House of Delegates Session—2024

June 9 and 11, 2024

Proceedings of the 76th annual session of the ASHP House of Delegates, June 9 and 11, 2024

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Paul W. Abramowitz, Secretary

The 76th annual session of the ASHP House of Delegates was held at the Oregon Convention Center, in Portland, Oregon, in conjunction with Pharmacy Futures 2024.

First meeting

The first meeting was convened at 1:00 p.m. Sunday, June 9, by Chair of the House of Delegates Melanie A. Dodd. Chair Dodd introduced the persons seated at the head table: Paul C. Walker, Immediate Past President of ASHP and Vice Chair of the House of Delegates; Nishaminy (Nish) Kasbekar, President of ASHP and Chair of the Board of Directors; Leigh A. Briscoe-Dwyer, 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 188 delegates representing 48 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 75th 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 75th 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 Tyler Vest, Chair of the Committee on Nominations, for the report of the Committee on Nominations (Appendix IV).[a] Nominees were presented as follows:

President 2025-2026
Melanie A. Dodd, PharmD, PhC, BCPS, FASHP, Associate Dean for Clinical Affairs and Professor, University of New Mexico, Albuquerque, NM

Stephen F. Eckel, PharmD, MHA, Associate Dean for Global Engagement, UNC Eshelman School of Pharmacy, Chapel Hill, NC

Board of Directors, 2025-2028
Marie A. Chisholm-Burns, PharmD, PhD, MPH, MBA, FACHE, FASHP, FAST, Executive Vice President and Provost, Oregon Health & Science University, Portland, OR

Todd W. Nesbit, PharmD, MBA, CPEL, FASHP, Chief Pharmacy Officer and Vice President, The Johns Hopkins Health System, Baltimore, MD

Mollie A. Scott, PharmD, BCACP, CPP, FASHP, FNCAP, Regional Associate Dean and Clinical Professor, UNC Eshelman School of Pharmacy, Asheville, NC

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

Chair, House of Delegates, 2024-2027
Jesse H. Hogue, PharmD, Pharmacy Education Coordinator, Bronson Methodist Hospital, Kalamazoo, MI

Martin J. Torres, PharmD, FCSHP, Director of Pharmacy, UC Irvine Medical Center Pharmacy Department, Orange, CA

A "Meet the Candidates" session to be held on Monday, June 10, 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.)

Jennifer Tryon, Board Liaison to the **Council on Pharmacy Practice**, presented the Council's Policy Recommendations 1 through 5.

1. Prehospital Management of Medications
To assert that variation in the prehospital management and use of medications is a risk to patient safety and continuity of care; further,

To advocate for pharmacy workforce involvement in clinical and operational decision-making for prehospital management and utilization of medications; further,

~~To encourage the pharmacy workforce to assume responsibility for medication-related aspects of ensuring the continuity of care as patients transition from prehospital care to other care settings; further,~~

To collaborate with stakeholders involved in prehospital medication-use ~~cycle~~ decisions to improve patient safety, minimize variation, and reduce inefficiencies.

2. Role of Artificial Intelligence in Pharmacy Practice

To ~~recognize~~ embrace artificial intelligence (AI) as a tool with tremendous potential to improve patient care and the medication-use process~~; which should be implemented with caution due to potential unforeseen risks~~ through the enhancement of pharmacy practice; further,

To recognize that AI technologies offer innovative ways to gather clinical knowledge, assist learners, enhance educational experiences, and streamline administrative processes; further,

~~To encourage healthcare organizations to develop policies, procedures, and guidelines to determine which care settings, medications, and patient populations are appropriate candidates for the use of AI; further,~~

To advocate for ~~regulations and~~ standards, policies, and procedures that permit the use of AI in circumstances in which it has proven safe and effective as an augmentation of pharmacy services and to ensure safeguards along with its implementation; further,

To encourage the adoption of policies regarding the use of AI and ongoing surveillance of these tools to maintain professional integrity; further,

To advocate for pharmacy workforce involvement and transparency in the decision-making, design, validation, implementation, and ongoing evaluation of AI-related applications and technologies ~~that affect medication-use processes and tasks~~; further,

To recognize that ethical considerations must guide the development and use of AI in pharmacy practice, and to oppose any use of AI that compromises human interaction or replaces ethical decision-making, professional judgment, ~~or~~ critical thinking, or ~~is implemented solely to reduce healthcare staffing and resources; further,~~ the safety and effectiveness of pharmacy services

~~To advocate for regulations and standards that permit the use of AI in circumstances in which it has proven safe and effective~~.

