# House of Delegates

# Board of Directors Reports: Policy Recommendations for the June 2026 House of Delegates

# COUNCIL ON EDUCATION AND WORKFORCE DEVELOPMENT POLICY RECOMMENDATIONS

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

Dawn Moore, *Board Liaison*



## 1. Optimizing Career Fulfillment in Pharmacy

To recognize that fostering career fulfillment strengthens patient care and advances the profession by promoting a resilient, engaged, and purpose-driven workforce; further

To advocate for dedicated organizational roles focused on career fulfillment that integrate recognition strategies, structured development guidance, and individualized support across the care continuum; further,

To encourage the pharmacy workforce to align their professional development plans with their personal definitions of career fulfillment and core values to help support sustainable engagement and well-being throughout their careers.

***Rationale***

Career fulfillment represents a holistic and evolving concept that extends beyond workforce retention and professional development. While professional development equips individuals with skills, career fulfillment addresses the alignment of those skills and roles with personal values, well-being, and long-term satisfaction. The pharmacy workforce increasingly seeks meaningful work environments where structured development guidance, recognition

strategies, and individualized pathways reflect both organizational needs and individual aspirations.

Current organizational structures often require pharmacy leaders to juggle the dual responsibilities of overseeing daily operations and providing individualized career guidance and fulfillment-focused support. Establishing dedicated roles or frameworks to share these responsibilities can enhance workforce engagement, growth, and well-being ultimately advancing organizational performance and strategic goals.

Supporting career fulfillment requires organizations to create dedicated roles and structures that provide education, training, and tailored guidance. These efforts are particularly important during transitional moments, such as entry into practice, advancement to new responsibilities, or shifts into leadership or nontraditional roles. Frameworks that incorporate coaching and mentorship can help individuals navigate these transitions effectively and maintain engagement throughout their careers.

Equally important is empowering the pharmacy workforce to take ownership of their professional journeys by aligning personal values with professional development plans. By recognizing fulfillment as a key component of workforce well-being, organizations can create sustainable career pathways that not only enhance satisfaction and promote resilience but also elevate the profession and strengthen the quality of patient care delivered across all practice settings.

***Background***

Following robust discussion on the growing evidence of burnout, declining career satisfaction, and gaps in leadership readiness across the pharmacy workforce, the Council identified the need to more intentionally address the concept of career fulfillment as a foundation for long-term well-being and professional sustainability. The Council therefore proposed this policy to emphasize that optimizing career fulfillment through structured guidance, recognition, and individualized development can serve as both a preventive strategy against burnout and a catalyst for engagement, leadership growth, and organizational success. By advocating for dedicated roles and frameworks that support these functions, the policy aims to ensure that individuals can thrive personally and professionally while contributing to resilient, purpose-driven practice environments.

## 2. Quality of Pharmacy Education and Expansion of Colleges of Pharmacy

To support the Accreditation Council for Pharmacy Education's continuing role of promulgating accreditation standards and guidelines and engaging in sound accreditation processes to ensure quality in the education provided by colleges of pharmacy; further,

To acknowledge that, in addition to a robust curriculum, access to quality experiential educational sites and the availability of qualified faculty (including preceptors) are essential determinants of the ability to expand enrollment in existing or additional colleges of pharmacy; further,

To encourage the responsible evaluation of supply and demand projections when considering the establishment, expansion, or closure of colleges of pharmacy; further,

To advocate that pharmacy education should proactively incorporate established and emerging practice advancements and innovative technology, including those not yet fully implemented or widely adopted in current practice.

*This policy would supersede ASHP policy 1108.*

***Rationale***

The Council supports the Accreditation Council for Pharmacy Education's role in ensuring the quality of education provided by colleges of pharmacy. Multiple factors contribute to ongoing fluctuations in the supply and demand of the pharmacy workforce. It remains important that workforce projections are thoughtfully considered when decisions are made regarding program development and expansion. Colleges of pharmacy continue to face nationwide challenges related to enrollment trends, operational costs, and constrained higher education funding. Given our professional responsibility to prepare the next generation of pharmacists for the workforce, colleges of pharmacy and other partners should work innovatively to find solutions that support pipeline development, didactic and experiential education, workforce recruitment and retention, and sustainability across both academic and practice enterprises. Further, we support the ongoing research about the pharmacy workforce through reports such as data from the Bureau of Labor Statistics, the National Pharmacist Workforce Study, and other similar state-level projections.

Incorporating pharmacy practice advancements and innovative technology into pharmacy education is essential to prepare future-ready pharmacists who can thrive in evolving healthcare environments. As pharmacists take on expanded roles in clinical decision-making, public health, and digital health, education must align with these changes by integrating tools such as telepharmacy, and AI-assisted care.

Bridging the gap between academic training and real-world practice ensures graduates are competent, collaborative, and adaptable. Additionally, leveraging technologies such as virtual simulations and personalized learning platforms enhances student engagement and skill development. These innovations also support equitable healthcare delivery by training students to serve diverse and underserved populations through modern, accessible care models.

***Background***

The Council reviewed ASHP policy 1108, Quality of Pharmacy Education and Expansion of Colleges of Pharmacy, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To support the Accreditation Council for Pharmacy Education's continuing role of promulgating accreditation standards and guidelines and engaging in sound accreditation processes to ensure quality in the education provided by colleges of pharmacy; further,

To acknowledge that, in addition to a robust curriculum, access to quality experiential educational sites and the availability of qualified faculty (including preceptors ~~and specialty-trained clinical faculty~~) are essential determinants of the ability to expand enrollment in existing or additional colleges of pharmacy; further,

To ~~oppose expansion of enrollment in existing or new~~ encourage the responsible evaluation of supply and demand projections when considering the establishment, expansion, or closure of colleges of pharmacy ~~unless well-designed projections demonstrate that such enrollment increases are necessary to maintain a viable pharmacist workforce.~~; further

To advocate that pharmacy education should proactively incorporate established and emerging practice advancements and innovative technology, including those not yet fully implemented or widely adopted in current practice.

The Council recommended amending policy 1108 and its rationale to reflect the evolving realities of pharmacy academia within a rapidly changing healthcare landscape. Since the policy's original adoption, pharmacy education has faced significant shifts in enrollment trends, workforce dynamics, and expectations for practice readiness. It is essential that the growth of colleges of pharmacy and their enrollment capacities remain aligned with both workforce supply and demand projections and the profession's evolving needs. The proposed amendments emphasize responsible planning, sustainable expansion, and the integration of emerging technologies and practice innovations to ensure pharmacy graduates are well-prepared to meet contemporary and future healthcare challenges.

