



House of Delegates Session—2022

June 12 and 14, 2022

Proceedings of the 74th annual session
of the ASHP House of Delegates,
June 12 and 14, 2022

Proceedings of the 74th annual session of the ASHP House of Delegates, June 12 and 14, 2022

Paul W. Abramowitz, Secretary

The 74th annual session of the ASHP House of Delegates was held at the Phoenix Convention Center, in Phoenix, Arizona, in conjunction with the 2022 Summer Meetings.

First meeting

The first meeting was convened at 1:00 p.m. Sunday, June 12, by Chair of the House of Delegates Melanie A. Dodd. Chair Dodd introduced the persons seated at the head table: Thomas J. Johnson, Immediate Past President of ASHP and Vice Chair of the House of Delegates; Linda S. Tyler, President of ASHP and Chair of the Board of Directors; Paul C. Walker, President-elect of ASHP and Vice Chair of the Board of Directors; Paul W. Abramowitz, Chief Executive Officer of ASHP and Secretary of the House of Delegates; and Susan Eads Role, Parliamentarian.

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

The roll of official delegates was called. A quorum was present, including 190 delegates representing 50 states, the District of Columbia and Puerto Rico, as well as the federal services, chairs of ASHP sections and forums, ASHP officers, members of the Board of Directors, and ASHP past presidents (see Appendix I for a complete roster of delegates).

Chair Dodd reminded delegates that the report of the 73rd annual session of the ASHP House of Delegates had been published on the ASHP website and had been distributed to all delegates. Delegates had been advised earlier to review this report. The proceedings of the 73rd House of Delegates session were received without objection.

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

Report of the Committee on Nominations. Chair Dodd called on Kelly Smith, Vice Chair of the Committee on Nominations, for the report of the Committee on Nominations (Appendix IV).^a Nominees were presented as follows:

President 2023-2024

Stephen F. Eckel, PharmD, MHA, FAPhA, FASHP, FCCP, Associate Professor and Associate Dean, UNC Eshelman School of Pharmacy, Chapel Hill, NC

Nishaminy (Nish) Kasbekar, PharmD, BSPHarm, FASHP, Chief Pharmacy Officer Penn Presbyterian Medical Center, Philadelphia, PA

Board of Directors, 2023-2026

Jill S. Bates, PharmD, MS, BCOP, CPT, FASHP, National PHASER Pharmacy Program Manager, Department of Veterans Affairs, Durham, NC

Vickie L. Powell, PharmD, MS, BSPHarm, FASHP, Director of Pharmacy Operations,

New York Presbyterian Hospital, New York, NY

JoAnn Stubbings, BSPHarm, MHCA, RPh, Clinical Associate Professor Emerita, University of Illinois Chicago College of Pharmacy, Chicago, IL

Jennifer E. Tryon, PharmD, MS, FASHP, Chief Pharmacy Officer, Henry Ford Health System, Detroit, MI

Report of the Committee on Nominations for Treasurer. President Tyler presented the Report of the Committee on Nominations for Treasurer (Appendix V). Nominees were presented as follows:

Treasurer 2022-2025

Christene M. Jolowsky, BSPHarm, MS, FASHP, FMSHP, Senior Director of Pharmacy, Hennepin Healthcare System, Minneapolis, MN

James A. Trovato, PharmD, MBA, FASHP, Professor and Vice Chair of Academic Affairs and Administrator, Office of Continuing Education, University of Maryland School of Pharmacy, Baltimore, MD

The Committee on Nominations consisted of Donald Kishi, Chair (CA); Kelly Smith, Vice Chair (GA); Joshua Blackwell (TX); Rena Gosser (WA); Lisa Mascardo (IA); Christy Norman (GA); and Tyler Vest (NC).

A “Meet the Candidates” session to be held on Monday, June 13, was announced. The candidates for the executive committees of the sections of ASHP were then presented to the House.

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

Chair Dodd also announced that delegates could suggest minor wording changes (without introducing a formal amendment) that did not affect the substance of a policy proposal, and that the Board of Directors would consider these suggestions and report its decisions on them at the second meeting of the House.

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

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

Kristina L. Butler, Board Liaison to the **Council on Education and Workforce Development**, presented the Council’s Policy Recommendations 1 and 2.

***1. Advancing Diversity, Equity, and Inclusion in Education and Training**

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

To advocate that all members of the pharmacy workforce actively participate in the equitable

training and education of ~~Black, Indigenous, and People of Color (BIPOC) and other people with~~ from marginalized ~~identities~~ populations.

***2. Cultural Competency**

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

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

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

Note: This policy would supersede ASHP policy 1613.

Pamela K. Phelps, Board Liaison to the **Council on Pharmacy Management**, presented the Council's Policy Recommendations 1 through 6.

***1. Revenue Cycle Management and Reimbursement and Pharmacist Compensation for Drug Product Dispensing (minor editorial changes only):**

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

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

To collaborate with payers in developing

~~improved~~ optimal methods of reimbursing pharmacies and pharmacists for the costs of drug products dispensed, pharmacy and pharmacist services, and associated overhead; further,

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

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

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

Note: This policy would supersede ASHP policies 1710 and 1807.

2. Role of the Pharmacist in Service-Line Development and Management

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

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

***3: Value-Based Purchasing**

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

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

To support pharmacy workforce efforts to ensure safe and appropriate medication use by

using data and technology for continuous quality improvement in pharmacy-designed, medication-related value-based purchasing initiatives; further,

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

Note: This policy would supersede ASHP policy 1209.

***4. Financial Management Skills**

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

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

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

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

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

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

Note: This policy would supersede ASHP policy 1207.

[Note that the House referred policy recommendations 5, Health-System Use of Drug Products Provided by Outside Sources, and 6, Screening for Social Determinants of Health, to the Board for further consideration.]

Kim W. Benner, Board Liaison to the **Council on Pharmacy Practice**, presented the Council's Policy Recommendations 1 through 5.

***1. Use of Inclusive Verbal and Written Language**

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

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

To urge healthcare leadership to promote use of inclusive language ~~through organizational policies and procedures~~; further,

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

***2. Autoverification of Medication Orders**

To recognize the importance of pharmacist verification of medication orders, and the important role pharmacists have in developing

and implementing systems for autoverification of select medication orders; further,

To recognize that ~~safe and efficient~~ autoverification of select medication orders under institution-guided criteria can ~~allow more~~ effective use of pharmacist resources by expanding access to pharmacist patient care; further,

To discourage implementation of autoverification as a means to reduce pharmacist hours pharmacy resources as a matter of convenience or to subvert current laws and standards requiring pharmacists to review all medication orders; further,

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

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

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

***3. Pharmacist Prescribing in Interprofessional Patient Care**

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

To advocate for comprehensive medication management that includes autonomous ~~and~~ accountable prescribing authority for pharmacists ~~practitioners~~ as part of comprehensive medication management optimal interprofessional care, ~~recognizing that a single prescriber should not be responsible for prescribing and dispensing any given medication;~~ further,

To advocate that all pharmacists on the interprofessional team have a National Provider Identifier that is accessible and recognized by payers.

Note: This policy would supersede ASHP policy 1213.

***4. Universal Vaccination for Vaccine-Preventable Diseases in the Healthcare Workforce**

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

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

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

To urge healthcare organizations to have policies that address additional infection prevention practices required for ~~the expected small number of~~ exempted healthcare workers; further,

To develop tools, education, and other resources to promote vaccine confidence, increase vaccination rates, and ~~prevent~~

minimize vaccine-preventable diseases among healthcare workers.

Note: This policy would supersede ASHP policies 2140 and 2138.

***5. Pharmacy Workforce's Role in Vaccination**

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

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

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

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

To advocate for the inclusion of pharmacist-provided vaccination training in college of pharmacy curricula and pharmacy technician-provided vaccination training in formal technician training programs; further,
[CLAUSE MOVED FROM BELOW]

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 ~~documenting~~ timely documentation of vaccine

~~administrations of vaccinations~~ 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 advocate for the inclusion of pharmacist-provided vaccination training in college of pharmacy curricula and pharmacy technician-provided vaccination training in formal technician training programs; further,~~
[CLAUSE MOVED ABOVE]

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, ~~and~~ resources, and equipment for the pharmacy workforce to support vaccination efforts to ensure patient safety and avoid or respond to occupational burnout; further,

To advocate for appropriate reimbursement for pharmacists, pharmacy technicians, and student pharmacists for vaccination services rendered; further,

To work with federal, state, and local governments and others to improve the vaccine development and supply system in

order to ensure an adequate and equitably distributed supply of vaccines.

Note: This policy would supersede ASHP policies 1309 and 2122.

Leigh A. Briscoe-Dwyer, Board Liaison to the **Council on Public Policy**, presented the Council's Policy Recommendations 1 and 2.

***1. Patient Disability Accommodations**

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

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

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

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

***2. Drug Pricing Proposals**

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

Jamie S. Sinclair, Board Liaison to the **Council on Therapeutics**, presented the Council's Policy Recommendations 1 through 7.

***1. Post-Intensive Care Syndrome**

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

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

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

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

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

***2. Use of Veterinary Pharmaceuticals in Human Subjects**

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

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

~~To engage stakeholders and regulatory bodies to address the misuse of veterinary pharmaceuticals in humans; further,~~

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

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

To encourage research, monitoring, and reporting on the adverse effects of human

consumption of veterinary pharmaceuticals to define the public health impact of and to quantify the strain these agents place on the healthcare system.

3. Pharmacist's Role in Respiratory Pathogen Testing and Treatment

To advocate that state board of pharmacy regulations include respiratory pathogen testing and associated prescribing or dispensing under pharmacists' scope of practice; further,

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

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

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

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

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

***4. Use of Intravenous Drug Products for Inhalation**

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

and administration of intravenous drug products for inhalational use; further,

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

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

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

***5. Enrollment of Underrepresented Populations in Clinical Trials**

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

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

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

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

To advocate recognize that pharmacists should be involved in the design of clinical

~~trials to~~ provide guidance on drug dosing, administration, and monitoring in all patient populations.

Note: This policy would supersede ASHP policy 1723.

***6. Pediatric Dosage Forms**

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

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

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

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

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

Note: This policy would supersede ASHP policy 9707.

***7. Substance Use Disorder**

To affirm that a patient with a substance use disorder (SUD) is a disease state has a chronic condition with associated ~~neurological~~ neurodevelopmental, physiologic, and psychosocial changes ~~and is not a personal choice~~; further,

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

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

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

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

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

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

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

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

Note: This policy would supersede ASHP policy 9711.

The meeting adjourned at 5:20 p.m.

Second meeting

The second and final meeting of the House of Delegates session convened on Tuesday, June 14, at 4:00 p.m. A quorum was present.

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

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

Board of Directors duly considered matters.

Pursuant to Bylaws section 7.3.1.1, the Board met on the morning of June 14 to "duly consider" the policies amended at the first meeting. Two policy recommendations were approved without amendment. Eighteen policy recommendations were amended or edited by the House of Delegates, and two policy recommendations were referred to the Board. The Board agreed with the House's amendments and editorial changes to 16 policy recommendations, with nonsubstantive editorial changes to three of those 16 policy recommendations. The Board did not accept House amendments to two policy recommendations (Council on Pharmacy Practice 2 and 5) and offered revised language for those two policy recommendations, as noted below (amendments made by the House are delineated as follows: words added are underlined; words deleted are ~~stricken~~. Text added by the Board is indicated in **bold double underline**; text deleted by the Board is indicated in ~~**bold double strikethrough**~~):

Council on Pharmacy Practice 2. Autoverification of Medication Orders

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

To recognize that ~~safe and efficient~~ autoverification of select medication orders under institution-guided criteria can help allow more effective use of pharmacist resources by expanding access to pharmacist patient care; further,

To discourage implementation of autoverification as a means to reduce pharmacist hours ~~pharmacist hours~~ ~~pharmacy resources as a matter of convenience or to subvert current laws and standards requiring pharmacists to review all medication orders~~; further,

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

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

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

Council on Pharmacy Practice 5. Pharmacy Workforce's Role in Vaccination

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

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

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

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

To advocate for the inclusion of pharmacist-provided vaccination training in college of pharmacy curricula and pharmacy technician-provided vaccination training in formal technician training programs; further,
[CLAUSE MOVED FROM BELOW BY THE HOUSE]

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 documenting 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 advocate for the inclusion of pharmacist-provided vaccination training in college of pharmacy curricula and pharmacy technician-provided vaccination training in formal technician training programs; further,~~
[CLAUSE MOVED ABOVE BY THE HOUSE]

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, ~~and~~ resources, and equipment for the pharmacy workforce to support vaccination efforts to ensure patient safety and avoid or respond to occupational burnout; further,

To advocate for appropriate reimbursement for ~~pharmacists, pharmacy technicians, and student pharmacists~~ for vaccination services rendered; further,

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

Note: This policy would supersede ASHP policies 1309 and 2122.

In addition, the Board offered revised language for the two policy recommendations referred to the Board at the first meeting of the House as noted below (text added by the Board to the policy recommendation as introduced is indicated in **bold double underline**; text deleted by the Board is indicated in ~~**bold double strikethrough**~~):

**Council on Pharmacy Management 5.
Health-System Use of Drug Products
Provided by Outside Sources**

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

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

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

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

Note: This policy would supersede ASHP policy 2032.

Council on Pharmacy Management 6. Screening for Social Determinants of Health

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

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

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

To encourage the use of SDoH data to identify opportunities to reduce healthcare disparities

and improve healthcare access and equity; further,

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

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

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

The House voted to accept the Board's revised language for all four policy recommendations.

New Business. Chair Dodd announced that, in accordance with Article 7 of the Bylaws, there was one item of New Business to be considered. Chair Dodd called on Katherine Miller (KS) to introduce the New Business (Appendix IX). Following discussion and amendment, the item was approved for referral to the Board of Directors. With House amendments (underlined type indicating text added; ~~strickethrough~~ indicating text deleted), the New Business reads as follows:

Access to Reproductive Health Services

Motion:

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

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

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

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

Background:

The National Institute of Health defines reproductive health as “the condition of male and female reproductive systems during all life stages. These systems are made of organs and hormone-producing glands, including the pituitary gland in the brain.”¹ Studies show that there have been long standing disparities in access to and outcomes from reproductive health services in the United States, especially for racial-ethnic minorities.² For example, black women have the highest maternal morbidity and mortality rates in the country. These disparities include contraceptive use, reproductive cancers, preterm deliveries, and maternal morbidity and mortality.

On May 3, 2022, a Supreme Court of the United States’ (SCOTUS) draft opinion overturning *Roe v. Wade* was leaked to the media. If SCOTUS releases a final opinion overturning *Roe*, decisions about abortion rights will be delegated to the states. Without a federal precedent, states are likely to implement a patchwork of regulations around abortion, with some outlawing it entirely and others enshrining a right to abortion in state law. Thirteen states have existing “trigger laws,” which will outlaw abortion the moment *Roe* is overturned. The impacts of these state laws are likely to extend into several areas impacting the

practice of pharmacy and patient access to necessary treatments/medications:

- **Access to Necessary Treatment:** pharmacists are involved in treating patients with ectopic pregnancy or cancer diagnoses in pregnant patients. These laws could limit patient access to lifesaving treatments because of the risk of legal liability for providers. Pharmacists have a role in providing medications for these treatments as well as supporting patients’ mental health and well-being related to reproductive health.
- **Access to Medications:** A number of companies have formed that provide telehealth access to medications used to induce abortion. There are likely to be challenges to interstate mail order of these medications domestically. Additionally, some companies are located overseas (e.g., Austria, India), which raises questions about foreign importation of medication. ASHP policy generally opposes importation of medications from other countries for wholesale purposes due to supply chain security concerns but does not object to patients ordering from legitimate foreign pharmacies for their personal needs. Additionally, some medications such as misoprostol which are used off-label as abortifacients but which have other clinical uses may become harder to access for patients because of provider fears around legal liability for prescribing or dispensing these medications. Access to medications is an issue of national security. For instance, by law, the Department Of Defense is required to make contraceptive services available to all female active-duty servicemembers
- **Clinician Judgment:** Restrictions on medication abortion function as limitations on clinicians’ professional judgment. As noted above, because some medications can be used off-label as abortifacients, it is possible that there will be increased

scrutiny of the prescribing and dispensing of certain medications. Further, some states are pursuing laws that would allow citizens a private right of action against a clinician who assists in an abortion (also known as “bounty laws”). This could create civil and/or criminal liability against clinicians who prescribe or dispense abortion medications.

Aside from these major areas of concern, depending on the wording of the potential SCOTUS opinion, other procedures that are not abortion but might result in destruction of an embryo could be called into question. This could result in restrictions on medications used to induce labor to protect the pregnant patient or even for in-vitro fertilization (IVF) purposes. Additionally, because Roe was based on the protection of personal privacy, overturning it may also call other privacy-related rulings into question, including *Griswold v. Connecticut*, which allowed women access to contraception.

The decision to terminate a pregnancy is complicated, difficult, and often extremely emotional choice between healthcare providers and patients, and it often involves weighing the risks to the pregnant patient. Healthcare providers involved in these decisions and providing these treatments would be subject to unjust criminal prosecution under several state laws should *Roe v. Wade* be overturned. Additionally, pregnant patients themselves could be prosecuted for seeking lifesaving treatment under these laws. There is already precedent for pregnant patients facing legal difficulties and forced interventions in the United States.³

Suggested Outcomes:

- 1) Adoption of proposed language which can be used to advocate on behalf of patients and health care providers
- 2) ASHP investigate current educational standards on reproductive health including

disparities in access and outcomes for different patient populations in schools of pharmacy and residency accreditation standards and propose new policy if needed

References:

1. National Institute of Environmental Health Sciences. Reproductive Health. <https://www.niehs.nih.gov/health/topics/conditions/repro-health/index.cfm> (accessed 5/16/2022).
2. Sutton MY, Anachebe NF, Lee R et al. Racial and ethnic disparities in reproductive health services and outcomes, 2020. *Obstet Gynecol.* 2021; 137:225–33.
3. Paltrow LM, Flavin J. Arrests of and forced interventions on pregnant women in the United States, 1973-2005: implications for women's legal status and public health. *J Health Polit Policy Law* 2013; 38:299-343. [doi:10.1215/03616878-1966324](https://doi.org/10.1215/03616878-1966324).

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

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

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

Chair Dodd then installed the chairs of ASHP's sections: Jaclyn Boyle, Section of Ambulatory Care Practitioners; Christi Jen, Section of Clinical Specialists and Scientists; Sarah Stephens, Section of Inpatient Care Practitioners; Lindsey Amerine, Section of Pharmacy Practice Leaders; and Scott L. Canfield, Section of Specialty Pharmacy Practitioners. Chair Dodd then recognized the

Proceedings of the 74th Annual Session

remaining members of the executive committees of sections and forums.

Installation. Chair Dodd then installed Paul C. Walker as President of ASHP and Vivian Bradley Johnson and Samuel V. Calabrese as members of the Board of Directors (Appendix

XI). (See Appendix XII for the Inaugural Address of the Incoming President.)

Adjournment. The 74th annual June meeting of the House of Delegates adjourned at 6:00 p.m.

ROSTER

ASHP HOUSE OF DELEGATES

Phoenix, Arizona
June 12-14, 2022

Presiding – Melanie A. Dodd, Chair
Thomas J. Johnson, Vice Chair

First Meeting: Sunday, June 12, 2022
Second Meeting: Tuesday, June 14, 2022

OFFICERS AND BOARD OF DIRECTORS			
Linda S. Tyler, President			
Paul C. Walker, President-Elect			
Thomas J. Johnson, Immediate Past President			
Christene M. Jolowsky, Treasurer			
Paul W. Abramowitz, Chief Executive Officer			
Kim Benner, Board Liaison, Council on Pharmacy Practice			
Leigh Briscoe-Dwyer, Board Liaison, Council on Public Policy			
Kristina L. Butler, Board Liaison, Council on Education and Workforce Development			
Nishaminy Kasbekar, Board Liaison, Commission on Affiliate Relations			
Pam Phelps, Board Liaison, Council on Pharmacy Management			
Jamie Sinclair, Board Liaison, Council on Therapeutics			
Melanie A. Dodd, Chair of the House			
PAST PRESIDENTS			
Roger Anderson	Debra Devereaux	Clifford Hynniman	Kelly Smith
John Armitstead	Rebecca Finley	Marianne Ivey	Thomas Thielke
Jannet Carmichael	Diane Ginsburg	Philip Schneider	Sara White
Kevin Colgan	Harold Godwin	Steven Sheaffer	T. Mark Woods
STATE	DELEGATES		ALTERNATES
Alabama (3)	Thomas Achey Laura Matthews Whitney White		Megan Roberts
Alaska (2)	Ursula Iha Shawna King		Gretchen Glaspy
Arizona (3)	Melinda Burnworth Christopher Edwards Danielle Kamm		Janelle Duran Christi Jen Carol Rollins Jake Schwarz
Arkansas (2)	Jeff Cook Kendrea Jones		

California (7)	Kathy Ghomeshi Brian Kawahara Elaine Law Sarah McBane James D. Scott	Daniel Kudo Stacey Raff Kethen So
Colorado (3)	Sarah Anderson Karen McConnell Tara Vlasimsky	Clint Hinman
Connecticut (3)	Lena Devietro ² David Goffman Marta Stueve	Teresa Papstein Colleen Teevan
Delaware (2)	Cheri Briggs	Samantha Landolfi
Florida (5)	Kathy Baldwin Jeffrey Bush Elias Chahine Julie Groppi Sara Panella	
Georgia (3)	Susan Jackson Christy Norman Anthony Scott	Davey Legendre
Idaho (2)	Paul Driver Audra Sandoval	
Illinois (5)	Megan Corrigan Andy Donnelly Bernice Man R. Jason Orr Carrie Vogler	Noelle Chapman Chris Crank Trish Wegner
Indiana (3)	Chris Lowe Christopher Scott Tate Trujillo	John Hertig
Iowa (3)	John Hamiel Candace Jordan Marisa Zweifel	Mike Daly Jessica Nesheim Emmeline Paintsil
Kansas (3)	Katherine Miller Zahra Nasrazadani Joanna Robinson	Brian Gilbert Marshall Johnson Kevin Mahler Talal Nassar Katherine Ulloa Katie Wilson
Kentucky (3)	Dale English Thomas Platt	Rebecca Cheek Gavin Howington Derek Pohlmeier
Louisiana (3)	Jason Chou Kisha Gant Myra Thomas	Paul Menasco Renesha Yarbrough
Maine (2)	Matthew Christie Kathryn Sawicki	Anne Andrie

Maryland (4)	Nicole Kiehle Janet Lee Dorela Priftanji Meghan Swarthout	Giae Derisse Marybeth Kazanas
Massachusetts (4)	Jackie MacCormack-Gagnon Monica Mahoney Francesca Mernick Marla O'Shea-Bulman	Nick Edmonds
Michigan (4)	Rox Gatia Jesse Hogue Jessica Jones Stephen Stout	Lama Hsaiky
Minnesota (3)	Kristi Gullickson Sue Haight John Pastor	Matthew Ditmore Susan Flaker Garrett Schramm
Mississippi (3)	Joshua Fleming Andrew Mays Katie Schipper	Chris Ayers
Missouri (3)	Laura Butkievich Joel Hennenfent Amy Sipe	Davina Dell-Steinbeck Nathan Hanson Christina Stafford
Montana (2)	Lindsey Firman	Julie Neuman
Nebraska (3)	Tiffany Goeller Emily Johnson ² Katie Reisbig Jerome Wohleb ¹	James Bird Michele Higgins
Nevada (2)	Kate Ward	
New Hampshire (2)	Tonya Carlton Elizabeth Wade	Dave DePiero
New Jersey (4)	Barbara Giacomelli Deborah Sadowski Craig Sastic Nissy Varughese	Daniel Abazia Ken Bevenour Julie Kalabalik-Hoganson
New Mexico (2)	Joe Anderson ² Amy Busing	Stephen Adams
New York (5)	Angela Cheng Robert DiGregorio Russ Lazzaro Vickie Powell Kim Zammit	Heide Christensen Mark Sinnet Frank Sosnowski
North Carolina (4)	Stephen Eckel Angela Livingood Mollie Scott Tyler Vest	Mary Parker

North Dakota (2)	Maari Loy Elizabeth Monson	
Ohio (5)	Rachel Chandra John Feucht II Kellie Musch Kembral Nelson Jacalyn Rogers	Megan Adelman Nicole Harger Dykes Fouad Eid Daniel Lewis Jordan Long
Oklahoma (3)	Christopher Pack Edna Patatanian	Wiley Williams
Oregon (3)	Aron Beugli ² Ryan Gibbard Edward Saito ¹ Victoria Wallace	Michael Lanning
Pennsylvania (4)	Danielle Auxer Paul Green Arpit Mehta Christine Roussel	Jennifer Belavic Scott Bolesta Brad Cooper
Puerto Rico (2)	Mirza Martinez	Giselle Rivera
Rhode Island (2)	Margaret Charpentier Bryan McCarthy	Karen Nolan Martha Roberts
South Carolina (3)	Carolyn Bell Lisa Gibbs	Laura Holden
South Dakota (2)	Joseph Berendse Laura Stoebner	Thaddaus Hellwig Anne Morstad
Tennessee (4)	Don Branam Meredith Gilbert-Plock Jennifer Pauley Jodi Taylor	Holly Lowe Agatha Nolen
Texas (6)	Latresa Billings Joshua Blackwell Steven Knight Randy Martin Patricia Meyer Binita Patel	Rodney Cox
Utah (3)	Jennie Barlow Mikayla Mills Whitney Mortensen	Kavish Choudhary Erin Fox Karen Gunning Anthony Trovato David Young
Vermont (2)	Jeffrey Schnoor	Kristina Stemple
Virginia (4)	Catherine Floroff Lisa Hammond Brian Spoelhof Darren Stevens	

Washington, D.C. (2)	Carla Darling Michelle Eby	Sue Carr
Washington State (4)	Erica Diamantides James Houpt Karen White Roger Woolf	Rena Gosser
West Virginia (2)	Chris Fitzpatrick Derek Grimm	
Wisconsin (4)	Tom Dilworth Justin Konkol John Muchka Katie Reinke	Christina Andros Carmen Gust Carolyn Oxencis Tahmeena Siddiqui
Wyoming (2)	Jamie Homecker Tonja Woods	Linda Gore-Martin
SECTIONS AND FORUMS	DELEGATES	ALTERNATES
Ambulatory Care Practitioners	Jaclyn Boyle ¹ Daniel Truelove ²	
Clinical Specialists and Scientists	Douglas Slain	Christi Jen
Community Pharmacy Practitioners	Melissa Ortega	
Inpatient Care Practitioners	Delia Carias	Sarah Stephens
Pharmacy Educators	Tim Brown	
Pharmacy Informatics and Technology	Barry McClain	Benjamin Anderson
Pharmacy Practice Leaders	Jeffrey Little	Lindsey Amerine
Specialty Pharmacy Practitioners	Scott Canfield ² Tara Kelley ¹	
New Practitioners Forum	Erin Boswell	Charna Ross
Pharmacy Student Forum	Autumn Pinard	Ella Domingo
Pharmacy Technician Forum	JoAnn Myhre	Cindy Jeter
FRATERNAL	DELEGATES	ALTERNATES
U.S. Air Force	LTC Jin Kim	LTC Rohin Kasudia
U.S. Army		LTC Rob Brutcher
U.S. Navy	LT Chirag Patel	LT Staci Jones
U.S. Public Health Service	LCDR Carl Coates	CDR Christopher McKnight (Coast Guard) LCDR Kali Autrey
Veterans Affairs	Terri Jorgenson ² Anthony Morreale ¹	Virginia "Ginny" Torrise

¹Seated in Sunday meeting only.

²Seated in Tuesday meeting only.

House of Delegates

REPORT ON THE VIRTUAL HOUSE OF DELEGATES

March 18-25, 2022

RESULTS OF THE VOTING

From March 18-25, the ASHP House of Delegates (roster attached as an Appendix) voted on sixteen policy recommendations. Delegates approved fifteen policy recommendations by 85% or more, the threshold for final approval. One policy recommendation did not receive 85% of the votes and will be sent to the June House of Delegates in 2022.

The fifteen policy recommendations **approved** are as follows:

State-Specific Requirements for Pharmacist and Pharmacy Technician Continuing Education

Source: Council on Education and Workforce Development

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

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

Note: This policy supersedes ASHP policy 1111.

ASHP Statement on Professionalism

Source: Council on Education and Workforce Development

To approve the ASHP Statement on Professionalism.

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

Preceptor Skills and Abilities

Source: Council on Education and Workforce Development

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

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

Note: This policy supersedes ASHP policy 1201.

Mobile Health Tools, Clinical Apps, and Associated Devices

Source: Council on Pharmacy Management

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

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

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

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

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

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

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

Note: This policy supersedes ASHP policy 1708.

Transitions of Care

Source: Council on Pharmacy Management

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

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

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

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

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

Note: This policy supersedes ASHP policy 1208.