3. Independent Prescribing Authority

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

To ~~recognize~~ affirm that pharmacists are highly trained medication experts on the interprofessional care team ~~capable of making~~ who make ~~independent and autonomous~~ evidence-based decisions ~~on medication therapy management~~; further,

To advocate that credentialed and privileged pharmacists have independent ~~and autonomous~~ authority to initiate, monitor, modify, and deprescribe all schedules and classes of medications; further,

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

To advocate that ~~all~~ pharmacists ~~have a National Provider Identifier that is~~ be recognized as authorized providers by payers, pharmacies, and industry.

Note: This policy supersedes ASHP policies 2236 and 2251.

4. Pharmacist's Role on Ethics Committees

To advocate that pharmacists should be

included as members of~~, or identified as a resource to,~~ hospital and health-system ethics committees; further,

To encourage pharmacists to actively seek ethics consultations ~~or solicit input from their institution's ethics committee,~~ as appropriate; further,

To advocate for inclusion of ethics in pharmacy education and encourage pharmacists serving on ethics committees to seek advanced training in healthcare ethics.

Note: This policy supersedes ASHP policy 1403.

5. Safe Handling and Administration of Hazardous Drugs

To advocate that pharmaceutical manufacturers and wholesale distributors employ decontamination practices to eliminate surface contamination on packages ~~and vials~~ of hazardous drugs (HDs); further,

To advocate that pharmaceutical manufacturers develop closed-system transfer device compatible, ready-to-administer HD products; further,

~~To inform pharmacists and other personnel of the potential presence of surface contamination on the packages and vials of HDs; further,~~

To advocate ~~that the Food and Drug Administration require~~ for standardized labeling and package design for HDs that would alert handlers to the potential presence of surface contamination~~, including development of CSTD-compatible, ready-to-administer HD products~~; further,

~~To advocate that all healthcare settings proactively conduct an interprofessional assessment of risk for exposure to HDs during handling and administration, including the use of closed-system transfer devices (CSTDs); further,~~

To advocate for pharmacist involvement in the development of policies, procedures, and operational assessments regarding administration of HDs~~, including when CSTDs cannot be used; further,~~

~~To advocate that the Food and Drug Administration require standardized labeling and package design for HDs that would alert handlers to the potential presence of surface contamination, including development of CSTD-compatible, ready-to-administer HD products; further,~~

~~To encourage healthcare organizations, wholesalers, and other trading partners in the drug supply chain to adhere to published standards and regulations~~.

Note: This policy supersedes ASHP policies 1615 and 1902.

Vivian Bradley Johnson, Board Liaison to the **Council on Public Policy**, presented the Council's Policy Recommendations 1 through 3.

1. Order Verification

To advocate ~~that a prescriber should not be solely responsible for medication ordering, dispensing, and administration as well as any patient monitoring and evaluation, except when a double check would limit patient access to care~~ for implementation of independent double checks, when feasible, to reduce the risk of error when a single practitioner is solely responsible for ordering, dispensing, administering, and monitoring medication therapy.

2. Liability Protection

To advocate that pharmacists be able to dispense medications and provide ~~evidence-based dispensing and~~ care to patients per their clinical judgment and their conscience without fear of ~~criminal or civil~~ legal or regulatory consequences, workplace sanctions, social

stigmatization, harassment, or ~~liability~~ harm; further,

To advocate that these protections ~~against liability~~ extend to referrals for out-of-state care and for dispensing to patients from another state.

3. State Prescription Drug Monitoring Programs
To support continued state implementation of prescription drug monitoring programs that collect real-time, relevant, and standard information from all dispensing outpatient entities about controlled substances and monitored prescriptions; further,

To advocate that such programs and states seek adoption into health information exchanges to best integrate into electronic health records and to allow prescribers, ~~pharmacists~~ the pharmacy workforce, and other practitioners to proactively monitor data for appropriate assessment and dispensing; further,

To advocate that such programs improve their interstate data integration to enhance clinical decision-making and end-user satisfaction; further,

To advocate against unilateral use of these systems that may lead to patient stigmatization or prevent them from seeking appropriate medical care; further,

To encourage policies that allow ~~practicing pharmacists~~ the pharmacy workforce to gain access to databases without holding licensure in each state; further,

To promote research on the effects of prescription drug monitoring programs and electronic health record programs on ~~opioid~~ prescribing, dispensing, misuse, morbidity, and mortality.