# COUNCIL ON PHARMACY MANAGEMENT POLICY RECOMMENDATIONS

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



## 1. Advancing Technology Innovation and Vendor Accountability in Health-System Pharmacy

To urge hospitals and health systems to engage pharmacy departments in the governance and evaluation of technologies impacting patient care, further;

To encourage pharmacy leaders to take ownership of implementing medication-related technology, including pharmacy department processes and governance; further,

To support collaboration between pharmacy leaders and technology vendors in the design and implementation of technologies that improve patient-care outcomes and the user experience; further,

To advocate for changes in federal law that would recognize technology vendors' safety accountability.

*This policy would supersede ASHP Policy 2406.*

***Rationale***

The adoption of medication-related technology [e.g., health information technology (HIT)] in hospitals has been steadily increasing. The 2024 ASHP National Survey of Pharmacy Practice in Hospital Settings reports basic analytics (e.g., data from smart pumps, clinical decision support, compounding technology) are used in nearly 80% of hospitals and advanced analytics (e.g., artificial intelligence, machine learning, predictive analytics) are used in about 7% of hospitals, an increase from 4% in 2021 and 2.6% in 2020. Investing in technology and properly integrating it within healthcare can prevent errors, improve quality, and prevent waste. Emerging or novel technologies offer opportunities to transform the medication use process. These technologies offer significant opportunities to increase direct patient care time, close care gaps, reduce administrative burden, and minimize repetitive tasks. However, without a coordinated approach, adoption can be fragmented, underused, or misaligned with hospital goals.

Before selecting or upgrading medication-related technology, organizations must determine their needs and goals. For instance, the Office of the National Coordinator for HIT maintains the Health IT Playbook to help clinicians, administrators, and clinician-practice staff. The Health IT Playbook provides tools to help healthcare organizations choose and implement the right HIT systems for their needs. As hospitals and providers implement HIT within their institutions and practices, however, they often encounter new types of errors and problems. The medical literature is replete with many reports of the unintended consequences of HIT, so continuous monitoring of these systems is required. It has become increasingly important to properly assess the interface between HIT and users to identify whether any new risk has been introduced to the system and implement HIT appropriately, considering medication-use processes and human factors. Critical questions hospitals and health systems face include (1) when do HIT advances exceed the capacity for integration into workflow, (2) when does HIT begin to introduce risk into the medication-use process rather than improve patient safety, and (3) what are the accountabilities of HIT providers, regulators, and providers to ensure the necessary product development and assessments are made before implementation of new HIT.

ASHP advocates that the pharmacy department be part of the implementation team for any medication-related technology within an institution. Pharmacy technology solutions are capital investments with major budget implications costing millions of dollars annually. Given the rising cost of healthcare and internal competition for finite capital dollars, it is important to identify solutions that will improve quality and safety while being fiscally responsible. Pharmacy leaders must assume responsibility for guiding the design, selection, risk assessment, and implementation of new and existing medication-related technologies within the department of pharmacy, including their governance and continuous evaluation. Technology assessment tools should be applied by the pharmacy workforce to proactively determine gaps in function prior to implementation, during upgrades, and as part of the continuous evaluation of technology performance. The use of failure modes effects analysis (FMEA) and other resources should be considered. Organizations selecting or upgrading medication-related technology should work closely with implementation partners or vendors to ensure the following: (1) products are suited to the organization's needs; (2) Technology will be usable by clinicians and staff; and (3) accurate estimates of resources needed are identified to implement and support new or upgraded technology. It is imperative that technology vendors provide comprehensive estimates that clearly specify all required human, technical, financial, and operational resources

and time commitments necessary for the implementation, integration, training, and long-term support of new or upgraded technology solutions. These processes also provide opportunities to examine and optimize care delivery processes. Tailoring both technology and processes around care pathways takes advantage of the technology's potential to support safer care, inclusive of patient goals, while reducing burdens on healthcare professionals. Risk assessment should also be considered when implementing any new technology to ensure that unintended consequences are minimized. Regulatory and accreditation organizations include components of risk assessment and quality improvement within their criteria, but hospitals need to incorporate these into their overall plans. Such risk assessments may lead to reduced scrutiny of certain medication-related technology implementations as purchasers are often not required to research each product's capabilities and limitations. Finally, federal law should recognize vendors' accountability for the safety of their products as implemented.

Pharmacy workforce involvement in the development of technologies is critical. ASHP supports collaboration between pharmacy leaders and technology vendors to share pharmacy input for the development or enhancement of innovative technologies that improve patient outcomes and optimize usability. The medication-use process is inherently a multi-disciplinary process requiring involvement from numerous health-system departments. Pharmacy leadership is necessary and core principles of system-wide strategic alignment, collaboration, and change management are also fundamental. ASHP encourages members of the pharmacy workforce to actively pursue and engage in opportunities to influence technology construction.

***Background***

The Council reviewed ASHP policy 2406, Risk Assessment of Health Information Technology as part of a new topic discussion and voted to recommend amending it, as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To urge hospitals and health systems to engage ~~directly involve departments of~~ pharmacy departments in the governance and evaluation of technologies impacting patient care ~~performing appropriate risk assessment before new health information technology (HIT) is implemented or existing HIT is upgraded, and as part of the continuous evaluation of current HIT performance~~; further,
>
> To encourage pharmacy leaders to take ownership of implementing medication-related technology, including pharmacy department processes and governance; further,
>
> ~~To advocate that HIT technology vendors provide estimates of the resources required to implement and support new technologyHIT; further,~~
>
> To support collaboration between pharmacy leaders and ~~collaborate with HIT~~ technology vendors ~~to encourage the development~~ in the design and implementation of technologies ~~HIT~~ that improve~~s~~ patient-care outcomes and the user experience; further,
> To advocate for changes in federal law that would recognize ~~HIT~~ technology vendors' safety accountability.

The rapid development of new and innovative technologies has presented challenges for pharmacy departments not only to keep pace with what is available but also to fully understand the implications and required maintenance. As the Council discussed these challenges, specific opportunities for pharmacy advocacy and engagement emerged. First, the continued need to advocate for involvement of department of pharmacy leaders or representation at all levels during the investigation and review of all new technologies that impact the medication use process. Second, it is the responsibility of pharmacy leadership to ensure that internal pharmacy processes and governance are in place to supplement broader organizational processes, which involves fostering appropriate change management efforts for the department. Finally, the vital role of pharmacy workforce involvement throughout the process, including in the development of new technologies.

Review of current ASHP policy led to suggestions to modify an existing policy, 2406, Risk Assessment of Health Information Technology. Specific modifications included broadening the focus of the policy beyond risk assessment and incorporating department of pharmacy responsibilities for execution of technology implementation beyond HIT. Additionally, advocacy for frontline input from the pharmacy workforce into the development of technology was a noted gap to address. The Council highlighted considerations ASHP could address through education and resource development to orient members on aspects of this topic. One consideration includes a vendor assessment or rubric tool to assist with governance considerations and requests for technology proposals. Additional guidance for the consideration and adoption of emerging technologies would better support pharmacy's role in innovation within health-systems. Lastly, it was suggested that the policy recommendation be shared with the Section of Pharmacy Informatics and Technology executive committee for feedback.

