ASHP House of Delegates

2020 Policy Recommendations
The House of Delegates
Ultimate authority over ASHP professional policies

One annual session consisting of 4 meetings: 2 meetings at the ASHP Summer Meeting and 2 virtual meetings in the spring and fall.

Reviews policy proposals that have been approved by the Board of Directors.

Most of these professional policy proposals are contained in reports from ASHP councils.
ASHP Policy Process

Governance

House of Delegates

Board of Directors

Other Appointed Groups

Component Groups

Members

Operations

ASHP Professional Policy
March Virtual House of Delegates

The policy recommendations on the next 15 slides will be voted on during the March virtual House of Delegates to be held March 6-13.

• The online voting process does not permit amendments.
• Delegates are encouraged to vote against recommendations they feel should be amended.
• >85% votes needed for approval
• <85% policies will be presented at the June House
• Policies not reaching that level of consensus will be considered by the House of Delegates in June.
To discontinue ASHP policy 1006, Definition of Meaningful Use of Health Information Technology, which reads:

To advocate to policymakers (public and private) that definitions of "meaningful use of health information technology" address interoperability of medication orders and prescriptions, medication decision support and continuous improvement, and quality reporting; further,

To advocate with respect to interoperability of medication orders and prescriptions that (1) a common medication vocabulary be mandated to promote the semantic interoperability of medication use across the continuum of care, because a common vocabulary is essential for comparative effectiveness research and for communicating medication information; and (2) communication of orders and electronic prescriptions must be demonstrated to be functional and semantically interoperable with pharmacy information systems; further,
To advocate with respect to medication decision support and continuous improvement that (1) medication decision support should include but not be limited to allergy, drug interaction (e.g., drug-lab or drug-disease interactions), duplicate therapy, and dose-range checking; and (2) that such a decision-support service must include an ongoing, continuous improvement process to attune the decision-support service to the needs of the providers who use it; further,

To advocate with respect to quality reporting that the ability to quantify improved patient safety, quality outcomes, and cost reductions in the medication-use process is essential, particularly in antimicrobial and adverse event surveillance.
COT: Safety and Effectiveness of Ethanol for Prevention or Treatment of Alcohol Withdrawal Syndrome

To oppose the use of oral or intravenous ethanol for the prevention or treatment of alcohol withdrawal syndrome (AWS) because of its poor effectiveness and safety profile; further,

To support hospital and health-system efforts that prohibit the use of oral or intravenous ethanol therapies to prevent or treat AWS; further,

To support the removal of oral or intravenous ethanol from hospital and health systems for the prevention and treatment of AWS; further,

To educate clinicians about evidence-based therapies for AWS.

Note: This policy would supersede ASHP policy 1514.
COT: Excipients in Drug Products

To advocate that manufacturers remove unnecessary, potentially allergenic excipients from all drug products; further,

To encourage manufacturers to publicly disclose all excipients in drug products; further,

To advocate that the Food and Drug Administration require manufacturers to declare the name and derivative source of all excipients in drug products on the official label; further,

To advocate that vendors of medication-related databases incorporate, expand, and maintain interoperable information about excipients; further,
To promote research that evaluates the safety of excipients to guide clinical practice and to support the reporting and dissemination of this information via published literature, registries, and other mechanisms; further,

To foster education on the potential adverse events that may be caused by excipients; further,

To encourage documentation of allergic reactions or intolerances to or restrictions on specific excipients in the health record.

Note: This policy would supersede ASHP policy 1528.
COT: Gabapentin as a Controlled Substance

To advocate that the Drug Enforcement Administration reschedule gabapentin to Schedule V due to its low potential for abuse and patient harm.
COT: Evaluation of Abuse-Deterrent Drug Mechanisms

To encourage manufacturers to develop safe and efficacious abuse-deterrent formulations for drugs known to be abused and misused; further,

To promote research on the efficacy of abuse-deterrent mechanisms in preventing prescription drug abuse, and to support the reporting and dissemination of this information; further,

To advocate for legislation that would limit out-of-pocket expenditures for such formulations.

