory considerations for pharmacist leadership, state of emergency, and considerations related to effective healthcare system-design for safe medication use and patient safety.

**Council on Therapeutics 2224: Drug Desensitization**

To encourage an allergy reconciliation process to ensure allergy documentation is accurate and complete for drug desensitization; further,

To advocate for pharmacist involvement in the interdisciplinary development of institutional drug desensitization policies and procedures; further,

To support the creation and implementation of drug desensitization order sets and safeguards in the electronic health record to minimize potential error risk; further,

To recommend appropriate allocation of resources needed for the drug desensitization process, including adequate availability of allergic reaction management resources near the desensitization location; further,

To support the education and training of pharmacists regarding allergy reconciliation, drug desensitization processes, and allergic reaction prevention and management; further,

To recommend patient education and appropriate documentation in the electronic health record of the outcomes of the drug desensitization process.

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

**Council on Therapeutics 2225: ASHP Statement on Pharmacist Prescribing of Statins**

To approve the ASHP Statement on Pharmacist Prescribing of Statins.

*This statement supersedes the ASHP Statement on Over-the-Counter Availability of Statins dated June 14, 2005.*

This statement has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

**Section of Ambulatory Care Practitioners 2226: ASHP Statement on the Role of Pharmacists in Primary Care**

To approve the ASHP Statement on the Role of Pharmacists in Primary Care.

*This statement supersedes the ASHP Statement on the Pharmacist's Role in Primary Care dated June 7, 1999.*

This statement has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

**Section of Pharmacy Informatics and Technology 2227: ASHP Statement on Telehealth Pharmacy Practice**

To approve the ASHP Statement on Telehealth Pharmacy Practice.

*This statement supersedes the ASHP Statement on Telepharmacy dated November 18, 2016.*



This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts. A new Section for Digital and Telehealth Practitioners was created in November 2022 with the goal of addressing the rapidly evolving advances in telehealth and virtual healthcare delivery, data utilization, and digital health technology. The section provides a unique new membership home within ASHP for pharmacists, student pharmacists, pharmacy residents, pharmacy technicians, and all who are currently practicing or aspire to practice in telehealth and virtual care settings where current and emerging digital healthcare technologies and data are being utilized for the betterment of patient care. As of April 2023, the Section has over 844 members and has launched a website with member resources and a new ASHP Connect community for Section members.

### **Council on Pharmacy Management 2228: Role of the Pharmacist in Service-Line Development and Management**

To recognize pharmacists bring unique clinical, operational, and financial expertise to help organizations develop and manage high-value health-system service lines; further,

To support the role of pharmacy leadership in the development and management of high-value health-system service lines.

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **AJHP articles:**

- [Integration of investigational drug services in an oncology service line](#)
- [Integration of a pharmacy resident into a new specialty pharmacy service line through the longitudinal research project](#)

#### **ASHP podcasts:**

- [Pharmacy Leadership and Oversight of Additional Service Lines](#)
- [Establishing Infrastructure to Develop Pharmacy Population Health and Service Line Payer Engagement](#)
- [Hospital at Home: Operational Considerations](#)

### **Council on Therapeutics 2229: Pharmacist's Role in Respiratory Pathogen Testing and Treatment**

To advocate 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 prescribing, dosing, and dispensing 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-driven testing and reporting to appropriate public health agencies prior to dispensing of antimicrobials; further,

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



To promote training and education of the pharmacy workforce to competently engage in respiratory pathogen testing and treatment when clinically indicated.

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

### **Council on Education and Workforce Development 2230: Advancing Diversity, Equity, and Inclusion in Education and Training**

To advocate that health systems and organizations cultivate training and education partnerships that advance diversity, equity, and inclusion; further,

To advocate that all members of the pharmacy workforce actively participate in the equitable training and education of people from marginalized populations.

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts. In 2022, the ASHP Commission on Credentialing (COC) approved changes to the pharmacy residency accreditation standard requiring accredited residencies to incorporate diversity and inclusion practices in the design and structure of their programs. The COC will evaluate programs using the new criteria beginning in 2023. The Diversity and Cultural Competence (DCC) workgroup, a COC subcommittee, developed the Diversity Resource Guide for Diversity in Residency Training and the Pharmacy Workforce in March 2022. The guide assists residency programs and other organizations in meeting the new standard and increasing the racial and ethnic diversity in residency programs and the pharmacy workforce. In addition, the [ASHP Inclusion Center](#) showcases ASHP's longstanding commitment to nurturing the principles of diversity, equity, and inclusion in the pharmacy community. The site is a home for ASHP's collection of resources, including clinical and editorial content from *AJHP*, on-demand CE programs, and member spotlights. This ASHP policy is also reflected in the following activities:

- [Report of the ASHP Task Force on Racial Diversity, Equity, and Inclusion](#)
- ASHP's [Writing Inclusive Job Descriptions: Gender-Neutral Language Recommendations](#)

#### ***AJHP* articles:**

- [Leading diversity, equity, and inclusion efforts within the pharmacy department](#)
- [Walker calls for diverse and inclusive pharmacy workforce](#)

#### **ASHP podcasts:**

- [Speaking Clearly: Inclusive and Bias-Free Negotiations](#)
- [Implementing Diversity, Equity, and Inclusion Initiatives in Schools and Colleges of Pharmacy](#)
- [MCM 2021 DEI Feature: Integration and Advancement of Diversity, Equity, and Inclusion in the Pharmacy Workplace](#)
- [Sowing the Seeds for Sustainable Change in Diversity, Equity and Inclusion - Creation of a Pharmacy Diversity Council](#)
- [Draft Recommendations from the ASHP Task Force on Racial Diversity, Equity, and Inclusion](#)

#### **ASHP webinars:**

- [Speaking Clearly: Inclusive and Bias Free Negotiations in All Your Transactions](#)
- [Laying the Foundation \(Part 1\): How to Understand You and Your Role in Inclusive Conversations](#)

**Council on Education and Workforce Development 2231: Cultural Competency**

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

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

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

*This policy supersedes ASHP policy 1613.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts. The [ASHP Inclusion Center](#) showcases ASHP's longstanding commitment to nurturing the principles of diversity, equity, and inclusion in the pharmacy community. The site is a home for ASHP's collection of resources, including clinical and editorial content from *AJHP*, on-demand CE programs, and member spotlights. This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts. The [ASHP Inclusion Center](#) showcases ASHP's longstanding commitment to nurturing the principles of diversity, equity, and inclusion in the pharmacy community. The site is a home for ASHP's collection of resources, including clinical and editorial content from *AJHP*, on-demand CE programs, and member spotlights. This ASHP policy is also reflected in the following activities:

- ASHP's [Writing Inclusive Job Descriptions: Gender-Neutral Language Recommendations](#)

***AJHP* article:**

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- [Sowing the Seeds for Sustainable Change in Diversity, Equity and Inclusion - Creation of a Pharmacy Diversity Council](#)

**ASHP webinars:**

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- [Laying the Foundation \(Part 1\): How to Understand You and Your Role in Inclusive Conversations](#)

**Council on Pharmacy Management 2232: Revenue Cycle Management and Reimbursement and Pharmacist Compensation for Drug Product Dispensing**

To encourage the pharmacy workforce to serve as leaders in the development and implementation of strategies to optimize medication-related revenue cycle compliance, which includes verification of prior authorization, patient portion of payment, billing, reimbursement, and financial documentation for the healthcare enterprise; further,

To advocate for the development of consistent, transparent billing and reimbursement policies and practices by both government and private payers; further,

To collaborate with payers in developing optimal methods of reimbursing pharmacies and pharmacists for the costs of drug products dispensed, pharmacy and pharmacist services, and associated overhead; further,

To educate the pharmacy workforce and stakeholders about those methods; further,

To advocate that information technology (IT) vendors enhance the capacity and capability of IT systems to support and facilitate medication-related purchasing, billing, and audit functions; further,

To investigate and publish best practices in medication-related revenue cycle compliance and management.

*This policy supersedes ASHP policies 1710 and 1807.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

**ASHP professional certificate:**

- [Pharmacy Revenue Cycle Management Certificate](#)

**ASHP advocacy:**

- [Pharmacist's role in a post public health emergency](#)
- [Advancing the Pharmacist's Role in Primary Care](#)

**ASHP podcast:**

- [Leveraging Outcomes Data and Developing Relationships with Payers](#)

**ASHP resource center:**

- [Compensation and Sustainable Business Models](#)

This policy is included in our communications with policymakers and healthcare stakeholders regarding policy, practice, and regulatory considerations for pharmacist leadership, reimbursement, and considerations related to effective system design for safe medication use and patient safety.

**Council on Pharmacy Management 2233: Value-Based Purchasing**

To support value-based purchasing reimbursement models when they are appropriately structured to improve healthcare quality, patient satisfaction, and clinical outcomes, and encourage medication error reporting and quality improvement; further,

To affirm the role of pharmacists in actively leading the design and interdisciplinary implementation of medication-related value-based purchasing initiatives; further,

To support pharmacy workforce efforts to ensure safe and appropriate medication use by using data and technology for continuous quality improvement in pharmacy-designed, medication-related value-based purchasing initiatives; further,

To advocate that the Centers for Medicare & Medicaid Services and others guide the development of a common portfolio of measures for potential alignment across regulated programs, federal programs and agencies, and the private sector.

*This policy supersedes ASHP policy 1209.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

#### ASHP news:

- [Value-based pharmacy models in population health care](#) following Pharmacy Executive Leadership Alliance (PELA®) and the Section of Pharmacy Practice Leaders forum on population health management.

#### ASHP advocacy:

- [Executive Order to the Department of Health and Human Services](#) to reduce prescription prices for beneficiaries enrolled in Medicare and Medicaid programs. The order in turn supports leaning towards a value-based model for the patient's healthcare.

This policy is included in our communications with policymakers and healthcare stakeholders regarding policy, practice, and regulatory considerations for reimbursement and considerations related to effective system design for safe medication use and patient safety.

### Council on Pharmacy Management 2234: Financial Management Skills

To foster the systematic and ongoing development of management skills for the pharmacy workforce in the areas of (1) health-system economics, (2) business plan development, (3) financial analysis, (4) metrics for clinical and distributive services, (5) pharmacoeconomic analysis, (6) diversified pharmacy services, (7) compensation for pharmacists' patient-care services, and (8) revenue cycle compliance and management; further,

To encourage colleges of pharmacy to incorporate these management areas in course work, electives (e.g., financial and managerial accounting), and experiential education; further,

To promote the growth of dual PharmD/MBA degree programs, postgraduate training, and other degree programs focused on financial management, and similar certificates or concentrations; further,

To encourage financial management skills development in pharmacy residency training programs; further,

To provide education for new practitioners and student pharmacists on foundational skills for business administration and personal financial management; further,

To promote education on financial management for other members of the pharmacy workforce (e.g., pharmacy technicians, data scientists, inventory specialists, department business managers).