Note: This policy supersedes ASHP policy 1408.

Vickie L. Powell, Board Liaison to the **Council on Therapeutics**, presented the Policy Recommendations 1 through 3.

1. Testing for Pregnancy Status
To affirm that pregnancy testing should occur only with the patient's informed consent/assent, when feasible, and only when the test results would change medical management; further,

To affirm that a positive pregnancy test should not compromise the integrity of evidence-based, patient-centered care.

2. 5-HT$_2$ Agonist, Entactogen, and Empathogen (Psychedelic) Assisted Therapy
To recognize that psychedelic-assisted therapy (PAT) has demonstrated therapeutic potential and should be further researched; further,

To recognize that in PAT there is not a standardized product subject to the same regulations as a prescription drug product, and to support the development of standardized formulations of psychedelics that would provide consistent potency and quality; further,

To encourage state boards of pharmacy, regulatory agencies, and safety bodies with an interest in PAT to promote research best practices and regulatory standards for medication preparation, compounding, and administration to ensure safety and quality; further,

To advocate that when psychedelics are used for PAT, healthcare providers, including pharmacists, should assess patients for medical, pharmacologic, and psychosocial contraindications prior to use and provide medical assistance as needed.

3. Nonprescription Status of Rescue and Reversal Medications
To support the ~~over-the-counter (OTC)~~ nonprescription status of medications intended for evidence-based rescue use or reversal of potentially fatal events, in delivery systems appropriate for administration by lay persons; further,

~~To work with federal, state, and local governments and others to improve the rescue and reversal medication development and supply system to ensure an adequate and equitably distributed supply of these medications; further,~~

~~To advocate that all insurers and manufacturers maintain coverage and limits on out-of-pocket expenditure so that patient access to rescue and reversal medications is not compromised; further,~~

To promote practices and policies that ensure affordable and equitable access to rescue and reversal medications; further,

To support and foster standardized education and training on the role of rescue and reversal medications and their proper storage, proper administration, safe use, and appropriate follow-up care.

Kristi Gullickson, Board Liaison to the **Council on Education and Workforce Development**, presented the Council's Policy Recommendations 1 through 4.

1. Opposition to Pharmacy Jurisprudence Examination Requirement
To advocate for the removal of ~~a~~ standalone examination of federal or state pharmacy law as a requirement for licensure to increase interstate practice flexibility; further,

To ~~advocate that employers provide initial and~~ support ongoing education of the pharmacy workforce on pertinent federal and state pharmacy laws; further,

To acknowledge that it is a professional obligation of ~~a pharmacist~~ the pharmacy workforce to practice in compliance with federal and state laws.

2. Pharmacy Technician Education Requirements
To recognize that highly trained and skilled pharmacy technicians working in advanced roles regularly perform complex and critical medication-use procedures, and that a safe and effective medication-use process depends significantly on the skills, knowledge, and competency of those pharmacy technicians to perform those tasks; further,

~~To reaffirm that all pharmacy technicians should complete an ASHP-accredited training program, be certified by the Pharmacy Technician Certification Board and be licensed by state boards of pharmacy; further,~~

To advocate that ~~beyond those requirements,~~ pharmacy technicians working in advanced roles ~~should complete at a minimum an~~ have additional training, such as an associate ~~of science~~ degree, and demonstrate ongoing competencies specific to the tasks to be performed, to ensure patient safety~~; further,~~

~~To advocate that expansion of pharmacy technician duties into expanded, advanced roles should include consideration of potential risk to patients and that ongoing quality assurance metrics should be established to assure patient safety~~.

Note: This policy supersedes ASHP policy 1203.

3. Pharmacy Residency Training
To continue efforts to increase the number of ASHP-accredited pharmacy residency training programs and positions available; further,

To promote efforts to increase recruitment and retention of residents in ASHP-accredited pharmacy residency programs; further,

To encourage stakeholders to evaluate priority areas within pharmacy for future residency training needs.

Note: This policy supersedes ASHP policy 0917.

Kim W. Benner, Board Liaison to the **Council on Pharmacy Management**, presented the Council's Policy Recommendation.

1. Documentation of Patient-Care Services in the Permanent Health Record
To advocate for public policies that support documentation of patient-care services provided by the pharmacy workforce in the permanent patient health record; further,

~~To promote inclusion of the pharmacy workforce in organization-based credentialing and privileging processes and in collaboration with an organization's clinical informatics team to ensure accurate and complete documentation of the care provided to patients and to validate the impact of patient care provided by the pharmacy workforce on patient outcomes and cost of care; further,~~

To advocate ~~that~~ for the design and use of electronic health records ~~be designed~~ with a common documentation space to accommodate all healthcare team members ~~and support the communication needs of pharmacy~~.