*Note: This policy would supersede ASHP policy 1512.*
COT: Anticancer Treatment Parity

To support anticancer treatment parity legislation at both the state and federal level that ensures equality of access and insurance coverage for all anticancer drug products approved by the Food and Drug Administration (FDA); further,

To advocate all insurers and manufacturers design plans containing limits on out-of-pocket expenditure so that patient cost sharing for anticancer treatment is equivalent, regardless of treatment modality or route of administration; further,

To encourage the development of policies and endorse practices that contribute to a decrease in anticancer treatment costs to the consumer; further,

To continue to foster the development of best practices, including adherence monitoring strategies, and education on the safe use and management of anticancer agents, regardless of route of administration.

Note: This policy would supersede ASHP policy 1516.
To support efforts by the Food and Drug Administration (FDA) and other stakeholders to improve the quality, consistency, accessibility, targeting, and simplicity of consumer medication information (CMI); further,

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

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

To advocate that FDA explore alternative models of CMI content development and maintenance that will ensure the highest level of accuracy, consistency, and currency, and conforms with health literacy requirements; further,
To advocate that the FDA engage a single third-party author to provide editorial control of a highly structured, publicly and easily accessible central repository of CMI in a format that is suitable for ready export; further,

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

*Note: This policy would supersede ASHP policy 1513.*
COT: Pharmacist’s Leadership Role in Anticoagulation Therapy Management

To advocate that pharmacists provide leadership in caring for patients receiving drug products for anticoagulant therapy management; further,

To advocate that pharmacists be responsible for coordinating the individualized care of patients receiving drug products for anticoagulation therapy management; further,

To encourage pharmacists who participate in anticoagulation therapy management to educate patients, caregivers, prescribers, and other members of the interprofessional healthcare team about anticoagulant drug product uses, drug interactions, reversal therapies and strategies, adverse effects, the importance of adhering to therapy, access to care, and recommended laboratory testing and other monitoring.

*Note: This policy would supersede ASHP policy 1703.*
COT: Use of Surrogate Endpoints for FDA Approval of Drug Uses

To support efforts by the Food and Drug Administration (FDA) and other stakeholders to qualify the appropriateness of surrogate endpoints; further,

To support the continued use of qualified surrogate endpoints by the FDA as a mechanism to evaluate the effectiveness and safety of new drugs and new indications for existing therapies, when measurement of definitive clinical outcomes is not feasible; further,

To advocate that the FDA consistently enforce existing requirements that drug product manufacturers complete postmarketing studies for drugs approved based on qualified surrogate endpoints in order to confirm that the expected improvement in outcomes occurs, and to require that these studies be completed in a timely manner.

Note: This policy would supersede ASHP policy 1011.
To encourage pharmacy leaders to work in collaboration with physicians, nurses, health-system administrators, and others to outline key pharmacist services that are essential to safe and effective patient care; further,

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

To support the following principles:

• Sufficient qualified staff must exist to ensure safe and effective patient care;

• During periods of staff shortages, pharmacists must exert leadership in directing resources to services that are the most essential to safe and effective patient care;
Within their own organizations, pharmacists should develop contingency plans to be implemented in the event of insufficient staff—actions that will preserve services that are the most essential to safe and effective patient care and will, as necessary, curtail other services; and

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

Note: This policy would supersede ASHP policy 0201.
CPM: Health-System Facility Design

To advocate the development and the inclusion of contemporary pharmacy and medication-use specifications in national and state healthcare design standards to ensure adequate space for safe provision of pharmacy products and patient care services; further,

To promote pharmacist involvement in the design-planning and space-allocation decisions of healthcare facilities.

Note: This policy would supersede ASHP policy 0505.
CPhP: Role of the Pharmacy Workforce in Identifying and Caring for Victims of Human Trafficking

To recognize that human trafficking is a significant public health problem in the U.S.; further,

To affirm that the pharmacy workforce has important roles in identifying and caring for victims of human trafficking; further,

To foster education, training, and the development of resources to prepare the pharmacy workforce for their roles in identifying and caring for victims of human trafficking.
CPhP: Use of Two Patient Identifiers in the Outpatient Setting

To encourage the use of two identifiers to confirm patient identity when transferring filled prescriptions to the possession of the patient or patient’s agent for outpatient use.