Continuous Performance Improvement

Source: Council on Pharmacy Management

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

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

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

Note: This policy supersedes ASHP policy 0202.

Institutional Review Board and Investigational Use of Drugs

Source: Council on Pharmacy Practice

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

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

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

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

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

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

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

Note: This policy supersedes ASHP policy 0711.

Pharmacist's Role in Team-Based Care

Source: Council on Pharmacy Practice

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

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

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

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

Note: This policy supersedes ASHP policy 1215.

Drug Testing as Part of Diversion Prevention Programs

Source: Council on Public Policy

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

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

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

Note: This policy supersedes ASHP policy 1717.

Drug Samples

Source: Council on Public Policy

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

This policy supersedes ASHP policy 9702.

Naloxone Availability

Source: Council on Therapeutics

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

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

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

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

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

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

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

Note: This policy supersedes ASHP policy 2014.

Safe and Effective Therapeutic Use of Invertebrates

Source: Council on Therapeutics

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

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

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

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

Note: This policy supersedes ASHP policy 1724.

Criteria for Medication Use in Geriatric Patients

Source: Council on Therapeutics

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

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

To advocate for the development, refinement, and validation of new criteria that

consider drug-, disease-, and patient-specific factors, and criteria and quality measures that demonstrate the ability to decrease the occurrence of adverse drug events in geriatric patients; further,

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

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

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

Note: This policy supersedes ASHP policy 1221.

Medication Adherence

Source: Council on Therapeutics

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

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

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

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

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

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

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

Note: This policy supersedes ASHP policy 1222.

ASHP Statement on the Pharmacy Technician’s Role in Pharmacy Informatics

Source: Section of Pharmacy Informatics and Technology

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

Note: This statement supersedes the ASHP Statement on the Pharmacy Technician’s Role in Pharmacy Informatics dated June 3, 2013.

The House **voted to not approve** the following policy recommendation:

Cultural Competency

Source: Council on Education and Workforce Development

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

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

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

Note: This policy would supersede ASHP policy 1613.

NOTES ON VOTING

Over 94% (198) of delegates to the virtual House of Delegates participated in the voting, with 96% (154) of state delegates voting; 91% of registered past presidents voted; and 84% of state delegations had 100% participation by their delegates.

HOUSE OF DELEGATES
Melanie A. Dodd, Chair
Thomas J. Johnson, Vice Chair

As of March 25, 2022

OFFICERS AND BOARD OF DIRECTORS			
Linda S. Tyler, President			
Paul C. Walker, President-Elect			
Thomas J. Johnson, Immediate Past President			
Christene M. Jolowsky, Treasurer			
Paul W. Abramowitz, Chief Executive Officer			
Kim Benner, Board Liaison, Council on Pharmacy Practice			
Leigh Briscoe-Dwyer, Board Liaison, Council on Public Policy			
Kristina L. Butler, Board Liaison, Council on Education and Workforce Development			
Nishaminy Kasbekar, Board Liaison, Commission on Affiliate Relations			
Pam Phelps, Board Liaison, Council on Pharmacy Management			
Jamie Sinclair, Board Liaison, Council on Therapeutics			
Vivian Bradley Johnson, Board Member-Elect			
Samuel V. Calabrese, Board Member-Elect			
Melanie A. Dodd, Chair of the House			
PAST PRESIDENTS			
R. David Anderson	Debra Devereaux	Robert Lantos	Steven Sheaffer
Roger Anderson	Fred Eckel	Herman Lazarus	Kelly Smith
John Armitstead	Rebecca Finley	James McAllister	Thomas Thielke
Daniel Ashby	Lisa Gersema	Gerald Meyer	Sara White
Paul Baumgartner	Diane Ginsburg	John Murphy	T. Mark Woods
Jill Martin Boone	Harold Godwin	Kathleen Pawlicki	David Zilz
Cynthia Brennan	Mick Hunt	Cynthia Raehl	
Bruce Canaday	Clifford Hynniman	Philip Schneider	
Jannet Carmichael	Marianne Ivey	Kathryn Schultz	
Kevin Colgan	Stan Kent	Bruce Scott	
STATE	DELEGATES		ALTERNATES
Alabama (3)	Thomas Achey Laura Matthews Whitney White		Megan Roberts
Alaska (2)	Ursula Iha Shawna King		Gretchen Glaspy
Arizona (3)	Melinda Burnworth Christopher Edwards Danielle Kamm		Janelle Duran Christi Jen Carol Rollins Jake Schwarz
Arkansas (2)	Jeff Cook Kendrea Jones		

California (7)	Steven Gray Daniel Kudo Elaine Law Sarah McBane James D. Scott Kethen So Keith Yoshizuka	Brian Kawahara Stacey Raff
Colorado (3)	Sarah Anderson Karen McConnell Tara Vlasimsky	Clint Hinman
Connecticut (3)	David Goffman Marta Stueve Colleen Teevan	Teresa Papstein
Delaware (2)	Cheri Briggs Troy Rehrig	Samantha Landolf
Florida (5)	Kathy Baldwin Elias Chahine Julie Groppi Jennifer Miles Sara Panella	
Georgia (3)	Susan Jackson Christy Norman Anthony Scott	Davey Legendre
Idaho (2)	Paul Driver Audra Sandoval	
Illinois (5)	Noelle Chapman Megan Corrigan Andy Donnelly Bernice Man Carrie Vogler	Chris Crank R. Jason Orr Trish Wegner
Indiana (3)	Chris Lowe Christopher Scott Tate Trujillo	John Hertig
Iowa (3)	John Hamiel Candace Jordan Jessica Nesheim	Mike Daly Emmeline Paintsil Marisa Zweifel
Kansas (3)	Brian Gilbert Katherine Miller Joanna Robinson	Marshall Johnson Kevin Mahler Zahra Nasrazadani Talal Nassar Katherine Ulloa Katie Wilson
Kentucky (3)	Dale English Joan Haltom Thomas Platt	Rebecca Cheek Gavin Howington Derek Pohlmeier
Louisiana (3)	Jason Chou Kisha Gant Myra Thomas	Paul Menasco Renesha Yarbrough

Maine (2)	Matthew Christie Kathryn Sawicki	Anne Andrlé
Maryland (4)	Nicole Kiehle Janet Lee Elizabeth Rodman Molly Wascher	Giae Derisse Marybeth Kazanas
Massachusetts (4)	Jackie MacCormack-Gagnon Monica Mahoney Francesca Mernick Marla O'Shea-Bulman	Nick Edmonds
Michigan (4)	Rox Gatia Jesse Hogue Jessica Jones Stephen Stout	Lama Hsaiky
Minnesota (3)	Kristi Gullickson Sue Haight John Pastor	Matthew Ditmore Susan Flaker Garrett Schramm
Mississippi (3)	Joshua Fleming Andrew Mays Katie Schipper	Chris Ayers
Missouri (3)	Laura Butkievich Joel Hennenfent Amy Sipe	Davina Dell-Steinbeck Nathan Hanson Christina Stafford
Montana (2)	Starla Blank Lindsey Firman	Julie Neuman
Nebraska (3)	Tiffany Goeller Katie Reisbig Jerome Wohleb	James Bird Michele Higgins Emily Johnson
Nevada (2)	Adam Porath Kate Ward	
New Hampshire (2)	Tonya Carlton Dave DePiero	Elizabeth Wade
New Jersey (4)	Daniel Abazia Julie Kalabalik-Hoganson Deborah Sadowski Nissy Varughese	Ken Bevenour Barbara Giacomelli Craig Sastic
New Mexico (2)	Stephen Adams Amy Buesing	
New York (5)	Angela Cheng Heide Christensen Robert DiGregorio Mark Sinnet Kim Zammit	Mark Klang Russ Lazzaro
North Carolina (4)	Angela Livingood Mary Parker Mollie Scott Tyler Vest	

North Dakota (2)	Maari Loy Elizabeth Monson	
Ohio (5)	Rachel Chandra Kellie Musch John Feucht II Kembral Nelson Jacalyn Rogers	Megan Adelman Fouad Eid Nicole Harger Dykes Daniel Lewis Jordan Long
Oklahoma (3)	Emily Gray Christopher Pack Edna Patatanian	Wiley Williams
Oregon (3)	Ryan Gibbard Edward Saito Victoria Wallace	Michael Lanning
Pennsylvania (4)	Danielle Auxer Paul Green Arpit Mehta Christine Roussel	Jennifer Belavic Scott Bolesta Brad Cooper
Puerto Rico (2)	Mirza Martinez Carlos Mendez	Giselle Rivera
Rhode Island (2)	Margaret Charpentier Bryan McCarthy	Karen Nolan Martha Roberts
South Carolina (3)	Carolyn Bell Lisa Gibbs Jennifer Thompson	Laura Holden
South Dakota (2)	Joseph Berendse Laura Stoebner	Thaddaus Hellwig Anne Morstad
Tennessee (4)	Don Branam Agatha Nolen Jennifer Pauley Jodi Taylor	Meredith Gilbert-Plock Holly Lowe
Texas (6)	Latresa Billings Joshua Blackwell Steven Knight Randy Martin Patricia Meyer Binita Patel	Rodney Cox
Utah (3)	Karen Gunning Anthony Trovato David Young	Jennie Barlow Kavish Choudhary Erin Fox
Vermont (2)	Ali Porter Jeffrey Schnoor	Kristina Stemple
Virginia (4)	Catherine Floroff Lisa Hammond Brian Spoelhof Darren Stevens	
Washington, D.C. (2)	Carla Darling Michelle Eby	Sue Carr

Washington State (4)	Rena Gosser James Houpt Karen White Roger Woolf	
West Virginia (2)	Chris Fitzpatrick Derek Grimm	
Wisconsin (4)	Christina Andros Tom Dilworth Justin Konkol John Muchka	Carmen Gust Carolyn Oxencis Katie Reinke Tahmeena Siddiqui
Wyoming (2)	Jamie Homecker Tonja Woods	Linda Gore-Martin
SECTIONS AND FORUMS	DELEGATES	ALTERNATES
Ambulatory Care Practitioners	Daniel Truelove	Jaclyn Boyle
Clinical Specialists and Scientists	Douglas Slain	Christi Jen
Community Pharmacy Practitioners	Melissa Ortega	
Inpatient Care Practitioners	Delia Carias	Sarah Stephens
Pharmacy Educators	Marie Chisholm-Burns	James Trovato
Pharmacy Informatics and Technology	Barry McClain	Benjamin Anderson
Pharmacy Practice Leaders	Jeffrey Little	Lindsey Amerine
Specialty Pharmacy Practitioners	Tara Kelley	Scott Canfield
New Practitioners Forum	Erin Boswell	Charnae Ross
Pharmacy Student Forum	Autumn Pinard	Ella Domingo
Pharmacy Technician Forum	JoAnn Myhre	Cindy Jeter
FRATERNAL	DELEGATES	ALTERNATES
U.S. Air Force	LTC Rohin Kasudia	Maj. Jin Kim
U.S. Army	LTC Joe Taylor	LTC Rob Brutcher
U.S. Navy	LT Chirag Patel	LT Staci Jones
U.S. Public Health Service	LCDR Carol Coates	CDR Christopher McKnight
Veterans Affairs	Dr. Heather Ourth	Dr. Virginia "Ginny" Torrise

House of Delegates

REPORT ON THE VIRTUAL HOUSE OF DELEGATES

May 13-19, 2022

RESULTS OF THE VOTING

From May 13 to 19, the ASHP House of Delegates (roster attached as an Appendix) voted on sixteen policy recommendations. Delegates approved eight policy recommendations and four statements by 85% or more, the threshold for final approval.

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

Career Counseling (85.9%)

Source: Council on Education and Workforce Development

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

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

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

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

Note: This policy supersedes ASHP policy 8507.

Workforce Diversity (89.9%)

Source: Council on Education and Workforce Development

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

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

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

Note: This policy supersedes ASHP policy 0705.

Pharmacy Executive Oversight of Areas Outside Pharmacy (93.4%)

Source: Council on Pharmacy Management

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

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

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

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

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

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

Hospital-at-Home Care (87.4%)

Source: Council on Pharmacy Practice

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

To support HAH care models that provide high-quality, patient-centered pharmacist care, including but not limited to: (1) clinical pharmacy services that are fully integrated with the care team; (2) a medication distribution model that is fully integrated with the providing organization's distribution model and in which the organization's pharmacy

leader retains authority over the medication-use process; (3) information technology (IT) systems that are integrated or interoperable with the organization's IT systems and that allow patient access to pharmacy services, optimize medication management, and promote patient safety; and (4) ensuring the safety of the pharmacy workforce throughout the HAH care delivery process; further,

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

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

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

To encourage research on HAH care models.

Promoting Telehealth Pharmacy Services (92.4%)

Source: Council on Pharmacy Practice

To advocate for innovative telehealth pharmacy practice models that (1) enable the pharmacy workforce to promote clinical patient care delivery, patient counseling and education, and efficient pharmacy operations; (2) improve access to pharmacist comprehensive medication management services; (3) advance patient-centric care and the patient care experience; and (4) facilitate pharmacist-led population and public health services and outreach; further,

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

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

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

Tamper-Evident Packaging on Multidose Products (94.9%)

Source: Council on Pharmacy Practice

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

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

Note: This policy supersedes ASHP policy 9211.

Pharmacist's Role in Medication Procurement, Distribution, Surveillance, and Control (93.9%)

Source: Council on Pharmacy Practice

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

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

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

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

Note: This policy supersedes ASHP policy 0232.

ASHP Statement on the Role of the Pharmacy Workforce in Emergency Preparedness (98.0%)

Source: Council on Pharmacy Practice

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

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

Drug Desensitization (92.9%)

Source: Council on Therapeutics

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

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

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

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

the desensitization location; further,

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

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

ASHP Statement on Pharmacist Prescribing of Statins (93.9%)

Source: Council on Pharmacy Practice

To approve the ASHP Statement on Pharmacist Prescribing of Statins.

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

ASHP Statement on the Role of Pharmacists in Primary Care (91.4%)

Source: Section of Ambulatory Care Practitioners

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

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

ASHP Statement on Telehealth Pharmacy Practice (97.0%)

Source: Section of Pharmacy Informatics and Technology

To approve the ASHP Statement on Telehealth Pharmacy Practice.

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

The House **voted to not approve** the following policy recommendations:

Advancing Diversity, Equity, and Inclusion in Education and Training (83.8%)

Source: Council on Education and Workforce Development

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

To advocate that the pharmacy workforce actively participate in the equitable training and education of Black, Indigenous, and People of Color (BIPOC) and other people with marginalized identities.

Revenue Cycle Management and Reimbursement and Pharmacist Compensation for Drug Product Dispensing (81.8%)

Source: Council on Pharmacy Management

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

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

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

To educate pharmacists and stakeholders about those methods; further,

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

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

Note: This policy would supersede ASHP policies 1710 and 1807.

Screening for Social Determinants of Health (79.8%)

Source: Council on Pharmacy Management

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

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

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

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

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

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

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

Pediatric Dosage Forms (83.3%)

Source: Council on Therapeutics

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

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

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

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

Note: This policy would supersede ASHP policy 9707.

NOTES ON VOTING

Over 94% (198) of delegates to the virtual House of Delegates participated in the voting, with 94% (151) of state delegates voting; 99% of registered past presidents voted; and 80% of state delegations had 100% participation by their delegates.

HOUSE OF DELEGATES
Melanie A. Dodd, Chair
Thomas J. Johnson, Vice Chair

As of May 18, 2022

OFFICERS AND BOARD OF DIRECTORS			
Linda S. Tyler, President			
Paul C. Walker, President-Elect			
Thomas J. Johnson, Immediate Past President			
Christene M. Jolowsky, Treasurer			
Paul W. Abramowitz, Chief Executive Officer			
Kim Benner, Board Liaison, Council on Pharmacy Practice			
Leigh Briscoe-Dwyer, Board Liaison, Council on Public Policy			
Kristina L. Butler, Board Liaison, Council on Education and Workforce Development			
Nishaminy Kasbekar, Board Liaison, Commission on Affiliate Relations			
Pam Phelps, Board Liaison, Council on Pharmacy Management			
Jamie Sinclair, Board Liaison, Council on Therapeutics			
Melanie A. Dodd, Chair of the House			
PAST PRESIDENTS			
R. David Anderson	Debra Devereaux	Robert Lantos	Thomas Thielke
Roger Anderson	Fred Eckel	Herman Lazarus	Sara White
John Armitstead	Rebecca Finley	Gerald Meyer	T. Mark Woods
Daniel Ashby	Lisa Gersema	John Murphy	David Zilz
Paul Baumgartner	Diane Ginsburg	Cynthia Raehl	
Jill Martin Boone	Harold Godwin	Philip Schneider	
Cynthia Brennan	Mick Hunt	Kathryn Schultz	
Bruce Canaday	Clifford Hynniman	Bruce Scott	
Jannet Carmichael	Marianne Ivey	Steven Sheaffer	
Kevin Colgan	Stan Kent	Kelly Smith	
STATE	DELEGATES		ALTERNATES
Alabama (3)	Thomas Achey Laura Matthews Whitney White		Megan Roberts
Alaska (2)	Ursula Iha Shawna King		Gretchen Glaspay
Arizona (3)	Melinda Burnworth Christopher Edwards Danielle Kamm		Janelle Duran Christi Jen Carol Rollins Jake Schwarz
Arkansas (2)	Jeff Cook Kendrea Jones		

California (7)	Steven Gray Daniel Kudo Elaine Law Sarah McBane James D. Scott Kethen So Keith Yoshizuka	Brian Kawahara Stacey Raff
Colorado (3)	Sarah Anderson Karen McConnell Tara Vlasimsky	Clint Hinman
Connecticut (3)	David Goffman Marta Stueve Colleen Teevan	Teresa Papstein
Delaware (2)	Cheri Briggs Troy Rehrig	Samantha Landolfa
Florida (5)	Kathy Baldwin Elias Chahine Julie Groppi Jennifer Miles Sara Panella	
Georgia (3)	Susan Jackson Christy Norman Anthony Scott	Davey Legendre
Idaho (2)	Paul Driver Audra Sandoval	
Illinois (5)	Noelle Chapman Megan Corrigan Andy Donnelly Bernice Man Carrie Vogler	Chris Crank R. Jason Orr Trish Wegner
Indiana (3)	Chris Lowe Christopher Scott Tate Trujillo	John Hertig
Iowa (3)	John Hamiel Candace Jordan Jessica Nesheim	Mike Daly Emmeline Paintsil Marisa Zweifel
Kansas (3)	Brian Gilbert Katherine Miller Joanna Robinson	Marshall Johnson Kevin Mahler Zahra Nasrazadani Talal Nassar Katherine Ulloa Katie Wilson
Kentucky (3)	Dale English Joan Haltom Thomas Platt	Rebecca Cheek Gavin Howington Derek Pohlmeier
Louisiana (3)	Jason Chou Kisha Gant Myra Thomas	Paul Menasco Renesha Yarbrough

Maine (2)	Matthew Christie Kathryn Sawicki	Anne Andrlé
Maryland (4)	Nicole Kiehle Janet Lee Dorela Priftanji Molly Wascher	Giae Derisse Marybeth Kazanas
Massachusetts (4)	Jackie MacCormack-Gagnon Monica Mahoney Francesca Mernick Marla O'Shea-Bulman	Nick Edmonds
Michigan (4)	Rox Gatia Jesse Hogue Jessica Jones Stephen Stout	Lama Hsaiky
Minnesota (3)	Kristi Gullickson Sue Haight John Pastor	Matthew Ditmore Susan Flaker Garrett Schramm
Mississippi (3)	Joshua Fleming Andrew Mays Katie Schipper	Chris Ayers
Missouri (3)	Laura Butkievich Joel Hennenfent Amy Sipe	Davina Dell-Steinbeck Nathan Hanson Christina Stafford
Montana (2)	Starla Blank Lindsey Firman	Julie Neuman
Nebraska (3)	Tiffany Goeller Katie Reisbig Jerome Wohleb	James Bird Michele Higgins Emily Johnson
Nevada (2)	Adam Porath Kate Ward	
New Hampshire (2)	Tonya Carlton Dave DePiero	Elizabeth Wade
New Jersey (4)	Daniel Abazia Julie Kalabalik-Hoganson Deborah Sadowski Nissy Varughese	Ken Bevenour Barbara Giacomelli Craig Sastic
New Mexico (2)	Stephen Adams Amy Buesing	
New York (5)	Angela Cheng Robert DiGregorio Russ Lazzaro Mark Sinnet Kim Zammit	Heide Christensen Mark Klang
North Carolina (4)	Angela Livingood Mary Parker Mollie Scott Tyler Vest	

North Dakota (2)	Maari Loy Elizabeth Monson	
Ohio (5)	Rachel Chandra Kellie Musch John Feucht II Kembral Nelson Jacalyn Rogers	Megan Adelman Fouad Eid Nicole Harger Dykes Daniel Lewis Jordan Long
Oklahoma (3)	Emily Gray Christopher Pack Edna Patatanian	Wiley Williams
Oregon (3)	Ryan Gibbard Edward Saito Victoria Wallace	Michael Lanning
Pennsylvania (4)	Danielle Auxer Paul Green Arpit Mehta Christine Roussel	Jennifer Belavic Scott Bolesta Brad Cooper
Puerto Rico (2)	Mirza Martinez Carlos Mendez	Giselle Rivera
Rhode Island (2)	Bryan McCarthy Karen Nolan	Margaret Charpentier Martha Roberts
South Carolina (3)	Carolyn Bell Lisa Gibbs Jennifer Thompson	Laura Holden
South Dakota (2)	Joseph Berendse Laura Stoebner	Thaddaus Hellwig Anne Morstad
Tennessee (4)	Don Branam Meredith Gilbert-Plock Jennifer Pauley Jodi Taylor	Holly Lowe Agatha Nolen
Texas (6)	Latresa Billings Joshua Blackwell Steven Knight Randy Martin Patricia Meyer Binita Patel	Rodney Cox
Utah (3)	Karen Gunning Anthony Trovato David Young	Jennie Barlow Kavish Choudhary Erin Fox
Vermont (2)	Ali Porter Jeffrey Schnoor	Kristina Stemple
Virginia (4)	Catherine Floroff Lisa Hammond Brian Spoelhof Darren Stevens	
Washington, D.C. (2)	Carla Darling Michelle Eby	Sue Carr

Washington State (4)	Rena Gosser James Houpt Karen White Roger Woolf	
West Virginia (2)	Chris Fitzpatrick Derek Grimm	
Wisconsin (4)	Christina Andros Tom Dilworth Justin Konkol John Muchka	Carmen Gust Carolyn Oxencis Katie Reinke Tahmeena Siddiqui
Wyoming (2)	Jamie Homecker Tonja Woods	Linda Gore-Martin
SECTIONS AND FORUMS	DELEGATES	ALTERNATES
Ambulatory Care Practitioners	Daniel Truelove	Jaclyn Boyle
Clinical Specialists and Scientists	Douglas Slain	Christi Jen
Community Pharmacy Practitioners	Melissa Ortega	
Inpatient Care Practitioners	Delia Carias	Sarah Stephens
Pharmacy Educators	Marie Chisholm-Burns	James Trovato
Pharmacy Informatics and Technology	Barry McClain	Benjamin Anderson
Pharmacy Practice Leaders	Jeffrey Little	Lindsey Amerine
Specialty Pharmacy Practitioners	Tara Kelley	Scott Canfield
New Practitioners Forum	Erin Boswell	Charna Ross
Pharmacy Student Forum	Autumn Pinard	Ella Domingo
Pharmacy Technician Forum	JoAnn Myhre	Cindy Jeter
FRATERNAL	DELEGATES	ALTERNATES
U.S. Air Force	LTC Rohin Kasudia	Maj. Jin Kim
U.S. Army	LTC Joe Taylor	LTC Rob Brutcher
U.S. Navy	LT Chirag Patel	LT Staci Jones
U.S. Public Health Service	LCDR Carol Coates	CDR Christopher McKnight
Veterans Affairs	Dr. Heather Ourth	Dr. Virginia "Ginny" Torrise

House of Delegates

HOUSE OF DELEGATES

REPORT OF THE

COMMITTEE ON NOMINATIONS

June 12, 2022

Phoenix, Arizona

Donald Kishi (Chair), California
Kelly Smith (Vice Chair), Georgia
Joshua Blackwell, Texas
Rena Gosser, Washington
Lisa Mascardo, Iowa
Christy Norman, Georgia
Tyler Vest, North Carolina
Kristine Gullickson (1st Alternate), Minnesota
Dave Lacknauth (2nd Alternate), Florida
Maritza Lew (3rd Alternate), California

ASHP COMMITTEE ON NOMINATIONS

Madam Chair, Fellow Delegates:

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

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

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

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

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

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

The Committee's year-long process of receiving nominations and screening candidates is designed to solicit extensive membership input and, ultimately, to permit the Committee to candidly and confidentially assess which candidates best fit ASHP's needs. The Committee has met twice virtually since the last session of the House of Delegates: on January 11 and on March 18, 2022, via teleconference; and in person on April 20, 2022, at ASHP Headquarters. Review of nominees' materials was conducted continuously between March and April 2022 solely via secure electronic transmissions. This process has been reviewed for quality improvement and will be repeated for the 2022–2023 nomination cycle.

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

Based upon recommendations from membership, state affiliates, and ASHP staff, the Committee contacted over 745 individuals identified as possible candidates. Some individuals were invited to accept consideration for more than one office. Of the nominees who responded to the invitation to place themselves in nomination, the breakdown by office is as follows:

PRESIDENT-ELECT: 6 accepted

BOARD OF DIRECTORS: 15 accepted

A list of candidates that were slated was provided to delegates following the Committee's meeting on April 20, 2022.

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

President-Elect

Stephen F. Eckel, PharmD, MHA, FAPhA, FASHP, FCCP (Chapel Hill, NC)

Nishaminy (Nish) Kasbekar, PharmD, BSPHarm, FASHP (Philadelphia, PA)

Board of Directors

Jill S. Bates, PharmD, MS, BCOP, CPT, FASHP (Durham, NC)

Vickie L. Powell, PharmD, MS, BSPHarm, FASHP (New York, NY)

JoAnn Stubbings, BSPHarm, MHCA, RPh (Chicago, IL)

Jennifer Tryon, PharmD, MS, FASHP (Detroit, MI)

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

CANDIDATES FOR PRESIDENT 2023–2024

Stephen F. Eckel, PharmD, MHA, FAPhA, FASHP, FCCP (seckel@unc.edu) is the Associate Dean for Global Engagement at the UNC Eshelman School of Pharmacy. He is also an Associate Professor in the division of practice advancement and clinical education. In addition, he leads a two-year Masters of Science in Pharmaceutical Sciences with a specialization in health-system pharmacy administration. This degree collaborates with twelve hospitals across the country that sponsor the residency and includes an online option for working professionals. At UNC Medical Center, he is Residency Program Director of the two-year program in health-system pharmacy administration. He has worked with almost 250 residents over the years.

Eckel received his Bachelor of Science in Pharmacy and Doctor of Pharmacy from the University of North Carolina at Chapel Hill. He completed a pharmacy practice residency at Duke University Medical Center and then joined UNC Hospitals as a clinical pharmacist. Eckel also holds a Master of Healthcare Administration from the UNC Gillings School of Global Public Health.

Eckel has been very active in the North Carolina Association of Pharmacists, serving as Chair of the ASHP state affiliate, a term on the Board, and as President of the merged organization. He is a frequent author in *AJHP*, past chair of the ASHP Council of Pharmacy Practice, and past member of the ASHP Board of Directors. In 2015, the ASHP Foundation awarded him the Pharmacy Residency Excellence Preceptor Award. He is a Fellow of ASHP, APhA, and ACCP.

Statement:

The one constant of healthcare is change. While many pharmacists do not like change, it creates opportunities to be accountable for the medication-use process and to increase our involvement in the patient-centric practice of pharmacy. Now, more than ever, health-system pharmacists need to be innovative leaders within their spheres of influence. Employing skills like creativity, innovation, and problem solving can be the differentiator between whether we will create the future or wait for someone outside of the profession to do it.

I have focused my career on providing novel ideas to solve the challenges that face our profession and leveraging change and using creativity to help us meet our professional ideals. I have utilized the tools and direction ASHP provides the pharmacy profession and am committed to ensuring ASHP continues to provide the resources and guidelines needed for success.

I am also passionate and committed that our professional society remains diverse and inclusive for all. I will work with ASHP to continue their focus on implementing the recommendations from the Task Force on Racial Diversity, Equity, and Inclusion. We will not advance as an organization or profession until all of us are able to flourish at an individual level.

I am extremely honored to receive this nomination as ASHP has always been my professional home. There are many leaders who have utilized their skills in the past to bring health-system pharmacy to this point, and I am committed to do the same for future generations.