## 2. Standard of Care Regulatory Model

1 To promote the adoption of a standard of care regulatory model for pharmacists.

***Rationale***

Standard of care regulatory models for pharmacy practice (e.g., pharmacist-provided clinical care, patient safety, automation, compounding standards) allow pharmacists to operate with greater autonomy and use their professional judgment and expertise within a defined scope of practice. States with existing standard of care regulatory models include: Idaho (implemented in 2018), Alaska (transitioned to through rulemaking in 2023), Montana (passed a bill in 2023), and Iowa (adopted via legislative reform in 2024). The federal pharmacy services (e.g., Veterans Affairs, Department of Defense, Public Health Service) operate under a standard of care framework and credential and privilege pharmacists using a defined scope of practice.

As regulation of pharmacy practice has become more complex, there is a growing interest in adopting a standard of care regulatory model, which has the potential to remove a significant volume of detailed rules. Today, many states have complex rules dictating exactly

which test, therapy, or disease state intervention pharmacists can provide. Each new statutory allowance introduced into pharmacy practice often necessitates the development of corresponding competencies or implementation of training courses. Much like physicians, nurses, and other healthcare professionals, pharmacists should instead be held to the standard of care rather than relying on 'brightline' rules or standards, which leave little room for interpretation. The standard of care model allows practice to align with the highest level of education and training for that individual.

Like physicians, privileging and credentialing will help to determine the appropriate education and training associated with the scope of practice required for the setting. ASHP encourages health systems to incorporate pharmacists into established privileging programs that align with education, training, and practice experience in their designated setting(s) (see ASHP policy 1415, Credentialing, Privileging, and Competency Assessment). Within many health-systems, pharmacists have been integrated into their privileging processes but adoption of standard of care regulatory models will require revised privileging procedures and pharmacists' inclusion in healthcare insurance credentialing procedures to support reimbursement. ASHP advocates for the inclusion of pharmacists in health insurance credentialing processes consistent with their authorized scope of practice (see ASHP policies 2011, Credentialing and Privileging by Regulators, Payers, and Providers of Collaborative Practice; and 2405, Pharmacist Access to Provider Networks).

***Background***

The implementation of a standard of care regulatory model within multiple states in recent years led to discussion with the Council. The Council discussed benefits of the model, chiefly the reduction of strict regulatory parameters but also acknowledged the challenges that may accompany this new model. Pharmacists have long relied on 'brightline' regulations to define what they are allowed to do and not do. This new model aligns more closely with the medical model of practice, shaping practice to the scope of training. Privileging may become a key component for implementation of standard of care models, and Council members noted this is a significant opportunity for ASHP to provide support. Notably, organizations with an established privileging process will likely be able to incorporate pharmacists and may evolve more quickly than pharmacy practice sites that do not have access to an established privileging program. In addition to support for privileging models, members noted that overall standard of care education was needed to support further adoption as well as case studies following implementation. Other ideas for member resources included networking events, a state affiliate toolkit, and a toolkit to support engagement with hospital executives and boards of trustees to support privileging.

Given the broad application and interest in this topic, the Council will share the draft policy statements with the Council on Public Policy, the Council on Pharmacy Practice, and other pertinent ASHP member groups.

# COUNCIL ON PHARMACY PRACTICE
# POLICY RECOMMENDATIONS

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

Todd Nesbit, *Board Liaison*



## 1. Promoting Environmental Sustainability in Healthcare

To acknowledge the importance of environmental sustainability in promoting and preserving public health; further,

To encourage implementation of environmentally conscious clinical and operational practices that reduce waste within the healthcare system; further,

To advocate for legislation and regulation that enables waste-minimization efforts in medication-use practices; further,

To encourage members of the pharmacy workforce to seek out opportunities that promote environmental sustainability and health.

***Rationale***

In healthcare, sustainability refers to the implementation of cost-efficient, environmentally responsible practices that support healthy and resilient communities over time. Environmental health, a key component of public health, focuses on how natural and built environments affect human health and disease.

As part of the built environment, healthcare facilities are increasingly expected to enhance environmental stewardship in support of patient and public health. Healthcare

activities generate substantial amounts of waste, which, if improperly managed, can have serious environmental and public health consequences. According to the World Health Organization (WHO), approximately 85% of healthcare waste is non-hazardous general waste, while the remaining 15% consists of hazardous materials, including infectious, chemical, and radioactive waste. Improper disposal of both hazardous and non-hazardous healthcare waste can contribute to environmental pollution, the spread of infectious diseases, and occupational risks for healthcare workers.

In the United States, healthcare facilities produce more than six million tons of solid waste annually, with plastics accounting for 20% to 25% of that total. Approximately 91% of plastics, including those used in healthcare, are not recycled, contributing to landfill accumulation and environmental degradation. A single hospital bed is estimated to generate nearly 30 pounds of waste per day, highlighting the scale of the issue in high-volume facilities.

***Background***

The Council discussed whether ASHP policy was needed related to waste in healthcare and the promotion of environmental sustainability. While ASHP professional policy 2313 is entitled "Reducing Healthcare Sector Carbon Emissions to Promote Public Health," Council members felt that sustainability and waste were not adequately addressed.

The ASHP Strategic Plan, revised and released in 2025, includes a goal under the Public & Global Health strategic pillar to "lead environmental stewardship associated with sustainable medication-use practices." This goal emphasizes the importance of promoting environmentally responsible medication-use practices (e.g., disposal, procurement), advancing pharmacy's role in sustainability initiatives, and engaging with key stakeholders to address environmental sustainability and stewardship challenges. This policy aligns with the strategic plan's broader commitment to promoting environmentally responsible clinical and operational practices, reducing waste, advocating for supportive regulatory frameworks, and elevating pharmacy's leadership in sustainability efforts.

## 2. Body Size Inclusivity

To recognize that body size bias influences health outcomes, social interactions, and decisions across workplaces and healthcare settings; further,

To promote the use of body size inclusivity in practice to ensure a comprehensive, patient-centered approach to care; further,

To encourage adoption of best practices that minimize body size bias across professional and healthcare settings.

***Rationale***

Body size inclusivity is defined as "accepting and respecting a wide range of body types and ensuring that all individuals, regardless of their body size, feel valued and included." It is the

intentional acknowledgment, respect, and accommodation of people of all body sizes in personal, professional, and organizational settings. In contrast, weight stigma refers to discriminatory acts and ideologies targeted towards individuals because of their weight and size, favoring smaller body sizes and perpetuating stigma, bias, and discrimination. Research demonstrates that weight-based stigma is a social determinant of health, associated with increased psychological stress, anxiety, depression, and lower self-esteem, contributing to both mental and physical health burdens for affected individuals.