Note: This policy supersedes ASHP policy 1419.

2. Safe Medication Sourcing, Preparation, and Administration in All Sites of Care
To advocate that all sites of care be required to meet the same regulatory standards for medication sourcing, preparation, and administration to ensure safety and quality.

Note: This policy supersedes ASHP policy 1914.
The meeting adjourned at 5:30 p.m.

Second meeting
The second and final meeting of the House of Delegates session convened on Tuesday, June 11 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 Kaskebar 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 10 to "duly consider" the policies amended at the first meeting. Two policy recommendations were approved without amendment. Thirteen policy recommendations were amended or edited by the House of Delegates, and one policy recommendation were referred to the Board. The Board agreed with the House's amendments and editorial changes to 11 policy recommendations, with nonsubstantive editorial changes to two of those 11 policy recommendations. The Board did not accept House amendments to two policy recommendations (Council on Pharmacy Practice 3 and Council on Education and Workforce Development 2) and offered revised language for those 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
1. Independent Prescribing Authority
~~To affirm that prescribing is a collaborative~~

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

To ~~recognize~~ affirm that pharmacists are highly trained medication experts on the interprofessional care team ~~capable of making~~ who make ~~independent and autonomous~~ evidence-based decisions ~~on medication therapy management~~; further,

To advocate that ~~**credentialed and privileged**~~ pharmacists have independent ~~and autonomous~~ authority to initiate, monitor**,** modify, and deprescribe all schedules and classes of medications**, commensurate with the pharmacist's training and in accordance with the standard of care**; further,

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

To advocate that ~~all~~ pharmacists ~~have a National Provider Identifier that is~~ be recognized as authorized providers by payers**,** pharmacies, and industry.

Note: This policy supersedes ASHP policies 2236 and 2251.

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

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2. ~~Pharmacy Technician Education Requirements~~ Additional Education Requirements for Pharmacy Technicians in Advanced Roles

To recognize that highly trained and skilled pharmacy technicians working in advanced roles regularly perform complex and critical medication-use procedures, and that a safe and effective medication-use process depends significantly on the skills, knowledge, and competency of those pharmacy technicians to perform those tasks; further,

~~To reaffirm that all pharmacy technicians should complete an ASHP-accredited training program, be certified by the Pharmacy Technician Certification Board and be licensed by state boards of pharmacy; further,~~

To reaffirm that all pharmacy technicians should complete an ASHP-accredited training program, be certified by the Pharmacy Technician Certification Board and be licensed by state boards of pharmacy; further,

To advocate that ~~beyond those requirements,~~ pharmacy technicians working in advanced roles ~~should complete at a minimum an~~ have additional training, such as an associate ~~of science~~ degree**,** and demonstrate ongoing competencies specific to the tasks to be performed**,** to ensure patient safety~~; further,~~

~~To advocate that expansion of pharmacy technician duties into expanded, advanced roles should include consideration of potential risk to patients and that ongoing quality assurance metrics should be established to assure patient safety~~.

Note: This policy supersedes ASHP policy 1203.

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

New Business. Chair Dodd announced that, in accordance with Article 7 of the Bylaws, there were two items of New Business to be considered. Chair Dodd called on Jesse Hogue (MI) and Andrew Kaplan (FL) to introduce the New Business (Appendix IX). Following discussion and amendment, the items were approved for referral to the Board of Directors. With House amendments (underlined type indicating text added; ~~strikethrough~~ indicating text deleted), the first item of New Business reads as follows:

Reconsideration of the Council on Public Policy Liability Protection Policy Proposal

Motion:
To advocate that pharmacists be able to dispense medications and provide ~~evidence-based dispensing and~~ care to patients per their clinical judgment and their conscience without fear of ~~criminal or civil~~ legal or regulatory consequences, workplace sanctions, social stigmatization, harassment, or ~~liability~~ harm; further,

To advocate that these protections ~~against liability~~ extend to referrals for out-of-state care and for dispensing to patients from another state.

Background:
While we recognize the language was not perfect in the view of all delegates, given the urgent need to have a policy on the books to support advocacy efforts and the seeming misunderstanding of the proceedings at the Sunday session of the House of Delegates, we move to approve the original Council on Public Policy Liability Protection policy proposal rather than referring it back to Council. That language is captured as the motion above.