*This policy supersedes ASHP policy 1207.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

**ASHP publication:**

- [Financial Management for Health-System Pharmacists, 2nd Edition](#)

**ASHP professional certificate:**

- [Pharmacy Revenue Cycle Management Certificate](#)

**AJHP articles:**

- [Financial performance and reimbursement of pharmacist-led chronic care management](#)
- [Addressing the burden of student loan debt: A case-based review of influencing considerations](#)

**ASHP podcast:**

- [Financial Wellness: How to Invest in Your Future](#)

**Council on Pharmacy Practice 2235: Use of Inclusive Verbal and Written Language**

To recognize that stigmatizing and derogatory language can be a barrier to safe and optimal patient care as well as compromise effective communication among healthcare team members; further,

To promote the use of inclusive verbal and written language in patient care delivery and healthcare communication; further,

To urge healthcare leadership to promote use of inclusive language; further,

To provide education, resources, and competencies for the pharmacy workforce to champion the use of inclusive verbal and written language.

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts. The [ASHP Inclusion Center](#) showcases ASHP's longstanding commitment to nurturing the principles of diversity, equity, and inclusion in the pharmacy community. The site is a home for ASHP's collection of resources, including clinical and editorial content from *AJHP*, on-demand CE programs, and member spotlights. The ASHP policy is also reflected in the following activities:

- [Report of the ASHP Task Force on Racial Diversity, Equity, and Inclusion](#)
- ASHP's [Writing Inclusive Job Descriptions: Gender-Neutral Language Recommendations](#)

**AJHP articles:**

- [Leading diversity, equity, and inclusion efforts within the pharmacy department](#)
- [Walker calls for diverse and inclusive pharmacy workforce](#)

**ASHP podcasts:**

- [Speaking Clearly: Inclusive and Bias-Free Negotiations](#)
- [Implementing Diversity, Equity, and Inclusion Initiatives in Schools and Colleges of Pharmacy](#)
- [MCM 2021 DEI Feature: Integration and Advancement of Diversity, Equity, and Inclusion in the Pharmacy Workplace](#)
- [Sowing the Seeds for Sustainable Change in Diversity, Equity and Inclusion - Creation of a Pharmacy Diversity Council](#)
- [Draft Recommendations from the ASHP Task Force on Racial Diversity, Equity, and Inclusion](#)

**ASHP webinars:**

- [Speaking Clearly: Inclusive and Bias Free Negotiations in All Your Transactions](#)
- [Laying the Foundation \(Part 1\): How to Understand You and Your Role in Inclusive Conversations](#)

This policy is included in our communications with policymakers and healthcare stakeholders regarding policy, practice, and regulatory considerations for inclusivity and considerations related to effective healthcare information system-design for safe medication use and patient safety.

**Council on Pharmacy Practice 2236: Pharmacist Prescribing in Interprofessional Patient Care**

To advocate that healthcare delivery organizations establish credentialing and privileging processes for pharmacists that delineate scope of practice, support pharmacist prescribing, and ensure that pharmacists who prescribe are accountable, competent, and qualified to do so; further,

To advocate for comprehensive medication management that includes autonomous prescribing authority for pharmacists as part of optimal interprofessional care; further,

To advocate that all pharmacists on the interprofessional team have a National Provider Identifier (NPI); further,

To advocate that payers recognize pharmacist NPIs.

*This policy supersedes ASHP policy 1213.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts. The ASHP policy is reflected in the following activities:

- Due to ASHP advocacy efforts the US Office of Personnel Management (OPM) established under the [Federal Employee Health Benefits Program to reimburse pharmacists as providers for patient assessment and prescribing of COVID-19 therapy](#). The program reimburses licensed pharmacists for the patient assessment and prescribing of Paxlovid (nirmatrelvir and ritonavir). The expansion of pharmacy practice has led to a [Request for Medicaid and Children's Health Insurance Plan](#) to reimburse pharmacists under the PREP Act for payment of clinical services for pharmacists to prescribe Paxlovid. A similar letter was sent as a joint effort between multiple pharmacy organizations including ASHP to [Dr. Ashish Jha of the White House Coronavirus Task Force](#).
- Pharmacists take [an active role in prescribing hormonal contraceptives in 20 states](#), allowing for higher accessibility for birth control and have another avenue other than waiting for appointments for their primary care providers.

**AJHP articles:**

- [Pharmacist-driven assessment and prescribing of COVID-19 therapeutics: A large, tertiary academic medical center's experience](#)
- [ASHP Statement on Pharmacist Prescribing of Statins](#)
- [ASHP Statement on the Role of Pharmacists in Primary Care](#)
- [Maximizing pharmacists' scope of practice](#)

**ASHP podcasts:**

- [Provider Status for Pharmacists: Lessons Learned](#)
- [The Ohio Story: Pursuits of Pharmacy Provider Status](#)
- [Maximizing Medicaid: How Provider Status Intersects with Medicaid Coverage](#)

This policy is included in our communications with policymakers and healthcare stakeholders regarding policy, practice, and regulatory considerations for pharmacist leadership, interprofessional collaboration, and considerations related to effective healthcare system-design for safe medication use and patient safety.

#### **Council on Pharmacy Practice 2237: Universal Vaccination for Vaccine-Preventable Diseases in the Healthcare Workforce**

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

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

To support employers in establishing and implementing mandatory vaccine requirements for healthcare workers if evidence-based risk assessments determine they are safe and promote patient and public health; further,

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

To develop tools, education, and other resources to promote vaccine confidence, increase vaccination rates, and minimize vaccine-preventable diseases among healthcare workers.

*This policy supersedes ASHP policies 2138 and 2140.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts. The ASHP policy is reflected in the [ASHP stance on mandatory COVID-19 vaccination of healthcare employees](#) and [signing of a joint statement](#) calling for all healthcare employees required to be vaccinated against COVID-19.

This policy is included in our communications with policymakers and healthcare stakeholders regarding policy, practice, and regulatory considerations related to effective healthcare system-design for safe medication use and patient safety.

#### **Council on Public Policy 2238: Patient Disability Accommodations**

To promote safe, inclusive, and accessible care for patients with disabilities; further,

To advocate for research to enhance capabilities in meeting the needs of patients with disabilities; further,

To advocate for inclusion of caring for patients with disabilities in college of pharmacy and pharmacy technician program curricula and in postgraduate residencies; further,

To support pharmacy workforce training to improve awareness of the barriers patients with disabilities face and ensure equitable care.

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.



**Council on Public Policy 2239: Drug Pricing Proposals**

To advocate for drug pricing and transparency mechanisms that ensure patient access to affordable medications, preserve existing clinical services and patient safety standards, and do not increase the complexity of the medication-use system.

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

**Council on Therapeutics 2240: Post-Intensive Care Syndrome**

To recognize that multidimensional rehabilitation is essential for recovery after intensive care; further,

To support research on and dissemination of best practices in the prevention, identification, and treatment of post-intensive care syndrome (PICS) in patients of all ages; further,

To advocate that health systems support the development and implementation of interdisciplinary clinics, inclusive of pharmacists, to treat patients with PICS, including provisions for telehealth and innovative practice models to meet the needs of patients with PICS; further,

To advocate for the integration of post-ICU patient and ICU caregiver support groups; further,

To provide education on the role of the pharmacist in caring for patients with PICS.

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

**Council on Therapeutics 2241: Human Use of Veterinary Pharmaceuticals**

To oppose human use of pharmaceuticals approved only for veterinary use; further,

To support use of veterinary pharmaceuticals only under the supervision of a licensed veterinarian in compliance with the Animal Medicinal Drug Use Clarification Act of 1994; further,

To encourage state and federal regulatory bodies as well as other stakeholders to monitor the misuse of veterinary pharmaceuticals and, when appropriate, limit the public availability of those pharmaceuticals; further,

To educate healthcare professionals and the public about the adverse effects of human consumption of veterinary pharmaceuticals; further,

To encourage research, monitoring, and reporting on the adverse effects of human consumption of veterinary pharmaceuticals to define the public health impact of and to quantify the strain these agents place on the healthcare system.

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

**Council on Therapeutics 2242: Use of Intravenous Drug Products for Inhalation**

To encourage healthcare organizations to develop an interdisciplinary team that includes pharmacists and respiratory therapists to provide institutional guidance; safety recommendations regarding preparation, dispensing, delivery, and exposure; and electronic health record support for prescribing and administration of intravenous drug products for inhalational use; further,



To advocate for further research on the pharmacokinetic and pharmacodynamic characteristics of drugs not approved for inhalational administration, devices for administration, and the effects of excipients; further,

To foster the development of educational resources on the safety and efficacy of inhalational administration of drug products not approved for that route and devices for administration; further,

To encourage manufacturers to develop ready-to-use inhalational formulations when evidence supports such use.

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Therapeutics 2243: Enrollment of Underrepresented Populations in Clinical Trials**

To support the enrollment of underrepresented populations in clinical trials; further,

To advocate that drug product manufacturers and researchers conduct and report outcomes of pharmacokinetic, pharmacodynamic, and pharmacogenomic research in underrepresented populations to facilitate safe and effective dosing of medications in these patient populations; further,

To advocate that if such research considers age, sex, gender, ethnicity, or race, the reason for such consideration be based on validated ethical or scientific reasons and be specified in the research protocol; further,

To foster the use and development of postmarketing research strategies to support the safe and effective use of drug products for approved and off-label indications in underrepresented populations; further,

To advocate that pharmacists should be involved in the design of clinical trials to provide guidance on drug dosing, administration, and monitoring in all patient populations.

*This policy supersedes ASHP policy 1723.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Therapeutics 2244: Pediatric Dosage Forms**

To support research on and development of pediatric-specific drug formulations; further,

To encourage manufacturers to develop formulations suitable for pediatric administration during research that includes pediatric patients; further,

To encourage manufacturers of off-patent medications that are used in pediatric patients to develop formulations suitable for pediatric administration; further,

To advocate that manufacturers comparably price a newly developed pediatric-specific commercial product to that of its extemporaneously prepared formulation; further,

To educate prescribers and caregivers regarding the nuances of pediatric drug administration to ensure the availability of an appropriate dosage form is considered when selecting and administering safe and effective therapies for a pediatric patient.

*This policy supersedes ASHP policy 9707.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Therapeutics 2245: Substance Use Disorder**

To affirm that a patient with a substance use disorder (SUD) has a chronic condition with associated neurodevelopmental, physiologic, and psychosocial changes; further,

To recognize that dehumanizing language and stigmatization regarding SUD and persons who use drugs (PWUD) create barriers to healthcare access and result in poor clinical outcomes; further,

To recognize the disproportionately harmful health impact that criminalization and policing practices related to SUD and PWUD have had on communities, particularly those of color; further,

To advocate for destigmatization efforts and elimination of barriers to care for SUD and PWUD; further,

To support risk mitigation and harm reduction strategies, including syringe services programs, recognizing the roles they have in public health efforts to reduce infectious disease burden, improve access to healthcare, improve patient trust, and reduce expenditures; further,

To advocate for expansion of comprehensive medication management services provided by pharmacists for prevention, treatment, and recovery services within the interprofessional care team and throughout the continuum of care; further,

To support pharmacists leading community-based comprehensive preventive health and treatment programs; further,

To encourage the inclusion of longitudinal SUD training in didactic pharmacy curricula, starting with an early initiation of education; use of evidence-based practices, including risk mitigation, harm reduction, and destigmatizing communication strategies; and increasing experiential education pertaining to SUD; further,

To support and foster standardized education and training on SUD, including dispelling common misconceptions to the pharmacy workforce and other healthcare professionals.