*Note: This policy would supersede ASHP policy 1024.*
To discontinue ASHP policy position 1526, Prescription Drug Abuse, which reads:

To affirm that pharmacists have leadership roles in recognition, prevention, and treatment of prescription drug abuse; further,

To promote education on prescription drug abuse, misuse, and diversion-prevention strategies.
CPhP: Medication Errors and Risk Management

To discontinue ASHP policy position 0021, Medication Errors and Risk Management, which reads:

To urge that pharmacists be included in health care organization’s risk management processes for the purpose of (a) assessing medication-use systems for vulnerabilities to medication errors, (b) implementing medication-error prevention strategies, and (c) reviewing occurrences of medication errors and developing corrective actions.
The policy recommendations in the next set of slides are scheduled to be considered at the June live meeting of the House of Delegates June 7 and 9 in Seattle, Washington.

If any of the policy recommendations from the March virtual House of Delegates meeting are defeated, they will also be considered to the June House meeting.

Proposed policies are found on the House of Delegates website and are debated on the ASHP House of Delegates Connect community by delegates and other ASHP members.

All ASHP members, including delegates, are encouraged to use the ASHP House of Delegates Connect community to review and comment on any of the proposed policies. Web-based discussion in advance of a House meeting may influence how delegates vote, and it also permits delegates to discuss potential amendments before the June House.
CPuP: Credentialing and Privileging by Regulators, Payers, and Providers of Collaborative Practice

To recommend the use of credentialing and privileging in a manner consistent with other healthcare professionals to assess a pharmacist’s competence to engage in patient care services.

Note: This policy would supersede ASHP policy 1907.
CPuP: Access to Affordable Healthcare

To advocate for access to affordable healthcare for all residents of the United States, including coverage of medications and related pharmacist patient care services; further,

To advocate that the full range of available methods be used to (1) ensure the provision of appropriate, safe, and cost-effective healthcare services; (2) optimize treatment outcomes; (3) minimize overall costs without compromising quality; and (4) ensure patient choice of healthcare providers, including pharmacy services; further,

To advocate that healthcare payers seek to optimize continuity of care in their design of benefit plans.

Note: This policy would supersede ASHP policy 1001.
CPuP: Care-Commensurate Reimbursement

To advocate that reimbursement for healthcare services be commensurate with the level of care provided, based on the needs of the patient.
CPuP: Importation of Drug Products

To oppose wholesale importation of drug products as a method to lower drug costs.

Note: This policy would supersede ASHP policy 0413.
CPuP: Public Quality Standards for Biologic Products

To oppose federal or state legislation that would remove the requirement for biologic products to adhere to public quality standards; further,

To review and evaluate current public standards to ensure that they are relevant and appropriate to biologic products.
CPuP: New Categories of Licensed Pharmacy Personnel

To oppose the creation of new categories of licensed pharmacy personnel.
CPuP: Funding, Expertise, and Oversight of State Boards of Pharmacy

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

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

To advocate that health systems are adequately represented on state boards of pharmacy; further,
CPuP: Funding, Expertise, and Oversight of State Boards of Pharmacy (cont’d)

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

To advocate that inspections be performed only by pharmacists competent about the applicable area of practice.

Note: This policy would supersede ASHP policy 1507.
CPuP: Dispensing by Nonpharmacists and Nonprescribers

To reaffirm the position that to ensure optimal patient outcomes all medication dispensing functions must be performed by, or under the supervision of, a pharmacist; further,

To reaffirm the position that any relationships that are established between a pharmacist and other individuals in order to carry out the dispensing function should preserve the role of the pharmacist in (a) maintaining appropriate patient protection and safety, (b) complying with regulatory and legal requirements, and (c) providing individualized patient care; further,
To advocate that all medication dispensing be held to the same regulatory standards that apply to dispensing by a pharmacist; further,

To urge pharmacists to assume a leadership role in medication dispensing in all settings to ensure adherence to best practices.