Suggested Outcomes:
In addition to having a policy on the books for near-term advocacy efforts, the Council on Public Policy should revisit this policy in consideration of the rich discussion on Connect and at the House of Delegates for the purpose of further optimizing it and addressing the concerns with the current language.

Re-classification of Reproductive Health Medications as Controlled Substances

Motion:
To amend ASHP policy 2250, Access to Reproductive Health Services, be revised by addition of a new clause 4, reading:

To advocate that states should not re-classify medications related to reproductive health, such as misoprostol and mifepristone, not be reclassified as controlled substances, given the low likelihood of personal abuse or physiological dependence, and that dispensing of those medications not be required to be reported to prescription drug monitoring programs; further,

Background:
Louisiana re-classified misoprostol and mifepristone as Schedule IV controlled substances in legislation that will go into effect October 2024.

We believe ASHP policy should advocate against this restriction and similar restrictions which may be entertained in other states.

While several states place medications into more restrictive schedules than the federal level, this additional oversight is typically intended for medications which have potential for abuse and that abuse may lead to physical dependence or psychological dependence - examples being Kentucky classifies gabapentin as a Schedule V controlled substance, and New York treats benzodiazepines like Schedule II controlled substances.

There is no evidence that either misoprostol or mifepristone have a likelihood of abuse or have demonstrated risk of physical dependence. Placing these medications into a controlled substance schedule creates unnecessary

burdens on providers, pharmacists, nurses and patients which can impede access to reproductive health efforts, with seemingly little benefit to public health.
Further, scheduling these medications creates a false impression among patients, practitioners, and the public that these medications are dangerous and require additional restrictions.

Finally, with these medications being treated as controlled substances, they will be required to be reported through state prescription drug monitoring programs (PDMP's). We believe this information could be potentially used inappropriately to surveil use of medications used in reproductive health, empowering the state(s) to monitor the termination of pregnancies, even across state lines (since many states share PDMP data).

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 Kasbekar with an inscribed gavel commemorating her term of office.
Chair Dodd then installed the chairs of ASHP's sections and The Pharmacy Technician Society: Sara M. Panella, Section of Ambulatory Care Practitioners; Megan Musselman, Section of Clinical Specialists and Scientists; Lucas Schulz, Section of Inpatient Care Practitioners; Jeffrey Chalmers, Section of Pharmacy Informatics and Technology; Katherine (Kat) A. Miller, Section of Pharmacy Practice Leaders; Erica Diamantides, Section of Specialty Pharmacy Practitioners; and Alfred Awuah, New Practitioner's Forum. Chair Dodd then recognized the remaining members of the executive committees of sections and forums.

Chair Dodd explained that the Pharmacy Technician Forum delegate will now be replaced by the President of The Pharmacy Technician Society (TPTS). Daniel Nyakundi is the current President and delegate for TPTS.

Installation. Chair Dodd then installed Leigh Briscoe-Dwyer as President of ASHP (Appendix XI). (See Appendix XII for the Inaugural Address of the Incoming President.)

Adjournment. The 76th annual June meeting of the House of Delegates adjourned at 6:00 p.m.

ASHP HOUSE OF DELEGATES

Melanie A. Dodd, Chair
Paul C. Walker, Vice Chair

As of June 4, 2024

OFFICERS AND BOARD OF DIRECTORS
Nishaminy Kasbekar, President
Leigh A. Briscoe-Dwyer, President-Elect
Paul C. Walker, Immediate Past President
Christene M. Jolowsky, Treasurer
Paul W. Abramowitz, Chief Executive Officer
Kim W. Benner, Board Liaison, Council on Pharmacy Management
Melanie A. Dodd, Chair of the House
Kristine K. Gullickson, Board Liaison, Council on Education and Workforce Development
Vivian Bradley Johnson, Board Liaison, Council on Public Policy
Pamela K. Phelps, Board Liaison, Commission on Affiliate Relations
Vickie L. Powell, Board Liaison, Council on Therapeutics
Jennifer E. Tryon, Board Liaison, Council on Pharmacy Practice