*This policy supersedes ASHP policy 9711.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Pharmacy Practice 2246: Autoverification of Medication Orders**

To recognize the importance of pharmacist verification of medication orders, and the important role pharmacists have in developing and implementing systems for autoverification of select medication orders; further,

To recognize that autoverification of select medication orders under institution-guided criteria can help expand access to pharmacist patient care; further,

To discourage implementation of autoverification as a means to reduce pharmacist hours; further,

To promote and disseminate research, standards, and best practices on the safety and appropriateness of autoverification of medication orders; further,

To encourage healthcare organizations to develop policies, procedures, and guidelines to determine which care settings, medications, and patient populations are appropriate candidates for autoverification of select medication orders in order to support the implementation of autoverification models for those circumstances; further,

To advocate for regulations and accreditation standards that permit autoverification of select medication orders in circumstances in which it has proven safe.

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

[ASHP's Autoverification Toolkit](#) evaluates the use of autoverification in health systems to improve patient safety and healthcare outcomes by allowing more time spent on clinical pharmacy activities by streamlining the verification process.

#### **AJHP Articles:**

- [Implementation and safety evaluation of autoverification for select low-risk, high-volume medications in the emergency department](#)

#### **ASHP podcasts:**

- [Insights and Perspectives on Autoverification](#)

#### **ASHP webinars:**

- [Autoverification: Is it Right for You?](#)

This policy is included in our communications with policymakers and healthcare stakeholders regarding policy, practice, and regulatory considerations related to effective healthcare system-design for safe medication use and patient safety.

### **Council on Pharmacy Practice 2247: Pharmacy Workforce's Role in Vaccination**

To affirm that the pharmacy workforce has a role in improving public health and increasing patient access to vaccinations by promoting and administering appropriate vaccinations to patients and employees in all settings; further,

To collaborate with key stakeholders to support the public health role of the pharmacy workforce in the administration of adult and pediatric vaccinations; further,

To advocate that states grant pharmacists and appropriately supervised student pharmacists the authority to initiate and administer all adult and pediatric vaccinations; further,

To advocate that states grant appropriately supervised pharmacy technicians the authority to prepare and administer all adult and pediatric vaccinations; further,

To advocate for the inclusion of pharmacist-provided vaccination training in college of pharmacy curricula and pharmacy technician-provided vaccination training in technician training programs; further,

To advocate that members of the pharmacy workforce who have completed a training and certification program acceptable to state boards of pharmacy and meeting the standards established by the Centers for Disease Control and Prevention may provide such vaccinations; further,

To advocate that state and federal health authorities establish centralized databases for timely documentation of vaccine administrations that are interoperable and accessible to all healthcare providers; further,

To advocate that state and federal health authorities require all vaccination providers to report their documentation to these centralized databases, if available; further,

To encourage the pharmacy workforce to educate all patients, their caregivers, parents, guardians, and healthcare providers to promote vaccine confidence and convey the importance of vaccinations for disease prevention; further,

To encourage the pharmacy workforce to seek opportunities for involvement in disease prevention through community vaccination programs; further,

To foster education, training, and the development of resources to assist the pharmacy workforce and other healthcare professionals in building vaccine confidence; further,

To advocate for adequate staffing, resources, and equipment for the pharmacy workforce to support vaccination efforts to ensure patient safety; further,

To advocate for appropriate reimbursement for vaccination services rendered; further,

To work with federal, state, and local governments and others to improve the vaccine development and supply system in order to ensure an adequate and equitably distributed supply of vaccines.

*This policy supersedes ASHP policies 1309 and 2122.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts. The ASHP policy is reflected in the [ASHP COVID-19 Vaccine Confidence Toolkit](#). In addition, when the [HHS gave pharmacists the authorization to administer Monkeypox vaccines in a response to ASHP's request](#), the result was shown that pharmacists remain a vital resource for emergency vaccination efforts since the peak of the COVID-19 epidemic. The trust of the federal health department reinforces pharmacy as a mainstay in national vaccination efforts.

#### **ASHP CEO blogs:**

- [Broadens Vaccine Confidence Outreach](#)
- [GTMRx Establishes National Task Force to Build Vaccine Confidence](#)

#### **ASHP podcasts:**

- [Expansion of Community Pharmacies' Role in Public Vaccine Delivery to Children: The Landscape, the Opportunities, and the Need](#)

- [Public Health and Community Pharmacy Vaccination Efforts: Best Practices, Opportunities and Lessons Learned from the COVID-19 Pandemic](#)
- [Meet the Vaccine Navigators](#)
- [Give It Your Best Shot! Evaluating Covid-19 Vaccine Best Practices](#)

#### **AJHP articles:**

- [The 2022 human monkeypox outbreak: Clinical review and management guidance](#)
- [Pharmacists: Essential providers of COVID-19 care](#)
- [States pave the way for practice advancement](#)
- [ASHP Statement on the Role of Pharmacists in Primary Care](#)

#### **ASHP webinars:**

- [Essential Elements of Successful Mass Immunization Programs: A Discussion with Pharmacy Leaders](#)

This policy is included in our communications with policymakers and healthcare stakeholders regarding policy, practice, and regulatory considerations for pharmacist leadership, patient experience, and considerations related to effective healthcare system-design for safe medication use and patient safety.

#### **Council on Pharmacy Management 2248: Health-System Use of Drug Products Provided by Outside Sources**

To support care models in which drug products are procured and/or prepared for administration by the pharmacy and are obtained from a licensed, verified source to ensure drug product and patient safety and continuity of care; further,

To encourage hospitals and health systems not to permit administration of drug products supplied to the hospital, clinic, or other healthcare setting by the patient, caregiver, or pharmacy contracted by a healthcare insurance payer or pharmacy benefit manager; further,

To advocate adequate reimbursement for preparation, order review, and other costs associated with the safe provision and administration of drug products; further,

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

*This policy supersedes ASHP policy 2032.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts. [White bagging](#) is a key [advocacy issue](#) for ASHP. This policy is included in our communications with policymakers and healthcare stakeholders regarding policy, practice, and regulatory considerations for pharmacist leadership and considerations related to effective system design for safe medication use and patient safety.

#### **Council on Pharmacy Management 2249: Screening for Social Determinants of Health**

To encourage social determinants of health (SDoH) screening and data collection using standardized codes during the provision of pharmacy patient care services; further,

To promote the integration of SDoH data into the design and delivery of clinical pharmacy services, including the creation of targeted interventions and leveraging the use of clinical decision support to improve patient outcomes; further,

To encourage the use of SDoH data in reporting and evaluating the effectiveness of pharmacist patient care; further,

To encourage the use of SDoH data to identify opportunities to reduce healthcare disparities and improve healthcare access and equity; further,

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

To advocate for the funding of community resources related to improving patient access to medications, and the integration of these resources into health-system care delivery models; further,

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

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **ASHP webinars:**

- [Integrating Social Determinants of Health Data and Knowledge into Clinician Workflow](#)
- [Expanding Primary Care with PGY2 Residents and Population Health Approaches](#)

#### **ASHP podcast:**

- [Training Future Pharmacists on Social Determinants of Health](#)

#### **ASHP statements:**

- [ASHP Statement on the Pharmacist's Role in Public Health](#)
- [ASHP Statement on Racial and Ethnic Disparities in Health Care](#)

#### **AJHP article:**

- [ASHP Foundation Pharmacy Forecast 2023: Strategic Planning Guidance for Pharmacy Departments in Hospitals and Health Systems](#)

This policy is included in our communications with policymakers and healthcare stakeholders regarding policy, practice, and regulatory considerations for pharmacist leadership and considerations related to effective system design for safe medication use and patient safety.

### **House of Delegates 2250: Access to Reproductive Health Services**

To recognize that reproductive healthcare includes access to and safe use of medications; further,

To recognize that reproductive health services include pre-conception, conception, post-conception, and termination of pregnancies; further,

To advocate for access to safe, comprehensive reproductive healthcare for all patients, including historically underserved patient groups such as patients of color, those with limited means, and those living in rural areas; further,

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

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Education and Workforce Development 2251: Qualifications and Competencies Required to Prescribe Medications**

To affirm that prescribing is a collaborative process that includes patient assessment, understanding of the patient's diagnoses, evaluation and selection of available treatment options, monitoring to achieve therapeutic outcomes, patient education, and adherence to safe and cost-effective prescribing practices; further,

To affirm that safe prescribing of medications, performed independently or collaboratively, requires competent professionals who complement each others' strengths at each step.

*This policy supersedes ASHP policy 1202.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Pharmacy Management 2252: Standard Drug Administration Schedules**

To support the principle that standard medication administration times should be based primarily on optimal pharmacotherapeutics and safe medication administration practices, with secondary consideration of workload, caregiver preference, patient preference, and logistical issues; further,

To encourage the development of hospital-specific or health-system-specific standard administration times through an interdisciplinary process coordinated by the pharmacy; further,

To encourage information technology vendors to adopt these principles in system design while allowing flexibility to meet site-specific patient needs.

*Note: This policy supersedes ASHP policy 0707.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Pharmacy Management 2253: Unit Dose Packaging Availability**

To advocate that pharmaceutical manufacturers provide all medications used in health systems in unit dose packages or, when applicable, in packaging that optimizes medication safety, improves operational efficiency, and reduces medication waste; further,

To urge the Food and Drug Administration to support this goal in the interest of public health and healthcare worker and patient safety.

*Note: This policy supersedes ASHP policy 1801.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Therapeutics 2254: Pain Management**

To advocate for improved access to equitable and patient-centered pain care for all patient populations; further,

To advocate that pharmacists actively participate in the development and implementation of multimodal pain management stewardship programs, policies, protocols, and research; further,

To support pharmacist participation and collaboration in interprofessional healthcare teams for selecting appropriate drug therapy regimens, educating patients and caregivers, monitoring patients, and continually assessing outcomes of pain management therapy; further,

To advocate that pharmacists lead efforts to prevent inappropriate use of pain therapies, including engaging in strategies to detect and address patterns of medication use that can increase the risk of serious adverse events; further,

To foster the development of educational resources on multimodal pain therapy, substance use disorder, and prevention of adverse effects; further,

To encourage and support the education of the pharmacy workforce and other healthcare providers regarding the principles of multimodal pain management and substance use disorder, including approaches to reduce stigma, improve access to care, and improve general health and well-being.

*Note: This policy supersedes ASHP policy 1722.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Therapeutics 2255: Therapeutic Indication for Prescribed Medications**

To advocate that all healthcare professionals involved in a patient's care have immediate access to the intended therapeutic purpose of prescribed medications in order to ensure safe and effective medication use; further,

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

To advocate for implementation of a universal, interoperable coding system for labeled therapeutic indications that can be integrated throughout the medication-use process, enabling optimum clinical workflows and decision support functionality; further,

To advocate for federal and state laws and regulations to include diagnosis-based indication(s) on medication order(s) and prescription(s), and to allow the withholding of indication on medication prescription labels when patient privacy risks outweigh benefits.

*Note: This policy supersedes ASHP policies 0305 and 2123.*

This policy has been published in ASHP Best Practices (online edition) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Review of ASHP Policies to Insert Pharmacogenomics Where Appropriate: Justin Konkol, Wisconsin**

ASHP should take a global review of all current policy and insert pharmacogenomics where appropriate.

ASHP staff has implemented a process to review policies undergoing sunset review to address inclusion of pharmacogenomics where possible. This process will ensure that all ASHP policies are reviewed in that



context in the next 5 years. A global review in a shorter timeframe was considered too burdensome on volunteer council members.