Nishaminy (Nish) Kasbekar, PharmD, BPharm, FASHP (kasbekan@pennteam.upenn.edu) is the Chief Pharmacy Officer at Penn Presbyterian Medical Center in Philadelphia, Pennsylvania. Kasbekar earned her Bachelor of Science in Pharmacy and Doctor of Pharmacy degrees from the Philadelphia

College of Pharmacy and Science and completed residencies in pharmacy practice and infectious diseases at the Hospital of the University of Pennsylvania. She began her career providing direct patient care as a clinical pharmacy specialist in infectious diseases, implementing an antimicrobial stewardship program. In her 25 years at Penn Medicine, she has led many strategic and programmatic initiatives expanding the scope, services, and influence of the pharmacy department in inpatient and ambulatory areas.

Her ASHP service includes Board of Directors (2019-2022); chair, Section Advisory Group on Multi-Hospital Pharmacy Executives; chair, Council on Pharmacy Practice; Women in Pharmacy Leadership Steering Committee; *AJHP* Editorial Board; and delegate to the ASHP House of Delegates for over eight years. In addition, she has served as chair, Vizient Practice Advancement Committee; president, Pennsylvania Society of Health-System Pharmacists; president, Pennsylvania Pharmacists Association Educational Foundation; and president, Delaware Valley Society of Health-System Pharmacists. Kasbekar has also received numerous recognitions for her work and contribution to pharmacy, including the PSHP Pharmacist of the Year Award, Joe E. Smith Award, Sister M. Gonzales Duffy Award, and as a Fellow of ASHP. Kasbekar has also published and presented on a variety of topics, including leadership development, process improvement in healthcare, well-being and resilience, and innovative practice models.

Statement:

The pandemic has accelerated the pace of change in healthcare and fueled a paradigm shift in pharmacy, providing leaders a unique opportunity to work in dynamic and novel ways. The role of the pharmacist has also evolved from an under-utilized ancillary resource to a front-line healthcare worker integral during a challenging healthcare crisis. In addition, the increasing complexity of medications, rising drug costs, challenging regulations, focus on outcomes, and workforce shortages have put pharmacists at the center of navigating initiatives that provide safe and quality care.

As we look to the future, healthcare delivery will be significantly re-engineered, and the below focus areas will be important for ASHP:

- *Enable members to create innovative strategic models for practice advancement.*
- *Harvest an entrepreneurial spirit to leverage collaboration with disruptive innovators and vertical integrators to promote productive partnerships.*
- *Embrace digital technology to create new delivery models utilizing pharmacists outside of conventional norms.*
- *Invest in initiatives to create safe, high-quality, and equitable patient care by supporting programs focused on well-being, resilience, and elimination of healthcare disparities.*
- *Inspire and lead the professional development of the younger workforce for effective succession planning.*

As ASHP members, our unity of thought and continued pursuit of professional excellence will allow us to move forward strategically, creatively, and in a transformative way.

I am deeply honored by this nomination and would consider it a privilege to serve the members as ASHP President.

CANDIDATES FOR BOARD OF DIRECTORS 2023–2026

Jill S. Bates, PharmD, MS, BCOP, CPT, FASHP (batesjill@gmail.com) is the National PHASER Pharmacy Program Manager for the Department of Veterans Affairs in Durham, N.C., and Associate Professor of Clinical Education at the UNC Eshelman School of Pharmacy. Dr. Bates received a bachelor's degree from Eastern Illinois University, a master's degree with a concentration in biochemistry and biophysics from Northern Illinois University, and a doctor of pharmacy from the University of Illinois at Chicago. Dr. Bates also completed two years of postgraduate work at Duke University Medical Center, the first year concentrating on pharmacy practice and the second as a resident in oncology pharmacy. She is certified through multiple organizations in precision medicine, pharmacogenomics, and precision oncology.

Throughout her 16-year career, Dr. Bates has cared for hundreds of patients within multiple practice settings. In her current role at the VA and in collaboration with other stakeholders, Dr. Bates leads a movement to develop and grow national programs in pharmacogenomics and precision oncology and establish pharmacy's role within these programs. Her involvement in ASHP has spanned over a decade. During this time, Dr. Bates has served as vice-chair and chair of the Council on Therapeutics, delegate to the House of Delegates, faculty for the Oncology Board Certification Review course, member of the Women in Leadership Task Force, chair of the Section of Clinical Specialists and Scientists (SCSS), and a member of multiple committees. In recognition of this service, Dr. Bates was designated ASHP Fellow in 2018 and awarded the SCSS Distinguished Service Award in 2019.

Statement:

Health is a state of physical, mental, and social well-being, and good health enables people to live abundant lives. Sustaining good health is relational; it requires multiple components working together, ideally in team-based care. As providers and treatment plan experts, pharmacists have tremendous responsibility. We must always focus on the welfare of humanity and the relief of suffering, as we pledged when entering the profession.

Our patients are central to the welfare of humanity. Our service is guided by treatment plan expertise and the culturally universal golden rule to “do unto others as you would have them do unto you.” Compassion should be our benchmark—both for patients and for ourselves. Burnout is at crisis levels within the field, and we must care for our own to maintain a thriving community that provides optimal care for others. The “square of common good” philosophy emphasizes creating systems and relationships that focus on respect, integrity, and compassion to best attain justice.

We also face a pressing need to ensure that all persons have access to pharmacist care. Leading public health efforts that prioritize integrity-based healthcare policies and pricing practices is key. Recognizing that 80% of healthcare spending is focused on preventable chronic diseases, we should advocate for and integrate foundational healthy behaviors within comprehensive medication management.

It is a true honor to be considered for the ASHP Board of Directors. If elected, I pledge to uphold values that support the advancement of pharmacy practice and good health for all persons.

Vickie L. Powell, PharmD, MS, BSPHarm, FASHP (Vip9006@nyp.org) is the Site Director of Pharmacy Operations at New York-Presbyterian Hospital. The hospital is affiliated with two of the nation's

leading medical colleges: Columbia University College of Physicians and Surgeons and Weill Cornell Medical College. The hospital and its academic affiliates share a commitment to pursuing clinical excellence, engaging in groundbreaking biomedical research, outstanding medical education, and providing prevention and wellness services to the community. Vickie is a clinical assistant professor of pharmacy at Long Island University and a guest lecturer at the Touro College of Pharmacy.

Vickie received a Bachelor of Science degree in Pharmacy from Xavier University of Louisiana; a Master of Science degree in Pharmacy Administration from Long Island University, New York, and a PharmD degree from Howard University, Washington DC. She is a fellow of ASHP, a BPS Employee Advisory Council member, and is currently working with ACCP on the upcoming Bridging Pharmacy Education and Practice Summit.

Vickie is the past president of the New York City Society and New York State Council of Health-System Pharmacists (NYSCHP). She remains active in both organizations and recently chaired NYSCHP's inaugural DEI committee. Vickie's sustained ASHP service includes: delegate to the House of Delegates, member of the Council on Education and Workforce Development, ASHP Policy-Process CQI Special Committee, Board of Canvassers, ASHP Committee on Nominations, Council on Pharmacy Practice, ASHP Task Force on Racial Diversity, Equity, and Inclusion, and the Certified Pharmacy Executive Leaders Advisory Committee, and chair of the ASHP Advocacy and PAC Advisory Committee.

Statement:

"Change will not come if we wait for some other person or if we wait for some other time. We are the ones we've been waiting for. We are the change that we seek." –Barack Obama

The role of the pharmacist will change considerably over the coming years. We must continue collaborative advocacy efforts to achieve pharmacist provider status in all states and expand legislators' awareness of the pharmacist's role on the healthcare team. We must work with other organizations to standardize a professional identity for pharmacists beyond dispensing and highlight our many contributions to medication safety. We must continue education on healthcare disparities, cultural diversity, equity, and inclusion.

I am passionate about the importance of mentoring, and I am a living testimony to the 'power of mentoring. "Alone we can do so little, together we can do so much." (Helen Keller). The achievements of any organization stem from the cumulative efforts of our teamwork. To sustain growth and continuity, we must actively recruit, mentor, and groom members to take on leadership roles. Being a good pharmacist is not just a matter of mastering the scientific principles but also having the will and spirit to serve others.

I challenge you to adopt the motto, "Each One Teach One." If we each commit to mentor one other person, our organization will continue to thrive. I am honored to be slated on the ballot and would be grateful for the opportunity to serve.

JoAnn Stubbings, BSP Pharm, MHCA, RPh (joanns@uic.edu) is Clinical Associate Professor Emerita, Department of Pharmacy Practice, University of Illinois Chicago College of Pharmacy. A graduate of Ohio State University College of Pharmacy (BS) and University of Mississippi School of Pharmacy (MHCA), she has experience in the pharmaceutical industry, consulting, academia, ambulatory care

pharmacy, and specialty pharmacy. She built one of the first accredited health-system specialty pharmacies at the University of Illinois Hospital and Health Sciences System. She currently works for the College of Pharmacy on accreditation, strategic planning, and new program development, such as a Bachelor of Science in Pharmaceutical Sciences and six new areas of concentration. Her passions include public policy and mentoring students, pharmacists, and technicians. She frequently speaks and publishes on specialty pharmacy, healthcare reform, pharmacist provider status, payment for services, the 340B Drug Pricing Program, Medicare Part D, and Risk Evaluation and Mitigation Strategies.

Stubbings served ASHP as the inaugural chair of the Section of Specialty Pharmacy Practitioners (SSPP), co-authored the first ASHP National Survey on Specialty Pharmacy Practice, and served as chair of the SSPP Committee on Nominations and as a delegate to ASHP's House of Delegates. She currently serves on the SSPP Educational Steering Committee. As a delegate she introduced a proposal that became ASHP Policy 2031, Continuity of Care in Insurance Payer Networks. She received ASHP's Distinguished Service Award for the SSPP in 2021 and the 2022 Board of Directors' Award of Excellence.

Statement:

My vision for pharmacy practice is to achieve integrated pharmacy services across the continuum of care to ensure access and equity for patients and providers. Patients should have access to pharmacy services where they receive care without restrictions imposed by insurance networks. Culture, race, disability, socioeconomic status, sexual orientation, or other social determinants of health should not restrict patients' access to pharmacy services. Likewise, health-system pharmacists and pharmacies should have access to pharmacy and provider networks.

Pharmacist provider recognition is an issue that needs ASHP's continued involvement and advocacy. Progress is being made at the state level and with the recent introduction of H.R. 7213. Another important issue for ASHP is the development and support of the pharmacy workforce. I support advanced training and roles for pharmacy technicians, layered learning training models for pharmacy students, and an increase in pharmacy residencies to allow nearly all pharmacy students to match to a residency if they desire. A third issue is the impact of corporate pharmacy on the practice of pharmacy. We must protect our profession and practice model from being managed by outside business interests and advocate for PBM reform, DIR fee fairness, 340B continuity, and access to payer networks. Finally, ASHP should continue to be our professional home and support our need to lead fulfilling professional and personal lives, including issues related to diversity, equity, inclusion, burnout, mental health, and work-life balance.

I am honored to be among the esteemed candidates nominated for the ASHP Board of Directors.

Jennifer Tryon, PharmD, MS, FASHP (jtryon2@hfhs.edu) is the Chief Pharmacy Officer at Henry Ford Health in Detroit, Michigan, leading inpatient, outpatient, and health plan pharmacy teams for the integrated delivery network. Having practiced pharmacy in community hospitals, academic health systems, and integrated delivery networks, she has broad perspectives on unique challenges across health-system pharmacy. Committed to teaching, Jennifer has lectured in multiple schools of pharmacy and is an Associate Faculty for the ASHP Foundation's Pharmacy Leadership Academy. She has been the Residency Program Director for multiple HSPAL and postgraduate year-1 residency programs and has enjoyed training over 100 pharmacy residents. Jennifer received her MS from the

University of Wisconsin and her PharmD from the University of Iowa College of Pharmacy. She completed a two-year health-system pharmacy administration residency at the University of Wisconsin Hospital and Clinics.

Jennifer has served ASHP as the Chair of the Section of Pharmacy Practice Leaders, the Council on Pharmacy Management, and section advisory groups and served in the House of Delegates. She is Past President of the Oregon Society of Health-System Pharmacists and has held other elected positions in multiple pharmacy associations.

She chairs the Autonomous Pharmacy Advisory Board and has a passion for innovative models to advance healthcare. She is frequently invited to present on leadership and business of pharmacy topics within the United States and internationally. Jennifer was honored with the 2021 Distinguished Service Award for the ASHP Section for Pharmacy Practice Leaders and was named a 2020 Emerging Industry Leader by *Managed Healthcare Executive*.

Statement:

The headwinds we face in healthcare today demand revised and innovative approaches. As delivery models evolve from fee-for-service to value based, pharmacy professionals are well-positioned to address the medication needs of patients in a way that improves outcomes. Our unique skills can be leveraged to address diverse healthcare challenges such as physician shortages in primary health, achieving quality standards for value-based care, workforce shortages, escalating drug costs, health disparities, and inconsistencies in the pharmacy supply chain. As a profession, we should continue to build on advancements of telehealth adoption resulting from our COVID-19 response and leverage technology to best meet the needs of patients in traditional and emerging settings. This will enable more patient-facing interaction and top of license activities.

ASHP has long served as the collective voice for health-system pharmacy and can provide advocacy support for members' creative solutions to these fluctuations in pressure. The national scope and influence of ASHP are vital to ensure that pharmacy professionals are empowered through legislative policy and the sharing of best practices. It is an opportune time to address these challenges as a profession, and ASHP plays a vital role in our success.

Throughout my career, ASHP has been my professional home. It would be an honor and a privilege to serve on its Board.

House of Delegates

**REPORT OF THE
BOARD OF DIRECTORS
ON
NOMINATIONS FOR ASHP TREASURER**

June 12, 2022

Phoenix, Arizona

This year, our Treasurer, Ms. Christene Jolowsky, will complete her term in that office. Accordingly, and pursuant to section 4.1.3 of the Bylaws, the Board hereby submits two names as nominees to the office of Treasurer. As provided in section 7.4.1 of the Bylaws, ASHP members will elect by majority vote a Treasurer to a three-year term of office.

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

To facilitate selection of the nominees, the Board formed a committee consisting of Pamela K. Phelps (Chair), Melanie A. Dodd, Thomas J. Johnson, Paul C. Walker, and Paul W. Abramowitz. The committee met on March 18, 2022, via teleconference and reviewed the qualifications of members who had agreed to be considered as candidates, and selected two candidates. The Board of Directors approved the slated candidates on April 20.

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

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

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

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

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

The Treasurer of ASHP also serves as Treasurer of the ASHP Research and Education Foundation.

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

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

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

Your Board is pleased to place in formal nomination two members for election as the Treasurer of ASHP, Christene M. Jolowsky and James A. Trovato.

Christene M. Jolowsky, BSP Pharm, MS, FASHP, FMSHP (cjolowsky@gmail.com) is the Senior Pharmacy Director for Hennepin Healthcare System, Minneapolis. She completed her BSP Pharm and MS in Pharmacy Administration at the University of Minnesota and a two-year ASHP-accredited administrative residency at the University of Minnesota Hospital. She is an Assistant Professor at the University of Minnesota College of Pharmacy, teaching in both the PharmD and graduate curriculums.

In her current role, she is responsible for inpatient, retail, and clinic-based pharmacy services for the system and the Poison Control Center. Chris has led teams around patient safety and clinical service initiatives. Her expertise is in clinical and operational performance improvement. Key accomplishments include promoting technician, student, and residency training and expanding the roles and scope of practice for pharmacists.

Chris is the current Treasurer of ASHP and the ASHP Foundation. Her service to ASHP includes serving as President and on the Board of Directors, and serving on many councils, committees, and task forces for ASHP and local and state health-system chapters. She has been a Minnesota delegate to ASHP's House of Delegates and served as President of the Minnesota Society of Health-System Pharmacists (MSHP). She is a Fellow of both ASHP and MSHP.

Chris was honored with the Distinguished Service Award for the ASHP Section of Pharmacy Practice Managers in 2009, the University of Minnesota College of Pharmacy's Preceptor of the Year and MSHP's Hallie Bruce Award in 2005, and the MSHP Hugh F. Kabat Award in 2012.

Statement:

Pivot, wellness, grit, and resiliency. These are just a few of the terms which have become mainstream over the past several years. We have faced and transcended a pandemic and have navigated new territories in the provision of care to our patients, our colleagues, and ourselves. These territories also extend to ASHP, as we've navigated the pandemic while staying focused on our mission toward patient care in the management of medication use. And we have needed to pivot and respond as well.

As Board members, we have a duty to provide oversight to the actions of ASHP, on behalf of the members. Specifically, as Treasurer, this duty includes being a link for our members and the Board, focusing on the financial aspects of our Society. This includes assuring we continue to devote resources to areas that support our members in continuing to provide care and grow services in this turbulent, whitewater world of healthcare.

I am proud of the decisions and the work ASHP has accomplished through the past several years to be strategic with our decisions focusing on maintaining services and managing costs. I am honored by this nomination, and I look forward to the opportunity to continue to serve the Society as Treasurer.

James A. Trovato, PharmD, MBA, FASHP (jtrovato@rx.umaryland.edu) is Professor and Vice Chair of Academic Affairs at the University of Maryland School of Pharmacy in Baltimore. He also serves as the Pharmacist Research Advisor for the Pharmaceutical Research Computing (PRC) Center in the Department of Pharmaceutical Health Services Research and Administrator for Continuing Education, University of Maryland School of Pharmacy.

Trovato has a demonstrated history of leadership and management in pharmacy education. He is skilled in oncology therapeutics, instructional design, clinical pharmacology, and curricula development and assessment. Trovato completed a BS in pharmacy from the Massachusetts College of Pharmacy, a PharmD degree from Purdue University, and an ASHP-accredited oncology residency at the University of Texas Health Science Center at San Antonio.

Trovato's recent ASHP involvement includes member, ASHP Board of Canvassers; member, Forecast Survey Panel for the ASHP Foundation's Pharmacy Forecast report; ASHP Faculty Liaison; and Faculty Advisor to the University of Maryland School of Pharmacy SSHP. He is Past President of the Maryland Society of Health-System Pharmacists. Trovato has served ASHP as Chair, ASHP Board of Canvassers; Vice Chair, FASHP Recognition Committee; Chair, House of Delegates; member, ASHP Board of Directors; Chair and director-at-large, Executive Committee of the Section of Clinical Specialists and Scientists; Chair, Council on Educational Affairs; and multi-year ASHP delegate.

Statement:

I believe the following characteristics are critical to allowing the ASHP Treasurer to be considered a valued member of the ASHP Board of Directors:

- *Detail oriented, organized, and methodical*
- *Strong moral compass*
- *Transparent with their fellow Board members*
- *Committed to fulfilling their responsibilities*
- *Strong interpersonal and communication skills*
- *Knowledgeable of the ASHP's governing documents*

I believe these characteristics are necessary to educate and guide ASHP Board members to use funds for the betterment of ASHP and its members. The Treasurer should have a vision for how ASHP can improve its long-term financial success to better serve our community in the future.

I believe having strong financial health allows ASHP to provide our members with the necessary tools, resources, and educational activities that enable them to provide preventive care services and optimize and be accountable for the health and medication outcomes of our patients.

I am humbled to have received this nomination and would welcome the opportunity to serve the pharmacy profession as Treasurer of ASHP.



House of Delegates

Board of Directors Report: Policy Recommendations for the June 2022 House of Delegates

	<u>Page</u>
COUNCIL ON EDUCATION AND WORKFORCE DEVELOPMENT POLICY RECOMMENDATIONS.....	3
1. Advancing Diversity, Equity, and Inclusion in Education and Training.....	3
2. Cultural Competency	4
COUNCIL ON PHARMACY MANAGEMENT POLICY RECOMMENDATIONS.....	6
1. Revenue Cycle Management and Reimbursement and Pharmacist Compensation for Drug Product Dispensing.....	6
2. Role of the Pharmacist in Service-Line Development and Management.....	9
3. Value-Based Purchasing.....	11
4. Financial Management Skills.....	13
5. Health-System Use of Drug Products Provided by Outside Sources	15
6. Screening for Social Determinants of Health.....	16
COUNCIL ON PHARMACY PRACTICE POLICY RECOMMENDATIONS	19
1. Stigmatizing and Derogatory Language in Healthcare	19
2. Autoverification of Medication Orders.....	21
3. Pharmacist Prescribing in Interprofessional Patient Care	22
4. Universal Vaccination for Vaccine-Preventable Diseases in the Healthcare Workforce.	24
5. Pharmacy Workforce’s Role in Vaccination.....	28



COUNCIL ON PUBLIC POLICY POLICY RECOMMENDATIONS..... 33

- 1. Patient Disability Accommodations 33
- 2. Most-Favored Nation and Drug Pricing Proposals..... 34

COUNCIL ON THERAPEUTICS POLICY RECOMMENDATIONS 36

- 1. Post-ICU Syndrome 36
- 2. Use of Veterinary Compounds in Human Subjects..... 37
- 3. Pharmacist’s Role in Respiratory Pathogen Testing and Treatment 39
- 4. Use of Intravenous Drug Products for Inhalation 40
- 5. Enrollment of Underrepresented Populations in Clinical Trials 42
- 6. Pediatric Dosage Forms..... 44
- 7. Substance Use Disorder 45

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.

Kristina Butler, *Board Liaison*

Council Members

Christopher Edwards, *Chair* (Arizona)
Angela Bingham, *Vice Chair* (Pennsylvania)
Joseph Barone (New Jersey)
Joshua Blackwell (Texas)
Manouchkathé Cassagnol (New York)
Stacy Dalpoas (North Carolina)
Glen Gard (Illinois)
Ann Lloyd (Oklahoma)
Miguel Lopez, *Student* (New Mexico)
Tera Moore (Washington, D.C.)
Jennifer Robertson (Tennessee)
Caroline Sierra (California)
Ted Walton (Georgia)
Sophia Chhay, *Secretary*

1. Advancing Diversity, Equity, and Inclusion in Education and Training

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

- 3 To advocate that the pharmacy workforce actively participate in the equitable training
- 4 and education of Black, Indigenous, and People of Color (BIPOC) and other people with
- 5 marginalized identities.

Rationale

Black, Indigenous, and People of Color (BIPOC) and other people with marginalized identities can experience disparities when receiving or accessing healthcare. Implicit biases exist against underrepresented minorities among many healthcare providers (Hall WJ, Chapman MV, Lee KM, et al. Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: a systematic review. *Am J Public Health*. 2015; 105:e60-e76), which can further perpetuate medication nonadherence, decreased trust in healthcare, and ultimately increased morbidity and mortality.

ASHP created the Task Force on Racial Diversity, Equity, and Inclusion in June 2020. One of its three focus areas was education and training, which resulted in two key recommendations (13 and 16). The first of these recommendations encourages hospitals and health systems

to include statements and/or integrate expectations into their departments' planning and operations for the equitable training of underrepresented minorities. Further, the Task Force recommended hospitals and health systems partner with knowledgeable organizations to help educate and train the pharmacy workforce on how to support future underrepresented minority pharmacy workforce members (e.g., training on implicit bias, cultural competency, and fostering an inclusive climate)([Report of the ASHP Task Force on Racial Diversity, Equity, and Inclusion](#). *Am J Health-Syst Pharm*. 2021; 78:903–906). Organizations are encouraged to partner with their respective offices of diversity, equity, and inclusion (DEI) as well as local or national organizations to support these education and training efforts (e.g., National Association for Equity, Diversity, and Inclusion [NAEDI] and Government Alliance on Race and Equity [GARE]). By advancing DEI in the education and training of the pharmacy workforce, the profession can positively impact patient care.

Background

The Council considered this topic as a recommendation of the ASHP Task Force on Racial Diversity, Equity, and Inclusion. The proposed policy recommendation underscores the critical effort to prioritize advancing DEI in the education and training of the pharmacy workforce and the positive impact those efforts have on patient care.

2. Cultural Competency

- 1 To foster the ongoing development of cultural competency within the pharmacy
- 2 workforce; further,

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

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

Note: This policy would supersede ASHP policy 1613.

Rationale

The United States is rapidly becoming a more diverse nation. Culture influences a patient's belief and behavior toward health and illness. Cultural competence can significantly affect clinical outcomes. Research has shown that overlooking cultural beliefs may lead to negative health consequences. According to the National Center for Cultural Competency, there are numerous examples of benefits derived from the impact of cultural competence on quality and effectiveness of care in relation to health outcomes and well-being. Further, pharmacists can contribute to providing "culturally congruent care," which can be described as "a process of effective interaction between the provider and client levels" of healthcare that encourages provider cultural competence while recognizing that "[p]atients and families bring their own

values, perceptions, and expectations to healthcare encounters which also influence the creation or destruction of cultural congruence.” The [Report of the ASHP Ad Hoc Committee on Ethnic Diversity and Cultural Competence](#) and the [ASHP Statement on Racial and Ethnic Disparities in Health Care](#) support ways to raise awareness of the importance of cultural competence in the provision of patient care so that optimal therapeutic outcomes are achieved in diverse populations.

When considering holistic approaches to patient care, clinicians should recognize and respond effectively to all personal and social identities, including but not limited to the categories of sexual identity and gender expression, age, national origin, socioeconomic origin, ethnicity, culture, gender, race, religion or spirituality, and physical, sensory, or mental disability. Spiritually congruent care may be expressed in prayer requests, in clinician-chaplain collaborations, and through health care organizations’ religious accommodations for patients and staff. Numerous publications have outlined the role of spirituality in overall health, longevity, and quality of life, especially for patients with severe illness. The pharmacy workforce should be educated on the importance of individual patient spirituality and its impact on health and on ways to facilitate patient access to spiritual care services.

Background

The Council reviewed ASHP policy 1613, Cultural Competency, in response to a delegate recommendation from the 2021 ASHP House of Delegates and at the request of a Council member and voted to recommend amending it as follows (underscore indicates new text):

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

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

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

The Council reviewed the recommendation and background proposed by the delegates and felt that existing policy 1613, Cultural Competency, could be revised to address the intent of the delegate recommendation regarding the pharmacist’s role in spiritual care. To ensure this concept is clearly addressed in the revised policy, the Council recommended adding the second clause and changing the third clause to recognize individual patient spirituality in holistic approaches to care.

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.

Pamela Phelps, *Board Liaison*

Council Members

Arpit Mehta, *Chair* (Pennsylvania)
Christopher Scott, *Vice Chair* (Indiana)
Ryan Costantino (Texas)
Daniel Dong (California)
Monica Dziuba (Louisiana)
Amanda Hays (Missouri)
Jessica Hill (New Jersey)
Christy Norman (Georgia)
Joseph Pinto (New York)
Alex Shantiai, *Student* (Florida)
Tara Vlasimky (Colorado)
Jason Wong (Oregon)
Eric Maroyka, *Secretary*

1. Revenue Cycle Management and Reimbursement and Pharmacist Compensation for Drug Product Dispensing

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

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

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

- 10 To educate pharmacists and stakeholders about those methods; further,

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

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

Note: This policy would supersede ASHP policies 1710 and 1807.

Rationale

Pharmacy has an increasingly important role in optimizing revenue capture and avoiding revenue erosion resulting from improper billing or inadequate documentation of medication-related charges. Pharmacy needs to be involved in aspects of medication-related billing, including not just pharmacy drug charges and billing but also contracting and negotiating for carve-outs. Pharmacy leaders need to actively engage senior leadership and collaborate with various departments to ensure organizational success in revenue cycle management.

Recently, organizations have experienced increasing compliance pressures. This pressure comes from many sectors, including Centers for Medicare & Medicaid Services (CMS) programs plus state-specific requirements, third-party payers, and financial intermediaries. These policies impact organizations in two ways: increased requirements before the insurers will pay for a claim, and increased audit pressure to be sure the organizations are billing accurately. The frequency and nature of audits has also been changing. Insurers have increased the use of audits to control costs. Government agencies have also increased the use of audits. CMS has implemented [Recovery Audit Contractor \(RAC\)](#) audits, and the Office of the Inspector General is also auditing organizations. Results of the audits can have significant financial impact on the organization when money needs to be returned based on improper billing or lack of documentation.

Historically, pharmacy departments have great strength in managing supply chain issues. Drug expenditures are typically a significant portion of any hospital's budget, and the pharmacy department is a key leader in managing these expenses. However, pharmacy departments are involved in broader revenue cycle management in variable ways. In some organizations, the billing or patient accounting departments, or in some cases a contracted third-party vendor, handle all billing issues with various degrees of pharmacy department involvement. Accurate billing requires integration of the organization's clinical services, pharmacy, billing, and chargemaster functions. The required elements for proper billing may reside in several systems. As coverage decisions become more complex, pharmacy expertise is increasingly required in the clinical coverage decisions and information integration in order to be successfully reimbursed for services. For the healthcare enterprise to successfully manage compliance and optimize revenue capture there must be effective collaboration among various departments. Pharmacy knowledge and leadership is increasingly required to ensure organizational success in revenue cycle management.