PAST PRESIDENTS			
Roger Anderson	Lisa Gersema	Gerald Meyer	Linda Tyler
John Armitstead	Diane Ginsburg	John Murphy	Sara White
Daniel Ashby	Harold Godwin	Cynthia Raehl	T. Mark Woods
Jill Martin Boone	Mick Hunt	Philip Schneider	David Zilz
Cynthia Brennan	Clifford Hynniman	Kathryn Schultz	
Bruce Canaday	Marianne Ivey	Bruce Scott	
Kevin Colgan	Thomas Johnson	Steven Sheaffer	
Debra Devereaux	Stan Kent	Janet Silvester	
Fred Eckel	Robert Lantos	Kelly Smith	
Rebecca Finley	Lynnae Mahaney	Thomas Thielke	

STATE	**DELEGATES**	**ALTERNATES**
Alabama (3)	Nancy Bailey Danna Nelson Megan Roberts	Nathan Pinner
Alaska (2)	Shawna King Laura Lampasone	
Arizona (3)	Melinda Burnworth Christopher Edwards Kelly Erdos	Janelle Duran Jake Schwarz Sarah Stevens
Arkansas (3)	Jama Huntley Phillip Jackson Brandy Hubbard	Josh Maloney

California (7)	Gary Besinque Katrina Derry Daniel Kudo Elaine Law Sarah McBane Caroline Sierra Steven Thompson	Kethen So
Colorado (3)	Clint Hinman Lance Ray Tara Vlasimsky	Bridger Singer
Connecticut (3)	Molly Leber Colleen Teevan	Sam Abdelghany Christina Hatfield Jason Zyber
Delaware (2)	Cheri Briggs Pooja Dogra	
Florida (6)	Jeffrey Bush Andrew Kaplan Dionis Malo Sara Panella Heather Petrie William Terneus	Margareth Larose Pierre Farima Raof
Georgia (3)	Davey Legendre Christy Norman Samantha Roberts	Matthew Hurd Kunal Patel
Hawaii (2)	Shelley Kikuchi Mark Mierzwa	Wesley Sumida
Idaho (2)	Paul Driver Victoria Wallace	Jessica Bowen
Illinois (5)	Andy Donnelly Bernice Mann Jennifer Phillips Radhika Polisetty Matthew Rim	Chris Crank Sharon Karina Nikola Markoski Samantha Rimas
Indiana (3)	Andrew Lodolo Christopher Scott Tate Trujillo	
Iowa (3)	John Hamiel Lisa Mascardo Jessica Nesheim	Emmeline Paintsil Jenna Rose Jennifer Williams
Kansas (3)	Christina Crowley Brian Gilbert Katie Wilson	Jeff Little Katherine Miller Zahra Nasrazadani Megan Ohrlund
Kentucky (3)	Dale English Scott Hayes Thomas Platt	Kortney Brown Stephanie Justice Chelsea Maier

Louisiana (3)	Jason Lafitte Heather Maturin Heather Savage	Tara Montgomery
Maine (2)	Brian McCullough Megan Rusby	Kathryn Sawicki
Maryland (4)	John Hill Terri Jorgenson Marybeth Kazanas Janet Lee	Justin Hare Molly Wascher
Massachusetts (4)	Jason Lancaster Frankie Mernick Marla O'Shea-Bulman Russel Roberts	Monica Mahoney
Michigan (4)	Jesse Hogue Lama Hsaiky Jessica Jones Rebecca Maynard	Rox Gatia Ed Szandzik
Minnesota (3)	Lance Oyen John Pastor Rachel Root	Paul Morales Scott Nei Cassie Schmitt
Mississippi (2)	Caroline Bobinger Andrew Mays	Joshua Fleming
Missouri (3)	Joel Hennenfent Amy Sipe Mel Smith	Nathan Hanson Cassie Heffern Sayo Weihs
Montana (2)	Julie Neuman Logan Tinsen	JoEllen Maurer
Nebraska (3)	Tiffany Goeller Katie Reisbig David Schmidt	Jolyn Merry
Nevada (2)	Adam Porath Kate Ward	
New Hampshire (2)	Melanie McGuire Elizabeth Wade	Marilyn Hill
New Jersey (4)	Rich Artymowicz Julie Kalabalik-Hoganson Deb Sadowski Craig Sastic	Barbara Giacomelli Agnieszka Pasternak Jennifer Sternbach
New Mexico (2)	Lisa Anselmo Nick Crozier	
New York (5)	Amisha Arya (1st meeting) Travis Dick Paul Green Mark Sinnet Leila Tibi-Scherl (2nd meeting) Kimberly Zammit	Brendan Begnoch Charrai Byrd Angela Cheng Carline Fevry Courtney Jarka Christine Nguyen