#### **ASHP to Encourage Incorporation of Pharmacy Technician Training into High School Career and Technical Programs: Maari Loy, North Dakota**

Technicians graduate with ASHP-accredited tech certificate at high school graduation.

ASHP agrees that educating and promoting the pharmacy technician careers to students in various stages of early educational levels is important to stimulate interest in the career choice. ASHP is currently working with all high school programs that apply for ASHP/ACPE technician education and training programs to provide them with extensive education regarding preparation for the accreditation process. Webinars have been produced and placed on the ASHP website to assist program directors in having a greater understanding of the accreditation standards, regulations, and other areas essential in the making of a good program. In addition, periodic and customized sessions have been provided specifically for state board of education groups (i.e., Virginia Board of Education) that have mandated that all of their high school technician education and training programs apply for accreditation. Work is being done to produce a video to explain opportunities of pharmacy technicians to share to high school students.

In addition, ASHP has created a [Pharmacy Technician Resource Center](#) and provides among many other things information about [starting](#) an accredited pharmacy technician training program. ASHP conducted [two online surveys](#) in late 2021 to better understand the pharmacy technician shortage in hospitals and health systems and current needs and realities of the pharmacy technician role, and one of the outcomes was [PharmTech Ready](#), which provides tools for hospitals and health systems to enhance the skills of their pharmacy technician workforce. ASHP has been an organizational partner in creating [Pharmacy is Right for Me](#), an educational campaign that aims to inspire and foster the next generation of pharmacy leaders in the United States. ASHP will explore the possibility of adding pharmacy technician roles to that campaign. Finally, the Council on Education and Workforce Development has revised ASHP policy regarding promotion of the pharmacy profession, which will likely be considered at the virtual House of Delegates in November.

#### **Revision of ASHP Policy 1410, Access to Oral Contraceptives Through an Intermediate Category of Drug Products: Mollie Scott, North Carolina**

Assess policy to be more inclusive of all staff-administered contraceptives and to encourage access regardless of patient age.

The Council on Therapeutics considered this delegate recommendation and has proposed a policy that will be considered by the House in June 2023.

#### **Early Review of New ASHP Policy: Advancing Diversity, Equity, and Inclusion in Education and Training: Zahra Nasrazadani, Kansas; Christopher Edwards, Arizona; and Josh Blackwell, Texas**

Requesting early review of policy Advancing Diversity, Equity, and Inclusion in Education and Training; recommend that the initiating council (CEWD) revisit this amended policy in the upcoming year, rather than at the scheduled sunset review.

This recommendation was discussed by Council on Education and Workforce leadership, and it was concluded that although the wording of the Council's policy recommendation was amended by the House, the intent of the Council and the Task Force was met in the final wording of the policy.

#### **Review of New ASHP Policy, Autoverification of Medication Orders, To Include Pharmacy Resources: Jodi Taylor, Tennessee**

Please consider changing "pharmacist hours" in clause 3 to "pharmacy resources" to improve protection.

This recommendation was discussed by Council on Pharmacy Practice at its winter 2023 meeting. In response to delegate recommendations from the June 2022 meetings of the House of Delegates, the Council reviewed ASHP policy 2246, Autoverification of Medication Orders. The Council suggested that the rationale for that policy be updated as follows:

The purpose of autoverification of medication orders is to improve medication-use safety and quality and more efficiently and effectively utilize pharmacy personnel. When autoverification functionality is used, medications ordered via computerized provider order entry (CPOE) are evaluated against predetermined parameters in electronic health records (EHRs). Orders that fall within set parameters are autoverified and available to be administered; those that fall outside the parameters require review by a pharmacist. Critical values, patient history, and clinical decision support tools are used to create the algorithm that determines whether a medication order is reviewed. The healthcare community has long recognized the importance of pharmacist verification of medication orders, and that role is no less important when developing and implementing systems for autoverification of select medication orders. Recent experience has shown that autoverification of medication orders, when done safely and efficiently, can allow more effective use of pharmacist resources by expanding access to pharmacist patient care.

In the 2016 ASHP survey of health systems, 51.6% of hospitals utilized the autoverification functionality in the CPOE system; this rose to 62.2% utilization by the 2019 survey. Of the health systems surveyed in 2019 that utilized autoverification, 52.9% autoverified in selected areas (e.g., all emergency department orders, perioperative orders); 50.2% identified selected medications for autoverification in specific areas (e.g., pain medications in the emergency department); and 17.1% of hospitals had autoverification for select medications (e.g., flushes, influenza vaccine) throughout the hospital. Between 2016 and 2019, overall use of autoverification and autoverification of select medications throughout the hospital and for select medications in certain areas increased. In contrast, the use of autoverification for all medications in a select area of the hospital decreased from 2016 to 2019.

According to the ASHP survey, the most commonly cited reasons for not implementing autoverification were patient safety concerns (40.4%); “our hospital has not discussed this” (23.2%); and requirements by law, regulation, or accreditors (22.9%). Less common reasons were that EHR software does not have the functionality (6.9%) and EHR limitations on criteria used for autoverification (4.6%). Healthcare professionals have also expressed a concern about medication optimization: medication appropriateness may not be the same as medication optimization. Pharmacy directors have also stated that staffing determinations based on pharmacist workload and other measurable metrics must be carefully considered; autoverification should not be a mechanism for reducing pharmacist hours or pharmacy resources, which would negate the potential to expand patient care services. In addition, safeguards are needed to prevent misinterpretation and misuse of autoverification, which could compromise patient safety.

The Council decided that an additional clause related to interoperability of autoverification logic was not needed because ASHP policy 2015, Network Connectivity and Interoperability for Continuity of Care, broadly addresses the topic. In addition, the Council suggested that the [ASHP Autoverification Toolkit](#) be updated to include the following:

1. ASHP policy 2246, Autoverification of Medication Orders;
2. The Joint Commission’s interpretation of the use of autoverification technology for medication ordering and dispensing; and
3. Updated literature (e.g., Bienvenida A, Kroll C, Ruhland D et al. Implementation and safety evaluation of autoverification for select low-risk, high-volume medications in the emergency department. *Am J Health-Syst Pharm*. 2022; 79: 2150-58, <https://doi.org/10.1093/ajhp/zxac241>).

#### **Pharmacists in Ambulatory Surgery Centers and/or Outpatient Surgery Centers: Tricia Meyer, Texas**

To advocate for a higher level of pharmacy services and oversight by the pharmacist in ambulatory surgical center and/or hospital outpatient surgery center.

ASHP currently has policy position 1914, Safe Medication Preparation, Compounding, and Administration in All Sites of Care, which reads: To advocate that all sites of care be required to meet the same regulatory standards for medication preparation, compounding, and administration to ensure safety and quality. The ASHP Council on Pharmacy Management discussed this topic during its September 2022 Council meetings to consider potential actions. The Council discussed the background provided, which noted that ambulatory/outpatient surgery centers typically do not have dedicated pharmacist staffing. Pharmacist consultants may perform medication reviews for three to four hours on a monthly or quarterly basis, and this review is evolving in much the same way long-term care consulting has. Consultant hours do not allow time for effective controlled substance review, safe medication practices, and drug security during their review of medication use at an ambulatory surgery center (ASC).

Council members acknowledged safe medication management in this setting has been largely neglected as a practice. Medication management in the ambulatory setting can be complicated because of state and federal regulations and requirements imposed by accrediting organizations. Perioperative medication use and administration, postoperative pain management, medication disposal, staff member and physician education, proper documentation in the medical record, pharmacoeconomics, sterile compounding needs, and controlled medication management and oversight are all important components of this segment of care.

As hospital-based care and pharmacy costs become increasingly relevant in managing the overall cost of healthcare, third-party payers have increased their attention to nonhospital sites of care, increasing the pressure to manage this trend. Payers are working to funnel patients to lower-cost settings that deliver comprehensive care outside of the traditional hospital setting. Some ASCs are physically separate, while others are affiliated financially and administratively to hospital outpatient departments.

A significant challenge that confronts hospitals and health systems is the level of infrastructure investment required to adequately address practice standards and regulatory and accreditation requirements focused on quality and medication safety (e.g., United States Pharmacopeia Chapters <797> and <800>, state boards of pharmacy regulations, and the standards of accreditors such as The Joint Commission and Det Norske Veritas Healthcare). ASCs are commonly devoid of this same level of regulatory and accreditation scrutiny.

The Council noted the continued need for efforts by ASHP to ensure pharmacy leadership is part of business discussions regarding site-of-care discussions to help with continuity of care, promotion of safe medication use (e.g., regulatory requirements, practice standards), and bringing awareness to health-system leadership regarding potential changes in revenue, quality, and safety gaps with use of nonhospital-based sites of care. The Council expressed its desire for ASHP to advocate and provide leadership on necessary actions needed to influence agencies that develop reimbursement models in order to ensure reasonable rules and regulations are enforced and implemented in the best interest of patients, the public, and providers.

ASHP recently endorsed the [ISMP Guidelines for Safe Medication Use in Perioperative and Procedural Settings](#) and revised the [ASHP Guidelines on Perioperative Pharmacy Services](#) in 2019. Coupled with these guidelines, the Council felt ASHP member education and events (e.g., roundtables) exploring pharmacy opportunities to think innovatively about ASCs and their influence on safe medication use, total cost of care, patient experience, and competitive positioning are necessary. Pointing out potential gaps in standards of care with ASCs will raise awareness and help bring to the attention of organizational compliance and risk management professionals.

Finally, the Council suggested the rationale for ASHP policy 1914, Safe Medication Preparation, Compounding, and Administration in All Sites of Care, be revised to make specific mention of ASCs.

**Advocate for the Prioritization of Using Ready-To-Administer Medications in Procedural Areas: Steven Knight, Texas**

To encourage that medications used in procedural areas or non-operating room anesthesia be supplied to providers in their ready to administer dosage form minimizing the safety risks of potentially mislabeling or not labeling syringes.

This recommendation was shared with the 2022-2023 Council on Pharmacy Practice for its consideration. Following are a few ASHP resources that align with the recommendation: ASHP policy 0402, Ready-to-Use Packaging for All Settings; ASHP policy 1711, Ready-to-Administer Packaging for Hazardous Drug Products Intended for Home Use; [ASHP Guidelines on Perioperative Pharmacy Services](#); and [ASHP National Survey on Pharmacy Practice in Hospital Settings: Dispensing and Administration – 2020](#) (the survey highlights that one of the top reasons for outsourcing is for supply of ready-to-administer medications).

#### **Development of a Drug Diversion Prevention and Investigation Training Program for Pharmacists and Diversion Specialists: Angela Livingood, North Carolina**

ASHP should develop a training program dedicated to the prevention of drug diversion and investigation of diversion incidents within the health-systems for pharmacists charged with this responsibility.

ASHP will explore this as a potential topic for a professional certificate program. ASHP is also considering the development of a gap-assessment tool to complement the recently revised [ASHP Guidelines on Preventing Diversion of Controlled Substances](#). In addition, ASHP is developing a gap analysis tool that will aid insitutions in implementing a diversion control program.

#### **Revision of New ASHP Policy, Autoverification of Medication Orders: Randy Martin, Texas**

Revise the ASHP policy on autoverification to account for potential misinterpretations and adverse impact upon patient safety and allocation of pharmacy resources.