Several healthcare organizations have developed policies and initiatives to promote body size inclusivity, aiming to reduce psychological harm and stigma associated with weight bias. For example, the World Obesity Foundation has advocates for system-level change to eliminate weight bias in healthcare and other sectors. The Massachusetts Medical Society emphasizes that with increased risk of weight bias comes increased incidence and prevalence of depression, social rejection, anxiety, and suicidality across all ages. Lastly, the Health at Every Size (HAES) movement promotes body size inclusivity while focusing on overall health rather than weight. HAES emphasizes holistic well-being, self-acceptance, and the removal of weight-centered biases from health assessments and social interactions. It offers the following HAES principles and framework of care:

- Healthcare is a human right for people of all sizes, including those at both extremes of weight.
- Comprehensive care is free of anti-fat bias and considerate of all body types.
- Wellbeing, care, and healing are collective and deeply personal resources.
- Health is a sociopolitical construct that is often reflective the of society's values.

Professional policies can play a central role in promoting body size inclusivity by setting clear expectations for equitable treatment, implementing anti-discrimination protections, and providing training to staff and leadership on recognizing and counteracting weight and height bias. Organizations can also audit existing policies and practices through a body-size lens to identify areas for improvement, while maintaining the collection of body size information needed for patient care decisions. By institutionalizing these changes, organizations signal a commitment to the psychological safety and dignity of all employees, reducing stigma, and promoting an environment where health, productivity, and professional success are not contingent on body size. Pharmacists and pharmacy technicians with education and training on the importance of body size inclusivity represents an opportunity to be a trusted and patient-centered professional.

***Background***

The Council discussed this topic in response to a recommendation from the 2025 ASHP House of Delegates which urged consideration of whether ASHP policies contribute to or mitigate potential psychological harms or stigma relate to body size. As a result, the Council determined there was a gap in policy and developed one related to body size inclusivity.

### 3. Pharmacy Workforce Leadership in Improving Vaccine Access

The pharmacy workforce is the leader in increasing patient access to vaccinations to improve public health; 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 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 payer coverage guarantees without cost sharing of vaccines recommended by recognized state and federal organizations and in accordance with clinical practice norms; 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 supply of vaccines.

*This policy would supersede ASHP policy 2247.*

***Rationale***

Increasing adult and pediatric patients' access to vaccinations is an important public health challenge. The unique training and expertise of members of the pharmacy workforce in all aspects of the medication-use system can help expand patients' access to vaccinations and promote disease prevention in all practice settings. Hospital and health-system pharmacists, student pharmacists, and pharmacy technicians provide care to a patient population that is at risk and often critically ill, and such patients are especially dependent on herd immunity. Patients in rural areas, where a pharmacy may provide the only convenient access to a healthcare professional, will benefit from increased pharmacy workforce vaccination authority.

Although all states permit pharmacist administration of some vaccines, state laws differ in the range of vaccines pharmacists and pharmacy technicians may administer and the patient populations they are permitted to vaccinate. During the COVID-19 public health emergency, new regulatory flexibility under the Public Readiness and Emergency Preparedness (PREP) Act allowed pharmacy technicians and pharmacy students, under the supervision of a licensed pharmacist, to administer COVID-19 and influenza vaccines through 2029. Permanently allowing trained and certified pharmacists, including student pharmacists, to order and administer all adult and pediatric vaccines (e.g., by eliminating the requirement that some vaccinations be conducted within a collaborative practice agreement) would encourage standardization of pharmacy vaccination practice within and among states, as would permitting appropriately trained and supervised pharmacy technicians to prepare and administer vaccinations. ASHP also advocates for payer coverage guarantees without cost sharing of vaccines and appropriate reimbursement of the pharmacy workforce for all vaccination services.

To aid in sharing important patient vaccination information, centralized and interoperable databases of patient vaccinations should be established, and all authorized vaccination providers, including pharmacists, student pharmacists, and pharmacy technicians, should be required by law or regulation to document their vaccinations in those databases in a timely manner when they become available.

Pharmacists, student pharmacists, pharmacy technicians, and pharmacy educators should embrace their role in this important public health effort by providing education about the importance of vaccination in disease prevention, participating in community vaccination

programs, and training vaccination providers.

The pharmacy workforce has an integral role in promoting disease prevention by promoting vaccine confidence. The CDC defines vaccine confidence as "the trust that patients, their families, and providers have in recommended vaccines, the providers who administer vaccines, and the processes and policies that lead to vaccine development, licensure or authorization, manufacturing, and recommendations for use." Building vaccine confidence can involve helping patients, caregivers, healthcare providers, and members of the public overcome vaccine hesitancy, which is a delay in acceptance or refusal of vaccination despite availability of vaccination services.

The pharmacy workforce, and in particular its leaders, also has an important role in working with federal, state, and local government, the pharmaceutical industry, and other stakeholders to improve the vaccine development and supply system to ensure a consistent and adequate supply of vaccines.

***Background***

The Council revised ASHP policy 2247, Pharmacy Workforce's Role in Vaccination, to ensure it addresses the importance of maintaining insurance coverage for vaccines without cost sharing. It provided an opportunity to review the entire policy while considering recent shifts in federal and state vaccine policy decisions and to take a more aggressive stance on emphasizing the pharmacy workforce's role as a leader in vaccination efforts. The Council recommended to change the title to "Pharmacy Workforce Leadership in Improving Vaccine Access" and the rationale, and voted to recommend amending it as follows:

> ~~affirm that~~ The ~~the~~ pharmacy workforce is the leader ~~has a role~~ in ~~improving public health and~~ increasing patient access to vaccinations to improve public health ~~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 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 payer coverage guarantees without cost sharing of vaccines recommended by recognized state and federal organizations and in accordance with clinical practice norms; 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 supply of vaccines.

### 4. Pharmacy Workforce Right of Conscience and the Patient's Right of Access to Therapy

To affirm the value of shared decision-making that balances the pharmacy workforce's and other healthcare professionals' rights of conscience with safeguards to protect patient well-being; further,

To recognize the right of the pharmacy workforce to decline participation in non-emergent care delivery scenarios for which they consider to be morally, religiously, or ethically troubling; further,

To support systems that protect patients' access to legally prescribed and medically necessary treatments while reasonably accommodating members of the pharmacy workforce's right of conscience in a nonpunitive manner; further,

To support the principle that a member of the pharmacy workforce exercising the right of conscience must be respectful of, and serve the legitimate health care 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.