North Carolina (4)	Leslie Barefoot Mary Parker Jeffrey Reichard Tyler Vest	Angela Livingood Mollie Scott
North Dakota (2)	Maari Loy Katrina Rehak	Elizabeth Monson Saidee Oberlander
Ohio (5)	Ashley Duty Cynthia King Dan Lewis Kellie Musch Kembral Nelson	Ben Lopez Joshua Musch Jerry Siegel
Oklahoma (3)	Corey Guidry Jeremy Johnson Andrea Rai	
Oregon (3)	Ryan Gibbard (2nd meeting) Michael Lanning (1st meeting) Edward Saito Ryan Wargo	
Pennsylvania (4)	Arpit Mehta Kimberly Mehta Cassandra Redmond Christine Roussel	Jennifer Belavic Scott Bolesta Jill Rebuck Joseph Stavish Evan Williams
Puerto Rico (2)	Carlos Méndez Bauza Idaliz Rodriguez Escudero	Mirza Martínez Giselle Rivera
Rhode Island (2)	Nelson Caetano Martha Roberts	Ray Iannuccillo Karen Nolan
South Carolina (3)	Thomas Achey Carolyn Bell Lisa Gibbs	Harrison Jozefczyk
South Dakota (2)	Betsy Karli Anne Morstad	Joseph Berendse Laura Stoebner
Tennessee (4)	Kelly Bobo Erin Neal Grayson Peek Jodi Taylor	Don Branam Jennifer Robertson
Texas (6)	Latresa Billings Joshua Blackwell Todd Canada Rodney Cox Binita Patel Jeffrey Wagner	Abimbola Farinde Jerry James
Utah (3)	Conor Hanrahan Elyse MacDonald Krystal Moorman-Bishir	Shannon Inglet Whitney Mortensen
Vermont (2)	Jeffrey Gonzalez Emily Piehl	Julie MacDougall Kevin Marvin

Virginia (4)	Kathy Koehl Amy Schultz Brian Spoelhof Rodney Stiltner	June Javier
Washington, D.C. (2)	Sue Carr Kelly Mullican	Joann Lee
Washington State (3)	Lauren Bristow Chris Greer Karen White	
West Virginia (2)	Chris Fitzpatrick Derek Grimm	
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Pharmacy Student Forum	Heather Howell	Charbel Aoun
Pharmacy Technician Forum	Daniel Nyakundi	Tyler Darcy
FRATERNAL	**DELEGATES**	**ALTERNATES**
U.S. Air Force	Lt Col Rohin Kasudia	Maj. Elizabeth Tesch
U.S. Army	LTC Victoria O'Shea	MAJ Danielle Zsido
U.S. Navy	LT Staci Jones	LCDR Chirag Patel
U.S. Public Health Service	CDR Christopher McKnight	Jeffrey Gildow Russ Gunter
Veterans Affairs	Heather Ourth	Tera Moore Anthony Morreale

House of Delegates

REPORT ON THE VIRTUAL HOUSE OF DELEGATES

March 15-22, 2024

RESULTS OF THE VOTING

Between March 15 and 22, the ASHP House of Delegates (roster attached as an Appendix) voted on 20 policy recommendations. Delegates approved 12 policy recommendations by 85% or more, the threshold for final approval. Eight policy recommendations did not receive 85% of votes cast and will be sent to the June House of Delegates.

POLICY RECOMMENDATIONS APPROVED

The 12 policy recommendations **approved** are as follows (percentage of delegates voting to approve follows the policy title):

Role of the Pharmacy Workforce in Improving Mental Health (94.6%)
Source: Council on Pharmacy Practice
To advocate for equitable and destigmatized access to mental healthcare services for all patients across their lifespan, including members of the healthcare workforce; further,

To affirm the essential role of pharmacists, as members of the interprofessional care team, in increasing patient access to mental healthcare services; further,

To urge all members of the pharmacy workforce to raise awareness of, screen for, triage, and provide education on mental health conditions; further,

To advocate for expansion of mental health-related comprehensive medication management services provided by pharmacists; further,

To advocate for adequate funding of mental health awareness programs and for funding that promotes equitable access to mental healthcare services.

Suicide Awareness, Prevention, and Response (95.5%)
Source: Council on Pharmacy Practice
To support the goal of zero suicides; further,

To collaborate with key stakeholders in support of suicide awareness, prevention, and response; further,

To acknowledge that optimal suicide awareness, prevention, and response efforts focus both on patients and on the healthcare workforce; further,

To recognize that pharmacists, as key members of the interprofessional care team, are integral to suicide awareness, prevention, and response efforts, and to acknowledge the vital role of other members of the pharmacy workforce in those efforts; further,

To foster the use and development of clinically validated tools to aid the pharmacy workforce in assessing the influence of medications and other factors on suicidality; further,

To advocate for adequate government and healthcare organization funding for suicide awareness, prevention, and response; further,

To enhance awareness of local, state, national, and global suicide awareness, prevention, and response resources.