In well-intentioned efforts to reduce healthcare costs, public and private payers often seek to minimize the reimbursement to pharmacies for drug products. Historically, those reimbursements have sometimes exceeded the simple cost of the drug product to reimburse pharmacies for associated costs (e.g., storage, compounding, preparation, dispensing). Each insurer has different requirements for coverage determinations, and coverage decisions have

become more complex. More drugs now require prior authorization processes. In some cases, even if the prior authorization process has been used, the charge is denied. Medicare has implemented requirements for self-administered drugs (SADs), and diabetic supplies are now handled under durable medical equipment (DME) requirements, which may require different data elements before a bill is processed. Medicaid requires the National Drug Code (NDC) prior to payment, and billing requirements for Medicare and Medicaid programs are not harmonized. Healthcare Common Procedure Coding System (HCPCS) codes also need to be attached where indicated. It is challenging to keep up with all the changes. International Classification of Disease 10 (ICD-10) codes further complicate required coding.

Current IT solutions are inadequate and do not effectively facilitate effective billing. Current systems are often not designed to capture all necessary information required to properly document and bill. Even when necessary data is captured, it often resides in different departmental computer systems that are not integrated and designed to share data. There is a need for better IT solutions to facilitate both billing and audits. Greater consistency in billing and reimbursement practices would facilitate greater compliance and enable the development of effective technology solutions to improve billing and reimbursement processes.

Since pharmacy leaders have had variable levels of engagement in revenue cycle management, there is a need for education, tools, and resources related to best practices. Because cost-management efforts are likely to continue to reduce pharmacy reimbursement, other means of compensating pharmacies for those expenses will need to be found, and pharmacists and other stakeholders will require education about those reimbursement methods. In addition, pharmacists and pharmacies need to be reimbursed for professional services associated with management of medications and related patient care. Some pharmacy departments have created a business manager position in part to deal with these issues. This position is often not a pharmacist, but a staff member with business training. New roles for pharmacy technicians have also emerged in this area. ASHP and the Section of Pharmacy Practice Leaders are committed to developing and sharing best practices and providing education to support pharmacists in optimizing reimbursement and pharmacist compensation for drug product dispensing and pharmacy's role in revenue cycle compliance.

Background

The Council reviewed ASHP policy 1710, Revenue Cycle Compliance and Management, as part of sunset review and voted to recommend consolidating it with ASHP policy 1807, Reimbursement and Pharmacist Compensation for Drug Product Dispensing. Policy 1807 is incorporated as the third and fourth clauses, amending policy 1710 as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

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

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

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

To educate pharmacists and stakeholders about those methods; further,

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

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

The Council noted revision of the policy is to express that revenue cycle management expertise may extend beyond the pharmacist to include pharmacy technicians and support staff. The Council concluded that the incorporation of ASHP policy 1807 eliminates redundancy between the two policies and adds increased emphasis on the importance of collaborating with payers. Finally, the Council noted the need for intentional education of pharmacists and stakeholders (e.g., healthcare executives, finance team) as a best practice.

2. Role of the Pharmacist in Service-Line Development and Management

- 1 To recognize pharmacists bring unique clinical, operational, and financial expertise to
- 2 help organizations develop and manage high-value, health-system service lines; further
- 3 To support the role of pharmacy leadership in the development and management of
- 4 high-value, health-system service lines.

Rationale

To drive success in the current market, health systems, especially those within integrated delivery networks, must optimize growth by applying strong tactics to acquire and retain patients. Service-line development is structuring patient-centered care in clinically specific areas across the healthcare system. Service-line design groups patients into specific areas of need, improving care coordination and accountability and allowing for a nimble response to changes (e.g., in the allocation of resources).

Pharmacists bring clinical, operational, and financial expertise to help organizations (1) optimize resources, (2) ensure safe medication use and patient-centric system design, (3) drive patient and provider satisfaction, (4) improve patient outcomes, and (5) achieve financial growth when part of critical decision-making for setting an organization's overall service-line growth and management strategy. For example, pharmacists working as part of a specialty

pharmacy can leverage their expertise to assess a certain population within a service line, with the goal of improving care and patient safety while promoting use of cost-effective treatments. Most specialty pharmacies allow pharmacists to oversee financial, operational, and clinical services, which has led to growth in patient access and revenue for health systems. Health systems can reap many benefits from expanding service lines, including increased patient volumes, improved health outcomes, boosted market share, and improved patient and provider satisfaction. By focusing on developing high-value service lines, health systems have the opportunity to achieve financial growth and significant return on investment. Growing high-value service lines is one of the most effective ways in which hospitals and health systems can add value to the healthcare system. Growing service lines requires careful strategic planning, and success hinges on an organization's proficiency in (1) understanding and predicting patient needs; (2) acquiring commercial health plans; (3) using an omni-channel approach; (4) focusing on provider referrals; (5) safe medication use and patient-centric system design (e.g., medication stewardship, formulary alignment, medication-use policies); and (6) ensuring the C-suite is fully committed to the service-line development strategy. High-value service lines exemplify exceptional performance in many ways, including attracting the most patients and providers, driving the most revenue, achieving the highest care success rates, and presenting the greatest growth potential. Healthcare organizations identify their high-value service lines by analyzing financial data, external market factors (e.g., value-based contracts), and other relevant economic conditions. Data analytics and effective patient communication are important when healthcare organizations are working to grow service lines. High-value service lines may differ among hospitals, depending on the patients and markets they serve. During times of scarce capital and growing demand for services, service-line analysis becomes a high-priority task for hospital and health-system decision-makers. Leaders must face hard questions when it comes to identifying the areas of operations critical to an institution's long-term financial viability and should ensure those service lines get the investment and management attention they need. Service-line analysis may also mean eliminating low-volume and/or unprofitable service lines that drain resources. Before hospital leaders decide to discontinue a given service line, they should consider whether the line has been properly managed. Many hospitals may have inadvertently harmed service-line management by not investing sufficiently in the resources needed for success.

In today's environment, successful service-line development efforts need input from pharmacy leaders from the outset of discussions through implementation and management. Engagement in every step of service-line development and management assures long-term success as strategic direction is set. Success as a pharmacy leader is predicated on building and maintaining relationships with diverse groups of people in order to be part of setting the overall strategy for an organization. This relationship-building may include partnering with nontraditional healthcare participants to develop new strategies for care. As healthcare markets continue to shift away from volume and toward value, appealing to patients by building high-value service lines designed to meet patients' unique needs will become increasingly important.

Background

The Council recognized that organizations commonly struggle to assemble the right mix of decision-makers to ensure the strategic success of service-line-related discussions. Pharmacy possesses the knowledge, skills, and abilities in a variety of key areas (e.g., people, process efficiencies, technology, revenue cycle, formulary decisions) to help ensure enterprise strategic decisions that are most beneficial at the outset of discussions. The Council suggested ASHP explore the creation of a business development resource to assist pharmacy leaders in approaches to getting a seat at the table and understanding role once at the table (e.g., growth, revenue, process sustainability, clinical outcomes, operational considerations, medication safety).

3. Value-Based Purchasing

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

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

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

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

Note: This policy would supersede ASHP policy 1209.

Rationale

Value-based purchasing is one aspect of a portfolio of healthcare reform incentives based on pay-for-performance principles. The [Hospital VBP Program](#) adjusts payments to hospitals under the [Inpatient Prospective Payment System \(IPPS\)](#) based on the quality of care they deliver. In April 2021, the [Centers for Medicare & Medicaid Services \(CMS\)](#) announced efforts to (1) readdress 2020 policies during the duration of COVID-19 public health emergency (PHE) and (2) close healthcare equity gaps and provide greater accessibility to care, requesting comments regarding the modernization of the quality measurement enterprise to digital quality measurement. In response to the pandemic, CMS established the New COVID-19 Treatments Add-on Payment (NCTAP) for eligible discharges during the PHE. To enhance the medical workforce in rural and underserved communities, CMS is proposing to distribute 1,000 additional physician residency slots to qualifying hospitals, phasing in 200 slots per year over

five years. To address the future of digital quality measurement, CMS is currently reviewing proposals and holding discussions through 2022.

CMS was seeking comment on plans to modernize its quality measurement enterprise by:

- clarifying the definition of digital quality measures;
- using the Fast Healthcare Interoperability Resources (FHIR) Standard for electronic clinical quality measures that are currently in the various quality programs;
- standardizing data required for quality measures for collection via FHIR-based application programming interfaces;
- leveraging technological opportunities to facilitate digital quality measurement;
- better supporting data aggregation; and
- developing a common portfolio of measures for potential alignment across CMS regulated programs, federal programs and agencies, and the private sector.

ASHP recognizes the pharmacist's leadership role while explicitly acknowledging the interdisciplinary nature of initiatives designed to achieve value-based purchasing measures.

Background

The Council reviewed ASHP policy 1209, Value-Based Purchasing, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

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

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

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

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

The Council discussed the importance of pharmacy engagement in hospitals and health systems when it comes to designing the initiatives that drive value-based purchasing initiatives. Often, active membership on the design team does not include pharmacy. There needs to be thoughtful consideration of what pharmacy can reasonably control within an organization in terms of achievable tactics to improve a specific goal. Pharmacy leaders need to engage their entire departments in these efforts to ensure that there is a concerted approach toward improving patient care.

4. Financial Management Skills

- 1 To foster the systematic and ongoing development of management skills for the
2 pharmacy workforce in the areas of (1) health-system economics, (2) business plan
3 development, (3) financial analysis, (4) metrics for clinical and distributive services, (5)
4 pharmacoeconomic analysis, (6) diversified pharmacy services, (7) compensation for
5 pharmacists' patient-care services, and (8) revenue cycle compliance and management;
6 further,
- 7 To encourage colleges of pharmacy to incorporate these management areas in course
8 work, electives (e.g., financial and managerial accounting), and experiential education;
9 further,
- 10 To promote the growth of dual Pharm.D./M.B.A. degree programs and similar certificates
11 or concentrations offered by colleges of pharmacy; further,
- 12 To encourage financial management skills development in pharmacy residency training
13 programs; further,
- 14 To provide education for new practitioners and student pharmacists on foundational
15 skills for business administration and personal financial management; further,
- 16 To promote education on financial management for other members of the pharmacy
17 workforce (e.g., pharmacy technicians, data scientists, inventory specialists, department
18 business managers).

Note: This policy would supersede ASHP policy 1207.

Rationale

Revenue cycle compliance and management represent an increasingly important aspect of the business operations of hospitals and health systems. Pharmacy leaders must exert leadership in managing medication-related revenue cycle compliance in order to ensure financial success of the healthcare enterprise. The development of foundational skills in financial literacy and business management is critical for many members of the pharmacy workforce (e.g., residents, new practitioners, student pharmacists, pharmacy technicians, and support staff such as data scientists, inventory specialists, or department business managers) to gain perspectives on contemporary management techniques and fiscal solvency. Some ways to achieve this are through (1) college of pharmacy curriculum (e.g., dual Pharm.D./M.B.A. degree or similar programs) or experiential program requirements; (2) during residency training as incorporated projects; or (3) as a certificate program for student pharmacists, residents, and new

practitioners. Pharmacy leaders must also develop and maintain knowledge in this area to sharpen skills in planning, forecasting, decision-making, and implementation.

Background

The Council reviewed ASHP policy 1207 Financial Management Skills, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

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

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

To promote the growth of dual Pharm.D./M.B.A. degree programs and similar certificates or concentrations offered by colleges of pharmacy; further,

To encourage financial management skills development in pharmacy residency training programs ~~and new practitioner orientation~~; further, [CLAUSE MOVED UP FROM BELOW]

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

~~To encourage financial management skills development in pharmacy residency training programs and new practitioner orientation.~~ [CLAUSE MOVED UP WITH EDITS]

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

The Council suggested ASHP provide education and resources, including assembling existing resources as a portfolio of products (e.g., certificate program, Pharmacy Leadership Academy, Pharmacy Manager Boot Camp) to help pharmacy leaders, residents, new practitioners, and student pharmacists develop or sharpen foundational financial management skills in the critical functions necessary for success in pharmacy business administration. Other opportunities for ASHP to explore related to member professional development in this area include personal financial management and career planning and development strategies.

5. Health-System Use of Drug Products Provided by Outside Sources

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

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

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

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

Note: This policy would supersede ASHP policy 2032.

Rationale

Hospitals and health systems have a responsibility to confirm drug product integrity and pedigree to ensure safe and appropriate administration of drug products. Drug products supplied to a hospital or health system without an institution's direct oversight raise questions about the product's proper storage and pedigree. These drug products include patient home drug products, including clinician-administered pharmaceuticals (i.e., brown bagging) brought in by the patient or caregiver, and clinician-administered pharmaceuticals shipped from an external pharmacy directly to the location where they are being administered (i.e., white bagging). ASHP supports care models in which drug products are procured and/or prepared for administration by the pharmacy and are obtained from a licensed, verified source and encourages hospitals and health systems not to permit administration of drug products supplied by the patient, caregiver, or a pharmacy contracted by a healthcare insurance payer or pharmacy benefit manager.

Healthcare insurance and pharmacy benefit management (PBM) models should ensure fair reimbursement and payment for drug product preparation and administration and in the provision of direct patient care services for drug products supplied to patients. Due to patient safety and supply chain risks, hospitals and health systems should advocate for action from boards of pharmacy to directly address payer-mandated drug-distribution models and encourage state policymakers to prohibit insurers and PBMs from mandating white and brown bagging, including prohibiting insurers and PBMs from steering patients away from hospitals and health systems that refuse to accept potentially dangerous white-bagged or brown-bagged drug products.

Background

The Council reviewed ASHP policy 2032, Health-System Use of Medications Supplied to Hospitals by Patients, Caregivers, or Specialty Pharmacies, and voted to recommend amending it as follows (underscore indicates new text; ~~striketrough~~ indicates deletions):

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

To encourage hospitals and health systems not to permit administration of ~~medications~~ drug products supplied to the hospital, ~~or clinic, or other healthcare setting~~ by the patient, caregiver, or ~~specialty healthcare insurance payer or pharmacy benefit management contracted~~ pharmacy contracted by a healthcare insurance payer or pharmacy benefit manager ~~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 advocate adequate reimbursement for preparation, order review, and other costs associated with the safe provision and administration of drug products ~~medications~~; further,

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

ASHP has been focusing on addressing white-bagging as a top advocacy priority. The Council noted the need for more detailed policy to support ASHP advocacy efforts addressing the disruptions in patient care and risks to patient safety associated with white- and browning-bagging of clinician-administered drug products. The Council emphasized that specialty drug products should not be equated with clinician-administered drug products, because some specialty drug products can be self-administered, and conversely, some clinician-administered drug products might not be considered specialty drug products. It was noted the definition of specialty drug products is itself amorphous and open to varying interpretations. Since specialty drug products are often high-cost therapies, there is much interest devoted to specialty drug products, and ASHP should be cautious not to craft policy that bad actors could theoretically sidestep by simply changing their definition of specialty drug products.

6. Screening for Social Determinants of Health

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

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

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

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

- 10 To educate the pharmacy workforce and learners about SDoH, including cultural
- 11 competency, and the impact on patient care delivery and health outcomes; further,

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

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

Rationale

Social determinants of health (SDoH) are defined by the Centers for Disease Control and Prevention (CDC) as the “conditions in the environments where people are born, live, learn, work, play, worship and age.” These conditions can have a significant impact on healthcare outcomes, health equity, and the quality of life for individuals and communities. SDoH have been found to account for 80-90% of modifiable contributors to health outcomes. The CDC recognizes five distinct SDoH domains: [Economic Stability](#), [Education Access and Quality](#), [Healthcare Access and Quality](#), [Neighborhood and Built Environment](#), and [Social and Community Context](#). From a third-party payer perspective, the recent shift of many organizations from fee-for-service to value-based reimbursement models places more emphasis on SDoH, screening, and evidence-based decision making to prioritize long-term health outcomes. Healthy People 2030, a national program developed by the Office of Disease Prevention and Health Promotion within the U.S. Department of Health and Human Services, includes 355 measurable, data-driven, national objectives to improve the health and well-being of the American public by the year 2030. Efforts to address SDoH through pharmacy practice have varied. A 2018 survey of postgraduate pharmacy residents and their program directors found that only 1% of residents and 4% of residency program directors stated they had received training on Healthy People 2030.

The pharmacy workforce has opportunities to advance the use of SDoH in clinical practice (e.g., consults, medication reconciliation, patient assistance programs) to improve health outcomes. Patient screenings and data collection to ascertain SDoH should use standardized codes (e.g., ICD-10-CM Z codes, SNOMED-CT value sets) that are consistent, discrete data elements that are reportable and can be shared with other technologies, leading

to actionable intelligence to enhance quality improvement initiatives. To support this goal, there is a need for broader implementation of SDoH health information technology (IT) tools into general practice and development of policies for how to appropriately use SDoH in clinical decision-making. The Office of the National Coordinator for Health Information Technology has identified four priority areas for advancing interoperability and use of SDoH data: standards and data, infrastructure, policy, and implementation. The 2020-2025 Federal Health IT Strategic plan includes strategies such as increasing standardization of SDoH data, integrating all captured SDoH data into electronic health records, strengthening health IT infrastructure through secure exchange of data and interprofessional collaboration, and leveraging data to improve related health outcomes. Many health IT and electronic health record (EHR) vendors have invested significant resources in development of SDoH tools and products. Among these products are screening tools, population health metrics, referral and care transition tools, and analytic and reporting tools. Most vendors use the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) framework, which is a standardized patient risk assessment tool as well as a repository of resources to act on SDoH data. Vendors develop screening tools that are largely customizable to the needs of each customer organization or health system. In many situations, there is a need for patients to be referred to community-based organizations or external programs to address SDoH during transitions of care. Health systems must have access to appropriate technology-based platforms to exchange SDoH data and make referrals for patients at discharge or transfer to another institution. Lack of standardization of data and reporting across health systems makes sharing of best practices and metric goal-setting difficult. Additional tools available within some EHR platforms include those measuring quality of life, suicidal ideation rating, community service referral capabilities, and use of secondary survey data in conjunction with the CDC social vulnerability index to further evaluate population health at a community level. SDoH tools can be categorized as either single domain, such as the Hunger Vital Sign tool to evaluate food insecurity, or multiple domain, such as the WE CARE survey to evaluate education, employment/income, food insecurity, and housing/utility domains. The validity of each tool should be considered before implementing into practice. The Pharmacy Quality Alliance (PQA) has developed a [Medication Access Framework for Quality Measurement](#) and is evaluating a pharmacy measure concept to address the social determinants of health that hinder patient medication access and contribute to poor health outcomes.

Background

The Council acknowledged that advancing the use of SDoH data in clinical and community settings with integration within electronic clinical decision support workflows to support patient-centered care is of considerable interest among stakeholders. ASHP should continue to expand and amplify its efforts to provide education, training, and resources to equip the pharmacy workforce and learners with knowledge on how to have sensitive conversations with patients, triage concerns raised from SDoH screening, and influence a culture of understanding (e.g., food bank volunteer, free clinic support), leading to action.

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.

Kim Benner, *Board Liaison*

Council Members

Amanda Hansen, *Chair* (Ohio)
Kuldip Patel, *Vice Chair* (North Carolina)
Earnest Alexander (Florida)
Jason Babby (New York)
Michelle Chu (California)
Barbara Hintzen (Minnesota)
Terri Jorgenson (Maryland)
Karen McConnell (Colorado)
Alex Mersch (Iowa)
Jennifer Morris (Texas)
Christopher Pack (Oklahoma)
Aaron Steffenhagen (Wisconsin)
Adriana Weiser, *Student* (Texas)
Anna Legreid Dopp, *Secretary*

1. Stigmatizing and Derogatory Language in Healthcare

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

- 3 To urge healthcare leadership to promote use of inclusive language through
- 4 organizational policies and procedures; further,

- 5 To provide education, resources, and competencies for the pharmacy workforce and
- 6 other healthcare workers regarding the use of inclusive verbal and written language.

Rationale

Inclusive verbal and written language (i.e., language that is free of stigma, bias, and oppression) is essential for the provision of equitable patient care. The use of derogatory and stigmatizing language in the healthcare environment is a risk to patient safety and a threat to optimal health. In addition, when used among care team members, it introduces a culturally insensitive and noninclusive work environment. Stigmatizing language may fuel and trigger implicit or explicit bias in a healthcare clinician or team member and harm patients, worsen health outcomes, and compromise team dynamics. Derogatory and stigmatizing language may occur between patients and the care team, among care team members, and in medical

documentation. Commitment to the use of [conscious language](#)—the intentional use of words and terms to create empathetic, inclusive, and non-stigmatizing content—is suggested as an alternative to ensure language and communication does not lead to poorer health outcomes, health inequities, and stigma.

The use of stigmatizing and derogatory language in medical chart documentation becomes even more damaging as patients have increased access to their own health records (Davis B. [Derogatory language in charting: the domino effect](#). *Patient Safety*. 2021; 3:74-8.). Patients may not be empowered to take ownership of their care if stigmatizing and derogatory language is used. The same can apply for verbal communications. The use of argot or slang to disguise the meaning to bystanders may be useful to build bonds between colleagues but is unprofessional and creates judgments about patients not based in facts (Goldman B. [Derogatory slang in the hospital setting](#). *AMA J Ethics*. 2015; 17:167-71).

There are multiple strategies for eliminating the use of stigmatizing language in the course of caring for a patient, such as using person-first and technical language and avoiding the use of sensational or fear-based language. Eliminating derogatory and stigmatizing language from healthcare settings requires leadership commitment across the spectrum of care delivery and an educated and empowered healthcare workforce. Pharmacists, student pharmacists, and pharmacy technicians have a professional duty to provide culturally competent and compassionate patient care and can serve as champions in eliminating the use of stigmatizing language in healthcare.

Background

The Council considered this new policy topic after a recommendation was made during the 2021 ASHP House of Delegates calling for ASHP to develop policy that directly addresses the use of derogatory and stigmatizing language in healthcare. The Council recognized that pharmacists, student pharmacists, and pharmacy technicians have a professional duty to practice culturally competent and compassionate care and that the pharmacy workforce can be champions of eliminating the use of stigmatizing language in healthcare.

2. Autoverification of Medication Orders

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

- 4 To recognize that safe and efficient autoverification of medication orders can allow more
- 5 effective use of pharmacist resources by expanding access to pharmacist patient care;
- 6 further,

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

- 9 To promote and disseminate research on the safety, effectiveness, and efficiency of
- 10 autoverification of medication orders; further,

- 11 To encourage healthcare organizations to develop policies and procedures to determine
- 12 which care settings, medications, and patient populations are appropriate candidates for
- 13 autoverification of medication orders, and to support the implementation of
- 14 autoverification models for those circumstances; further,

- 15 To advocate for laws, regulations, and accreditation standards that permit
- 16 autoverification of medication orders in circumstances in which it has proven safe.

Rationale

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

In the 2016 ASHP survey of health systems, 51.6% of hospitals utilized the autoverification functionality in the CPOE system; this rose to 62.2% utilization by the 2019 survey. Of the health systems surveyed in 2019 that utilized autoverification, 52.9% autoverified in selected areas (e.g., all emergency department orders, perioperative orders);

50.2% identified selected medications for autoverification in specific areas (e.g., pain medications in the emergency department); and 17.1% of hospitals had autoverification for selected medications (e.g., flushes, influenza vaccine) throughout the hospital. Between 2016 and 2019, overall use of autoverification and autoverification of selected medications throughout the hospital and for selected medications in certain areas increased. In contrast, the use of autoverification for all medications in a selected area of the hospital decreased from 2016 to 2019.

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

Background

The Council considered this new policy topic because current ASHP policy does not explicitly address autoverification. Council members strived to create a policy position that outlines safeguards for the selective application of autoverification within healthcare settings in order to improve medication quality and safety while efficiently and effectively leveraging the expertise of the pharmacy workforce. The Council felt it was important to also address aspects of autoverification such as balanced performance and productivity measures, continuous quality improvement and research, and aligned regulatory standards.

3. Pharmacist Prescribing in Interprofessional Patient Care

- 1 To advocate that healthcare delivery organizations establish credentialing and privileging
- 2 processes that delineate the scope of and support pharmacist prescribing within the
- 3 hospital or health system and to ensure that pharmacists who prescribe are competent
- 4 and qualified to do so; further,

- 5 To advocate for autonomous and accountable prescribing authority for pharmacist
- 6 practitioners as part of comprehensive medication management, recognizing that a
- 7 single prescriber should not be responsible for prescribing and dispensing any given
- 8 medication.

Note: This policy would supersede ASHP policy 1213.

Rationale

The [American Medical Association](#) and the [American Academy of Family Physicians](#) have publicly and staunchly opposed any expansion of pharmacist scope of practice perceived to encroach on the practice of medicine. Pharmacist prescribing is implicit to interprofessional care delivery, however. Independent drug therapy decision-making by pharmacists in hospitals is already common and is often accepted or even expected by other licensed independent practitioners (e.g., physicians, physician assistants, and nurse practitioners). Practitioners participating in multidisciplinary teams with pharmacists come to rely on their knowledge and see an opportunity to free themselves from tasks that can be done by another professional with demonstrated competency and expertise. Pharmacists in specialty practices such as anticoagulation management, solid organ transplant, and nutrition support have long functioned in roles in which near-independent authority to manage drug therapy has resulted in improved outcomes. In settings such as the Indian Health Service and Veterans Affairs health systems, where access to primary or specialty care may be limited, care provided by pharmacists with prescribing authority has demonstrated the benefits of this model.

Some hospitals authorize pharmacists to manage drug therapy by enacting pharmacy and therapeutics committee policies that require use of an approved medical staff protocol and physician oversight for pharmacist-initiated orders. In practice, however, pharmacists often manage patients' clinical needs that cannot be appropriately treated per protocol with minimal physician oversight. Depending on the patient, medication, and degree of trust, physicians may co-sign such orders with only cursory review. To the extent allowed by hospital or health-system policy, physicians often delegate therapeutic decision-making to pharmacists, secure in the trust developed through established professional relationships and shared experiences in successfully dealing with challenging clinical situations, rather than through formal collaborative practice agreements. Common examples of de facto pharmacist prescribing include independently managing symptoms and side effects in oncology patients, identifying and resolving drug-induced disease or problems, managing anticoagulant therapy for patients whose clinical status falls outside specified parameters, and responding to general directives to simply "fix the problem" when medication therapy is indicated. Additionally, there are settings of care and pharmacy practice models that allow for autonomous and accountable prescribing authority for pharmacist practitioners as part of comprehensive medication management, without the need for collaborative practice authority. These are to be encouraged when possible while ensuring there is a firewall between prescribing and dispensing of medications.

Credentialing by individual healthcare organizations is a natural selection process for determining who is authorized to prescribe that avoids distinguishing pharmacists by practice setting and allows more latitude in scope of practice. The credentialing procedures to establish pharmacists' competency to prescribe must ensure that patients receive treatment from highly qualified caregivers. In addition to verifying appropriate education, licensure, and certification, the process should include

- the same transparency and rigor applied to other prescribers,
- criteria used to measure patient care quality, and
- peer review by pharmacists and others who are authorized to prescribe.

Healthcare organizations should use privileging methods that establish the scope of practice and clinical services that pharmacists are authorized to provide commensurate with their

demonstrated competency within an area or areas of clinical expertise. Pharmacists practicing in hospitals and health systems do not have or need privileges, such as admitting, that are not related to medication use.

Finally, interdisciplinary health professional training programs should incorporate the concept of pharmacist prescribing in a standard way.

Background

The Council reviewed ASHP policy 1213, Pharmacist Prescribing in Interprofessional Patient Care, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; strikethrough indicates deletions):

~~To define pharmacist prescribing as follows: patient assessment and the selection, initiation, monitoring, adjustment, and discontinuation of medication therapy pursuant to diagnosis of a medical disease or condition; further,~~

To advocate that healthcare delivery organizations establish credentialing and privileging processes that delineate the scope of and support pharmacist prescribing within the hospital or health system and to ensure that pharmacists who prescribe are competent and qualified to do so; further,

To advocate for autonomous and accountable prescribing authority for pharmacist practitioners as part of comprehensive medication management, recognizing that a single prescriber should not be responsible for prescribing and dispensing any given medication.

The Council sought to encourage autonomous prescribing authority rather than authority driven by delegation protocols or collaborative practice agreements. The changes are not intended to replace the review process of the dispensing pharmacist. Council members also discussed the need for a firewall between pharmacist prescribing and dispensing. They felt that ASHP policies 2137, Documentation of Pharmacist Patient Care, and 1215, Pharmacist's Role in Team-Based Care, were supplemental to this policy to ensure appropriate and consistent documentation of a treatment plan.

4. Universal Vaccination for Vaccine-Preventable Diseases in the Healthcare Workforce

- 1 To support policies and mandates that promote universal vaccination for preventable
- 2 infectious diseases among healthcare workers, including all members of the pharmacy
- 3 workforce, as a safeguard to patient and public health; further,
- 4 To encourage the use of evidence-based risk assessments to determine inclusions in and
- 5 exemptions from mandatory vaccine requirements; further,

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

9 To urge healthcare organizations to have policies that address additional infection
10 prevention practices required for the expected small number of exempted healthcare
11 workers; further,

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

Note: This policy would supersede ASHP policies 2140 and 2138.