*Note: This policy would supersede ASHP policy 0010.*
To recognize the public health benefits of naloxone for opioid reversal; further,
To support efforts to safely expand patient and public access to naloxone; further,
To support state efforts to authorize pharmacists’ prescribing authority for naloxone for opioid reversal; further,
To advocate for the development of affordable formulations of naloxone to increase accessibility; further,
To foster standardized education on the role of naloxone in opioid reversal and its proper administration, safe use, and appropriate follow-up care; further,
To support legislation that provides protections for those seeking or providing medical help for overdose victims.

Note: This policy would supersede ASHP policy 1510.
COT: Safety and Efficacy of Compounded Topical Formulations

To advocate for the development of processes that would ensure potency, quality, and standardization of compounded topical formulations; further,

To advocate that public and private entities establish a process to evaluate and regulate the safety, efficacy, and composition of compounded topical formulations; further,

To advocate that public and private payers and healthcare providers collaborate to create standardized and efficient methods for authorizing payment for medically necessary compounded topical formulations; further,
To encourage hospitals and health systems to develop policies and procedures to guide clinicians in making informed decisions regarding the prescribing and use of compounded topical formulations; further,

To encourage pharmacists to take a leadership role in developing and providing education on the safety and efficacy of compounded topical formulations to providers and consumers.
To advocate that Congress grant the Food and Drug Administration (FDA) authority to require the manufacturer of an approved drug product or licensed biologic product to conduct postmarketing studies on the safety of the product when the agency deems it to be in the public interest and to require additional labeling or withdrawal of the product on the basis of a review of postmarketing studies; further,

To advocate that Congress provide adequate funding to FDA and other agencies to fulfill this expanded mission related to postmarketing surveillance and studies; further,

To advocate that such studies compare a particular approved drug product or licensed biologic product with (as appropriate) other approved drug products, licensed biologic products, medical devices, or procedures used to treat specific diseases; further,
To advocate expansion of studies of approved drug products or licensed biologic products to improve safety and therapeutic outcomes and promote cost-effective use; further,

To encourage impartial private-sector entities to also conduct such studies.

Note: This policy would supersede ASHP policies 1004 and 0515.
CEWD: Residency Training for Pharmacists Who Provide Direct Patient Care

To recognize that optimal direct patient care by a pharmacist requires the development of clinical judgment, which can be acquired only through experience and reflection on that experience; further,

Pharmacists who provide direct patient care should have completed an ASHP-accredited residency or have attained comparable skills through practice experience; further,

To support the position that the completion of an ASHP-accredited postgraduate-year-one residency be required for all new college or school of pharmacy graduates who will be providing direct patient care.

Note: This policy would supersede ASHP policies 0701 and 0005.
To advocate that pharmacy practice leaders collaborate with internal and external partners who design, negotiate, and select their own organization’s health plans and pharmacy benefit management contracts to preserve the integrity of health-system pharmacy operations.
CPM: Preserving Patient Access to Pharmacy Services in Medically Underserved Areas

To advocate for funding and innovative payment models to preserve patient access to acute and ambulatory care pharmacy services in rural and medically underserved areas; further,

To support the use of telepharmacy to maintain pharmacy operations and pharmacist-led comprehensive medication management that extend patient care services and enhance continuity of care in rural and medically underserved areas; further,

To advocate that the advanced communication technologies required for telepharmacy be available in rural and medically underserved areas; further,

To advocate for funding of loan forgiveness or incentive programs that recruit pharmacists and pharmacy technicians to practice in rural and medically underserved areas.
CPM: Multistate Pharmacist Licensure

To advocate for multi-state pharmacist licensure to expand the mobility of pharmacists and their ability to practice remotely.
To oppose provider access criteria that impose requirements or qualifications on participation in pharmacy payer networks that interfere with patient continuity of care or patient site-of-care options.
CPM: Network Connectivity and Interoperability for Continuity of Care

To advocate the use of electronic information systems, with appropriate security controls, that enable the integration of patient-specific data that is accessible in all components of a health system; further,

To support the use of technology that allows the transfer of patient information needed for appropriate medication management across the continuum of care; further,

To urge computer software vendors and pharmaceutical suppliers to provide standards for definition, collection, coding, and exchange of clinical data used in the medication-use process; further,

To pursue formal and informal liaisons with appropriate healthcare associations to ensure that the interests of patient care and safety in the medication-use process are fully represented in the standardization, integration, and implementation of electronic information systems; further,
To strongly encourage health-system administrators, regulatory bodies, and other appropriate groups to provide health-system pharmacists with full access to patient-specific clinical data; further,

To advocate that client-vendor agreements include timelines for data destruction; further,

To oppose the selling of data for unauthorized uses; further,

To educate health-system leaders about potential use and misuse of shared data.