*This policy would supersede ASHP policy 0610.*

***Rationale***

ASHP affirms members of the pharmacy workforces' right to decline to participate in therapies they consider to be morally, religiously, or ethically troubling but recognizes that a right of conscience must balance a pharmacist's or pharmacy technician's deeply held beliefs with his or her professional duty and the patient's autonomous right to access legally prescribed and medically indicated treatments. To achieve this balance, systems to protect the patient's right to timely access to therapy should be developed in advance of non-emergent clinical scenarios where a member of the pharmacy workforce might exercise the right of conscience. The right of conscience therefore creates an affirmative responsibility on the part of the pharmacist or pharmacy technician to proactively notify his or her employer about therapies of concern. In addition, a pharmacist and pharmacy technician exercising the right of conscience must respect and serve the legitimate healthcare needs and desires of the patient and must provide a referral without any actions to persuade, coerce, or otherwise impose on the patient the pharmacist's or pharmacy technician's values, beliefs, or objections. For the purposes of this policy, "referral" is defined in manner similar to that used by the American Academy of Family Physicians (Consultations, Referrals, and Transfers of Care; 2012 COD): a referral is a request from one member of the healthcare workforce to another to assume responsibility for management of one or more of a patient's specified problems, for a specified period of time, until the problem(s)' resolution, or on an ongoing basis, and represents a temporary or partial transfer of care to another member of the healthcare workforce for a particular condition. When conscience requires a pharmacist or pharmacy technician also to decline to refer the patient to a specific provider who can provide the legally prescribed and medically indicated

treatment, the pharmacist or pharmacy technician should offer impartial guidance to patients about how to inform themselves regarding access to the therapy. The National Catholic Bioethics Center suggests that healthcare providers declining to refer may assist patients with accomplishing a transfer of care to another provider or institution of the patient's choosing by providing a general list of other providers or institutions based on geographic vicinity or area of specialty, so long as the list is not developed based on the criterion of whether the providers are known or believed to offer the therapy in question. Institutions should have processes in place to ensure that the transfer of care process does not interfere with the patient's right to obtain legally prescribed and medically indicated treatments. Any accommodations made on the basis of a pharmacist's or pharmacy technician's decision to exercise the right of conscience should be nonpunitive.

***Background***

The Council reviewed ASHP policy 0610, Pharmacist's Right of Conscience and Patient's Right of Access to Therapy, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To affirm the value of shared decision-making that balances the pharmacy workforce's and other healthcare professionals' rights of conscience with safeguards to protect patient well-being; further,
>
> To recognize the right of the pharmacy workforce ~~pharmacists, as health care providers, and other pharmacy employees~~ to decline participation ~~to participate~~ in non-emergent care delivery scenarios for which ~~therapies~~ they consider to be morally, religiously, or ethically troubling; further,
>
> To support ~~the proactive establishment of timely and convenient~~ systems ~~by pharmacists and their employers~~ that protect ~~the~~ patient~~'~~s' access ~~right~~ to ~~obtain~~ legally prescribed and medically necessary ~~indicated~~ treatments while reasonably accommodating members of the pharmacy workforce's right of conscience in a nonpunitive manner ~~the right of conscience~~; further,
>
> To support the principle that a member of the pharmacy workforce ~~pharmacist~~ exercising the right of conscience must be respectful of, and serve the legitimate health care 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.

The Council noted significant change since the 2006 policy revision, particularly in the Emergency Medical Treatment & Labor Act care considerations and the lack of inclusive pharmacy technician policy. The revisions call for a balanced approach to shared decision-making in the context of healthcare professional conscience rights, references the pharmacy workforce as a whole, emphasizes application to non-emergent care delivery scenarios, and reinforces patient autonomy in care decisions related to their health. Given the changes in this

policy, the title was changed to: Pharmacy Workforce Right of Conscience and the Patient's Right of Access to Therapy.

### 5. Safe and Effective Extemporaneous Compounding

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

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

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

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

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

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

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

*This policy would supersede ASHP policy 2139*

***Rationale***

The practice of compounding has evolved along with the profession of pharmacy and it remains an essential component of patient care and pharmacy practice. With advances in pharmaceutical manufacturing, the need for preparation of individualized medications based on a prescription or medication order has decreased but not disappeared. Extemporaneous compounding of medications, when done to meet immediate or anticipatory patient needs, will likely always be an essential part of the practice of pharmacy, and cannot be replaced by any manufacturing model currently envisioned. Commercially and readily available drug products in the form necessary to meet patient needs should always be preferred to extemporaneously compounded alternatives, except when excipients or other components render the

commercially available product clinically inappropriate for an individual patient. When extemporaneous compounding is required, it should meet strict requirements to protect patients from receiving substandard or poor-quality medications that pose a safety risk to their health and well-being. In particular, extemporaneously compounded sterile preparations must ensure highest quality. Extemporaneous compounding should be performed only using drug substances that have been manufactured in Food and Drug Administration-registered facilities and that meet official United States Pharmacopeia (USP) compendial requirements. Such compounding should only be performed by adequately trained pharmacists and pharmacy technicians, in facilities and with equipment that meet technical and professional standards to ensure the quality and integrity of the compounded medication, and in accordance with USP standards and other applicable federal and state regulations. To facilitate such a high level of compounding, USP should develop drug monographs for commonly compounded preparations. ASHP and its members have always devoted a great deal of effort to promoting safe extemporaneous compounding, through education of pharmacists and pharmacy technicians, publication of best practices, and advocacy, recognizing the inherent risks of any such endeavor. Pharmacists and pharmacy technicians have a responsibility to safely prepare and distribute compounded medications to meet the unique and customized therapeutic needs of their patients, and ASHP and pharmacists therefore have a responsibility to educate prescribers, other healthcare professionals, and patients about the potential risks associated with the use of extemporaneously compounded preparations.

***Background***

The Council reviewed ASHP policy 2139, Safe and Effective Extemporaneous Compounding, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To affirm that extemporaneous compounding of medications, when done to meet immediate or anticipatory patient needs, is part of the practice of pharmacy and is not manufacturing; further,
>
> To support the principle that medications should not be extemporaneously compounded when drug products are commercially and readily available in the form necessary to meet patient needs; further,
>
> To encourage the pharmacy workforce members who compound medications to use only drug substances that have been manufactured in Food and Drug Administration-registered facilities and that meet official United States Pharmacopeia (USP) compendial requirements, where those exist; further,
>
> To advocate that all compounding activities meet applicable USP standards and federal and state regulations; further,
>
> To support the principle that the pharmacy workforce be adequately trained and have sufficient facilities and equipment that meet technical and professional standards to

ensure the quality of compounded medications; further,
To encourage USP to develop drug monographs for commonly compounded preparations; further,

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

The Council discussed the need for more public awareness and transparency related to compounded and modified medications. To capture that in ASHP policy, they voted to include patients in the last clause and to update the rationale to reflect the change.

### 6. Role of the Pharmacy Workforce to Combat Public Health Disinformation and Misinformation

To affirm that disinformation and misinformation undermine public health and trust in health care professionals, increasing risk of potential harm and adverse patient outcomes; further,

To educate the pharmacy workforce and public on how to recognize and counter disinformation and misinformation; further,

To oppose the dissemination of disinformation and misinformation by members of the pharmacy workforce; further,

To encourage state affiliates to actively dispel harmful health-related claims in their communities; further,

To collaborate with key partners to combat disinformation and misinformation.