Rationale

Vaccine-preventable diseases (VPDs) pose a threat to vulnerable patients, the healthcare workforce, and public health. Vaccines are effective in protecting the healthcare workforce and the patients they care for and with whom they interact.

Voluntary vaccination of healthcare workers (HCWs), supported by employer-offered strategies, increases vaccination rates to some extent. For example, the Centers for Disease Control and Prevention (CDC) estimates that in the 2019-2020 season, approximately 80% of healthcare workers were vaccinated against influenza, with rates over 90% among hospital employees, despite the fact that only approximately 70% of hospitals require an annual influenza vaccination and the CDC has recommended influenza vaccinations for HCWs since 1981.

Mandatory vaccination requirements, in contrast, carry heavier weight and can result in near-universal vaccination rates (Schumacher S et al. Increasing influenza vaccination coverage in healthcare workers: a review on campaign strategies and their effect. *Infection*. 2021; 49: 387–99. <https://doi.org/10.1007/s15010-020-01555-9>). The effectiveness of the mandatory approach has led to HCW vaccination requirements from the Occupational Safety and Health Administration, recommendations from the Centers for Disease Control and Prevention (CDC), policy endorsements from numerous professional organizations, and quality measures for federal and commercial payer reporting programs. For example, the CDC Advisory Committee on Immunization Practices proposes recommendations for the immunization of healthcare workforce based on (1) those diseases for which routine vaccination or documentation of immunity is recommended for healthcare personnel because of risks to them in their work settings and, should healthcare personnel become infected, to the patients they serve; and (2) those diseases for which vaccination of healthcare personnel might be indicated in certain circumstances. The current list of VPDs in which healthcare personnel are considered to be at substantial risk for acquiring or transmitting and in which vaccination is recommended includes hepatitis B, influenza, measles, mumps, rubella, pertussis, and varicella. In the future, this list may include vaccination against SARS-CoV-2.

In its recommendations, the CDC considers HCWs to include (but not be limited to)

physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual staff not employed by the healthcare facility, and persons (e.g., clerical, dietary, housekeeping, laundry, security, maintenance, administrative, billing, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCWs and patients.

The vaccination-related policies of various healthcare professional organizations contain similar themes. These policies recognize that mandatory vaccination policies improve vaccination rates, protecting patients and the healthcare workforce; acknowledge the limited circumstances that may preclude an HCW from being vaccinated (e.g., medical contraindications and legally required religious exemptions); express support for following evidence-based practices in determining which vaccines should be mandatory; and support education of the healthcare workforce on the benefits of vaccination.

Background

In response to discussion at the 2021 Regional Delegates Conferences (RDCs), the Council on Pharmacy Practice examined ways to harmonize and consolidate existing ASHP vaccination policies and voted to recommend amending ASHP policy 2140, Universal Immunization for Vaccine-Preventable Diseases in the Healthcare Workforce, as follows (underscore indicates new text; strikethrough indicates deletions):

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

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

To support employers in establishing and implementing mandatory vaccine requirements for healthcare workers ~~vaccines approved by the Food and Drug Administration (FDA) and encouraging the use of vaccines that have received FDA emergency use authorization,~~ if evidence-based risk assessments determine ~~if~~ they would be safe and promote patient and public health; further,

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

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

The 2021 ASHP House of Delegates approved four vaccination-related policies (2121, 2122, 2138, and 2140) and one vaccination-related NBI. The NBI was revised by the Board, and the House of Delegates voted in November to reconsider the proposed policy at its June meeting.

During the RDC discussions, delegates asked whether any of the related policy recommendations could be consolidated. In addition, the ASHP Board of Directors amended the NBI, COVID-19 Vaccination Requirements to Advance Patient Safety and Public Health, at its meeting in July, and those changes require review of ASHP policy position 2140, Universal Immunization for Vaccine-Preventable Diseases in the Healthcare Workforce, to harmonize the language of the two policies.

One of the questions raised by delegates at the RDC discussions was whether ASHP policy 2140, Universal Immunization for Vaccine-Preventable Diseases in the Healthcare Workforce, makes ASHP policy 2138, Influenza Vaccination Requirements to Advance Patient Safety and Public Health, redundant, given that influenza is a vaccine-preventable disease. In discussing the question, the Council on Pharmacy Practice considered whether influenza vaccination is important and specific enough to warrant its own policy and concluded that mention in the rationale of a revised policy 2140 would be adequate for ASHP policy purposes.

In recommending amendment of ASHP policy 2140, the Council recommended that the revised policy supersede ASHP policy 2138, Influenza Vaccination Requirements to Advance Patient Safety and Public Health, which reads as follows:

To advocate that hospitals and health systems require healthcare workers to receive an annual influenza vaccination in accordance with U.S. Centers for Disease Control and Prevention Advisory Committee on Immunization Practices recommendations; further,

To encourage the hospital and health-system pharmacy workforce to take a lead role in developing and implementing policies and procedures for vaccinating healthcare workers and in providing education on the patient safety benefits of annual influenza vaccination; further,

To work with the federal government and others to improve the vaccine development and supply system in order to ensure a consistent and adequate supply of influenza virus vaccine.

In its proposed amendments to ASHP policy 2140, the Council incorporated the core concepts of the NBI approved by the House of Delegates in June 2021 and amended by the Board of Directors, COVID-19 Vaccination Requirements to Advance Patient Safety and Public Health, which reads as follows:

To support employers in establishing and implementing mandatory COVID-19 vaccine requirements; further,

To advocate that healthcare organizations limit patient and staff risk of exposure to SARS-CoV-2 from individuals who are not immunized, which may include requiring unimmunized individuals to refrain from direct contact with patients and staff; further,

To urge healthcare organizations to have policies that address additional infection prevention practices required for healthcare workers who remain unimmunized against SARS-CoV-2; further,

To recognize that a small number of healthcare workers cannot be required to be vaccinated due to medical and religious reasons and therefore should be exempted from a mandate.

5. Pharmacy Workforce's Role in Vaccination

- 1 To affirm that the pharmacy workforce has a role in improving public health and
2 increasing patient access to vaccinations by promoting and administering appropriate
3 vaccinations to patients and employees in all settings; further,
- 4 To collaborate with key stakeholders to support the public health role of the pharmacy
5 workforce in the administration of adult and pediatric vaccinations; further,
- 6 To advocate that states grant pharmacists and appropriately supervised student
7 pharmacists the authority to initiate and administer all adult and pediatric vaccinations;
8 further,
- 9 To advocate that states grant appropriately supervised pharmacy technicians the
10 authority to prepare and administer all adult and pediatric vaccinations; further,
- 11 To advocate that members of the pharmacy workforce who have completed a training
12 and certification program acceptable to state boards of pharmacy and meeting the
13 standards established by the Centers for Disease Control and Prevention may provide
14 such vaccinations; further,
- 15 To advocate that state and federal health authorities establish centralized databases for
16 documenting administration of vaccinations that are accessible to all healthcare
17 providers; further,
- 18 To advocate that state and federal health authorities require all vaccination providers to
19 report their documentation to these centralized databases, if available; further,
- 20 To encourage the pharmacy workforce to educate all patients, their caregivers, parents,
21 guardians, and healthcare providers to promote vaccine confidence and convey the
22 importance of vaccinations for disease prevention; further,
- 23 To encourage the pharmacy workforce to seek opportunities for involvement in disease
24 prevention through community vaccination programs; further,
- 25 To advocate for the inclusion of pharmacist-provided vaccination training in college of
26 pharmacy curricula and pharmacy technician-provided vaccination training in formal
27 technician training programs; further,

- 28 To foster education, training, and the development of resources to assist the pharmacy
29 workforce and other healthcare professionals in building vaccine confidence; further,
- 30 To advocate for adequate staffing and resources for the pharmacy workforce to support
31 vaccination efforts and avoid or respond to occupational burnout; further,
- 32 To work with federal, state, and local governments and others to improve the vaccine
33 development and supply system in order to ensure an adequate and equitably
34 distributed supply of vaccines.

Note: This policy would supersede ASHP policies 1309 and 2122.

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 vulnerable 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 pharmacist vaccination authority.

Although all states permit pharmacist administration of some vaccines, state laws differ in the range of vaccines pharmacists 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 pediatric vaccinations. 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 pharmacist-provided vaccinations be conducted within a collaborative drug therapy management agreement) would encourage standardization of pharmacy vaccination practice within and among states, as would permitting appropriately supervised pharmacy technicians to prepare and administer vaccinations.

Only pharmacists, student pharmacists, and pharmacy technicians who undergo appropriate training and certification should be authorized by state boards to provide vaccinations. To ensure their consistency and quality, those training and certification programs should meet Centers for Disease Control and Prevention standards.

To aid in sharing important patient vaccination information, centralized 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 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 and health equity 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. Vaccine hesitancy is complex and context specific, varying across time, place, and vaccines, and is influenced by factors such as complacency, convenience, and confidence. Vaccine-hesitant patients, healthcare providers, and caregivers have been found to be responsive to vaccine information, consider vaccination, and are not opposed to all vaccines, and therefore would benefit from counseling.

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, and to ensure that vaccines supplies are equitably distributed to promote public health by reducing disparities in vaccine access.

Background

In response to discussion at the 2021 Regional Delegates Conferences (RDCs), the Council on Pharmacy Practice examined ways to harmonize and consolidate existing ASHP vaccination policies and voted to recommend amending ASHP policy 1309, Pharmacists’ Role In Immunization, as follows (underline indicates new text; ~~strikethrough~~ indicates deletions):

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

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

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

To advocate that state and federal health authorities establish centralized databases for documenting administration of ~~immunizations~~ vaccinations that are accessible to all healthcare providers; further,

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

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

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

To advocate for the inclusion of pharmacist-provided ~~immunization~~ vaccination training in college of pharmacy curricula and pharmacy technician-provided vaccination training in formal technician training 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 and resources for the pharmacy workforce to support vaccination efforts and avoid or respond to occupational burnout; further,

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

The Councils' recommended revisions address the pharmacist's role in promoting vaccine confidence outlined in ASHP policy 2122, Vaccine Confidence, which reads as follows:

To recognize the importance of vaccination to public health in the United States; further,

To affirm that members of the pharmacy workforce are integral members of the interprofessional team to promote disease prevention and health equity through vaccine confidence and access; further,

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

To promote pharmacy workforce engagement with patients, healthcare providers, and caregivers, and to educate patients on the risks of vaccine hesitancy and the importance of timely vaccination.

In addition, the Council adapted and broadened the final clause of ASHP policy 2138, Influenza Vaccination Requirements to Advance Patient Safety and Public Health, to describe the role of the pharmacy workforce in improving the vaccine development and supply system.

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.

Leigh Briscoe-Dwyer, *Board Liaison*

Council Members

Rusol Karralli, *Chair* (Texas)
Adam Porath, *Vice Chair* (Nevada)
Caryn Belisle (Massachusetts)
Michael Gabay (Illinois)
William Kernan (Florida)
Bernice Man (Illinois)
Luke Miller (Texas)
Delaney McGuirt, *Student* (Maryland)
Keenan Ryan (New Mexico)
Jeffrey Schnoor (Vermont)
Elizabeth Rodman (Wisconsin)
Kenric Ware (South Carolina)
Jillanne Schulte Wall, *Secretary*

1. Patient Disability Accommodations

- 1 To promote safe and accessible care for patients with disabilities; further,
- 2 To advocate for research to enhance capabilities in meeting the needs of patients with
- 3 disabilities; further,
- 4 To advocate for inclusion of caring for patients with disabilities in college of pharmacy
- 5 and pharmacy technician program curricula and in postgraduate residencies; further,
- 6 To support pharmacy workforce training to increase awareness of and learning about
- 7 patients with disabilities.

Rationale

Current statistics indicate that 20–30% of Americans have some type of disability. Many of these patients would benefit from the creation and adoption of technology and communication tools that improve how pharmacists and other providers interact with them. Because there is such a broad spectrum of potential patient needs, additional research on appropriate and safe implementation of technology and the creation of new solutions is needed and should be supported by federal, state, and private funding. Further, pharmacy schools and other

pharmacy workforce training programs should integrate education on serving patients with disability into their established curricula.

Background

The Council considered the need for policy regarding how pharmacists interact with patients with disabilities, including the potential need for policy advocating for technology and communications equipment that improves care for patients with disabilities. The Council's discussion of this topic was wide-ranging, with consideration of the different types and scale of disabilities that impact patients, and consequently, their interactions with pharmacists and other providers. The Council felt that policy was warranted but noted that the terminology and scope of the policy should be reviewed by experts on patients with disabilities and/or patient advocacy groups. Further, the Council recommended the following additional actions:

- including disability as an area of diversity for the DEI Task Force, ensuring adequate representation of various disability types;
- utilizing the DEI Task Force or a similar workgroup to develop a best practices document or white paper regarding accommodation of patients with disability that could function as a living, iterative document to supplement a static policy statement; and
- developing education and training on issues surrounding care for patients with disability.

2. Most-Favored Nation and Drug Pricing Proposals

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

Rationale

As drug prices have continued to climb, policymakers have proposed numerous solutions. While each proposal will need to be evaluated on its merits, it is critical that, at a minimum, policy solutions protect patient access to medications and limit or reduce patient out-of-pocket costs. However, drug pricing solutions should not threaten programs that support expanded patient services (e.g., the 340B Drug Pricing Program), create patient safety risks (e.g., certain drug importation proposals), or add to the administrative or practice burden of healthcare providers.

Background

The Council discussed drug pricing broadly initially, then focused in on Medicare price negotiation and most-favored nation proposals. Without detailed policy proposals, including implementation plans, the Council felt that it could not support specific solutions. Instead, the Council felt that ASHP policy that views drug pricing holistically would better serve member needs. As such, the Council outlined a few key elements that should be included in any policy that ASHP supports. Specifically, the Council suggested the following:

- if Medicare price negotiation is adopted, savings should be passed along to the patient;

- if a policy solution includes reductions in hospital reimbursement because of the way drug pricing has historically been structured, hospitals and health systems should be made whole to ensure that patient access is maintained;
- large-scale or mandatory demonstration of potential solutions should be designed to ensure patient safety; and
- the 340B program must be preserved.

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.

Jamie Sinclair, *Board Liaison*

Council Members

Rena A. Gosser, *Chair* (Washington)
Kelly Bobo, *Vice Chair* (Tennessee)
Brandon Bailey (California)
Scott Bolesta (Pennsylvania)
Rachel Chandra (Ohio)
Abigail Danos, *Student* (North Carolina)
Calvin Ice (Michigan)
Wesley Kufel (New York)
Andrew Mays (Mississippi)
Zahra Nasrazadani (Kansas)
Carolyn Oxencis (Wisconsin)
Russel Roberts (Massachusetts)
Vicki Basalyga, *Secretary*

1. Post-ICU Syndrome

- 1 To recognize that rehabilitation is essential for recovery after intensive care; further,
- 2 To support research on and dissemination of best practices in the prevention and
3 treatment of post-intensive care syndrome (PICS) in patients of all ages; further,
- 4 To advocate that health systems support the development and implementation of
5 interdisciplinary clinics to treat patients with PICS, including provisions for telehealth and
6 innovative practice models to meet the needs of PICS patients; further,
- 7 To advocate for the integration of post-ICU patient and ICU caregiver support groups.

Rationale

Post-intensive care unit (post-ICU) rehabilitation is essential for recovery after critical illness. Post-intensive care syndrome (PICS) is a conglomerate of new or worsening multidimensional impairments in physical, psychological, cognitive, and social status arising from critical illness that continue after hospital discharge. PICS is associated with high morbidity among patients discharged from ICUs, with 30-80% of patients having issues with remembering, paying attention, solving problems, or organizing and working on complex tasks.

The burden of PICS continues to grow. With only up to 50% of patients able to return to work within the first year, some are unable to return to the jobs they had before their illness and need help with activities after leaving the hospital. While PICS is widely discussed across medical disciplines, it is not well defined, nor are ways to prevent and treat this disorder well researched. It is recognized that these patients require an interdisciplinary treatment effort, including cognitive rehabilitation, mental health treatment, and intensive transitions of care interventions, as patients may be discharged on medications that should not be continued and they may need support to resume daily activities. The rapid COVID-19-related increase in patients requiring the use of ICUs has exacerbated the demand for high-quality PICS care, but the simultaneous expansion of telemedicine and other innovative patient care models has shown that rapid changes in team-based care can be achieved with the proper incentives and flexibilities.

Background

The Council discussed the needs of patients with PICS and the relationship of PICS care to innovative practice models such as the hospital-at-home model and telehealth pharmacy practice. The Council recognized that PICS is becoming a larger factor in the healthcare landscape and that pharmacists should be taking a leadership role as COVID-19 impacts the ICU patient care load.

2. Use of Veterinary Compounds in Human Subjects

- 1 To oppose human use of pharmaceuticals approved only for veterinary use; further,
- 2 To support use of veterinary pharmaceuticals only under the supervision of a licensed
3 veterinarian in compliance with the Animal Medicinal Drug Use Clarification Act of 1994;
4 further,
- 5 To engage stakeholders and regulatory bodies to address the misuse of veterinary
6 pharmaceuticals in humans; further,
- 7 To encourage state and federal regulatory bodies as well as other stakeholders to
8 monitor the misuse of veterinary pharmaceuticals and, when appropriate, limit the public
9 availability of those pharmaceuticals; further,
- 10 To educate healthcare professionals and the public about the adverse effects of human
11 consumption of veterinary pharmaceuticals; further,
- 12 To encourage research on the adverse effects of human consumption of veterinary
13 pharmaceuticals to define the public health impact of and to quantify the strain these
14 agents place on the healthcare system.

Rationale

Medications that are formulated for veterinary use are often supplied at higher concentrations, contain compounds not safe for human use, and require specialized knowledge to administer. The prevalence of drug misuse in the veterinary setting is not well documented, but surveys of veterinarians by the Idaho Board of Veterinary Medicine, Colorado Veterinarians, and Veterinary Hospitals in Pennsylvania found that they suspect 23% of animal owners misuse veterinary medicines on themselves, their children, or friends, and that the most-documented misused drugs are opioids, benzodiazepines, and ketamine. These findings are concerning because animals often require a more potent dose of controlled substances, which can be appealing for individuals with substance use disorders, and medications are often dispensed directly to the animal owner, bypassing pharmacists, who are critical players in prescription drug misuse risk mitigation.

In the United States, licensed veterinarians can prescribe, administer, carry, stock, and dispense medications, including veterinary-only drugs, drug compounds, and FDA-approved over-the-counter veterinary drugs. These drugs are typically veterinary formulations that are not tested for human safety or approved for human use, and the Animal Medicinal Drug Use Clarification Act of 1994 (AMDUCA) permits veterinarians to prescribe those drugs in an “extralabel” manner. Under AMDUCA regulations, “extralabel use” means the actual or intended use of a drug, by or on the order of a veterinarian, in a manner that is not in accordance with approved labeling (similar to off-label use in human medicine). Any deviation from labeled use, by veterinarians or lay persons, is an illegal use unless it meets all the requirements of FDA's extralabel drug-use rules. Deviations from the label include use in a species or production class not on the label and use of a different route of administration.

More recently, the COVID-19 pandemic has exacerbated human consumption of veterinary compounds, as some medications being studied for efficacy against the virus produce promising or equivocal preliminary results that are seized upon by the public and some prescribers, leading to inappropriate prescribing. For example, ASHP, APhA, and AMA have [called for](#) an immediate end to the prescribing, dispensing, and use of ivermectin for treatment of COVID-19 outside of a clinical trial. Due to the response of the medical community, many physicians and pharmacies are not writing or filling prescriptions for this medication, driving patients to purchase the animal formulation of ivermectin for human consumption. Earlier in the pandemic, a patient in Arizona consumed chloroquine phosphate meant for fish as a treatment for COVID-19 and died. The FDA, aware of the misuse of chloroquine products, issued a cautionary [letter to stakeholders](#) and worked with online marketplaces to remove the products from the market.

Finally, some veterinary compounds produce mild to life-threatening human adverse effects upon accidental or intentional exposure or ingestion. Patients exposed to or ingesting these products present to the emergency department with symptoms that range from bronchospasm, central nervous system stimulation, and miscarriage to sudden death, which demonstrates the need for timely reporting of abuses, misuses, or accidental exposures of these agents.

Background

This topic was discussed during Policy Week in response to reports that an increasing number

of patients are seeking out veterinary compounds in places like feed stores to prevent or treat COVID-19, based on preliminary studies reported by the media. The Council noted the clear and present danger in this approach to treatment of COVID-19, as the veterinary compounds often have different concentrations than those intended for human use, require dilution, contain excipients not safe for human consumption, or have resulted in morbidity and mortality. Upon research and discussion, the Council found that although the current environment has focused on COVID-19 therapies based on limited studies, this problem is not new, with concerns also surrounding the misuse of opioids intended for veterinary likely contributing to the opioid epidemic. Therefore, the Council believed a broad policy was necessary to address all facets of human consumption of veterinary compounds.

3. Pharmacist's Role in Respiratory Pathogen Testing and Treatment

- 1 To advocate that state board of pharmacy regulations include respiratory pathogen
- 2 testing and associated prescribing or dispensing under pharmacists' scope of practice;
- 3 further,

- 4 To support the development of specific and structured criteria for pharmacist
- 5 prescribing, dosing, and dispensing of antimicrobials for treatment of respiratory
- 6 infections; further,

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

- 10 To support the diagnosis and tracking of reportable diseases through pharmacist-driven
- 11 testing and reporting to appropriate public health agencies prior to dispensing of
- 12 antimicrobials; further,

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

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

Rationale

There is currently a patchwork of state legislation that permits pharmacists in collaborative practice agreements to perform rapid testing to diagnose group A streptococcal pharyngitis and prescribe antimicrobial therapy when a test is positive. This practice model has been shown to decrease the cost of diagnosis and treatment for children and adults and has demonstrated increased patient satisfaction. The availability of rapid influenza tests allows pharmacists to quickly diagnose and recommend treatment for influenza A and B, which has been found to

reduce the time to first dose of antiviral drugs among individuals with influenza-like illness, compared to those referred to prescribers. ASHP advocates development of specific and structured criteria for pharmacist prescribing, dosing, and dispensing of antimicrobials for this purpose, under a variety of models (e.g., autonomous prescribing authority for pharmacists, delegation protocols, or collaborative practice agreements).

Furthermore, a 2018 study found that 69% of pharmacists are willing to perform point of care testing (POCT) in a community pharmacy setting, and 86% either strongly agreed or agreed to be willing to recommend appropriate treatment for influenza and group A streptococcal pharyngitis. With collaborative practice agreements in place, patients can bypass visiting a primary care provider, empowering pharmacists to assume an active role not only in treating patients but also in promoting public health by reporting positive cases to local health departments, should rapid testing and reporting be a requirement of dispensing.

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

Background

The Council discussed how the availability of expanded respiratory panels in recent years, along with provisions of the Public Readiness and Emergency Preparedness (PREP) Act, has presented pharmacists with opportunities to order and perform testing, with the inclusion of serology, allowing for more comprehensive patient care. With the advent of the COVID-19 pandemic, such testing has expanded to include testing that indicates the administration of monoclonal antibodies in the outpatient arena as well as testing and treatment of pediatric patients. The Council recognized, however, that while some of these activities are authorized by the federal government, state-to-state variability on reimbursement and pharmacist duties remains. The Council strongly believed that respiratory pathogen testing and treatment should be a part of the pharmacy workforce responsibilities as a component of public health and antimicrobial stewardship initiatives.

4. Use of Intravenous Drug Products for Inhalation

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

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

- 9 To foster the development of educational resources on the safety and efficacy of
- 10 inhalational administration of drug products not approved for that route and devices for
- 11 administration; further,
- 12 To encourage manufacturers to develop ready-to-use inhalational formulations when
- 13 evidence supports such use.

Rationale

Practitioners have been increasingly seeking out novel delivery mechanisms for drugs to patients who require a more localized application. This approach has more frequently been seen through the nebulization of antibiotics and antifungals that are formulated for intravenous (IV) use as a part of an effort to treat an invasive pulmonary infection in critically ill patients. Nebulization of IV morphine has also been used to provide relief in chronic obstructive pulmonary disease exacerbations, dyspnea in cancer patients, and pain management in trauma patients. Data for these treatment efforts is limited to small patient populations, and the information on the pharmacokinetics, safety, and efficacy of drugs administered by this method remain insufficient. Furthermore, the number of drug products that are formulated exclusively for the purpose of aerosolization is limited, and the degree of pulmonary penetration depends on the properties of antimicrobial formulations, including size, viscosity, surface tension, osmolality, tonicity, and pH. Drug stability, safety for both the patient receiving and the person administering the drug, and the method of delivery also bear consideration. The mechanism of nebulization also introduces uncertainty. Because pneumatic nebulizers and ultrasonic nebulizers have different particle size tolerance and deliverability capabilities, susceptibility for contamination may vary, depending on the device used.

Nebulized drugs also present a potential risk to healthcare providers, who may be exposed to drug particles that are expelled through the device when administering the drug. Therefore, an interdisciplinary team that includes representatives from pharmacy and respiratory therapy (as it is often a respiratory therapist who administers the drug in an inpatient setting) is needed to ensure that occupational exposure is minimized, that patients are placed in rooms with proper ventilation, and that, if necessary, caregivers are provided with appropriate masks during administration.

There is evidence that certain drugs delivered by nebulization have a beneficial role in management of patient disease. It is important to recognize that nebulized drugs that are not commercially available may be compounded with both sterile and nonsterile ingredients and that, when possible, should be compounded with preservative- and additive-free formulations in order to improve patient tolerability. Due to this variability and potential source for sterile compounding and potential administration errors, where there is evidence that supports the use of compounded nebulized drugs, manufacturers should be encouraged to create a commercially available formulation for delivery via nebulizer.

Background

The Council discussion on the use of IV formulations for nebulization explored the logistical considerations that are required for creating nebulized drugs and often the paucity of data that

support the use in certain clinical situations. The Council identified the importance of including respiratory therapists in any conversation that includes adding a compounded nebulized drug to a patient's regimen, as they would be the caregiver at highest risk when administering drugs that have minimal data on safety and efficacy. The Council explored the informatics and patient safety considerations when ordering IV drugs for inhalation, as these drugs are often much more concentrated to be administered via nebulization and as a result may be inadvertently administered IV if someone is not familiar on administering via nebulization. For example, one member shared that in their institution a compounded racemic epinephrine/dexamethasone/sodium chloride nebulized solution made for peri-extubation is made in the hood, with a Luer-Lok syringe, and the only thing differentiating a drug to be given IV besides the label indicating administration is a blue cap. The member shared that a near-miss error that happened occasionally would be that a normal cap would be placed on the top of the syringe meant for nebulization and the contents of the syringe could have potentially been administered IV instead via inhalation. The Council did recognize that there are clinical situations in which the benefits of compounded nebulized solutions may benefit patient care, such as in palliative care, and suggested when such benefit has been demonstrated, that manufacturers should be encouraged to make commercially available products.

5. Enrollment of Underrepresented Populations in Clinical Trials

- 1 To support the enrollment of underrepresented populations in clinical trials; further,
- 2 To encourage drug product manufacturers to conduct and report outcomes of
3 pharmacokinetic and pharmacodynamic research in underrepresented populations to
4 facilitate safe and effective dosing of medications in these patient populations; further,
- 5 To advocate that if such research considers age, sex, gender, ethnicity, or race, the
6 reason for such consideration be based on validated ethical or scientific reasons and be
7 specified in the research protocol; further,
- 8 To foster the use and development of postmarketing research strategies to support the
9 safe and effective use of drug products for approved and off-label indications in
10 underrepresented populations; further,
- 11 To recognize that pharmacists should provide guidance on drug dosing, administration,
12 and monitoring in all patient populations.

Note: This policy would supersede ASHP policy 1723.

Rationale

Pregnant patients, fetuses, neonates, children, members of racial or ethnic minority groups, the elderly, and transgender individuals are populations in which the pharmacokinetic and pharmacodynamic properties of medications may differ from those of people typically enrolled in clinical trials. These differences can dramatically alter the behavior of drugs, producing supra- or subtherapeutic levels, which may result in adverse effects. While there has been legislation that provides incentives for drug manufacturers to study these effects, many drugs already approved by the FDA do not have such information or robust outcomes reporting for these at-risk populations. The need for this guidance is supported by the complexity of dosing for these patients, which varies based on medication- and patient-specific characteristics. There is a paucity of research in these patient populations, which is similar to the lack of preapproval studies in obese patients. ASHP also encourages independent clinical and practice-based research to further define clinical use of medications in the treatment of these patients, as well as clinician reporting of patient experience via published articles and clinical registries.

Background

The Council reviewed ASHP policy 1723, Clinical Investigations of Drugs Used in Elderly and Pediatric Patients, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~striketrough~~ indicates deletions):

~~To advocate for increased enrollment and outcomes reporting of pediatric and geriatric patients in clinical trials of medications; further,~~

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

To encourage drug product manufacturers to conduct and report outcomes of pharmacokinetic and pharmacodynamic research in ~~pediatric and geriatric patients~~ underrepresented populations to facilitate safe and effective dosing of medications in these patient populations; further,

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

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

To recognize that pharmacists should provide guidance on drug dosing, administration, and monitoring in all patient populations.