This recommendation was discussed by Council on Pharmacy Practice at it winter 2023 meeting. In response to delegate recommendations from the June 2022 meetings of the House of Delegates, the Council reviewed ASHP policy 2246, Autoverification of Medication Orders. The Council suggested that the rationale for that policy be updated as follows:

The purpose of autoverification of medication orders is to improve medication-use safety and quality and more efficiently and effectively utilize pharmacy personnel. When autoverification functionality is used, medications ordered via computerized provider order entry (CPOE) are evaluated against predetermined parameters in electronic health records (EHRs). Orders that fall within set parameters are autoverified and available to be administered; those that fall outside the parameters require review by a pharmacist. Critical values, patient history, and clinical decision support tools are used to create the algorithm that determines whether a medication order is reviewed. The healthcare community has long recognized the importance of pharmacist verification of medication orders, and that role is no less important when developing and implementing systems for autoverification of select medication orders. Recent experience has shown that autoverification of medication orders, when done safely and efficiently, can allow more effective use of pharmacist resources by expanding access to pharmacist patient care.

In the 2016 ASHP survey of health systems, 51.6% of hospitals utilized the autoverification functionality in the CPOE system; this rose to 62.2% utilization by the 2019 survey. Of the health systems surveyed in 2019 that utilized autoverification, 52.9% autoverified in selected areas (e.g., all emergency department orders, perioperative orders); 50.2% identified selected medications for autoverification in specific areas (e.g., pain medications in the emergency department); and 17.1% of hospitals had autoverification for select medications (e.g., flushes, influenza vaccine) throughout the hospital. Between 2016 and 2019, overall use of autoverification and autoverification of select medications throughout the hospital and for select medications in certain areas increased. In contrast, the use of autoverification for all medications in a select area of the hospital decreased from 2016 to 2019.

According to the ASHP survey, the most commonly cited reasons for not implementing autoverification were patient safety concerns (40.4%); “our hospital has not discussed this” (23.2%); and requirements by law, regulation, or accreditors (22.9%). Less common reasons were that EHR software does not have the functionality (6.9%) and EHR limitations on criteria used for autoverification (4.6%). Healthcare professionals have also expressed a concern about medication optimization: medication appropriateness may not be the same as medication optimization. Pharmacy directors have also stated that staffing determinations based on pharmacist workload and other measurable metrics must be carefully considered; autoverification should not be a mechanism for reducing pharmacist hours or pharmacy resources, which would negate the potential to expand patient care services. In addition, safeguards are needed to prevent misinterpretation and misuse of autoverification, which could compromise patient safety.

The Council decided that an additional clause related to interoperability of autoverification logic was not needed because ASHP policy 2015, Network Connectivity and Interoperability for Continuity of Care, broadly addresses the topic. In addition, the Council suggested that the [ASHP Autoverification Toolkit](#) be updated to include the following:

1. ASHP policy 2246, Autoverification of Medication Orders;
2. The Joint Commission’s interpretation of the use of autoverification technology for medication ordering and dispensing; and
3. Updated literature (e.g., Bienvenida A, Kroll C, Ruhland D et al. Implementation and safety evaluation of autoverification for select low-risk, high-volume medications in the emergency department. *Am J Health-Syst Pharm.* 2022; 79: 2150-58, <https://doi.org/10.1093/ajhp/zxac241>).

#### **Formalize Process To Refresh Background and Rationale Content During Sunset Review Process: Roger Woolf, Washington**

ASHP should formalize a standard process to update the background and rationale of policies under review to reflect current environment and encourage forward thinking content.

ASHP staff have instituted a process to refresh rationales when policies are reviewed or revised.

#### **Revisit ASHP Meeting Dress Code: Christopher Scott, Indiana**

Please evaluate loosening the ASHP meeting dress code.

The suggested attire at ASHP national meetings is business casual. This is published in the information about the meetings on the microsite for each meeting in the frequently asked questions section. In addition the onsite program for the upcoming ASHP Midyear Clinical Meeting & Exhibition includes this information. While some attendees may opt to dress in business attire, the suggested attire remains business casual for all ASHP’s meetings.

#### **Gun Violence Prevention: Brian Gilbert, Kansas; Katherine Miller, Kansas; Zahra Nasrasadani, Kansas; Joanna Robinson, Kansas; and Amy Sipe, Missouri**

To recommend that ASHP Board and Councils review policy 2107: Role of the Pharmacy Workforce in Preventing Accidental and Intentional Firearm Injury and Death and other related policies prior to its scheduled review to ensure it strongly states the views of ASHP members related to the national health crisis that is gun violence.

This recommendation was considered for addition to the agendas of the Council on Pharmacy Practice and the Council on Public Policy. Both council agendas were quite full this year, including expedited review of policies approved by the June 2022 House based on delegate and Board recommendation. It was decided that current policy 2107, which was developed after a thorough examination of gun violence issues at a Joint Council Meeting, and policy 0810, Education, Prevention, and Enforcement Concerning Workplace Violence, would serve ASHP’s current advocacy needs but that the topic would be considered for inclusion



on a council agenda again in the 2023-2024 policy year. Policy 2107 will be up for sunset review in June of next, and will certainly be re-examined then.

#### **Consideration of Alignment of ASHP Policies and Values with State and Local Laws When Selecting Locations for Meetings and Events: Ryan Gibbard, Victoria Wallace, and Edward Saito (Oregon)**

ASHP should host meetings or events where state and local laws are congruent with current and future ASHP policies and values (e.g. gun violence, diversity, healthcare inequities, etc).

Selection of locations for ASHP meetings and events is a complicated process and most of our meetings are scheduled years in advance of the meeting dates, in cities that can accommodate our unique needs and requirements. With respect to the Midyear Clinical Meeting & Exhibition in particular, its size and scope limits the number of available locations to us.

The number one consideration for all ASHP meetings is the health and safety of our attendees, staff and other meeting participants. For every event and location, we work closely with convention, hotel and city officials on a shared goal to provide a positive, welcoming experience for all.

ASHP works diligently to embrace and support the wide range of perspectives, values and beliefs represented across our membership. We are proud to represent a profession that is diverse and inclusive in every respect, and it is our express intent to ensure each and every one of our meetings delivers on that promise of inclusivity.

#### **ASHP To Educate Health System Pharmacists on How To Effectively Advocate To C-Suites On National Provider Status: Kathy Baldwin, Florida**

ASHP To Educate Health System Pharmacists on How To Effectively Advocate To C-Suites On National Provider Status

ASHP believes pharmacists have a moral and ethical professional obligation to advocate for changes that improve patient care as well as justice in the distribution of health resources, as articulated in ASHP's [Statement on Advocacy as a Professional Obligation](#). ASHP also recognizes that training and education is, and will continue to be, necessary for pharmacists to fulfil this obligation. Among ASHP's roles in advocacy is the generation of policy analysis, education and training aimed towards achieving an ultimate goal of grassroots empowerment among individual pharmacy professionals and the broader pharmacy practice community. ASHP seeks to generate content to inform pharmacists of the critical needs of our patients and profession in a manner that will better enable them to effectively persuade Federal, state, local and institutional stakeholders to champion policy that will maximize utilization of pharmacists' skills and training towards the improve the health of communities and society as a whole. ASHP's Pharmacy Executive Leadership Alliance (PELA) was established in 2020 as a resource for chief pharmacy officers and multihospital system executive leaders to facilitate peer-to-peer knowledge transfer and shared strategic planning in addressing challenges and opportunities. ASHP will continue to explore opportunities to create high-impact resources for both PELA and the general membership aimed at improving outreach and dialogue with institutional stakeholders to maximize pharmacists' role in delivering optimal patient care.

#### **Development of Model State Pharmacy Practice Acts to Support Pharmacist Prescribing: Julie Groppi, Florida; Anthony Morreale, Department of Veterans Affairs; and Roger Wolff, Washington**

ASHP should convene a taskforce to develop model state practice acts to promote a consistent approach to advance pharmacist prescribing.

As most ASHP members are likely aware, optimizing medication use and access through pharmacist prescribing is a [PAI 2030 focused initiative](#). In addition, ASHP's Offices of Government Relations and Affiliate Relations are perpetually seeking opportunities to facilitate peer-to-peer communication and learning among our affiliate organizations toward better informing advocacy efforts and more effectively persuading state policymakers to support expanding pharmacists' role in optimal health care delivery. ASHP's Center on Pharmacy Practice Advancement, Council on Public Policy, and Offices of Government Relations and Affiliate

Relations will deliberate on strategies to best leverage members towards the generation of a uniform model pharmacy practice framework, including the potential formation of a member taskforce.

#### **House of Delegates Open Forum: Kat Miller, Kansas; Justin Konkol, Wisconsin; and Chris Edwards, Arizona**

To evaluate if the House of Delegates Open Forum meets the intent of gathering feedback on policies from ASHP membership.

ASHP staff discussed the operations of the Open Forum and agreed on the value of its purpose, which is to gather feedback on proposed policies from ASHP members. It was agreed that the Open Forum's purpose would be better described and publicized on the ASHP Summer Meetings website, and that steps would be taken at the meeting to encourage nondelegate members to speak up.

#### **Advancing High-Value Clinical Pharmacy Services: Tom Dilworth, Wisconsin**

To advocate that ASHP guide the identification and development of high-value clinical pharmacy services across the continuum of care; further,

To advocate that ASHP, health-systems and researchers collaborate to develop clinical pharmacy productivity metrics that allow pharmacy leaders to demonstrate the value of clinical pharmacy services across the continuum of care; further,

To advocate that health-systems and organizations prioritize high-value clinical pharmacy services while de-prioritizing lower-value clinical services and/or delegating lower-value clinical services to non-pharmacists and/or technology; further,

To advocate that ASHP guide the development of public relations materials that showcase the clinical services and value pharmacists bring to the healthcare enterprise suitable for use by health-systems, organizations and the pharmacy workforce to promote the profession and accurately describe clinical services provided by pharmacists to key stakeholders, including but not limited to payers, other healthcare providers, and the general public.

The recommendation raised a very important point for discussion, one that ASHP members have been working hard to address and shape for a long time now, without the traction needed or desired. To give an example of how long this topic has spanned the minds of members from a policy perspective, in 1998 a policy was developed entitled "Defining and Measuring the Quality of Clinical Services" and then in 2020 the Council on Pharmacy Practice developed Policy 2137, "Documentation of Pharmacist Patient Care." ASHP has some ongoing projects that align with the goals of this recommendation and will use the recommendation to guide and inform that work.

#### **Pharmacist's Role as Public Health and Preventative Health Experts: Julie Groppi, Florida**

ASHP should develop policy to highlight the essential public and preventative health roles of pharmacists.

In the past several years, ASHP has developed many policy positions that address the public health and preventive health role of pharmacists, including the following:

- 2118 - Supply Chain Resilience During Disasters and Public Health Emergencies
- 2223 - Role of the Pharmacy Workforce in Emergency Preparedness
- 2225 - Pharmacist Prescribing of Statins
- 2245 - Substance Use Disorder
- 2211 - Naloxone Availability
- 2247 - Pharmacy Workforce's Role in Vaccination
- 2122 - Vaccine Confidence
- 2125 - Tobacco, Tobacco Products, and Electronic Nicotine Delivery Systems

This year the House will consider the following policy recommendations as well:

- Use of Social Determinants of Health Data in Pharmacy Practice
- Pharmacist Prescribing Authority for Antiretroviral Therapy for the Prevention of HIV/AIDS
- Point-of-Care Testing and Treatment
- Availability and Use of Fentanyl Test Strips
- Raising Awareness of the Risks Associated with the Misuse of Medications

The public health and preventive health role of pharmacists is also addressed at length in the ASHP Statement on the Role of Pharmacists in Primary Care, the ASHP Statement on the Pharmacist's Role in Public Health, and the ASHP Statement on Racial and Ethnic Disparities in Health Care, which is slated for review and revision this fall.