***Rationale***

Public health disinformation and misinformation pose a growing threat to patient safety, population health, and trust in healthcare professionals. Disinformation is defined as false or misleading information that is deliberately created, presented, and disseminated with the intent to deceive, mislead, or cause harm. Misinformation is defined as inaccurate or false information shared without intent to deceive, often due to misunderstanding, incomplete information, or rapidly evolving science. In the public health context, disinformation often aims to undermine evidence-based guidance, erode trust in health institutions or professionals, or influence health behaviors in ways that increase risk to individuals or communities.

A longstanding area of concern related to disinformation and misinformation is with vaccines and vaccine preventable diseases. Maintaining public trust in vaccine evidence-based recommendations is essential to protecting patient and public health, and that trust depends on transparent, rigorous processes grounded in scientific evidence. The pharmacy workforce

needs to remain steadfast in their commitment to science-driven decision making related to vaccines and patient education in order to support shared clinical decision making.

Clinical decisions often require nuance, and pharmacists may reasonably differ in how they interpret evolving evidence, weigh risks and benefits, or apply guidelines to individual patients. Differences in evidence-informed professional opinions, including vaccine recommendations based on patient factors or emerging data, are not the same as misinformation. Good faith interpretation of available evidence, even when it does not fully align with a guideline, is an essential part of professional practice. Efforts to address disinformation must distinguish intentional or reckless spread of falsehoods from legitimate clinical judgment that reflects the complexity of real-world care.

ASHP, state affiliates, and its members have a professional duty to recognize and combat disinformation and misinformation with their constituencies and in their communities. It is imperative that the pharmacy workforce serve as a source of truth for scientific and evidence-based information. Many leading health professional organizations, including the American Medical Association and the American Nurses Association, have advanced policy statements that outline key elements for addressing disinformation and misinformation such as conveying clear definitions, reinforcing professional responsibility, providing trusted education and communication, creating accountability, and collaborating with other partners with similar goals and policy positions. ASHP should align and collaborate with peer pharmacy and medical organizations to reinforce shared principles and support critical public health initiatives that uphold scientific integrity and patient safety.

***Background***

The Council discussed whether ASHP policy was needed related to disinformation and misinformation in public health. The Council felt it was important to discuss the topic based on things they were seeing in their communities and as a result of a recommendation made during the 2025 ASHP House of Delegates related to misinformation and disinformation. The recommendation was entitled, “Defending evidence-based immunization policies and safeguarding the integrity of scientific advisory committees in public health.” The intent of the recommendation was to defend the core values of the pharmacy profession and immunization practices. Delegates to the ASHP House of Delegates from the following states endorsed the recommendation: MI, OR, OH, DC, IN, MO, TX, MD, PA, SC, UT, IA, TN, WI, IL, MA, WA, NJ, AZ, AL, AK, DE, CT. Council members determined that a new policy was needed to reinforce ASHP’s and the pharmacy workforce’s role as a source of truth during a time when misinformation and disinformation is so prevalent. The Council also noted that disinformation and misinformation needs to be included in the ASHP Statement on the Pharmacist’s Role in Public Health in a future revision.

# COUNCIL ON PUBLIC POLICY
# POLICY RECOMMENDATIONS

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

Vickie Powell, *Board Liaison*



## 1. FDA's Public Health Role

To affirm that the Food and Drug Administration's public health role is to ensure the safety and effectiveness of drugs, biologics, and medical devices through risk assessment, appropriate product approval and labeling, manufacturing oversight, maintaining consumer confidence in medications, and consultation with health professionals, while deferring to state regulation and professional self-regulation on matters related to the use of drugs, biologics, and medical devices; further,

To support the allocation of sufficient federal resources to allow FDA to meet its defined public health mission; further,

To support the appointment of practicing pharmacists to FDA advisory committees as one mechanism of ensuring that decisions made by the agency incorporate the unique knowledge of the profession of pharmacy for the further benefit of the patient; further,

To support an ongoing dialogue between FDA and ASHP for the purpose of exploring ways to advocate the best use of FDA-regulated products by consumers and health care professionals.

*This policy would supersede ASHP policy 0012.*

***Rationale***

ASHP recognizes the critical importance of the FDA in protecting public health by ensuring the safety of drugs, biologics, and medical devices. Strong federal oversight of drug safety is vital and requires robust federal funding to allow FDA to fulfill its mission, particularly in a rapidly evolving healthcare landscape. Public health would also benefit from the inclusion of practicing pharmacists, particularly those with hospital or health system experience, on FDA advisory committees, which would ensure that the agency has benefits from pharmacists' unique clinical and pharmacotherapeutic expertise, ultimately enhancing patient care. FDA's stakeholder engagement, including its long history of collaboration with ASHP and other pharmacy organizations, is integral to fostering shared efforts to promote medication and device safety, and must be protected from political interference.

***Background***

The Council reviewed ASHP policy 0012, FDA's Public Health Mission, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To ~~support~~ affirm that the Food and Drug Administration's public health role is to ensure ~~mission of ensuring~~ the safety and effectiveness of drugs, biologics, and medical devices through risk assessment, appropriate product approval, labeling approval, manufacturing oversight, maintaining consumer confidence in medications, and consultation with health professionals, while deferring to state regulation and professional self-regulation on matters related to the use of drugs, biologics, and medical devices; further,
>
> To support the allocation of sufficient federal resources to allow FDA to meet its defined public health mission; further,
>
> To support the appointment of practicing pharmacists to FDA advisory committees as one mechanism of ensuring that decisions made by the agency incorporate the unique knowledge of the profession of pharmacy for the further benefit of the patient; further,
>
> To support an ongoing dialogue between FDA and ASHP for the purpose of exploring ways to advocate the best use of FDA-regulated products by consumers and health care professionals.

The Council discussed changes to the policy at length, noting concern that any narrowing or additional specificity in the language could limit ASHP if there are unexpected political shifts. The Council further requested that a rationale for the policy be draft (see above) and noted that any significant shifts to FDA's public health mission should trigger a review of the policy. Council members noted that protecting the FDA should be a high priority area for ASHP and suggested additional actions for the Board to consider, including:

- An *AJHP* commentary or an opinion-editorial focused on FDA's critical role in public health; and
- Review the Pharmacist Code of Ethics and determine whether it should be updated to include protection against politicization and/or to require objectivity.

## 2. Protecting the Healthcare Workforce Against Artificial Intelligence Deepfakes

To advocate for federal and state laws and regulations that protect the pharmacy workforce and organizations against liability stemming from unauthorized AI content that uses a name, likeness, credentials or simulated professional interaction to spread medical misinformation or cause reputational harm; further,

To advocate for standardized frameworks for reporting AI deepfakes at the federal, state, and local levels.