6. Pediatric Dosage Forms

- 1 To support research on and development of pediatric-specific drug formulations; further,
- 2 To encourage manufacturers to develop formulations suitable for pediatric
- 3 administration during research that includes pediatric patients; further,
- 4 To advocate that manufacturers comparably price a newly developed pediatric-specific
- 5 commercial product to that of its extemporaneously prepared formulation; further,
- 6 To educate prescribers and caregivers regarding the nuances of pediatric drug
- 7 administration to ensure the availability of an appropriate dosage form is considered
- 8 when selecting and administering safe and effective therapies for a pediatric patient.

Note: This policy would supersede ASHP policy 9707.

Rationale

Pediatric patients are at high risk for medication errors because so few formulations are created for them. Challenges to pediatric dosage development include insufficient background information on the drug molecule in the target population, issues with safety and tolerability of excipients, taste-masking issues, technology requirements, the risks involved in clinical trials, small market size and low profitability, and lack of regulatory clarity.

To ensure that the proper dose is administered, different routes of administration, dosage forms, and strengths may be required. Because many existing formulations are not suitable for children, many hospitals and health systems will use components to extemporaneously prepare a formulation that provides a measurable, stable, and consistent delivery of a needed medication. The concentration and availability of these formulations, most often in the form of suspensions and solutions, may also vary in storage requirements, bioavailability, and palatability, all which can affect patient tolerability and adherence.

Furthermore, since many medications are needed for a relatively small patient population, often only a few commercial products are manufactured, resulting in the need for compounding. As a result, research is often stymied in the pediatric patient population as well, since compounding a medication may introduce variables that may affect results in unpredictable ways.

Boards of pharmacy have also recognized the safety issues surrounding variability in stability and concentrations of the same drug, and many have laws in place that prohibit the extemporaneous compounding of drugs in concentrations that are commercially available.

As pediatric patients have different tolerability to excipients, organ development, taste preferences, and swallowing abilities as they age, it is essential that pharmacists are a part of the team that determines a medication regimen. It is also important that caregivers are taught to properly measure, store, and administer pediatric formulations as a part of patient care.

Background

The Council reviewed ASHP policy 9707, Pediatric Dosage Forms, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

~~To support efforts that stimulate development of pediatric dosage forms of drug products.~~

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

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

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

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

7. Substance Use Disorder

- 1 To affirm that substance use disorder (SUD) is a disease state with associated
- 2 neurological changes and is not a personal choice; further,

- 3 To recognize that dehumanizing language and stigmatization regarding SUD and persons
- 4 who inject drugs (PWID) create barriers to healthcare access and result in poor clinical
- 5 outcomes; further,

- 6 To recognize the disproportionately harmful health impact that criminalization and
- 7 policing practices related to SUD and PWID have had on communities of color; further,

- 8 To advocate for destigmatization efforts and elimination of barriers to care for PWID;
- 9 further,

- 10 To support syringe services programs, recognizing the roles they have in public health
- 11 efforts to reduce infectious disease burden, improve access to healthcare, and reduce
- 12 expenditures; further,

- 13 To encourage the inclusion of longitudinal SUD training in didactic pharmacy curricula,
- 14 starting with an early initiation of education, use of evidence-based practices including
- 15 harm reduction strategies, and increasing experiential education sites pertaining to SUD;
- 16 further,

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

Note: This policy would supersede ASHP policy 9711.

Rationale

Substance use disorder (SUD) is a public health crisis that has grown to epidemic levels in the United States over the past 30 years. The Department of Health and Human Services recognized it as a public health emergency in 2017. In 2019, over 70,000 people died from drug overdoses, and between June 2019 and June 2020, overdoses of synthetic opioids caused over 48,000 deaths. Additionally, the Centers for Disease Control and Prevention (CDC) estimates that the economic burden of prescription opioid misuse alone in the United States is \$78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement. The National Academy of Medicine and the Department of Health and Human Services identify several populations that are at risk for SUD, including justice-involved populations; those living in rural areas; people who inject drugs (PWID); pregnant patients; children born to SUD; and those with lower incomes, insecure housing, and lacking access to health insurance. Additionally, researchers have demonstrated links between the increase in opioid overdoses and the rate of opioid prescriptions, particularly in populations in which overdoses had not been seen before. Age-adjusted rates of opioid overdose deaths from 1990 to 2017 have increased sixfold among Whites, climbed from 3.5 to 6.8 overdoses per 100,000 people among Hispanics, and among Blacks has increased from 3.5 to 12.9 per 100,000 people in the U.S. When considering infectious diseases, SUD had also been cited as a cause for a tripling of hepatitis C cases from 2010 to 2017 as well as increases in hepatitis B, human immunodeficiency virus, bacterial, and fungal bloodstream infections, as well as sexually transmitted infections and endocarditis.

SUD is a disease state with associated neurological changes, not a personal choice. Dehumanizing language and stigmatization regarding SUD and PWID create barriers to healthcare access and result in poor clinical outcomes. In addition, criminalization and policing practices related to SUD and PWID have disproportionately harmful health impact on communities of color.

The best approach to managing SUD is a multifaceted one that requires involvement at the community, hospital and health system, legislative, government, and provider levels. Programs must also include stakeholders from these levels at the planning, implementation, and enduring service stages to optimize uptake, adoption, and sustainability. Clear communication and coordination are also crucial so that successes and failures can be assessed, modified, or discontinued to suit the goals of prevention, treatment, harm reduction, and recovery.

Syringe service programs have proven effective as harm reduction strategies, not only in preventing deaths from injectable drug overdoses and infections but also as a site of care for providing such additional services as vaccinations; testing; referral to infectious disease care and substance use treatment; and access to and disposal of needles, syringes, and other

injection equipment. Elimination of barriers to sterile syringe access, including discouraging prescription or logbook requirements and providing methods of syringe disposal, promotes access to healthcare.

Education and tools for the pharmacy workforce that assist in supporting the needs of PWID should also incorporate specifics about destigmatization, harm reduction strategies, evidence-based practices, social determinants of health, and ways to provide trauma-informed and culturally sensitive care to patients. Education should include efforts to recognize bias and misinformation, as these contribute to the stigma that serves as a major barrier in treating SUD.

Background

The Council reviewed ASHP policy 9711, Interventions to Reduce High-Risk Behaviors and Intravenous Drug Users, as part of sunset review and voted to recommend amending it as follows (underline indicates new text; ~~strikethrough~~ indicates deletions):

~~ASHP supports the use of needle and syringe exchange programs, drug abuse treatment, and community outreach programs for substance abusers to reduce the risk of transmission of the human immunodeficiency virus (HIV), hepatitis B virus, and hepatitis C virus in intravenous drug users.~~

To affirm that substance use disorder (SUD) is a disease state with associated neurological changes and is not a personal choice; further,

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

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

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

To support syringe services programs, recognizing the roles they have in public health efforts to reduce infectious disease burden, improve access to healthcare, and reduce expenditures; further,

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

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

The Council also recommended changing the title of the policy and to use a more universally accepted term to describe this patient population (i.e., people who inject drugs).

2022 Report of the ASHP Treasurer

Am J Health-Syst Pharm. 2022; XX:0-0

Christene M. Jolowsky, BS Pharm, MS, FASHP, Hennepin Healthcare System, Minneapolis, MN, USA

Address correspondence to Ms. Jolowsky (cjolowsky@gmail.com).

Keywords: assets, finance, operations

© American Society of Health-System Pharmacists 2022. All rights reserved. For permissions, please e-mail: journals.permissions@oup.com.

<https://doi.org/10.1093/ajhp/zxac206>

The Treasurer has the responsibility to report on ASHP's financial condition to the membership annually. ASHP's fiscal year is from June 1 through May 31, coinciding with our policy development process and timetable. This report describes ASHP's actual financial performance for fiscal year (FY) 2021, projected financial performance for FY2022, and an FY2023 budget status update.

Fiscal Year 2021 Ending May 31, 2021—Actual

ASHP's FY2021 financial statement audit for the year ending May 31, 2021, was performed by Aronson LLC. The audit resulted in ASHP receiving the best opinion available, an unmodified opinion.

ASHP's core operations¹ had another successful year. Core gross revenue was \$50.9 million (Figure 1). Due to the impacts of COVID-19, revenue was down by \$5.8 million as compared to FY2020. Although ASHP's Midyear Clinical Meeting & Exhibition (MCM) was the largest ever, with more than 27,000 attendees, and ASHP's MCM cancellation insurance policy covered the FY2021 MCM budgeted net margin, the lower revenue is primarily attributable to holding a virtual MCM with significantly reduced registration pricing as opposed to an in-person MCM. In addition,

ASHP has continued its strong performance throughout the 2-plus years of the COVID-19 pandemic. . . . ASHP has accomplished much and is poised to continue to deliver valuable member services, tools, and resources, as well as products and programs to improve patient care and advance pharmacy practice.



ASHP provided free educational content in place of the 2020 in-person Summer Meetings. Also in FY2021, ASHP had record revenue from membership, professional certificates, certifications programs, and accreditation services. Membership grew to nearly 58,000 as of December 31, 2020, representing a 7.9% increase from the prior year. Core net income was \$5.4 million. Program development expenses, capital budget, and investment gain/(loss)² had net income of \$9.9 million, and ASHP terminated its defined benefit pension plan, resulting in final expenses of \$3.9 million. In total, FY2021 resulted in a positive \$11.3 million net change in ASHP's reserves/net assets.

Finally, the building fund³ had a surplus of \$13.8 million, primarily due to better-than-budgeted investment returns. The building fund remains on track to continue supporting ASHP's office space expenses and reach its long-term financial target. ASHP's total net assets at the end of FY2021 were nearly \$154.1 million (Figure 2) and our year-end balance sheet remained

strong, with an asset-to-liability ratio of 5.7:1.

Fiscal Year 2022 Ending May 31, 2022—Projected

The continuing COVID-19 pandemic brought many challenges to professional associations, especially those that conduct large in-person meetings, like ASHP. After much consideration, ASHP's leadership strategically paused its 2021 Summer Meetings and quickly transitioned its 2021 MCM to a virtual format with significantly reduced registration fees. Unlike in FY2021, ASHP was unable to obtain event cancellation insurance with communicable diseases coverage for the 2021 MCM since insurance companies ceased offering this type of coverage. As a result, as of April 30, 2022, FY2022 core gross revenue is projected to be in the range of \$43.1 million, which is a decrease of \$7.8 million as compared to FY2021. We anticipate that ASHP's FY2022 core net loss will be in the range of \$5.0 million (Figure 1). We are also projecting

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

	Actual Fiscal Year 2020 Ended May 31, 2020	Actual Fiscal Year 2021 Ended May 31, 2021	Projection* Fiscal Year 2022 Ended May 31, 2022	Budget Fiscal Year 2023 Ended May 31, 2023
CORE OPERATIONS				
Gross Revenue	56,759	50,915	43,100	56,499
Total Expense	(51,104)	(45,541)	(48,100)	(56,497)
CORE NET INCOME/(LOSS)	5,655	5,374	(5,000)	2
NET PROGRAM DEVELOPMENT EXPENSES, CAPITAL BUDGET, AND INVESTMENTS GAIN/(LOSS)				
	(1,453)	9,862	(4,800)	230
Pension Plan Adjustment	126	(3,911)	-	-
NET CHANGE IN RESERVES/NET ASSETS	4,328	11,325	(9,800)	232
BUILDING FUND	(4,140)	13,841	(9,700)	606

* Projection as of April 30, 2022.

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

	Actual as of May 31, 2020	Actual as of May 31, 2021
ASSETS		
Current assets	12,887	22,863
Fixed assets	6,646	5,708
Investments	138,589	157,818
Other assets	268	410
Total Assets	158,390	186,799
LIABILITIES		
Current liabilities	19,493	23,205
Long-term liabilities	9,969	9,500
Total Liabilities	29,462	32,705
RESERVES/NET ASSETS		
Total Net Assets	128,928	154,094
Total Liabilities and Net Assets	158,390	186,799

a net loss of \$4.8 million from net program development expenses, capital budget, and investment losses. In total, this results in a projected negative \$9.8 million net change in ASHP’s reserves/net assets. Finally, we anticipate that the building fund will have a net loss in the range of \$9.7 million.

Given ASHP’s previous fiscal year’s favorable \$11.3 million net change in reserves/net assets and a \$13.8 million net gain in the building fund, ASHP has performed financially well during this 2-year pandemic and remains financially strong for the future.

ASHP has accomplished a great deal during FY2022, including achieving yet another membership milestone—growing to 60,300 members as of December 31, 2021. We continued to develop and introduce new educational offerings in our professional certificate and publications lines, and were awarded a 3-year Health and Public Safety Workforce Resiliency Training Program grant from the Health Resources and Services Administration, an important success in our ongoing efforts to address burnout among the pharmacy workforce.

ASHP’s continued significant membership growth over the past 2 years is testament to the value ASHP demonstrates each and every day. Throughout the pandemic, ASHP has striven to meet the evolving demands of the pharmacy workforce, leveraging feedback from members to identify new ways to support practice advancement and professional development.

Fiscal Year 2023 Ending May 31, 2023 – Budget

ASHP’s Board of Directors has thoughtfully considered our FY2023 budget. We are seeing many positive signs that impact from the COVID-19 pandemic is abating and we are planning a return to in-person meetings, including our Summer Meetings in June, our Conference for Pharmacy Leaders and the National Pharmacy Preceptors Conference in October, and our MCM in Las Vegas in December. As our workforce evolves and changes, the Board of Directors continues to position ASHP for the future to ensure we can support our members and the profession with timely, valuable resources, products, and services.

Taking these and other factors into account, ASHP’s FY2023 budgeted net change in reserves/net assets is a surplus of \$232,000, with \$56.5 million in core gross revenue. The building fund, which is designed to pay for ASHP’s headquarters office space, has a budgeted surplus of \$606,000.

Conclusion

ASHP has continued its strong performance throughout the 2-plus years of the COVID-19 pandemic. While challenges remain as we move into post-pandemic recovery, with sound fiscal management and innovative and creative thinking ASHP has accomplished much and is poised to continue to deliver valuable member services, tools, and resources, as well as products and programs to improve patient care and advance pharmacy practice. We are very proud that our membership continues to grow and has now

surpassed 60,300, a strong sign that our organization provides value to pharmacy practitioners and our efforts are making a positive impact. The Board of Directors, Chief Executive Officer, and staff remain fully committed to ASHP's mission, vision, strategic plan, and supporting our members and the profession of pharmacy. We look forward to another successful year, and I am proud to serve this organization as your Treasurer!

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

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

expanded programs; (2) associated with time-limited programs; (3) capital asset purchases; or (4) supplemental operating expenses. These expenditures are primarily funded by investment income from reserves/net assets and the building sale reserve funds.

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

Joint address from the President and the Chief Executive Officer: It's Time to Return, Refocus, Refresh, and Reflect

Am J Health-Syst Pharm. 2022; XX:0-0

Linda S. Tyler, PharmD, FASHP,
University of Utah College of Pharmacy,
Salt Lake City, UT, USA

**Paul W. Abramowitz, PharmD, ScD
(Hon), FASHP, ASHP,** Bethesda, MD, USA

Address correspondence to Dr.
Abramowitz (ceo@ashp.org)

Published by Oxford University Press on
behalf of the American Society of Health-
System Pharmacists 2022.

<https://doi.org/10.1093/ajhp/zxac204>



Editor's note: The following is adapted from comments delivered by Dr. Tyler during the House of Delegates session of the 2022 ASHP Summer Meetings and Exhibition, held in June in Phoenix, AZ.

Good afternoon! It's great to be here in Phoenix! I am thrilled to be presenting to you in person today, and also very honored to represent my good friend and colleague, ASHP CEO Dr. Paul Abramowitz, as I present our joint remarks to the ASHP House of Delegates.

The Summer Meetings is our first in-person conference since December of 2019, and it's been 3 full years since our last in-person House of Delegates session in Boston. This year's meeting theme—return, refocus, and refresh—could not be more perfect. However, I'm going to add an important fourth “R” to the mix: reflect.

Reflect

A year ago, I delivered my inaugural address to our virtual House of Delegates. My address was titled, “High Velocity,” and I talked about how rapidly the healthcare landscape is changing as we continue to work through the ongoing and far-reaching impacts of the COVID-19 pandemic. As we continue to move forward, we should also

While the challenges have been too many to count, the pandemic has also opened up new lanes and the chance for positive change. It gives us opportunities to reshape our thinking and sharpen our focus on how best to leverage our expertise and experiences to serve our patients.

seek opportunities to remember and reflect on how much our profession has contributed to pandemic response and recovery. Both Dr. Abramowitz and I are immensely proud of how our members stepped up in so many ways to support patient care efforts in exceedingly challenging times. We are proud how ASHP has responded to these high-velocity changes to support our members and to recognize the valuable healthcare services we provide as pharmacy professionals.

Reflecting on this past year, we have had many bright spots. I would like to take a moment to highlight just a few. At the end of 2021, ASHP achieved an exciting milestone: reaching more than 60,000 members for the very first time. Overall, trends in association membership have been flat or declining, making this milestone even more impressive. Our growth represents a 5% increase across all membership categories for ASHP, including pharmacists, new practitioners, student

pharmacists, and pharmacy technicians. Most importantly, it signals that ASHP has been successful in adapting to the high-velocity changes within our profession, delivering high-value, relevant membership offerings that support our expanding and evolving roles across the pharmacy workforce.

In the past year, ASHP has engaged in exceptional advocacy efforts, leading the charge to support expanded access to pharmacist care at both the state and national levels. Recently, Maine passed a new law allowing pharmacists to dispense an emergency supply of chronic maintenance medications to patients. Arizona and West Virginia modernized collaborative practice laws. In addition, numerous states have expanded authority for pharmacist payment. Medicaid programs in 40 states now provide payment for some level of pharmacist care, and many states now authorize commercial payors to reimburse for pharmacist services. I commend the work of our state affiliates

and their strong advocacy to expand pharmacist roles.

At the national level, we are an executive committee member of the Future of Pharmacy Care Coalition. With the support of more than 100 organizations, we are advocating for the introduction of the Equitable Community Access to Pharmacist Services Act¹ to ensure patient access to pharmacist care.

We also continued our support and advocacy for the Pharmacy and Medically Underserved Areas Enhancement Act,² which would amend a section of the Social Security Act to include pharmacists on the list of recognized healthcare providers. We remain steadfast in our efforts to support expanded access to and reimbursement for pharmacists as they provide critical health services in communities throughout the country.

Throughout 2021, ASHP also continued to deliver valuable educational resources and content in multiple formats to support professional development and practice advancement.

- We issued 487,730 statements of continuing education credit across our educational offerings in 2021.
- We added 6 new professional certificates in 2021, including Opioid Stewardship; Anticoagulation; Crisis and Pandemic Management; Diversity, Equity, and Inclusion; Well-Being and Resilience; and Mental Health Support. In 2022, we launched 5 new professional certificates, including Weight Management; Telehealth; Basics of Cardiology Pharmacy; Non-Malignant Hematology; and Research Skills. We plan to offer a total of 30 certificates by the end of the year.
- We published 252 episodes of the @ASHPOfficial Podcast, garnering more than 275,580 total downloads.
- Over 2.3 million users accessed ASHP's practice resources on ASHP.org, and we saw significant increases in the use of patient-centered content on ASHP's newly redesigned consumer website, SafeMedication.com.

When future generations reflect on the early 2020s, there will be many examples of how scientific innovation as well as advancements in healthcare practice and delivery were critical to addressing and overcoming the COVID-19 pandemic. The rapid development and deployment of COVID-19 vaccines stands apart as a singular achievement. ASHP was at the leading edge of efforts to facilitate access and uptake of vaccines in communities across the country.

Advocacy efforts by ASHP and our state affiliates have resulted in several states granting authority to pharmacists to provide expanded services, including COVID-19 testing and COVID-19 treatment. At the federal level, pharmacists can order and administer selected COVID-19 prevention and treatment medications in all 50 states and territories.

ASHP was part of many collaborative efforts to build COVID-19 vaccine confidence in communities across the nation with resources such as our COVID-19 Vaccine Confidence Toolkit, which helps healthcare professionals build vaccine confidence in their neighborhoods. Original content on SafeMedication.com provides patients with trusted COVID-19 vaccine information in English and Spanish—and articles have been accessed more than 134,000 times. ASHP members have been highlighted in the US Department of Health and Human Services (HHS)-sponsored “We Can Do This” vaccine confidence media campaign that reached more than 49 million listeners.

When we talk about innovation in the pharmacy profession, we need to highlight the recent activities of the ASHP Innovation Center. In November 2021, ASHP announced the creation of the Pharmacogenomics Accelerator program in collaboration with the University of Minnesota College of Pharmacy. The Accelerator is a national learning experience designed to catalyze the implementation of clinical pharmacogenomics in health systems through an implementation science framework. It will support health

systems' implementation of pharmacogenomics through 3 specific activity streams supported by pharmacogenomics and implementation science experts.

Last spring, we partnered with the American Medical Association on a very successful joint pharmacogenomics virtual summit series promoting best practices for the application of pharmacogenomics in clinical settings. We have converted the 6 webinars into an enduring series worth 12 hours of continuing education credit. The webinars remain open access for all healthcare workers. In addition, several webinar speakers were featured in a special 2-part article series in *ASHP InterSections* highlighting their efforts to develop and lead pharmacogenomics programs and services.

As part of the Innovation Center's efforts to influence innovation and digital transformation to advance the safe and effective use of medicines, ASHP's Executive Forum on Cold Chain Management convened virtually in April to review the current state of pharmaceutical cold chain management in health systems. The event was the first in a series of executive forums on cold chain management.

Reflections on the past year also bring to mind the significant steps ASHP has taken toward strengthening an inclusive culture for all pharmacy practitioners. We implemented recommendations from the ASHP Task Force on Racial Diversity, Equity, and Inclusion.³ We launched the ASHP Inclusion Center, which includes a collection of content, educational programs, awards, and grant programs. We created a 7-part free educational webinar series that highlights best practices and actionable steps pharmacy professionals can use to recognize and combat bias and disparities in care. We also developed a Guided Mentorship Program to connect BIPOC pharmacy students and young practitioners with seasoned practitioners. You heard how we will continue our strong work in these areas in President Walker's inaugural address this morning. This

positions us to provide progressive leadership for our DEI efforts. Needless to say, it has been a remarkable year. Our collective achievements are especially noteworthy given the heightened demands of the pandemic.

Return

Riding high on the wave of high-velocity change, we are thrilled that 2022 marks our return to many of the events and activities that were paused during the pandemic. Networking and personal connections are important touchstones for our workforce, and the ASHP Summer Meetings is a perfect opportunity to build and strengthen relationships through small-group workshops and exclusive networking events.

Looking ahead, we are deep into our planning to bring back all of our meetings as in-person events for 2022. In October, the Chicago area will serve as the backdrop for our Conference for Pharmacy Leaders and our National Pharmacy Preceptors Conference.

We will cap off the year with what is sure to be an exceptional Midyear Clinical Meeting & Exhibition, to be held in Las Vegas from December 4 to 8. Registration will open later this summer. This year, we will be celebrating ASHP's 80th anniversary, so please mark your calendars for this celebration!

Refocus

As we continue to see signs of a waning pandemic, we are more than ready to move forward. But a return to normal as if nothing has changed just isn't possible. We can't simply move on. We must be willing and able to refocus and adapt. The pandemic has had a profound effect on each and every one of us. It has altered our routines and our perspectives in ways both big and small. As a result, we are all now experiencing and perceiving our profession, peers, and patients through a new lens. While the challenges have been too many to count, the pandemic has also opened up new lanes and the chance for positive change. It gives us opportunities to reshape our thinking

and sharpen our focus on how best to leverage our expertise and experiences to serve our patients.

As the profession undergoes high-velocity change, ASHP has sought to outpace the changes, creating new initiatives and products to support members and promote excellence at all levels of practice and across the continuum of patient care.

For institutions, we have developed the ASHP Certified Centers of Excellence in Medication-Use Safety and Pharmacy Practice program, recognizing hospitals and health systems that demonstrate the highest levels of pharmacy practice. Achieving this rigorous standard not only marks excellence in operations and practice but enhances the credibility and value of a pharmacy's services across the organization. The University of California San Diego Health recently became the first recipient of this important designation.

For individuals, ASHP's Certified Pharmacy Executive Leader program is a first-of-its-kind credential offering pharmacy leaders national recognition. Individuals enrolled in this program must meet a rigorous set of criteria and complete an in-person capstone at ASHP. We expect to formally credential our first capstone cohort this fall.

ASHP's Pharmacy Executive Leadership Alliance, or PELA, provided extensive knowledge sharing in 2021 as the profession refocuses on many innovative initiatives that impact the future of patient care. PELA has convened multiple summits with healthcare leaders to provide insightful reports and recommendations on timely topics, including telehealth innovations, hospital at home and alternative sites of care, and shifting from COVID-19 recovery to reimagining healthcare.

Our work to support and develop pharmacy leaders has long been a cornerstone of ASHP programming. As the healthcare landscape evolves and pharmacy workforce roles evolve and expand, these efforts have never been more important.

In 2021, we created a new Pharmacy Administration and Leadership

Residents' Collaborative to serve as a home within ASHP for unique offerings for the health-system pharmacy administration and leadership (HSPAL) resident community.

Just a few months ago, we completed a very successful 2022 residency matching process. I'm pleased to share that 5,561 individuals matched with 2,316 pharmacy residency programs across the country. The Match also continued its steady growth in the number of available residency positions. In the last 5 years, residency positions have increased by 1,196, or 26%. Specifically, PGY2 programs in palliative care/pain management grew by 107%, emergency medicine grew by 69%, and ambulatory care grew by 57%. Additionally, PGY1 community-based programs grew by 31%.

One of the greatest challenges currently facing our profession is the shortage of pharmacy technicians in hospitals and health systems. Organizations need strategies, tools, and resources to assist in the recruitment and retention of pharmacy technicians. ASHP recently launched PharmTech Ready, a solutions-based approach to pharmacy technician training. ASHP's PharmTech Ready is an off-the-shelf offering for the didactic component of a technician training program that is aligned with the ASHP/ACPE accreditation standards. It is applicable to a variety of healthcare settings and methods of delivery for technician training programs, including large health systems, individual hospitals, and colleges of pharmacy.

Refresh

Reflect. Return. Refocus. And now we turn to refresh. We have learned so much over the last 2 years—about public health, about the speed of scientific and clinical innovations, about our profession, about our ability to adapt and transform, and about ourselves and our teams. We now have the opportunity to ideate and innovate—to reflect on how things “used to be done” and refocus our energy to do them smarter with more impact.

“Refresh” brings to mind the critical importance of well-being and resilience in the pharmacy workforce. The mental health of our healthcare providers is essential to optimal patient care. ASHP continues to support the well-being and resilience of pharmacy professionals with work on the National Academy of Medicine Action Collaborative on Clinician Well-Being and Resilience. Earlier this year ASHP was awarded a 3-year, \$2.3 million grant from HHS, through the Health Resources and Services Administration.⁴ This grant was possible because ASHP has been at the forefront of promoting resiliency resources for pharmacy professionals. The grant is focused on reducing burnout and supporting mental health in our nation’s pharmacy and healthcare workforce.

ASHP recently issued a call for recruiting individuals for the Well-Being Ambassador Program. Those who join the program will be empowered to take local action to mitigate occupational burnout in their healthcare organizations. The program is open to healthcare workers, including pharmacists, pharmacy residents, student pharmacists, and pharmacy technicians. ASHP will collaborate with a broad network of stakeholders, including provider groups, federal agencies, and others, to meet its goal of enrolling 4,000 Well-Being Ambassadors, particularly in tribal, rural, and underserved areas.

Conclusion

We have so many opportunities for the pharmacy profession to refresh and reimagine. Healthcare will continue to evolve rapidly. During my year as your ASHP President, ASHP created new tools and resources to support you, our members, as you transformed your practices at high velocity. It has been a privilege to serve ASHP, our profession, and most importantly, you and our more than 60,000 members. Thank you!

At this time, I would like to recognize the dedication of the ASHP Board of Directors, especially for the resiliency they demonstrated in fulfilling their responsibilities this last year. On behalf of Dr. Abramowitz and myself, I want to thank you for your commitment, your leadership, and your passion for this organization and its mission.

I would also like to thank all who have served in the House of Delegates, and ASHP’s councils, Sections, Forums, and state affiliates. Each of these groups are foundational to our organization and supports our efforts to optimize medication use, improve patient care, and advance pharmacy practice. Your leadership was so important, especially over this last year.

I would also like to express my sincere appreciation to the ASHP staff for their relentless hard work. You help make it possible for pharmacy professionals across the country to optimize

medication use for patients and support pharmacists’ efforts to advance practice. We wouldn’t be where we are today without you.