ASHP takes this recommendation to heart and will continue to highlight the important roles pharmacists have in safeguarding the public health and preventive care.

### **Autoverification Logic Intraoperability: Arizona delegates Christopher Edwards, Melinda Burnworth, and Danielle Kamm**

To advocate for interoperable logic systems used in autoverification functionality across health records (EHRs).

The Council on Pharmacy Practice considered the suggestion to incorporate interoperable logic systems used in autoverification functionality across health records during the 2022-2023 policy year. The Council decided that an additional clause related to interoperability of autoverification logic was not needed because ASHP policy 2015, Network Connectivity and Interoperability for Continuity of Care, broadly addresses the topic. In addition, the Council suggested that the [ASHP Autoverification Toolkit](#) be updated to include the following:

1. ASHP policy 2246, Autoverification of Medication Orders;
2. The Joint Commission's interpretation of the use of autoverification technology for medication ordering and dispensing; and
3. Updated literature (e.g., Bienvenida A, Kroll C, Ruhland D et al. Implementation and safety evaluation of autoverification for select low-risk, high-volume medications in the emergency department. *Am J Health-Syst Pharm.* 2022; 79: 2150-58, <https://doi.org/10.1093/ajhp/zxac241>).

### **ASHP To Consider Completion of the Pharmacy Leadership Academy and Provide ACHE-Qualified Education Credits To Support Pharmacists Obtaining ACHE Fellow Designation: Lt. Col. Jin Kim, USAF and Lt. Col. Rohin Kasudia, USAF**

ASHP should consider partnering with ACHE so students completing ASHP's Leadership Academy can obtain dual CE credit and support obtaining FACHE designation.

ASHP has contacted ACHE to make a formal request for consideration of recognizing the PLA program content as ACHE-approved Fellow education.

### **Educating Middle School and High School Students about Opportunities in Pharmacy To Promote the Profession as a Possible Career Choice: John Muchka, Wisconsin**

To support the education of middle school and high school students on the many roles of pharmacists.

ASHP agrees that educating and promoting the pharmacy profession to students in various stages of early educational levels is important to stimulate interest in the profession as a career choice. We have been an organizational partner in creating [Pharmacy is Right for Me](#), which is an educational campaign that aims to inspire and foster the next generation of pharmacy leaders in the United States. In addition, members of several of ASHP's Pharmacy Practice Sections are actively in process of creating an online pre-pharmacy resource to further promote careers in pharmacy, including careers in health-system pharmacy. ASHP is currently working with all high school programs that apply for ASHP/ACPE technician education and training programs to provide them with extensive education regarding preparation for the accreditation process. Webinars have been produced and posted on the ASHP website to assist program directors in having a



greater understanding of the accreditation standards, regulations, and other areas essential in the making of a good program. In addition, periodic and customized sessions have been provided specifically for state board of education groups (i.e., Virginia Board of Education) that have mandated that all of their high school technician education and training programs apply for accreditation. Work is being done to produce a video to explain opportunities of pharmacy technicians to share to high school students. Finally, the Council on Education and Workforce Development has revised ASHP policy regarding promotion of the pharmacy profession, which will likely be considered at the virtual House of Delegates in November.

#### **Promotion of Open Forum on Saturday: Paul Driver, Indiana**

Increase the emphasis and importance of the Open Forum to delegates and nondelegates in promotional flyers for Summer Meeting

ASHP staff discussed the operations of the Open Forum and agreed on the value of its purpose, which is to gather feedback on proposed policies from ASHP members. It was agreed that the Open Forum's purpose would be better described and publicized on the ASHP Summer Meetings website, and that steps would be taken at the meeting to encourage nondelegate members to speak up.

#### **Ensure Adequate and Standardized Supply of Emergency Medications and Supplies in Non-EMS Accessible Locations: Christi Jen, SCSS; Stephanie Weightman, SCSS; Megan Musselman, SCSS; Christopher Edwards, Arizona; Jeff Little, Kansas; Jerome Wohleb, Nebraska; Zahra Nasrazadani, Kansas; Katie Reisbig, Nebraska; and Tiffany Goeller, Nebraska**

To advocate for pharmacist involvement in the interprofessional evaluation and recommendation of stocking of emergency medications and supplies in non-EMS accessible locations

The Council on Pharmacy Practice considered this recommendation at its Policy Week meeting and proposed a policy recommendation to be considered by the House in June 2023.

#### **RFID Standardization Requirements: Kellie Much, Ohio**

Request ASHP create a policy or statement regarding radio frequency identification (RFID) technology requirements and standardization for medications.

Members of the Section of Pharmacy Informatics and Technology are including the subject of RFID technology in its revision the ASHP statmenet on barcoding.

#### **Development of Interstate Experiential Education Opportunities: Justin Konkol, Wisconsin**

ASHP should partner with schools of pharmacy and health systems to develop future interstate experiential opportunities which can help advance diversity within healthcare systems.

ASHP efforts in promoting diversity within healthcare systems are reflected in the following activities:

##### **AJHP article:**

- [Leading diversity, equity, and inclusion efforts within the pharmacy department](#)

##### **ASHP podcasts:**

- [Implementing Diversity, Equity, and Inclusion Initiatives in Schools and Colleges of Pharmacy](#)
- [MCM 2021 DEI Feature: Integration and Advancement of Diversity, Equity, and Inclusion in the Pharmacy Workplace](#)
- [Sowing the Seeds for Sustainable Change in Diversity, Equity and Inclusion - Creation of a Pharmacy Diversity Council](#)

#### **New ASHP Policy on Pharmacoequity: Bernice Man, Illinois**

An ASHP Council (possibly Council on Public Policy) should develop new policy that addresses pharmacoequity.

The Council on Pharmacy Practice considered this recommendation at its Policy Week meeting and proposed a policy recommendation to be considered by the House in June 2023.

#### **Development of Hazardous Drug (HD) Environmental Monitoring and Medical Surveillance Guidelines: Christy Norman, Georgia**

To recommend development of robust and specific practice guidelines for environmental monitoring of hazardous drugs and personnel medical surveillance in pharmacy.

The Council considered this recommendation at its Policy Week meeting and voted to revise the the ASHP Guidelines on Handling Hazardous Drugs, last published in 2018, to include contemporary recommendations related to surface contamination monitoring.

#### **Professional Identity Formation: Vickie Ferdinand-Powell, Kimberly Zammit, and Robert DiGregorio (New York)**

Collaborative work is encouraged with organizations outside of ASHP to promote the development of a professional identity that reflects the many roles pharmacists play on the healthcare team.

This recommendation was discussed by Council on Education and Workforce Development leadership. This year Council revised ASHP policy 1828, Promoting the Image of Pharmacist and Pharmacy Technicians, as part of sunset review. It will likely be considered at the November virtual House. This recommendation provided important discussion points for consideration during the revision of the policy.

In addition, since the revision of the [ASHP Statement on Professionalism](#), the Section of Pharmacy Educators (SPE) has promoted the development of professional identity through two webinars (Precepting Generation Z, and Professional Identity Formation Starter Kit for Preceptors: What Is It and What Do I Need to Know?). A SPE workgroup has submitted a paper to *AJHP* on professional identity formation, and the following two articles on professional identity formation have been published:

- [Teaching at the critically ill patient's bedside: Linking clinical practice to professional identity](#)
- [Layered learning: Eight precepting strategies for the new attending pharmacist](#)

#### **Pharmacist Involvement in the Design of Clinical Trials: Jesse Hogue, Michigan**

ASHP should consider developing a policy statement or update the ASHP Guidelines on Clinical Drug Research to support and describe pharmacist involvement in the design of clinical trials to provide guidance on drug dosing, administration and monitoring in all patients.

This recommendation was discussed by Council on Education and Workforce Development leadership. The Council addressed ASHP policy 1828, Promoting the Image of Pharmacist and Pharmacy Technicians, as a sunset review during its Policy Week meeting, using this recommendation guiding discussion points for consideration. The revised policy will likely be considered by the ASHP House of Delegates in November.

#### **ASHP Statement on Pharmacy Workforce Shortages: Jerome Wohleb, Nebraska; Katie Reisbig, Nebraska; Emily Johnson, Nebraska; Melinda Burnworth, Arizona; Chris Edwards, Arizona; Christi Jen, Arizona; Tonya Carlton, New Hampshire; Elizabeth Wade, New Hampshire; Brian Kawahara, California; Cheri Briggs, Delaware; Deborah Sadowski, New Jersey; and Jeff Cook, Arizona**

The profession(s) within pharmacy should be proactive in planning and include innovative strategies to address predicted challenges in the workforce.

This recommendation is very timely and high on the priorities of ASHP and our membership as our nation has been dealing with both the patient care and fiscal challenges resulting from the workforce shortages and other concerns noted in your background. As you indicated in your recommendation, there is need for short-term resources and advocacy that is paired with long-term strategies. ASHP has numerous policies and statements that provide direction on workforce education, training, leadership, and workload. There is much work that needs to be done and your recommendation supports the urgency of these efforts.

Your recommendation describes actions needed but is titled “ASHP Statement.” I’m hoping you can provide clarification whether the intent of the recommendation is a policy statement (e.g., [Roles and Responsibilities of the Pharmacy Executive](#)) or other actions by ASHP. Perhaps we could connect by phone to discuss and I could get your insights on what elements of such a statement would be. I could then share your thoughts with the Council on Pharmacy Management and the Section of Pharmacy Practice Leaders Executive Committee. (I will send a Doodle poll based on clarification)

In the interim, I provide below a number of ASHP activities aimed at addressing the hospital and health-system workforce issues. The list is not exhaustive and is only the beginning of what will need to be a prolonged effort by ASHP, all the pharmacy associations, and practitioners as we develop sustainable practice models and workforce.