***Rationale***

Advances in artificial intelligence have enabled the rapid creation and spread of highly realistic synthetic media, including "deepfake" audio, video, text, and simulated professional interactions. When used to impersonate health professionals and pharmacy organizations without authorization, these technologies pose significant risks. Pharmacists, student pharmacists, and pharmacy technicians may have their names, likenesses, or credentials misused to lend credibility to false or misleading medical information. Such content can spread medication-related misinformation, undermine trust in evidence-based care, and cause reputational harm to pharmacy personnel falsely portrayed as providing inaccurate guidance. Current legal and regulatory frameworks do not consistently address AI-generated impersonation of healthcare professionals or provide clear protections when professional identities are misused. Federal and state policies are needed to protect the pharmacy workforce from liability and reputational harm and to ensure accountability for misuse. Standardized frameworks for reporting suspected AI deepfakes would also support timely identification and removal of harmful content, helping protect patient safety and maintain trust in medication-related information.

***Background***

Early this year, an ASHP member (who is also on CPuP) alerted the Council to an AI deepfake of him circulating on the internet. The deepfake video used his voice and likeness without his knowledge or consent to advertise a compounding pharmacy. Removing the video took a number of calls, including a report to his state's Board of Pharmacy. The incident occurred after CPuP's Winter Call, so the Council discussed the policy in a separate email conversation. The Council voted to recommend a new policy to advocate for protections for the pharmacy workforce, including standardized reporting frameworks.

# COUNCIL ON THERAPEUTICS
# POLICY RECOMMENDATIONS

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


**Council Members, 2025-2026**
Kunal Patel, *Chair* (Georgia)
Sarah Gaffney, *Vice Chair* (Virginia)
Chadi Abbas (Michigan)
Lynda Eckhardt (Kentucky)
Kelly Goodlet (Arizona)
Kristi Kelley (Alabama)
Rachel Meyers (New Jersey)
Michelle Patterson (Pennsylvania)
Lance Ray (Colorado)
Martha Roberts (Rhode Island)
Brittany Tschaen (Massachusetts)
K. Kit Wong (Federal Service)
Kayla Hay, *Student* (Alabama)
Vicki Basalyga, *Secretary*

Jennifer Tryon, *Board Liaison*


## 1. Tobacco, Tobacco Products, and Non-Tobacco Nicotine Delivery Systems

To discourage the use of tobacco, tobacco products, and non-tobacco-nicotine (NTN) delivery systems due to their long-term adverse health effects; further,

To oppose the distribution and sale of tobacco, tobacco products, and NTN delivery systems by pharmacies or facilities that contain a pharmacy; further,

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

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

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

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

To support the FDA as the authoritative regulating body of these products; further,

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

*This policy would supersede ASHP Policy 2125*

***Rationale***

Pharmacists, as healthcare providers, have long discouraged the use of tobacco and tobacco products as a threat to public health. Non-tobacco nicotine (NTN) is available in numerous forms, including electronic nicotine delivery systems (e.g. vaporizers, vape pens, hookah pens, and electronic cigarettes and pipes), and more recently, nicotine pouches. Contents of these highly addictive systems include nicotine, flavorings, propylene glycol, glycerin, potentially harmful aerosols, and other unknown ingredients. The long-term effects of use are still relatively unknown, and given these uncertainties, pharmacists should discourage their use. ASHP opposes the distribution or sale of tobacco, tobacco products, and other nicotine delivery systems by pharmacies or facilities that contain a pharmacy (e.g., grocery or retail stores) and advocates that hospitals and health systems be tobacco-free environments.

Through Section 907 of the Federal Food, Drug and Cosmetic Act, the Food and Drug Administration (FDA) has the authority to propose and adopt tobacco product standards including maximum N-Nitrosonornicotine (NNN) in smokeless tobacco products, nicotine yield in cigarettes, and other regulation for combusted tobacco products. The 2009 Family Smoking Prevention and Tobacco Control Act (TCA) prohibits cigarettes or any of their component parts (including the tobacco, filter, or paper) shall not contain artificial or natural flavor (other than tobacco or menthol) or an herb or spice. Flavor, an often characterizing element of tobacco products, has significantly influenced nicotine use in children and adolescents. In response to the increase in NTN products, Congress passed H.R.2471 which expanded FDA's authority to regulate tobacco products containing nicotine from any source, including synthetic nicotine. There is currently a Supreme Court case that could potentially challenge FDA's oversight over these products that if successful, would mean there would no regulation of these products.

Pharmacists have a role in recommending and managing drug therapy to support cessation of nicotine-containing products, including tobacco and electronic nicotine delivery systems, as described in the ASHP Therapeutic Position Statement on Cessation of Tobacco Use. Newer therapies, including varenicline, are associated with more and evolving safety risks when compared to nicotine replacement therapies. Given the complexity of drug therapy, pharmacists should play a central role in ensuring the safe and appropriate use of these therapies.

***Background***

The Council reviewed ASHP policy 2125, Tobacco, Tobacco Products and Electronic Nicotine Delivery Systems, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions) The Council also recommended a title change to reflect the new terminology updated throughout the policy to be Tobacco, Tobacco Products, and Non-Tobacco Nicotine Delivery Systems:

To discourage the use of tobacco, tobacco products, and ~~electronic~~ non-tobacco~~-~~ nicotine (NTN) delivery systems due to their long-term adverse health effects; further,

To oppose the distribution and sale of tobacco, tobacco products, and ~~electronic nicotine~~ NTN delivery systems by pharmacies or facilities that contain a pharmacy; further,

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

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

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

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

To support the FDA as the authoritative regulating body of these products;

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

## 2. Safe and Effective Use of Long-Acting Injectable Antipsychotics

To advocate for the pharmacist's role in the management of long-acting injectable (LAI) use; further,

To advocate for the establishment of centralized databases for timely documentation of LAI administrations that are interoperable and accessible to all healthcare providers; further,

To foster the development of best practices for the safe use and management of LAIs, regardless of site of care.

***Rationale***

Long-acting injectable (LAI) antipsychotics offer improved adherence, reduced relapse and hospitalization rates, and more consistent therapeutic drug levels with clear accountability for treatment engagement. However, their use may be limited by access barriers, clinician training or experience, as well as prescribing biases that reserve LAIs for patients with documented nonadherence rather than incorporating them as a proactive treatment option. System-level challenges include limited access, difficulty obtaining reimbursement, and fragmented care

pathways that disrupt continuity and follow-up. Because this class of medications often lacks standardized protocols for administration, documentation, and monitoring, patients may receive duplicated doses, missed doses, or incorrect formulations, particularly during transitions of care. Variability in prescribing practices, inadvertent switching of medications from initiation to maintenance regimens, irregular dosing intervals, and non-standardized documentation across care settings further complicates the use of these medications.