And finally, thank you for being a member of ASHP. You make everything happen! Enjoy the rest of your time here in Phoenix.

Disclosures

The authors have declared no potential conflicts of interest.

References

1. American Society of Health-System Pharmacists. ASHP applauds introduction of Equitable Community Access to Pharmacist Services Act. Published March 25, 2022. Accessed June 22, 2022. <https://www.ashp.org/news/2022/03/25/ashp-applauds-introduction-of-equitable-community-access-to-pharmacist-services-act>
2. American Society of Health-System Pharmacists. Pharmacy and Medically Underserved Areas Enhancement Act. Accessed June 22, 2022. <https://www.ashp.org/Advocacy-and-Issues/Provider-Status/Pharmacy-and-Medically-Underserved-Areas-Enhancement-Act>
3. American Society of Health-System Pharmacists. Report of the ASHP Task Force on Racial Diversity, Equity, and Inclusion. *Am J Health-Syst Pharm*. 2021;78:903-906. doi:10.1093/ajhp/zxab078
4. Health Resources and Services Administration. Health Workforce Resiliency Awards. Accessed June 22, 2022. <https://bhwh.hrsa.gov/funding/health-workforce-resiliency-awards>

House of Delegates

New Business Item: Access to Reproductive Health Services

Sponsors:

Lindsey Amerine (SPPL)
Kelly Bobo (COT)
Erin Boswell (NPF)
Christopher Edwards (AZ)
Brian Gilbert (KS)
Rena Gosser (COT)
Kristi Gullickson (MN)
Sue Haight (MN)
Christi Jen (AZ)
Terri Jorgenson (CPP)
Danielle Kamm (AZ)
Nicole Kiehle (MD)
Justin Konkol (WI)
Janet Lee (MD)
Jeff Little (SPPL)
Monica Mahoney (MA)
Arpit Mehta (PA)
Katherine Miller (KS)
Kellie Musch (OH)
Zahra Nasrazadani (COT)
John Pastor (MN)
Joanna Robinson (KS)
Amy Sipe (MO)
Meghan Swarthout (MD)
Molly Wascher (MD)

States or Entities Represented:

Arizona, Kansas, Maryland, Massachusetts, Minnesota, Missouri, Ohio, Pennsylvania, Wisconsin, New Practitioners Forum, Section of Pharmacy Practice Leaders, Council on Pharmacy Practice, Council on Therapeutics

Email Addresses:

Lindsey.amerine@unchealth.unc.edu, Kelly.Bobo@lebonheur.org, erin.boswell@uhkc.org,
cedwar8@gmail.com, brian.gilbert@wesleymc.com, rgosser@uw.edu,
Kristi.gullickson@allina.com, shaight1@fairview.org, cjenpharmd@gmail.com,
Terri.Jorgenson@va.gov, dkamm@honorhealth.com, Nicole.kiehle@umm.edu,
justin.konkol@froedtert.com, jlee469@jhmi.edu, jlittle@saint-lukes.org,

mmahoney@bidmc.harvard.edu, arpit.mehta@ahn.org, kmiller30@kumc.edu,
kellie.musch@ohiohealth.com, znasrazada@srhc.com, jpastor1@fairview.org,
jrobinson14@kumc.edu, asipe@kc.rr.com, mdavlin1@jhmi.edu, mwasche1@jhmi.edu

Subject: Access to Reproductive Health Services

Motion:

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

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

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

To affirm that healthcare workers should be able to provide reproductive health care without fear of legal consequence.

Rationale:

The National Institute of Health defines reproductive health as “the condition of male and female reproductive systems during all life stages. These systems are made of organs and hormone-producing glands, including the pituitary gland in the brain.”¹ Studies show that there have been long standing disparities in access to and outcomes from reproductive health services in the United States, especially for racial-ethnic minorities.² For example, black women have the highest maternal morbidity and mortality rates in the country. These disparities include contraceptive use, reproductive cancers, preterm deliveries, and maternal morbidity and mortality.

On May 3, 2022, a Supreme Court of the United States’ (SCOTUS) draft opinion overturning *Roe v. Wade* was leaked to the media. If SCOTUS releases a final opinion overturning *Roe*, decisions about abortion rights will be delegated to the states. Without a federal precedent, states are likely to implement a patchwork of regulations around abortion, with some outlawing it entirely and others enshrining a right to abortion in state law. Thirteen states have existing “trigger laws,” which will outlaw abortion the moment *Roe* is overturned. The impacts of these state laws are likely to extend into several areas impacting the practice of pharmacy and patient access to necessary treatments/medications:

¹ <https://www.niehs.nih.gov/health/topics/conditions/repro-health/index.cfm>, accessed 5/16/2022

² Sutton, M. Y., Anachebe, N. F., Lee, R., & Skanes, H. (2021). Racial and Ethnic Disparities in Reproductive Health Services and Outcomes, 2020. *Obstetrics and gynecology*, 137(2), 225–233.

- **Access to Necessary Treatment:** pharmacists are involved in treating patients with ectopic pregnancy or cancer diagnoses in pregnant patients. These laws could limit patient access to lifesaving treatments because of the risk of legal liability for providers. Pharmacists have a role in providing medications for these treatments as well as supporting patients' mental health and well-being related to reproductive health.
- **Access to Medications:** A number of companies have formed that provide telehealth access to medications used to induce abortion. There are likely to be challenges to interstate mail order of these medications domestically. Additionally, some companies are located overseas (e.g., Austria, India), which raises questions about foreign importation of medication. ASHP policy generally opposes importation of medications from other countries for wholesale purposes due to supply chain security concerns but does not object to patients ordering from legitimate foreign pharmacies for their personal needs. Additionally, some medications such as misoprostol which are used off-label as abortifacients but which have other clinical uses may become harder to access for patients because of provider fears around legal liability for prescribing or dispensing these medications. Access to medications is an issue of national security. For instance, by law, the Department Of Defense is required to make contraceptive services available to all female active-duty servicemembers
- **Clinician Judgment:** Restrictions on medication abortion function as limitations on clinicians' professional judgment. As noted above, because some medications can be used off-label as abortifacients, it is possible that there will be increased scrutiny of the prescribing and dispensing of certain medications. Further, some states are pursuing laws that would allow citizens a private right of action against a clinician who assists in an abortion (also known as "bounty laws"). This could create civil and/or criminal liability against clinicians who prescribe or dispense abortion medications.

Aside from these major areas of concern, depending on the wording of the potential SCOTUS opinion, other procedures that are not abortion but might result in destruction of an embryo could be called into question. This could result in restrictions on medications used to induce labor to protect the pregnant patient or even for in-vitro fertilization (IVF) purposes. Additionally, because Roe was based on the protection of personal privacy, overturning it may also call other privacy-related rulings into question, including *Griswold v. Connecticut*, which allowed women access to contraception.

The decision to terminate a pregnancy is complicated, difficult, and often extremely emotional choice between healthcare providers and patients, and it often involves weighing the risks to the pregnant patient. Healthcare providers involved in these decisions and providing these treatments would be subject to unjust criminal prosecution under several state laws should *Roe v Wade* be overturned. Additionally, pregnant patients themselves could be prosecuted for

seeking lifesaving treatment under these laws. There is already precedent for pregnant patients facing legal difficulties and forced interventions in the United States.³

Suggested Outcomes:

- 1) Adoption of proposed language which can be used to advocate on behalf of patients and health care providers
- 2) ASHP investigate current educational standards on reproductive health including disparities in access and outcomes for different patient populations in schools of pharmacy and residency accreditation standards and propose new policy if needed

Related ASHP Policies:

0610

PHARMACIST'S RIGHT OF CONSCIENCE AND PATIENT'S RIGHT OF ACCESS TO THERAPY

Source: Council on Legal and Public Affairs

To recognize the right of pharmacists, as health care providers, and other pharmacy employees to decline to participate in 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 right to obtain legally prescribed and medically indicated treatments while reasonably accommodating in a nonpunitive manner the right of conscience; further,

To support the principle that a 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.

This policy was reviewed in 2021 by the Council on Pharmacy Practice and by the Board of Directors and was found to still be appropriate.

0013

PATIENT'S RIGHT TO CHOOSE

Source: Council on Legal and Public Affairs

To support the right of the patient or his or her representative as allowed under state law to develop, implement, and make informed decisions regarding his or her plan of care; further,

To acknowledge that the patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment; further,

³ <https://pubmed.ncbi.nlm.nih.gov/23262772/>

To support the right of the patient in accord with state laws to (a) formulate advance directives and (b) have health care practitioners who comply with those directives.

This policy was reviewed in 2015 by the Council on Public Policy and by the Board of Directors and was found to still be appropriate.

1410

ACCESS TO ORAL CONTRACEPTIVES THROUGH AN INTERMEDIATE CATEGORY OF DRUG PRODUCTS

Source: Council on Therapeutics

To advocate that oral contraceptives be provided only under conditions that ensure safe use, including the availability of counseling to ensure appropriate self-screening and product selection; further,

To support expanded access to these products through a proposed intermediate category of drug products, as described by ASHP policy, that would be available from all pharmacists and licensed health care professionals (including pharmacists) who are authorized to prescribe medications; further,

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

This policy was reviewed in 2019 by the Council on Therapeutics and by the Board of Directors and was found to still be appropriate.

1714

RESTRICTED DRUG DISTRIBUTION

Source: Council on Public Policy

To oppose restricted drug distribution systems that (1) limit patient access to medications; (2) undermine continuity of care; (3) impede population health management; (4) adversely impact patient outcomes; (5) erode patients' relationships with their healthcare providers, including pharmacists; (6) are not supported by publicly available evidence that they are the least restrictive means to improve patient safety; (7) interfere with the professional practice of healthcare providers; or (8) are created for any reason other than patient safety.

This policy supersedes ASHP policy 0714.

House of Delegates

June 2022 House of Delegates Recommendations

The delegate[s] who introduced each Recommendation is [are] noted. Each Recommendation is forwarded to the appropriate body within ASHP for assessment and action as may be indicated.

1. Review of ASHP Policies To Insert Pharmacogenomics Where Appropriate

Justin Konkol (WI)

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

Background: Many clinical policies talk about evaluating treatment decisions on pharmacodynamics and pharmacokinetics. Would recommend to prevent unneeded wordsmithing in the house for future meetings to globally evaluate and insert this term where appropriate.

2. ASHP Incorporate Pharmacy Technician Training into High School Career and Technical Programs

Maari Loy (ND)

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

Background: Technician shortage. High schools already have students.

3. Revision of ASHP Policy 1410, Access to Oral Contraceptives Through an Intermediate Category of Drug Products

Mollie Scott (NC)

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

Background: Pharmacists provide a variety of products, not just oral.

4. Early Review of New ASHP Policy: Advancing Diversity, Equity, and Inclusion in Education and Training

Zahra Nasrazadani (KS), Christopher Edwards (AZ), Josh Blackwell (TX)

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

Background: The ASHP DEI Task Force has identified a need (Task Force recommendation #13) for equitable education and training, particularly as it applies to BIPOC, and even more specifically to learners who are Black. During the first session of the June 2022 House of Delegates, the above-named policy was the first to be reviewed and was immediately amended to erase BIPOC, thereby significantly severing the spirit of the policy and the reported intent of the Task Force. With so little discussion in the House, this decision warrants further consideration and deliberation. Equality requests that all people are treated with the same broad brush but EQUITY -- a primary charge of the Task Force -- demands application of individualized accommodations to people and populations according to their specific need. The policy recommendation as originally worded rightfully identified that need according to copious evidence and should be revised to the originally wording, prior to the amendment that undercut its important purpose. The ASHP Del Task Force has identified a need (Task Force recommendation #13) for equitable education and training, particularly as it applies to BIPOC, and even more specifically to learners who are Black. During the first session of the June 2022 House of Delegates, the above-named policy was the first to be reviewed and was immediately amended to erase 'BIPOC, thereby significantly severing the spirit of the policy and the reported intent of the Task Force. With so little discussion in the House, this decision warrants further consideration and deliberation. Equality requests that all people are treated with the same broad brush but EQUITY -- a primary charge of the Task Force -- demands application of individualized accommodations to people and populations according to their specific need. The policy recommendation as originally worded rightfully identified that need according to copious evidence and should be revised to the originally wording, prior to the amendment that undercut its important purpose.

5. Review of New ASHP Policy, Autoverification of Medication Orders, To Include Pharmacy Resources

Jodi Taylor (TN)

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

Background: RDC & Caucus discussions support this change.

6. Pharmacists in Ambulatory Surgery Centers and/or Outpatient Surgery Centers

Tricia Meyer (TX)

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

Background: Ambulatory surgery centers and/or outpatient surgery centers typically do not have regular pharmacists staffing. Pharmacist consultants may perform medication reviews for 3-4 hours on a monthly or quarterly basis. Hours of consultants do not allow time for effective controlled substance review, safe medication practices, and drug security.

7. Advocate for the Prioritization of Using Ready-To-Administer Medications in Procedural Areas

Steven Knight (TX)

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

Background: ISMP and APSF (Anesthesia Patient Safety Foundation) newsletters have identified safety risks associated with labeling mishaps or omissions. Adding the expectation that providers (e.g. anesthesiologists, CRNAs, etc.) draw up syringes from vials requiring labeling has inherent risks, like mixing up and mislabeling.

8. Development of a Drug Diversion Prevention and Investigation Training Program for Pharmacists and Diversion Specialists

Angela Livingood (NC)

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

Background: ASHP took a leading role in acknowledging drug diversion within hospitals and health-systems with the publication of Preventing Diversion of Controlled Substances guidelines and partnership with PTCB in designing Controlled Substance Diversion Prevention curriculum. Ultimately the Pharmacy Director or pharmacist designee is responsible for an institution's drug diversion program. Access to a certificate training program to inform these efforts will be an asset to drug diversion pharmacists/specialists and pharmacy leaders.

9. Revision of New ASHP Policy, Autoverification of Medication Orders

Randy Martin (TX)

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

Background: This new policy requires additional work and consideration as evidenced by extensive house discussion. There is significant potential for misinterpretation and misuse. In addition, this policy is in direct conflict with existing regulations and the Joint Commission.

10. Formalize Process To Refresh Background and Rationale Content During Sunset Review Process

Roger Woolf (WA)

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

Background: Informed review of current policy requires complete background and rationale that takes the following into account. 1) Environment changes since original 2) Scope of the issue being addressed 3) any newly accepted terminology and direction from the Board. Subsequently any new language or terms include in the policy update should have sufficient content added in rationale to support it. Several policy reviews in the house this year had outdated supporting information that made it difficult for delegates to connect to the revisions being proposed.

11. Revisit ASHP Meeting Dress Code

Christopher Scott (IN)

Please evaluate loosening the ASHP meeting dress code.

Background: Because it's 2022.

12. Gun Violence Prevention

Brian Gilbert (KS), Katherine Miller (KS), Zahra Nasrasadani (KS), Joanna Robinson (KS), Amy Sipe (MO)

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

Background: In May 2022 there were multiple incidences of mass shootings which involved elementary school children as well as health care professionals in a hospital setting. Countless lives have been lost due to gun violence with the CDC estimating 45,222 firearm related deaths in the United States in 2020 alone. The CDC estimates 124 US people die each day from a firearm related homicide or suicide with gun violence now being the leading cause of death in children. In addition to the moral and

psychological toll these acts have on the public it is estimated that gun violence related healthcare costs approached nearly \$1 billion in the 2016-2017 fiscal year per the US Government Accountability Office. Gun violence is an ever growing healthcare crisis of which medical organizations, including ASHP, are uniquely positioned to advocate on behalf of patients.

13. Consideration of Alignment of ASHP Policies and Values with State and Local Laws When Selecting Locations for Meetings and Events.

Ryan Gibbard, Victoria Wallace, Edward Saito (OR)

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

Background: ASHP has several policies relevant to the issues of violence prevention, diversity, and reducing healthcare inequities (i.e. 1705, 1718, 2036, 2017, 2035). In recognition of current societal events (e.g., Black Lives Matter Movement, discriminatory laws against LGBTQ+ individuals, eroding of women's rights, ongoing mass shootings), and to affirm that ASHP members have a right to feel safe when engaged in professional activities, we would like to see ASHP actions aligned with these policies and values. Furthermore, ASHP brings sizeable meetings and thus revenue to a number of locales throughout our country and is a visible presence in the locations that host these meetings. We advocate that ASHP consider the impact of local and state laws in choosing a meeting location and whether these laws create a safe and inclusive environment for those attending, consistent and in alignment with the values and policies of our organization. Words are not enough, and specific action must be taken to advocate for community health and protect the physical and psychological safety and well-being of our members when engaging in professional conferences and meetings.

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

Kathy Baldwin (FL)

Background: Change the narrative.

15. Development of Model State Pharmacy Practice Acts to Support Pharmacist Prescribing

Julie Groppi (FL), Anthony Morreale (DVA), Roger Wolff (WA)

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

Background: States have made great progress in advancing pharmacist prescribing but significant variations exist in terminology and approach. This taskforce should outline

recommendations for autonomous and collaborative prescribing while defining risks and benefits of the approaches. Concise recommendations will promote advancement of pharmacists to support comprehensive medication management services and increase access to patient care. This taskforce should include representatives from Department of Veterans Affairs as well as key state affiliates who have had success in expanding practice acts to identify best practices and may identify lessons learned.

16. House of Delegates Open Forum

Kat Miller (KS), Justin Konkol (WI), Chris Edwards (AZ)

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

Background: General ASHP membership was not actively present at the Open Forum of the 2022 House of Delegates which led the meeting to appear/run like a duplicative caucus. If the intent is to gather feedback from members, the open forum should be evaluated to ensure the time and/or venue is the most valuable to its members.

17. Advancing High-Value Clinical Pharmacy Services

Tom Dilworth (WI)

To advocate that ASHP guide the identification and development of high-value clinical pharmacy services across the continuum of care; further,
To advocate that ASHP, health-systems and researchers collaborate to develop clinical pharmacy productivity metrics that allow pharmacy leaders to demonstrate the value of clinical pharmacy services across the continuum of care; further,
To advocate that health-systems and organizations prioritize high-value clinical pharmacy services while de-prioritizing lower-value clinical services and/or delegating lower-value clinical services to non-pharmacists and/or technology; further,
To advocate that ASHP guide the development of public relations materials that showcase the clinical services and value pharmacists bring to the healthcare enterprise suitable for use by health-systems, organizations and the pharmacy workforce to promote the profession and accurately describe clinical services provided by pharmacists to key stakeholders, including but not limited to payers, other healthcare providers, and the general public.

Background: Pharmacists provide many high value clinical services across the continuum of care yet we lack succinct, validated metrics that capture the value pharmacists bring to the health care enterprise. There is an urgent need for ASHP to guide and foster the development of such metrics for use by pharmacy leaders so they may use these data to demonstrate the value of clinical pharmacy services in their organizations and promote these services to other healthcare providers, payors and the general public.

18. Pharmacist's Role as Public Health and Preventative Health Experts

Julie Groppi (FL)

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

Background: ASHP should highlight the public and preventative health roles of pharmacists that have evolved and develop a policy statement to describe pharmacists as public health leaders. This policy should describe efforts to promote expansion of the practice of pharmacy to be inclusive of efforts that focus on increasing patient access to medications and care, emphasizing access efforts to rural, underserved and underresourced areas. This should highlight efforts of pharmacists as public health leaders in areas where patient access is optimized by using pharmacists effectively such as hormonal contraception, PrEP and PEP, Test to Treat, "cold packs", STI treatment, etc.

19. Autoverification Logic Intraoperability

Christopher Edwards (AZ), Melinda Burnworth (AZ), Danielle Kamm (AZ)

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

Background: As research and best practices become available regarding logic models that lead to safe use of autoverification for select medication orders, implementation of these logic models will be limited to organizations that use the same EHR as the organization reporting the logic model. Ensuring intrapoperability will help to improve safety when implementing previously described autoverify logic across health systems.

20. ASHP To Consider Completion of the Pharmacy Leadership Academy and Provide ACHE-Qualified Education Credits To Support Pharmacists Obtaining ACHE Fellow Designation

Lt Col Jin Kim (USAF), Lt Col Rohin Kasudia (USAF)

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

Background: Fellow ACHE is the premier credentialing for hospital administrators. Many pharmacists in senior leadership roles have obtained this credential.

21. Educating Middle School and High School Students about Opportunities in Pharmacy To Promote the Profession as a Possible Career Choice

John Muchka (WI)

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

Background: There are many opportunities in pharmacy with our changing healthcare landscape. With decreasing enrollment in pharmacy schools and pharmacist shortage post pandemic the pool of pharmacists is dwindling. Teaching students about the many roles and opportunities in the profession may help with recruitment efforts.

22. Promotion of Open Forum on Saturday

Paul Driver (ID)

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

Background: The Open Forum is the only opportunity for nondelegates to give input on policies immediately before the HOD meeting. Currently it happens the day before the 1st meeting of the House. It seems to be poorly advertised and/or promoted. The attendance by delegates and nondelegates is not as robust as it could or should be. ASHP should place emphasis on the importance of this Forum in promotional flyers for the Summer Meeting to encourage nondelegates to attend and provide their input on the new policy proposals. Emphasize that this is the only opportunity as a nondelegate to effect change on national policy.

23. Ensure Adequate and Standardized Supply of Emergency Medications and Supplies in Non-EMS Accessible Locations

Christi Jen (SCSS), Stephanie Weightman (SCSS), Megan Musselman (SCSS), Christopher Edwards (AZ), Jeff Little (KS), Jerome Wohleb (NE), Zahra Nasrazadani (KS), Katie Reisbig (NE), Tiffany Goeller (NE)

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

Background: The US CFR 121.803 requires certain medications and supplies for flights for medical emergencies but do not require the stocking of epinephrine auto-injectors for ease of administration or naloxone, among many other medications/supplies. Many non-EMS accessible locations (e.g., airplanes) contains a stock of emergency supplies and medications that are not adequate or standardized to manage emergencies. Pharmacists play a significant role in an interprofessional team to evaluate emergency medications and supplies and ensure that non-EMS accessible locations have the resource needed to quickly manage a patient prior to transferring to a higher level of care.

24. RFID Standardization Requirements

Kellie Musch (OH)

Request ASHP create a policy or statement regarding RFID technology requirements and standardization for medications.

Background: The ASHP Foundation recently published a report on the use of RFID technology and how it continues to expand within health-system pharmacies. A guidance should recommend standards for tags and readability of the information to improve interoperability within the medication use process from drug manufacturers, 503B compounding pharmacies, and repackagers. Certain vendors have created proprietary standards for their passive RFID tags that impacts the readability of these tags between multiple systems. RAIN RFID Alliance promotes standardization between RFID quality and content.

25. Development of Interstate Experiential Education Opportunities

Justin Konkol (WI)

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

Background: Many schools of pharmacy continue to struggle with diversifying the student body based off the geographic make-up of their respective states. Development of new programs/structures which could bring students from more racially diverse SOP's to other states should be evaluated and developed to help provide a structure and framework that can be reproduced to support such a program. This would include rotation structure, hours requirement, housing options, state licensing rules/laws etc.

26. New ASHP Policy on Pharmacoequity

Bernice Man (IL)

I'd recommend an ASHP Council (possibly Council on Public Policy) develop new policy that addresses pharmacoequity.

Background: Pharmacoequity was a term coined in 2021 in JAMA (doi:10.100/jama.2021.17764) that aims to ensure that all individuals regardless of race and ethnicity, socioeconomic status, or availability of resources, have access to the highest quality medications required to manage their health needs. Current ASHP policy on equity doesn't address this concept.

27. Development of Hazardous Drug (HD) Environmental Monitoring and Medical Surveillance Guidelines

Christy Norman (GA)

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

Background: The ASHP Guidelines on Hazardous Drugs was most recently updated in 2018 to align with the publication of USP 800, and while the update was comprehensive, many of the recommendations in the guidelines mirror the level of detail provided by the USP 800 standard. In particular, there is little additional detail in the sections on hazardous drug environmental monitoring and medical surveillance of personnel handling hazardous drugs and both of these aspects of USP 800 are recommendations, not requirements of the standard. Since there is no clear guidance on best practices for these two aspects of safe handling, facilities and practitioners struggle on how to approach and how to implement new processes. The Safe To Touch consensus conference on HD surface contamination was convened September 2020 and resulted in the publication of 11 consensus statements regarding surface contamination monitoring for adoption by stakeholders in the drug supply chain, policy, and healthcare arenas (See: AJHP, 2021;78:1568-1575, <https://doi.org/10.1093/ajhp/zxab134>). The consensus statements go beyond guidance provided by USP 800 and provide high-level recommendations on what should be done for an effective HD environmental monitoring program, but do not provide the detail that is needed by practitioners and would typically be provided by an ASHP guideline document.

28. Professional Identity Formation

Vickie Ferdinand-Powell, Kimberly Zammit, Robert DiGregorio (NY)

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

Background: 1. The professional identity of pharmacists all over the world is as a dispenser.

2. Work needs to be done to educate legislators, the community, and others on the healthcare team about the education pharmacists complete.

29. Pharmacist Involvement in the Design of Clinical Trials

Jesse Hogue (MI)

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

Background: ASHP has Guidelines on Clinical Drug Research and Guidelines for the Management of Investigational Drug Products, but both focus on managing investigational drugs in the hospital and involvement in ongoing clinical trials. Neither supports or describes the involvement of pharmacists in the development of clinical trials to provide guidance on drug dosing, administration and monitoring. The Council on Therapeutics 5: Enrollment of Underrepresented Populations in Clinical Trials policy was amended to add a similar clause, but it seems like it either warrants being further developed in a stand-alone policy or that the Guidelines on Clinical Drug Research should be updated to include it.

30. ASHP Statement on Pharmacy Workforce Shortages

Jerome Wohleb (NE), Katie Reisbig (NE), Emily Johnson (NE), Melinda Burnworth (AZ), Chris Edwards (AZ), Christi Jen (AZ), Tonya Carlton (NH), Elizabeth Wade (NH), Brian Kawahara (CA), Cheri Briggs (DE), Deborah Sadowski (NJ), Jeff Cook (AR)

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

Background: Pharmacy will be facing workforce shortages in congruence with many other health care disciplines. Declining student enrollment, early pharmacist retirements, ongoing technician shortages have been identified in several states validating the urgency of this request. ACCP data is clearly representing this trend. During ASHP's Open Forum for Members, I requested a straw poll if interest in a recommendation submission and 65% of the delegates present were in favor.

In summary, this recommendation is supported by 11 delegates representing 7 states and one council member.

31. Access to Transgender Care to Manage Gender Dysphoria

Tim Brown (SPE), Jeff Little (SPPL)

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

Background: State laws against medical care to LGBTQ+ patients have increased dramatically. ASHP needs a stance or supportive policy for these patients.

32. Increased Delegate Work Time Between Caucus and House Meeting

Jodi Taylor (TN)

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

Background: Two policies were referred during the first meeting of the house that could have been optimized prior to presentation on the House floor if delegates had more time to work after the first Caucus. Additionally, delegates that did opt to fully engage in amendment drafting did not have time to get lunch before the first meeting of the House convened.

33. Revision of FDA Rule on Barcodes on Immediate Containers

Ben Anderson, Kevin Marvin (SOPIT)

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

Background: 2D Barcodes on wholesaler lots are currently required to carry the lot number and expiration dating but this rule does not currently apply to the immediate containers. Now that pharmacies are required to log this information to the patient level it is necessary to carry this requirement forward to the barcodes on the immediate containers to support efficiency, safety and capture of quality data in patient care systems. The current FDA rule requiring linear barcodes on the immediate containers needs revision.

34. Membership Dues

Dale English II (KY)

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

Background: The current landscape of inflation nationally as well as globally continues to hit all individuals throughout our nation and the world. While pharmacists continue to be compensated better than many individuals in our nation, we are not without being affected by the current level inflation. It is vital that ASHP consider how this is professionally and personally effecting ASHP members. ASHP has a responsibility to continue to assist its members during these challenging times of record inflation and not raising ASHP membership dues for at least the next two (2) years.

35. Residency Training and Direct Patient Care

Dale English II (KY)

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

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

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

Background: This recommendation is not meant to be in opposition of pharmacy residency training however until we have the capacity to allow all pharmacy graduates to complete a pharmacy residency is policy continues to be troublesome. If ASHP believes that pharmacy residency training should be a requirement for "pharmacists who provide direct patient care", ASHP needs to be working with all stakeholders to ensure pharmacy residency capacity is available for all Doctor of Pharmacy graduates. The terminology "pharmacists who provide direct patient care" cannot be limited to pharmacists working in the traditional health-system, inpatient environment, especially given ASHP's expansion to include the Section of Community Pharmacy Practitioners. Community pharmacists are the most accessible healthcare providers and are "pharmacists who provide direct patient care" to innumerable patients on a daily basis. This policy may be seen as possibly detrimental to the overall pharmacy profession given the limited number of pharmacy residencies, and especially as it pertains to "practice ready" graduates of ACPE accredited Doctor of Pharmacy programs.