1. Pharmacy Executive Leadership Alliance (PELA): The [PELA Advisory Panel](#) has discussed succession planning in health-system pharmacy practice and the technician workforce shortages.
  - a. A primary goal of PELA is to create community, education, and resources for the leaders of the very complex multi-hospital and large hospital pharmacy enterprises. An intended outcome is the provide an environment that both supports and sustains existing leaders and a platform to facilitate future leaders to be poised to fill these high level positions through retirements and vacancies.
  - b. PELA has a work group focused on pharmacy technicians that will be driving the establishment of necessary task descriptions, regulatory analysis, and education requirements to develop the data necessary to engage with HR associations, hospital executive associations, and others to support the pursuit of technician position classifications to aide in recruitment and retention.
2. Section of Pharmacy Practice Leaders (SPPL): At the SPPL Executive Committee’s Summer Meeting, they discussed the impact of decreased college of pharmacy (CoP) enrollments and potential projections on future workforce, succession planning as well as recent trend of departures from hospitals and health systems to other industries, and pharmacy technician shortages.
  - a. The concern noted with declining CoP enrollments was both the impact on overall workforce as well as a proportionally smaller pool of graduates interested in pursuing clinical and administrative leadership positions. This topic will be a continued focus, and with [ASHP’s Pharmacy Administration and Leadership Residents’ Collaborative](#) there will be a focused effort in providing students encouragement and information on how to pursue an HSPAL residency.
  - b. There is active discussion on repeating past ASHP research on leadership shortages and expectations for the future. This process will not replace the necessary work the SPPL will focus on this upcoming year but will provide important information to influence strategic decisions.
  - c. The SPPL and Pharmacy Technician Forum collaborated on a recent AJHP CPO Perspectives column ([“Stabilizing the pharmacy technician workforce as an imperative for the chief pharmacy officer”](#)) and there will be an extended workshop conducted by the authors at the [2022 Conference for Pharmacy Leaders](#).
3. ASHP National Technician Workforce Survey: This [survey](#) provided the clarity on the national scope of pharmacy technician workforce shortages and has been used to educate the healthcare press and other peer organizations on details and scope of the issues. It also provided data on the complexity of the tasks our pharmacy technicians provide to patient care.
4. ASHP Pharmacy Technician Recruitment and Retention Resource Center: This resource is in the development stages and will provide:

- a. Strategies based on needs and factors affecting a variety of institution types (e.g., the small- to mid-size community hospital, large multi-hospital system, large academic medical center, rural hospitals and clinics)
- b. Resources to help the pharmacy department work with HR to make the pharmacy technician position more attractive
- c. Tools for communicating to the C-Suite

Suggestions for changes in practice management/workflow to relieve workload issues in the delivery process when pharmacy technician staffing is short.

#### **Access to Transgender Care to Manage Gender Dysphoria: Tim Brown (SPE) and Jeff Little (SPPL)**

Policy supporting access to medications used for transgender patients for gender dysphoria management.

The Council on Therapeutics and the Council on Public Policy considered this recommendation at their Policy Week meetings, and the Council on Therapeutics has proposed a policy recommendation for consideration by the House in June 2023.

#### **Increased Delegate Work Time Between Caucus and House Meeting: Jodi Taylor, Tennessee**

Future HOD activity scheduling should evaluate if more work time can be allotted between the first caucus and the first meeting of the House (with full recognition of the challenges of meeting scheduling).

ASHP meeting staff have tried to balance the conflicting needs of delegates when scheduling the First Delegate Caucus and the First Meeting of the House. Given that not all delegates can attend a Saturday meeting, it was decided that the current Sunday morning caucus meeting was the best that could be done. ASHP has taken steps in recent years to increase delegate coordination through use of email, ASHP Connect, and the virtual House to ease the workload on delegates between the First Delegate Caucus and First Meeting.

#### **Revision of FDA Rule on Barcodes on Immediate Containers: Ben Anderson and Kevin Marvin (SOPIT)**

Advocate that the Food and Drug Administration (FDA) in coordination with U.S. Pharmacopeia (USP) implement rules for pharmaceutical manufacturers to encode lot numbers and expiration dates within the barcodes of internal and unit dose packages (immediate containers) to support automation of expiration date and lot number logging and validation to the patient level, furthermore, remove the requirement for linear barcodes on immediate containers to allow 2D barcodes that support this additional encoding.

This recommendation was considered for addition to the Council of Public Policy agenda this year, but it was noted that Drug Supply Chain Security Act (DSCSA) requirements are hastening a transition to two-dimensional barcodes. It was concluded that an advocacy push would not be likely to further speed the changes already underway.

#### **Membership Dues: Dale English II, Kentucky**

Recommend that given both the all-time record number of ASHP members as well as the very strong ASHP Treasurer's report that ASHP leadership strongly consider freezing any increases in membership dues for at least the next two (2) years given the current landscape of inflation nationally as well as globally.

ASHP has not raised membership dues since 2020. In this time, ASHP has significantly expanded its advocacy, professional practice resources, and membership offerings at no additional cost to its members. The ASHP Board of Directors takes its fiduciary responsibility very seriously, particularly in these difficult times. Decisions on dues increases take into consideration the financial position of ASHP as well as environmental scanning and assessment.

#### **Residency Training and Direct Patient Care: Dale English II, Kentucky**

Recommend ASHP provide an update on the effectiveness and impact of ASHP policy position 2027, "Residency Training for Pharmacists Who Provide Direct Patient Care" and ASHP's current and/or future plans of advocating this policy; further,

Recommend ASHP Section of Community Pharmacy Practitioners review and provide their input and/or recommendation on the terminology "pharmacists who provide direct patient care" utilized in the policy statement; further,

Recommend ASHP review the ACPE requirements that graduates of ACPE-accredited Doctor of Pharmacy programs are "practice ready," how this policy may be in opposition of ACPE accreditation standards, as well as the effects of this policy on patient care and the pharmacy profession.

ASHP policies are aspirational in nature. The policy Residency Training for Pharmacists Who Provide Direct Patient Care was approved at the 2020 ASHP House of Delegates, so this policy was only recently approved. ASHP professional policies developed by our members have long supported the value of residency training to prepare individuals to practice in hospitals and health systems and to provide direct patient care. Examples of such policies include 2219 – Hospital-at-Home Care, 2117 – Education and Training in Telehealth, 2249 – Screening for Social Determinants of Health, 1829 – Pharmacy Training Models, 1225 – Board Certification for Pharmacists, and 0917 – Pharmacy Residency Training. ASHP continues to close the gap between pharmacy students who are applying to residency programs and the number of available pharmacy resident positions. Additionally, ASHP policy 0917 – Pharmacy Residency Training supports this position.

#### **Medication Safety in Operating Rooms and Anesthesia Procedural Locations: Tricia Meyer, Texas**

ASHP align with the Anesthesia Patient Safety Foundation (APSF) to advocate for/recommend use of pre-filled syringes in anesthetic locations in addition to assisting pharmacist's members in developing budgetary justification through improved anesthesia provider efficiency, decreasing provider needle sticks, drug wastage etc., and methods to estimate the true benefit/cost ration of investing in safety.

ASHP appreciates learning more about APSF initiatives and was gratified to see Dr. Meyer's name and a few other pharmacists listed on the APSF Advisory Group on Medication Safety. The recommendation was shared with colleagues that work in medication safety work that aligns with medication preparation and was considered by the 2022-2023 Council on Pharmacy Practice. ASHP welcomes opportunities to engage with APSF in joint statements or work streams related to this topic.

# 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.

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Jannet Carmichael	Marianne Ivey	Bruce Scott	
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<b>Wyoming (2)</b>	Jonathan Beattie Jaime Bobinmyer Hornecker	
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<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>	Charnae Ross	Justin Moore
<b>Pharmacy Student Forum</b>	Ma Emmanuelle (Ella) Domingo	Austen Werab
<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



# House of Delegates

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## REPORT ON THE VIRTUAL HOUSE OF DELEGATES

May 12-18, 2023

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### 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

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

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<b>Vermont (2)</b>	Julie MacDougall Kevin Marvin	Jennifer Burrier

<b>Virginia (4)</b>	Catherine Floroff Amy Schultz Brian Spoelhof Darren Stevens	Neha Naik
<b>Washington, D.C. (2)</b>	Carla Darling Sumit Dua	Sue Carr
<b>Washington State (4)</b>	Lauren Bristow Chris Greer James Houpt Karen White	Rena Gosser Roger Woolf
<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	
<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>	Charnae Ross	Justin Moore
<b>Pharmacy Student Forum</b>	Ma Emmanuelle (Ella) Domingo	Austen Werab
<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



# 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 (2024-2025)**

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 (Three-Year Term: 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 (Two-Year Term: 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)

Current Board member Sam Calabrese will join ASHP as vice president of the accreditation services office effective June 2023. To fill his vacated seat on the ASHP Board of Directors, in accordance with the provisions of the ASHP bylaws, the Committee on Nominations slated two candidates to serve the remaining two years of his term.

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, BPSPharm, 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 (THREE-YEAR TERM: 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 (AACCP) 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 (TWO-YEAR TERM: 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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	<u>Page</u>
COUNCIL ON PHARMACY PRACTICE POLICY RECOMMENDATIONS .....	3
1.    Emergency Medical Kits.....	3
2.    Raising Awareness of the Risks Associated with the Misuse of Medications .....	4
3.    Standardization of Medication Concentrations .....	5
4.    Pharmacoequity.....	7
5.    Medication Administration by the Pharmacy Workforce .....	8
6.    Reducing Healthcare Sector Carbon Emissions to Promote Public Health .....	9
COUNCIL ON THERAPEUTICS POLICY RECOMMENDATIONS .....	12
1.    Availability and Use of Fentanyl Test Strips .....	12
2.    Manipulation of Drug Products for Alternate Routes of Administration.....	14
3.    DEA Scheduling of Controlled Substances.....	15
4.    Pharmacist Prescribing Authority for Antiretroviral Therapy for the Prevention of HIV/AIDS .....	17
5.    Point-of-Care Testing and Treatment.....	20
6.    Nonprescription Availability of Oseltamivir .....	23
7.    Over-the-Counter Availability of Oral Contraceptives .....	25
8.    Responsible Medication-Related Clinical Testing and Monitoring .....	27
9.    Therapeutic and Psychosocial Considerations of Patients Across the Gender Identity Spectrum.....	29



10. Removal of Injectable Promethazine from Hospital Formularies .....	31
COUNCIL ON EDUCATION AND WORKFORCE DEVELOPMENT POLICY RECOMMENDATION .....	35
1. Well-Being and Resilience of the Pharmacy Workforce.....	35
SECTION OF PHARMACY EDUCATORS POLICY RECOMMENDATION.....	38
1. ASHP Statement on Precepting as a Professional Obligation .....	38

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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)  
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Clarissa Garcia, *Student* (California)  
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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 (underscore indicates new text; ~~striketrough~~ 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; ~~strike through~~ 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 (underscore indicates new text; ~~strikethrough~~ indicates deletions):

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

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

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

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



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

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

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

- 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 patients' sex assigned at birth, self-identified gender, and (if applicable) gender-confirming therapies or procedures should be documented in a structured way in electronic health records. This documentation also helps healthcare providers address another of the unique biopsychosocial needs of transgender patients; like other healthcare providers, pharmacists should address transgender patients by their self-identified gender.

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

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

### **Background**

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

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

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

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

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

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

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

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

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

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

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

- 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; ~~strike~~~~through~~ 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; ~~strike~~~~through~~ 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)  
Cher Enderby (Florida)  
Marie A. Chisholm-Burns (Tennessee)  
Tim Brown (Georgia)  
Jennifer D. Arnoldi (Illinois)  
Kevin W. Chamberlin (Connecticut)  
Gina G. Luchen, *Director*

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### **1. ASHP Statement on Precepting as a Professional Obligation**

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

## Appendix:

### ASHP Statement on Precepting as a Professional Obligation

#### Position

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

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

#### Background

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

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

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

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

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

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

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

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

## Responsibilities of stakeholders

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

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

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

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

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

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

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

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

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



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

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

### **Responsibilities of preceptors**

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



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

### **Incorporating precepting into practice**

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

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

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

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

### **Conclusion**

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

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### Additional Information

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### Disclosures

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# 2023 Report of the ASHP Treasurer

**Christene M. Jolowsky**

The Treasurer has the responsibility to report annually on ASHP's financial condition to the membership. ASHP's fiscal year is from June 1 through May 31, coinciding with our policy development process and timetable. This report describes ASHP's actual financial performance for fiscal year FY2022, 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 revenue. We also showed record revenue from our professional certificates, certifications programs, and accreditation services. In addition, ASHP was awarded a Health and Human 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.