Integrating pharmacists into the administration process of LAIs has expanded access and improved safety. Patients with schizophrenia and related chronic conditions often require sustained therapy to prevent relapses and support recovery. Pharmacists are essential to optimizing care with long-acting injectable (LAI) antipsychotics. They administer injections, educate patients and providers, support medication adherence, monitor for side effects, and coordinate care. By serving as accessible points of contact, pharmacists help address barriers such as needle anxiety and limited access. Their active involvement enhances adherence and clinical outcomes, reduces hospitalizations, and expands treatment access—particularly in community pharmacy settings and through home-based services. The implementation of a standardized state or national LAI database similar to state PDMPs, is critical as it would centralize documentation from various settings, align dosing schedules, and offer clinicians real-time access to administration histories. Adopting this approach will enhance patient safety, reduce dosing errors, and facilitate greater pharmacist involvement in interdisciplinary care, consistent with ASHP's commitment to promoting medication management continuity and data interoperability for patient care.

***Background***

The Council discussed the use of LAI as a new topic on the agenda. Members discussed the barriers and disparities in the care of these patients including: lack of proper documentation (as paper charts are still often used), adverse events due to inappropriate administration intervals between doses, care coordination, and patient adherence. They also considered the role of the community pharmacist, as they are often more accessible than other providers, but recognized the burden this may place on our often short-staffed and overworked colleagues in the retail setting. The Council also discussed potential ways that these patients could be supported including, best practices on assessment, addressing the stigma around these agents and patients, and state-level advocacy for pharmacist management of these patients and best practices for administration and monitoring.

### 3. Dosing of Combination Antibiotics

To advocate for Food and Drug Administration approved labeling of combination antibiotics with dosing instructions that include each component; further,

To support the reduction of available formulations; further,

To encourage healthcare organizations to adopt strategies that ensure appropriate dosing of combination antibiotics; further,

6 To educate stakeholders and the public regarding the safe dosing and administration of
7 combination antibiotics for pediatrics and adults.

***Rationale***

Combination antibiotics pose a unique challenge for pharmacists because each product contains two active components, each with its own strength, and variations in how doses are calculated can create confusion in dosing, dispensing, and administration. In adults, dosing and dispensing of these drugs is done with standard doses equivalent to the sum of the two antibiotic components and are provided from manufacturers in standardized formulations, often in ready to administer bags. Conversely, pediatric patients are often dosed based on the weight-based dosing of one component of the combination drug (e.g the beta-lactam or the trimethoprim component) with a few exceptions based upon the goal of treatment. While most intravenous concentrations of these medications are standardized, there are 11 dosage formulations of amoxicillin-clavulanate on the US market, including five different amoxicillin to clavulanate ratios (i.e., 2:1, 4:1,7:1, 14:1, 16:1). These multiple ratio formulations further increase the risk of prescribing, dispensing, and administration errors which can impact the effectiveness and/or the toxicity of these antibiotics. While this phenomenon is decreasing, many manufacturers' labeling and dosing references describe doses in a variety of ways, and multiple presentations exist even within the same reference. This has also led to dosing errors with the intravenous antibacterial drugs due to confusion about the drug strength displayed on the vial and carton labels.

Furthermore, many pediatric patients are not treated at standalone children's hospitals where there is infrastructure and support, including pediatric specific order sets, pump libraries, drug information and pharmacists trained to care for pediatric patients exist. A 2024 study in Journal of Pediatric Pharmacology and Therapeutics (JPPT) surveyed pharmacists treating pediatric patients in a variety of settings cited that barriers to dosing and administration of combination drugs including: extended infusions, infusion pump interoperability challenges, CPOE (computerized physician order entry) auto-adjustments, dose rounding, drug shortages, premade adult products, non-formulary drugs, and different ordering processes for pediatric and adult patients. This study also found that order sets, guidelines, and intranet pages were the most common sources of internal antibiotic dosing recommendations, where dosing may be different than what is found in external antibiotic dosing references including Lexicomp, Micromedex, Sanford Guide and more. A 2023 study from JPPT reviewed amoxicillin-clavulanate use at standalone and children's hospitals within acute care hospitals and found that significant formulation selection variability exists across the United States with these institutions carrying on average five amoxicillin-clavulanate products.

In the outpatient setting, medication errors during order entry and dispensing include: information and knowledge gaps about medication indications or doses for pediatric patients, communication gaps between health care providers and caregivers, and product preparation vulnerabilities. An additional study that looked at pediatric medication errors, found that antibiotics emerged as the most frequently implicated drug class.

***Background***

This topic was recommended by a council member who practices in pediatrics and identified this as a practice issue. Members shared their experiences treating this population with combination antibiotics, citing the differences in dosing, logistics of appropriate prescribing, and difficulties in updating and maintaining EHRs and pump libraries, especially as new combination antibiotics come to market. Members also discussed the increase of infectious disease services providing dosing recommendations that varied from pediatric dosing practices.

## 4. Evidence-Based Medicine

To define evidence-based medicine as the conscientious, explicit, and judicious appraisal and application of the best-available current data integrated with provider expertise and patient values to inform the development and implementation of professional policies, standards, and clinical practice decisions.

***Rationale***

Evidence-based medicine (EBM), also known as evidence-based practice, evidence-based clinical practice, evidence-based healthcare, evidence-based method, and evidence-based approach are all encompassing terms that describe a methodical approach to clinical decision-making. EBM is a cornerstone of modern healthcare, emphasizing the use of the best available research evidence to guide clinical decision-making. The goal of EBM is to improve patient care by using the most current and reliable scientific research—such as randomized controlled trials, systematic reviews, and meta-analyses—to guide diagnosis, treatment, and management decisions. It involves critically evaluating and integrating evidence into the clinical decision-making process, ensuring that the interventions provided are both effective and appropriate for the individual patient.

However, there is controversy surrounding the term. This arises from its ideal of objective, standardized care, which sometimes clashes with the realities of clinical practice, patient individuality, and the inherent limitations of research. In recent years, particularly with the rapidly evolving need for safe and effective treatment during the COVID-19 pandemic, adoption of artificial intelligence, and proliferation of publications, the term evidence-based medicine has evolved from an approach to patient care that uses best available evidence, clinical expertise, and patient values to one that includes these values but also a more nuanced understanding of the complexities inherent in translating research into practice, recognizing that both organizations and clinicians are subject to their own biases. Ultimately, EBM uses diligent, explicit, and sensible use of available evidence to care for individual patients that integrates individual clinical expertise that is diverse in origin. EBM is not a replacement for individual clinical expertise and does not consist only of randomized controlled trials or meta-analyses, nor considers data that is outdated or impossible to practice.

***Background***

The Council discussed the term evidence-based medicine as a part of the evolution of the amount and quality of information and its role in medication misinformation, clinical decision

making, and the practice of pharmacy as well as its use in ASHP Policies. Review found there that are 52 references to the term evidence-based in ASHP Policies and rationales. The Council also discussed how other professional organizations use this term, how ASHP should define the term EBM as it pertains to developing professional policy, and the impact of removing this term from ASHP policy. The Council decided that a policy affirming ASHP's position would be in the organization's best interest.