36. Medication Safety in Operating Rooms and Anesthesia Procedural Locations

Tricia Meyer (TX)

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

Background: Many hospital pharmacy departments have been unwilling to adopt a full scope of pre-filled syringes in areas the OR and procedural locations due to expense. The APSF has placed medication safety as one of their top 10 priorities & are requesting pharmacy provide a full scope of pre-filled syringes, outsourced or in-sourced, to

anesthesia providers to help enhance medication safety. The anesthesia providers currently prepare syringes in a distracting and time pressured environment with preparing critical medications. The expense/cost of this initiative has stalled the implementation. Many hospital pharmacies only provide 1-2 prefilled syringes and allow anesthesia providers to prepare remaining at bedside. Anesthesia medications can be up to 30 medications administered during a surgery although 10 medications may be a realistic average. Additionally, with recent staffing shortages and high salary costs of contract CRNA's and AA's, pre-filled syringes can provide OR efficiency and improved throughput. In the UK, the Royal Pharmaceutical Society core guidance includes "manipulation of medicines in clinical areas is minimized and medicines are presented as pre-filled syringes or other ready to administer preparations wherever possible. . . .

In a recent book on Medication Safety during Anesthesia and the Peri-operative period, both authors (who are anesthesiologist's medication safety researchers and experts) send pharmacy a call to action by stating "It will be interesting to see how long it takes for this recommendation to be widely implemented. " ASHP has a history of collaboration with the American Society of Anesthesiologists and APSF.

ASHP Board of Directors, 2022-2023

Am J Health-Syst Pharm. 2022; XX:0-0



PAUL C. WALKER
PRESIDENT AND CHAIR OF
THE BOARD



NISHAMINY KASBEKAR
VICE CHAIR, PRESIDENT-ELECT



LINDA S. TYLER
IMMEDIATE PAST PRESIDENT



CHRISTENE M. JOLOWSKY
TREASURER



PAUL W. ABRAMOWITZ
CHIEF EXECUTIVE OFFICER



KIMBERLEY W. BENNER



LEIGH A. BRISCOE-DWYER



SAMUEL V. CALABRESE



MELANIE A. DODD
CHAIR, HOUSE OF DELEGATES



VIVIAN BRADLEY JOHNSON



PAMELA K. PHELPS



JAMIE S. SINCLAIR



**VICKIE L. POWELL
BOARD-ELECT**



**JENNIFER E. TRYON
BOARD-ELECT**

INAUGURAL ADDRESS OF THE INCOMING PRESIDENT

We Are Better Together!

Am J Health-Syst Pharm. 2022; XX:0-0

Paul C. Walker, PharmD, FASHP,
University of Michigan College of
Pharmacy, Ann Arbor, MI, USA

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

© American Society of Health-System
Pharmacists 2022. All rights reserved. For
permissions, please e-mail: journals.permissions@oup.com.

<https://doi.org/10.1093/ajhp/zxac205>

ASHP is a leader that
recognizes diversity is
foundational to the future of
our profession. Our policies and
actions on inclusion and equity
drive excellence within our
organization and the
profession.



Editor's note: The following is adapted from comments delivered by Dr. Walker during the 2022 ASHP Summer Meetings and Exhibition, held in June in Phoenix, AZ.

Good morning! It's wonderful to see everyone here today. This is our first live meeting since December 2019. We are all together again in person, and that's incredible! I'm excited about it. How about you?

This moment is especially meaningful because my message to you today is about being better together. That song we just heard, "We are One," the Official 2014 FIFA World Cup Song by Pitbull, expresses the sentiment that I want to impart to you today—that of unity, of diversity and inclusion, the idea that we are better together: *"Show the world we are one . . . It's your world, my world, our world today. And we invite the whole world, whole world to play."*

We are better together! We are better together as families, communities, teams, and friends. We are better together when we collaborate with colleagues, physicians, nurses, and others to achieve goals, solve problems, and get work done.

Successful collaboration

A very wise man once said, "Two are better than one because they have a good return for their labor"

(Ecclesiastes 4:9 [NKJV]). "Two are better than one, in that their cooperative efforts yield advantage" (Ecclesiastes 4:9 [CJB]). In other words, we are better together!

And although Solomon wrote these words in the mid-10th century BC, they are still relevant today. Collaboration is essential to the success of our profession and our work. We each have tremendous value—as individuals, as pharmacists, as members of our profession, teams, and communities. We each bring valuable, diverse perspectives to our work, and we are better together when diverse voices are included and heard. We are better together when, as healthcare providers, we partner together on interprofessional teams to care for patients. Ultimately, we are better together because diversity creates better outcomes and better solutions.

The Merriam-Webster Dictionary defines diversity as "the condition of having or being composed of differing elements . . . especially the inclusion of people of different races or cultures in a group or organization."¹ By definition, diversity is about more than just differences; it is about inclusion. To be better together, we must be intentional about inclusion.

US census data show that our country and the communities we

serve continue to become more diverse—every state in the union and the District of Columbia became more racially and ethnically diverse between 2010 and 2020.^{2,3} But our diversity is about more than just race and ethnicity; our diversity also encompasses dimensions of age, gender, sexual orientation, ableness, and other characteristics by which we identify ourselves and which make each of us unique. These changing demographics among our patients demand a response from us. They demand we give attention to diversity and inclusion.

Studies show that diversity of thought and inclusivity across teams lead to improved decision-making and problem-solving, and to innovative solutions, because diversity—that uniqueness among individuals—leads to creative conclusions.⁴ Additional studies show that companies with the highest level of gender diversity and ethnic diversity among their executive teams are more financially successful.⁵

Although studied less well in healthcare, diversity in this setting has been associated with improved outcomes, such as a 19% reduction in cardiovascular mortality, as well as improved population health and improved quality of care delivery.⁶⁻⁸ The reason: Diverse teams produce better

solutions to complex problems! And our patients *do* better when our workforce is diverse and inclusive. So, for the benefit of our patients, it is paramount that we invest in workforce diversity that reflects the communities we serve.

Successful collaboration can also happen on a smaller scale. I'm sure many of us would not be where we are today without the support of a mentor or the help of peers and colleagues whose unique perspectives opened our eyes to a different way of thinking. This is certainly true for me. I learned early in my career that collaboration was key to success. For example, to achieve the scholarly output needed for promotion through the clinical faculty ranks, collaboration was essential. Inviting people to collaborate with me in my work led to invitations to participate in the work of others, and this increased scholarly productivity for all of us.

Throughout my career, I have had mentors and collaborators who are Black. Still, being in a profession where Black Americans are underrepresented, I have also been in mentoring relationships and collaborations with people who are not Black. And I am better for the diversity of my relationships.

Health inequities

Let's take another look at Solomon's words that I shared earlier: "Two are better than one because they have a good return for their labor." As a nation, we face numerous health inequities that result in poorer health outcomes for people of color. Disparities are seen in rates of cancers, cardiovascular disease, diabetes, obesity, and renal disease.⁹⁻²³ They are seen in higher rates of infant and maternal mortality; they are seen in the lower overall life expectancy for Black Americans, Hispanic and Latino/Latina/LatinX Americans, Native Americans, and Alaska Native people as compared to White Americans.²⁴⁻²⁷

Health disparities include inferior pharmacotherapeutic outcomes, *and those reside squarely in our wheelhouse*. Studies continue to find that disparities exist for people of color in the use

of evidence-based treatments.²⁸⁻³² Even when insurance status, income, age, and the severity of condition are adjusted for, people of color tend to receive lower-quality healthcare when compared to White Americans.

The pandemic has highlighted longstanding inequities in healthcare for people of color that have caused excess morbidity and mortality, even including racial disparities in how COVID-19 vaccines were distributed in the first few months of their availability.³³⁻³⁵ These disparities extend beyond the higher burdens of disease, hospitalization, and death. The recent report of the Black Coalition Against COVID, titled "The State of Black America and COVID-19,"³⁶ found that "Black Americans [also] experienced significant economic, social, educational, and behavioral health crises. Black communities were disproportionately impacted by financial strain, loss of caregivers and elders, deficiencies in educational learning, and food insecurity . . . [and Black Americans] reported pandemic-related mental health concerns at a rate approximately 10 percentage points higher than White Americans." This report concluded, "The severity of COVID-19 among Black Americans was the predictable result of structural and societal realities, not differences in genetic predisposition."³⁶

The pandemic also triggered racist rhetoric blaming Asian Americans, Native Hawaiians, and Pacific Islander Americans for COVID-19. These communities suffered a substantial increase in public assaults that inflicted upon them pain and disability and caused anxiety, depression, and even suicidal ideation.³⁷⁻³⁹

The social protests in response to the murders of George Floyd, Breonna Taylor, and Ahmaud Arbery in the spring of 2020 further focused the nation's attention on the longstanding health inequities resulting from how communities of color are policed. In the year following George Floyd's death, 229 more Black people lost their lives at the hands of police across the United

States.⁴⁰ Just this past April, 26-year-old Patrick Lyoya was killed when a Grand Rapids, MI policeman shot him in the back of the head at point blank range following a routine traffic stop. And although it receives less media attention, Latino/Latina/LatinX Americans are also killed disproportionately by police.^{41,42}

Why is this important? Because this outrageous violence perpetrated by police against people of color is also a public health problem. It significantly drives unnecessary and costly injury, morbidity, and premature death among people of color.

ASHP policy recognizes violence in the US as a public health crisis and affirms the important role of the pharmacy workforce in violence prevention.⁴³ It calls for the profession to get involved in violence prevention efforts, even by leading initiatives in our communities and workplaces to counter the societal and public health impact of violence.

The 2001 report of the National Academies of Sciences, Engineering, and Medicine titled "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" identified structural racism and discrimination as the 2 primary causes for disparities in healthcare and found evidence of structural racism that negatively impacted the care and health outcomes of racialized minorities *in every location of healthcare delivery in every geographic region of the United States*.⁴⁴ In other words, structural racism and discrimination—the primary causes of health disparities in the United States—are pervasive in our healthcare system. And little has changed in the 20 years since the report was published.

Dr. Rachel Hardeman is the director of the Center for Antiracism Research for Health Equity at the University of Minnesota. She said, "Progress toward racial equity has been elusive for more than 400 years, and the world is now in a moment that requires that it invest in a different way of doing things."⁴⁵

Colleagues, we are in a moment that requires us to invest in different ways of doing things to produce better outcomes for all patients. This is a pivotal moment. Our profession requires that we invest in different ways to advance toward and achieve health equity. We must invest in diversity and inclusion. We are better together! Achieving our vision—that medication use will be optimal, safe, and effective for all people all of the time—is impossible without collaborations that are diverse, equitable, and inclusive. Equity and inclusion are imperative for successful collaboration—in healthcare and in society.

ASHP is a leader in diversity, equity, and inclusion efforts

Several healthcare professions, including pharmacy, have recognized that diversity is fundamental to providing safe, equitable, and effective healthcare. Dr. Sandro Galea, dean of the Boston University School of Public Health, has gone so far as to say, “We cannot have a healthy world without diversity and inclusion.”⁴⁶ I say, “We cannot have a healthy *nation*—we cannot have a healthy nation without diversity and inclusion.”

In June 2020, amid the national reckoning around racial and social justice, ASHP formed a Task Force on Racial Diversity, Equity, and Inclusion. I served as the task force’s chair and led our efforts to assess ASHP’s work in racial diversity, equity, and inclusion as they relate to issues facing Black Americans and to recommend actionable, sustainable steps ASHP could take to further address matters of diversity, equity, and inclusion.

Within 4 months, we advanced 30 recommendations that provide a blueprint for ASHP, the profession, other healthcare organizations, and the broader community for advancing health equity.⁴⁷ Once the recommendations were approved by the Board of Directors, the ASHP staff immediately began to implement them. To make meaningful change:

- We transformed the requirements for appointing our Committee on Nominations, which yielded the most diverse slate of ASHP Board and officer candidates in ASHP’s history.
- We launched the ASHP Inclusion Center, which houses a collection of resources to help pharmacy providers address health disparities.
- We implemented a 7-part educational series to combat bias and disparities in care. More than 8,000 learners participated.
- We have 14 diversity, equity, and inclusion continuing education sessions planned for our national meetings in 2022, including 4 sessions held here in Phoenix.
- We launched a new Guided Mentorship Program to connect student pharmacists of color with seasoned practitioners. The first cohort completed the program in March 2022.
- According to the Centers for Disease Control and Prevention, nearly 244 million doses of COVID-19 vaccines were administered at pharmacy locations nationwide.⁴⁸ Thank you to those ASHP members—pharmacists, student pharmacists, and pharmacy technicians—who participated in these unprecedented vaccination efforts and provided vaccine information and advice in communities across the country.
- ASHP’s multimedia COVID-19 Vaccine Confidence Toolkit for healthcare providers includes multilingual information, resources for promoting health equity, and advice for addressing misinformation.
- And SafeMedication.com, ASHP’s consumer website, provides patients with trusted COVID-19 vaccine information in Spanish and in English.

These are just a few examples of work done to advance the recommendations of the Task Force. And the work continues.

Diversity, equity, and inclusion are critical to ASHP’s forward progress

ASHP’s strong support of diversity, equity, and inclusion did not begin with the Task Force in June 2020. ASHP has a longstanding commitment to inclusiveness in the profession, and you can see what I mean from the wealth of rich content available through ASHP’s Inclusion Center.

Inclusion and diversity of perspective are critical to ASHP as we move forward in our efforts to improve medication use, enhance patient safety, and help all people achieve optimal health outcomes. ASHP has many projects and programs that extend well beyond the Task Force recommendations.

For instance, over the past year, ASHP has led multiple efforts to promote vaccine confidence in minority and medically underserved populations, including the following:

As another example of ASHP’s leadership in diversity, equity and inclusion efforts, the ASHP Commission on Credentialing is incorporating into the revised standards for residency accreditation items addressing diversity and inclusion. These will include the recruitment of a diverse and inclusive applicant pool, as well as the recruitment of a diverse and inclusive pharmacy workforce.

ASHP’s Practice Advancement Initiative 2030, or PAI 2030, includes 59 recommendations to ensure that the pharmacy profession meets the demands of future practice and patient care delivery models.⁴⁹ PAI 2030 specifically calls on pharmacy departments to strive to achieve diversity, equity, and inclusion in all technical, clinical, and leadership roles. As organizations move closer to successfully meeting the PAI 2030 recommendations, ASHP is supporting a more diverse pharmacist and pharmacy technician workforce.

This year, for the very first time, our 2022 Pharmacy Forecast Report addressed access, disparity, and equity as key themes. The report noted, for example, that although the use of healthcare technology expanded

during the COVID-19 pandemic, a lack of access to broadband internet and new technologies and challenges with low health literacy negatively impacted underserved populations.⁵⁰ The report also highlighted the importance of screening for social determinants of health in improving patient outcomes. It concluded that there are opportunities for the pharmacy team to advocate for equitable access to digital tools and use the Forecast's findings to optimize patient care.

Over the past year, ASHP has been a tremendous advocate for issues that directly affect the health of minority populations. Most recently, ASHP helped lead efforts to introduce new federal provider status legislation in the US House of Representatives. If enacted, the Equitable Community Access to Pharmacist Services Act⁵¹ will enable patients to maintain timely and equitable access to essential care and health services provided by pharmacists. ASHP also continues its efforts to pass the Pharmacy and Medically Underserved Areas Enhancement Act⁵² to provide Medicare beneficiaries in medically underserved communities access to pharmacist care.

And we remain committed to supporting state-level advocacy, which continues to see remarkable progress, with 40 states now having Medicaid programs that recognize pharmacists as providers, along with every state now expanding the ability of pharmacists to provide care.

Conclusion

In conclusion, Solomon's words—"Two are better than one because they have a good return for their labor"—are still true today. Yet, their imperative has evolved to be "we are better together" through diversity, equity, and inclusion. The work of ASHP, and the many initiatives I highlighted for you, prove that ASHP is a leader that recognizes diversity is foundational to the future of our profession. Our policies and actions on inclusion and equity drive

excellence within our organization and the profession.

We are better together when pharmacy professionals are part of the interprofessional patient care team!

We are better together because collaboration creates synergy.

We are better together when we combine our voices to advocate for our patients and our profession.

We are better together because diversity creates better outcomes!

Together we lead; together we grow; together we create a better future!

Together, we can continue ASHP's visionary leadership and advocacy for diversity, equity, and inclusion in our profession, and I plan to lead this effort.

I am honored to serve as your president and to lead us into the future we envision for our profession. Thank you for this opportunity to serve! As president, I will continue the work of the Task Force on Racial Diversity, Equity, and Inclusion, implementing and expanding its recommendations, ensuring that we are inclusive of all as we work to pursue our mission of safe and effective medication use. We are better together! Thank you!

Disclosures

The author has declared no potential conflicts of interest.

References

- Merriam-Webster Dictionary. Diversity. Accessed February 22, 2022. <https://www.merriam-webster.com/dictionary/diversity>
- USAFacts. Where has the U.S. gotten more diverse in recent years? Almost everywhere. Accessed April 7, 2022. https://usafacts.org/articles/us-diversity-2020-race-ethnicity/?utm_source=google&utm_medium=cpc&utm_campaign=ND-Race&gclid=EAIaIQobChMI3Jfw_cI9wIVCAqtBh05tguQEAAAYASAAEgLfuvD_BwE
- USAFacts. How the Black population in the US changed in the last census. Accessed April 7, 2022. <https://usafacts.org/articles/how-black-population-changed-in-the-last-census/>
- Diversity in organizations. Course Hero. Accessed February 22, 2022. <https://courses.lumenlearning.com/boundless-management/chapter/diversity-in-organizations/#:~:text=Diversity%20leads%20to%20a%20deeper,diversity%2Drelated%20laws%20and%20regulations>
- Hunt V, Yee L, Prince S, Dixon-Fyle S. Delivering through diversity. McKinsey & Company. Accessed February 22, 2022. <https://www.mckinsey.com/business-functions/people-and-organizational-performance/our-insights/delivering-through-diversity>
- Alsam M, Garrick O, Graziani G. Does diversity matter for health? Experimental evidence from Oakland. *Am Econ Rev*. 2019;109:4071-4111. doi:10.1257/aer.20181446
- Gomez LE, Bernet P. Diversity improves performance and outcomes. *J Natl Med Assoc*. 2019; 111:383-392. doi:10.1016/j.jnma.2019.01.006.
- LaVeist TA, Pierre G. Integrating the 3Ds—social determinants, health disparities, and health-care workforce diversity. *Public Health Rep*. 2014;129(suppl 2):9-14. doi:10.1177/00333549141291S204
- Zavala VA, Bracci PM, Carethers JM, et al. Cancer health disparities in racial/ethnic minorities in the United States. *Br J Cancer*. 2021;124:315-332. doi:10.1038/s41416-020-01038-6
- Fang P, He W, Gomez D, et al. Racial disparities in guideline-concordant cancer care and mortality in the United States. *Adv Radiat Oncol*. 2018;3:221-229. doi:10.1016/j.adro.2018.04.013
- Javid SH, Varghese TK, Morris AM, et al; Collaborative to Improve Native Cancer Outcomes (CINCO). Guideline-concordant cancer care and survival among American Indian/Alaskan Native patients. *Cancer*. 2014;120:2183-2190. doi:10.1002/cncr.28683
- Brown CP, Ross L, Lopez I, Thornton A, Kiros GE. Disparities in the receipt of cardiac revascularization procedures between blacks and whites: an analysis of secular trends. *Ethn Dis*. 2008;18(2, suppl 2):S2-S112-7.
- Blackston JW, Safford MM, Mefford MT, et al. Cardiovascular disease events and mortality after myocardial infarction among Black and White adults: REGARDS study. *Circ Cardiovasc Qual Outcomes*. 2020;13e006683. doi:10.1161/CIRCOUTCOMES.120.006683
- Churchwell K, Elkind MSV, Benjamin RM, et al. Call to action: structural racism as a fundamental driver of health

- disparities: a presidential advisory from the American Heart Association. *Circulation*. 2020;142:e454-e468. doi:10.1161/CIR.0000000000000936
15. Ferdinand KC, Yadav Y, Nasser SA, et al. Disparities in hypertension and cardiovascular disease in blacks: the critical role of medication adherence. *J Clin Hypertens (Greenwich)*. 2017;19:1015-1024.
 16. Spanakis EK, Golden SH. Race/ethnic difference in diabetes and diabetic complications. *Curr Diabetes Rep*. 2013;13:814-823.
 17. Walker RJ, Williams JS, Egede LE. Influence of race, ethnicity and social determinants of health on diabetes outcomes. *Am J Med Sci*. 2016;351:366-373. doi:10.1016/j.amjms.2016.01.008
 18. Dominguez K, Penman-Aguilar A, Chang M-H, et al. Vital signs: leading causes of death, prevalence of diseases and risk factors, and use of health services among Hispanics in the United States — 2009-2013. *MMWR Morb Mortal Wkly Rep*. 2015;64:469-478.
 19. Byrd AS, Toth AT, Stanford FC. Racial disparities in obesity treatment. *Curr Obes Rep*. 2018;7:130-138. doi:10.1007/s13679-018-0301-3
 20. Cullen MR, Lemeshow AR, Russo LJ, Barnes DM, Ababio Y, Habtezion A. Disease-specific health disparities: a targeted review focusing on race and ethnicity. *Healthcare (Basel)*. 2022;10:603. doi:10.3390/healthcare10040603
 21. Laster M, Shen JJ, Norris KC. Kidney disease among African Americans: a population perspective. *Am J Kidney Dis*. 2018;72:S3-S7.
 22. Powe NR. The pathogenesis of race and ethnic disparities: targets for achieving health equity. *Clin J Am Soc Nephrol*. 2021;16:806-808.
 23. United States Renal Data System, National Institute of Diabetes and Digestive and Kidney Diseases, National Institutes of Health. 2020 USRDS annual data report: epidemiology of kidney disease in the United States. Published 2020. Accessed February 22, 2022. <https://www.usrds.org/annual-data-report/>
 24. Jang CJ, Lee HC. A review of racial disparities in infant mortality in the US. *Children*. 2022;9:257. doi:10.3390/children9020257
 25. MacDorman MF, Thoma M, Declercq E, Howell EA. Racial and ethnic disparities in maternal mortality in the United States using enhanced vital records, 2016-2017. *Am J Public Health*. 2021;111:1673-1681. doi:10.2105/AJPH.2021.306375
 26. Singh GK, Lee H. Trends and racial/ethnic, socioeconomic, and geographic disparities in maternal mortality from indirect obstetric causes in the United States, 1999-2017. *Int J MCH AIDS*. 2021;10(1):43-54. doi:10.21106/ijma.448
 27. Singh GK, Daus GP, Allender M, et al. Social determinants of health in the United States: addressing major health inequality trends for the nation, 1935-2016. *Int J MCH AIDS*. 2017;6:139-164. doi:10.21106/ijma.236
 28. Hall-Lipsy EA, Chisholm-Burns MA. Pharmacotherapeutic disparities: racial, ethnic, and sex variations in medication treatment. *Am J Health-Syst Pharm*. 2010;67:462-468.
 29. Cronin KA, Howlader N, Stevens JL, Trimble EL, Harlan LC, Warren JL. Racial disparities in the receipt of guideline care and cancer deaths for women with ovarian cancer. *Cancer Epidemiol Biomarkers Prev*. 2019;28:539-545. doi:10.1158/1055-9965.EPI-18-0285
 30. Kogut SJ. Racial disparities in medication use: imperatives for managed care pharmacy. *J Manag Care Spec Pharm*. 2020;26:1468-1474. doi:10.18553/jmcp.2020.26.11.1468
 31. Phelps G, Qiao Y, Buckley MG, et al. Effects of the 2013 American College of Cardiology/American Heart Association Guidelines on racial and ethnic disparities in statin treatment among diabetics. *Res Social Adm Pharm*. 2020;16:544-552.
 32. Qato DM, Lindau ST, Conti RM, Schumm LP, Alexander GC. Racial and ethnic disparities in cardiovascular medication use among older adults in the United States. *Pharmacoepidemiol Drug Saf*. 2010;19:834-842. doi:10.1002/pds.1974
 33. Hughes MM, Wang A, Grossman MK, et al. County-level COVID-19 vaccination coverage and social vulnerability — United States, December 14, 2020–March 1, 2021. *MMWR Morb Mortal Wkly Rep*. 2021;70:431-436. doi:10.15585/mmwr.mm7012e1
 34. Hardeman A, Wong T, Denson JL, Postelnicu R, Rojas RC. Evaluation of health equity in COVID-19 vaccine distribution plans in the United States. *JAMA Netw Open*. 2021;4:e2115653. doi:10.1001/jamanetworkopen.2021.15653
 35. Freeman K, Ray-Warren D. Racial-ethnic residential clustering and early COVID-19 vaccine allocations in five urban Texas counties. *J Health Soc Behav*. Published online February 14, 2022. doi:10.1177/00221465221074915
 36. Black Coalition Against COVID. The state of Black America and COVID-19: a two-year assessment. Accessed May 21, 2022. <https://blackcoalitionagainstdcovid.org/the-state-of-black-america-and-covid-19/>
 37. Lu J. Why pandemics give birth to hate: from bubonic plague to COVID-19. NPR. Accessed May 23, 2022. <https://www.npr.org/sections/goatsandsoda/2021/03/26/980480882/why-pandemics-give-birth-to-hate-from-black-death-to-covid-19>
 38. Zhou S, Banawa R, Oh H. The mental health impact of COVID-19 racial and ethnic discrimination against Asian American and Pacific Islanders. *Psychiatry*. Published November 17, 2021. Accessed May 23, 2022. doi:10.3389/fpsyt.2021.708426
 39. Findling M, Blendon RJ, Benson J, Koh H. COVID-19 has driven racism and violence against Asian Americans: perspectives from 12 national polls. *Health Affairs*. Accessed May 23, 2022. <https://www.healthaffairs.org/doi/10.1377/forefront.20220411.655787>
 40. Rahman K. Full list of Black people killed by police in 2021. *Newsweek*. Published December 28, 2021. Accessed May 21, 2022. <https://www.newsweek.com/black-people-killed-police-2021-1661633>
 41. Foster-Frau S. Latinos are disproportionately killed by police but often left out of the debate about brutality, some advocates say. *Washington Post*. Published June 2, 2021. Accessed May 21, 2022. https://www.washingtonpost.com/national/police-killings-latinos/2021/05/31/657bb7be-b4d4-11eb-a980-a60af976ed44_story.html
 42. Arce J. It's long past time we recognized all the Latinos killed at the hands of police. *Time*. Published July 21, 2020. Accessed May 21, 2022. <https://time.com/5869568/latinos-police-violence/>
 43. American Society of Health-System Pharmacists. ASHP policy 2035: role of the pharmacy workforce in violence prevention. In: Hawkins B, ed. *ASHP Policy Positions 1982-2021*. American Society of Health-System Pharmacists; 2022:97-98. Accessed May 23, 2022. <https://www.ashp.org/-/media/assets/policy-guidelines/docs/browse-by-document-type-policy-positions-1982-2017-with-rationales-pdf.ashx>
 44. Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care; Smedley BD, Stith AY, Nelson AR, eds. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. National Academies Press; 2003. doi:10.17226/12875
 45. Hardeman RR. Improving the measurement of structural racism to

- achieve antiracist health policy. *Health Aff.* 2022;41:179-186. doi:10.1377/hlthaff.2021.01489
46. Galea S. The link between diversity, inclusion, and excellence in the pursuit of health. *Thrive*. Published May 17, 2021. Accessed February 22, 2022. <https://thriveglobal.com/stories/the-link-between-diversity-inclusion-and-excellence-in-the-pursuit-of-health/>
47. Report of the ASHP Task Force on Racial Diversity, Equity, and Inclusion. *Am J Health-Syst Pharm.* 2021;78:903-906. doi:10.1093/ajhp/zxab078
48. US Centers for Disease Control and Prevention. The Federal Retail Pharmacy Program for COVID-19 Vaccination. Accessed May 21, 2022. <https://www.cdc.gov/vaccines/covid-19/retail-pharmacy-program/index.html>
49. American Society of Health-System Pharmacists. ASHP Practice Advancement Initiative 2030 recommendations. Accessed May 21, 2022. <https://www.ashp.org/pharmacy-practice/pai/pai-recommendations>
50. DiPiro J. Pharmacy Forecast 2022. Introduction and methods. *Am J Health-Syst Pharm.* 2022;7:24-26.
51. American Society of Health-System Pharmacists. ASHP applauds introduction of Equitable Community Access to Pharmacist Services Act. Accessed May 21, 2022. <https://www.ashp.org/news/2022/03/25/ashp-applauds-introduction-of-equitable-community-access-to-pharmacist-services-act?loginreturnUrl=SSOCheckOnly>
52. American Society of Health-System Pharmacists. Pharmacy and Medically Underserved Areas Enhancement Act. Accessed May 21, 2022. <https://www.ashp.org/advocacy-and-issues/provider-status/pharmacy-and-medically-underserved-areas-enhancement-act?loginreturnUrl=SSOCheckOnly>