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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.

<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.

<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.

## Report of the ASHP Treasurer

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

Fiscal year 2023 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 three-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 two 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.

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 three years, ASHP has maintained a remarkable level of financial stability and membership growth. Sound fiscal management, coupled with visionary strategic thinking, have



## Report of the ASHP Treasurer

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!

**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	157,818	150,601
Other assets	410	478
<b>Total Assets</b>	186,799	168,219
<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	154,094	137,048
<b>Total Liabilities and Net Assets</b>	186,799	168,219





# House of Delegates

## 2023 ASHP HOUSE OF DELEGATES MEETINGS AT A GLANCE

### Baltimore Convention Center Baltimore, Maryland

- ◆ [House of Delegates Registration](#) **Pratt Street Lobby**  
Saturday, June 10, 10:30 a.m. – 5:45 p.m.  
Sunday, June 11, 7:00 a.m. – 11:00 a.m.  
[After then, delegates can register in the Executive Office, Room 334]  
**Level 300**
- ◆ [Open Forum for Members](#) **Room 337**  
Saturday, June 10, 2:30 – 4:30 p.m.  
**Level 300**
- ◆ [Delegate Primer on HOD Processes](#) **Room 340**  
(For all delegates and alternate delegates)  
Saturday, June 10, 4:30 – 5:30 p.m.  
**Level 300**
- ◆ [First Delegate Caucus](#) **Room 337**  
Sunday, June 11, 9:30 – 11:30 a.m.  
**Level 300**
- ◆ [Second Delegate Caucus](#) **Room 337**  
Tuesday, June 13, 12:15 – 2:00 p.m.  
**Level 300**
- ◆ [Other Caucuses](#) **Room 336**  
Federal Pharmacists, Sunday, June 11, 7:30 – 8:30 a.m.  
Small and Rural Hospitals, Sunday, June 11, 8:30 – 9:30 a.m.  
**Level 300**
- ◆ [First House of Delegates Meeting](#) **Ballroom I**  
Sunday, June 11, 1:00 – 5:00 p.m.  
**Level 400**
- ◆ [Meet the Candidates](#) **Room 337**  
Monday, June 12, 12:15 – 1:45 p.m.  
**Level 300**
- ◆ [Delegate Reception](#) **Holiday Ballroom 6**  
Monday, June 12, 5:30 – 6:30 p.m.  
**2nd Floor, Hilton**
- ◆ [Second House of Delegates Meeting](#) **Ballroom I**  
Tuesday, June 13, 4:00 – 6:00 p.m.  
**Level 400**



# House of Delegates

## AGENDA

### First Delegate Caucus

June 11, 2023

9:30 – 11:30 a.m.

Baltimore Convention Center, Room 337

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The First Delegate Caucus has two purposes:

- 1) To review the agenda for the first meeting of the House of Delegates and answer questions delegates have about the agenda.
  - 2) To facilitate the work of delegates who wish to amend policy recommendations.
- 

#### 1. Review of First Meeting Agenda

1. Call to Order
2. Roll Call of Delegates
3. Report on Previous Session
4. Ratification of Previous Actions
5. Report of Committee on Nominations
6. Board of Directors Reports:
  - A. Council on Pharmacy Practice
  - B. Council on Therapeutics
  - C. Council on Education and Workforce Development
  - D. Section of Pharmacy Educators
7. Report of the Treasurer
8. Recommendations of Delegates
9. Announcements
10. Adjournment of First Meeting

#### 2. Amendments to Policy Recommendations



# House of Delegates

## AGENDA

### Second Delegate Caucus

June 13, 2023

12:15 – 2:00 p.m.

Baltimore Convention Center, Room 337

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The Second Delegate Caucus has three purposes:

- 1) To review the agenda for the second meeting of the House of Delegates and answer any questions delegates have about the agenda.
  - 2) To present the Board's actions on policy recommendations amended by the House ("unfinished business").
  - 3) To present new business items coming before the House.
- 

#### 1. Review of Agenda

1. Call to Order
2. Quorum Call
3. Reports of the President and the CEO
4. Unfinished and New Business
5. Recommendations of Delegates
6. Installation of Officers and Directors
7. Announcements
8. Adjournment of Second Meeting

#### 2. Unfinished Business

#### 3. New Business



# House of Delegates

## AGENDA

### House of Delegates Open Forum

June 10, 2023

2:30 – 4:30 p.m.

Baltimore Convention Center, Room 337

Presiding – Melanie A. Dodd

Chair, House of Delegates

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The House of Delegates Open Forum has three purposes:

- 1) To present the proposed policies and reports that will be acted upon by the House to all interested Summer Meeting participants, and to give them an opportunity to share their views;
  - 2) To provide a forum for all interested meeting participants to discuss other issues that influence the practice of pharmacy in hospitals and health systems, including those that might merit consideration by the House and ASHP; and
  - 3) To install the elected members of the ASHP section executive committees and recognize outgoing forum executive committee members.
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- I. Installation of Section Executive Committee Members and Recognition of Outgoing Forum Executive Committee Members
- II. Discussion of Treasurer's Report
- III. Discussion of Policy Recommendations before the House – House of Delegates Chair will open the floor for questions about their respective reports and recommendations:
  - Council on Pharmacy Practice
  - Council on Therapeutics
  - Council on Education and Workforce Development
  - Section of Pharmacy Educators
- IV. Open discussion of other issues of interest to Open Forum participants, with emphasis on (a) new business items being contemplated by delegates, and (b) items that merit future exploration for policy development and programmatic areas that should be considered by ASHP.



House of Delegates  
June 11 and 13, 2023

Antitrust Statement

ASHP has a policy of strict compliance with federal and state antitrust laws. ASHP policymakers, including delegates to the House of Delegates, need to be aware of the possible antitrust exposure that may arise when representatives of competing entities with market power meet to discuss the types of issues on House of Delegates agendas. Although your service in the ASHP House of Delegates has as its express purpose carrying on discussions for the purpose of optimizing therapeutic outcomes and patient care, and is a voluntary venture, not undertaken on behalf of your respective employers or businesses, your activities may be interpreted as actions by competitors. It is important that delegates understand that they cannot come to understandings or agreements on activities or positions that might:

- 1) raise, lower or affect prices, reimbursement levels, discounts, fees, wages, and/or other terms and conditions for doing business;
- 2) allocate or divide markets or territories;
- 3) indicate a refusal to deal with particular customers, companies, or third-party payors; or
- 4) affect supply and demand of products and/or services.

It is acceptable to discuss pricing models, methods, systems, and other forms of voluntary consensus standards or guidelines based on objective evidence that do not lead to an agreement on restraining prices, wages, or related matters.

Information may be presented with regard to historical pricing activities so long as such information is general in nature and does not include specific data on current prices or wages in a particular trade area. Any discussion by delegates to the ASHP House of Delegates of current or future pricing, wages, fees, or other terms and conditions, which may lead to an agreement or consensus on prices, wages, or fees, is strictly prohibited. A violation of the antitrust laws may be inferred from discussions about pricing or wages followed by parallel decisions by group members, even in the absence of an oral or written agreement.

**President-Elect, President, Immediate Past President**

**CEO, Parliamentarian, HOD Chair**

1. Past Presidents (8)	9. Board of Directors (8)	17. NJ (4) NM (2) OK (3)
2. Past Presidents (8)	10. Section (9)	18. NY (5) NC (4)
3. Past Presidents (8)	11. Forum (3) Fraternal (5)	19. ND (2) OH (5) OR (3)
4. AL (3) AK (2) AZ (3)	12. IA (3) KS (3) KY (3)	20. PA (4) PR (2) RI (2) SD (2)
5. CA (4) AR (2) CO (3)	13. LA (3) ME (2) MD (4)	21. SC (3) TN (4) UT (3)
6. CA (3) CT (3) DE (2)	14. MA (4) MI (4)	22. TX (3) VT (2) VA (4)
7. FL (5) GA (3) HI (2)	15. MN (3) MS (3) MO (3)	23. TX (3) WM (2) WA (4)
8. ID (2) IL (5) IN (3)	16. MT (2) NE (3) NV (2) NH (2)	24. WV (2) WI (4) WY (2)
25. Empty Table- No chairs	26. Empty Table-No chairs	27. Empty Table-No chairs

**2023 ASHP House of Delegates Seating Chart**

## Parliamentary Terms and Procedures Often Used in the ASHP House of Delegates (HOD)

To:	You say:	2nd needed	Vote needed	Examples
Be recognized on floor of HOD	"Madam Chair, my name is ____; I am a delegate for ____; and I rise to ____."	N/A	N/A	Delegates and others speaking at HOD must be recognized by Chair before speaking; this is done by approaching microphone to get Chair's attention. Note: No delegate may speak more than twice to same question on the same day, and no delegate may make second speech on same question on same day until every member who desires to speak on it has had opportunity to do so once.
Introduce main motion (proposal)	"I move that..." or "I move to..."	Yes	Majority	Main motion is only motion whose introduction brings business before HOD.
Separate policy from main motion	"I'd like to separate Policy ____ for the purpose of ____."	No	No	To separate item (e.g., policy recommendation) from rest for separate consideration or action (typically used so that amendments to policy recommendation may be offered).
Amend motion	"I move to amend by..."	Yes	Majority	To amend policy recommendations, resolutions, or new business. Notes: 1) You may amend by: (a) inserting word(s) or paragraph; (b) striking word(s) or paragraph; (c) striking word(s) and inserting word(s); or (d) substitute by striking out entire paragraph, section, or article—or complete main motion or resolution—and inserting different paragraph or other unit in its place. 2) Only two proposed amendments may be pending at one time (i.e., amendment to main motion [primary amendment] and amendment to that amendment [secondary amendment]). 3) After motion (e.g., policy recommendation) is amended, it still must be adopted, as amended.
Refer [to Board]	"I move to refer..."	Yes	Majority	To refer an item to the Board of Directors for further consideration.
End debate	"I move the previous question."	Yes	2/3	To have HOD end debate and vote on pending motion(s).
Call upon Chair to enforce rules	"Point of order"	No	Chair rules	Raised when delegate thinks that rules of HOD (i.e., ASHP Bylaws, ASHP Rules of Procedure for HOD, or <i>Robert's Rules of Order Newly Revised</i> ) are being violated, thereby calling upon Chair to rule and enforce regular rules.
Request information	"Request for information"	No	No	Request directed to Chair, or through Chair to another officer or delegate, for information relevant to business at hand but not related to parliamentary procedure.
Reconsider	"I move to reconsider the vote on..."	Yes	2/3	To bring back for further consideration HOD-amended policy on which vote has already been taken.
Limit or extend limits of debate	"I move to limit discussion to two minutes per speaker."	Yes	2/3	Can limit debate by: 1) reducing number or length of speeches permitted; or 2) requiring that, at certain later hour or after debate for specified length of time, debate shall be closed. It can extend limits of debate by allowing more and longer speeches than under regular rules.