Note: This policy would supersede ASHP policy 0507.
To declare that decisions on the management of a medication formulary system, including criteria for use, (1) should be based on clinical, ethical, legal, social, philosophical, quality-of-life, safety, comparative effectiveness, and pharmacoeconomic factors that result in optimal patient care; (2) must include the active and direct involvement of physicians, pharmacists, and other appropriate healthcare professionals; and (3) should not be based solely on economic factors; further,

To support the concept of a standardized medication formulary system among components of integrated health systems when standardization leads to improved patient outcomes; further,

To oppose independent payer-directed formulary decisions that would increase the complexity of the medication-use system.

*Note: This policy would supersede ASHP policies 9601 and 1805.*
CPM: Health-System Use of Medications Supplied to Patients

To encourage hospitals and health systems not to permit administration of medications brought to the hospital or clinic by the patient, caregiver, or specialty pharmacy when storage conditions or the source cannot be verified, unless it is determined that the risk of not using such a medication exceeds the risk of using it; further,

To support care models in which medications are prepared for patient administration by the pharmacy and are obtained from a licensed, verified source; further,

To advocate adequate reimbursement for preparation, order review, and other costs associated with the safe provision and administration of medications.

Note: This policy would supersede ASHP policy 0806.
CPM: Health-System Use of Administration Devices Supplied Directly to Patients

To encourage hospitals and health systems not to permit the use of medication administration devices with which the staff is unfamiliar (e.g., devices brought in by patients), unless it is determined that the risk of not using such a device exceeds the risk of using it; further,

To encourage hospitals and health systems to train staff on the handling and use of medication administration devices brought in by patients; further,

To advocate that hospitals and health systems ensure that pharmacists participate in the identification of medication administration devices brought in by patients and communicate those findings to the interprofessional care team.

Note: This policy would supersede ASHP policy 0806.
CPhP: Role of the Pharmacy Workforce in Violence Prevention

To recognize that violence in the U.S. is a public health crisis; further,

To affirm that the pharmacy workforce has important roles in a comprehensive public health and medical approach to violence prevention, including leadership roles in their communities and workplaces; further,

To encourage members of the pharmacy workforce to seek out opportunities to engage in violence prevention efforts in their communities and workplaces; further,

To promote collaboration between the pharmacy workforce and community and healthcare organizations in violence prevention efforts; further,

To foster education, training, and the development of resources to prepare the pharmacy workforce for their roles in violence prevention; further,

To support research and dissemination of information on the effectiveness of pharmacy-focused violence-prevention strategies.
To recognize that accidental and intentional firearm injury and death in the U.S. is a public health crisis; further,

To affirm that the pharmacy workforce has important roles in the comprehensive public health and medical approach to reducing death and disability from firearm injury.
CPhP: Safe Use of Transdermal System Patches

To encourage hospitals and health systems to implement policies and procedures to ensure safe use of transdermal system patches; further,

To advocate for enhanced patient and consumer education and product safety requirements for transdermal system patches; further,

To encourage manufacturers of transdermal system patches to collaborate with pharmacists and other stakeholders to identify and implement packaging, labeling, and formulation changes that prevent accidental exposure and facilitate safe disposal.

Note: This policy would supersede ASHP policy 1404.
SOPIT: ASHP Statement on the Use of Artificial Intelligence in Pharmacy

To approve the ASHP Statement on the Use of Artificial Intelligence in Pharmacy.
Questions or Suggestions?

Feel free to contact:

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ASHP: https://www.ashp.org/Pharmacy-Practice/Policy-Positions-and-Guidelines/Participate-in-Guidance-Development