Note: This policy would supersede ASHP policy 1901.

Emergency Supplies of Drug Products (98.0%)
Source: Council on Public Policy
To discontinue ASHP policy 1906, Emergency Supplies of Drug Products, which reads:

> To advocate for states to allow any pharmacist, during a declared emergency, to dispense without a prescription an emergency supply of a drug product in quantities that meet the needs of patients.

Drug Nomenclature (100%)
Source: Council on Public Policy
To discontinue ASHP policy 9011, Drug Nomenclature, which reads:

> To work with the FDA, USP, and pharmaceutical industry to assure that drug products are named in a manner that clearly and without confusion permits identification of ingredients' strengths and changes.

Medication Stewardship Programs (93.6%)
Source: Council on Therapeutics
To advocate that pharmacists are foundational members of any medication stewardship program; further,

To affirm that pharmacists bring unique clinical, operational, safety, and financial expertise to help organizations develop and manage medication stewardship programs; further,

To promote pharmacist leadership in medication stewardship teams; further,

To encourage healthcare organizations to develop comprehensive medication stewardship programs that align with applicable laws, regulations, and accreditation standards; further,

To support incorporation and development of the pharmacy workforce in medication stewardship efforts; further,

To enhance awareness that medication stewardship includes disease state management across all levels of care and addresses barriers at the patient and system levels in order to improve the quality, safety, and value of patient care.

Research on Drug Use in Obese Patients (98.0%)
Source: Council on Therapeutics
To discontinue ASHP policy 1920, Research on Drug Use in Obese Patients, which reads:

> To encourage drug product manufacturers to conduct and publish pharmacokinetic and pharmacodynamic research in obese patients to facilitate safe and effective dosing of medications in this patient population, especially for medications most likely to be affected by obesity; further,
>
> To encourage manufacturers to include in the Food and Drug Administration (FDA)–approved labeling detailed information on characteristics of individuals enrolled in drug dosing studies; further,
>
> To advocate that the FDA develop guidance for the design and reporting of studies that support dosing recommendations in obese patients; further,
>
> To advocate for increased enrollment and outcomes reporting of obese patients in clinical trials of medications; further,
>
> To encourage independent research on the clinical significance of obesity on drug use, as well as the reporting and dissemination of this information via published literature, patient registries, and other mechanisms; further,
>
> To recognize that pharmacists are medication therapy experts who should provide guidance on appropriate drug dosing for obese patients.

Therapeutic Interchange (95.5%)
Source: Council on Therapeutics
To discontinue ASHP policy 8708, Therapeutic Interchange, which reads:

> To support the concept of therapeutic interchange of various drug products by pharmacists under arrangements where pharmacists and authorized prescribers interrelate on the behalf of patient care.

Flexible Workforce Models (92.0%)
Source: Council on Education and Workforce Development
To advocate for flexible workforce models that promote patient safety and continuity of care, optimize pharmacy operations, and enhance recruitment and retention of the pharmacy workforce.

Pharmacist Access to Provider Networks (97.0%)
Source: Council on Pharmacy Management
To advocate for laws and regulations that require healthcare payers to include pharmacists in their provider networks as standard coverage when providing patient care services within their scope of practice and the services are covered benefits; further,

To advocate that payers provide comparative, transparent sharing of performance and quality measure data for all providers in their networks, including pharmacists.

Note: This policy would supersede ASHP policy 2134.

Risk Assessment of Health Information Technology (98.0%)
Source: Council on Pharmacy Management
To urge hospitals and health systems to directly involve departments of pharmacy in performing appropriate risk assessment before new health information technology (HIT) is implemented or existing HIT is upgraded, and as part of the continuous evaluation of current HIT performance; further,

To advocate that HIT vendors provide estimates of the resources required to implement and support new HIT; further,

To collaborate with HIT vendors to encourage the development of HIT that improves patient-care outcomes and user experience; further,

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

Note: This policy would supersede ASHP policy 1418.

Unit Dose Packaging Availability (91.1%)
Source: Council on Pharmacy Management
To advocate that pharmaceutical manufacturers provide all medications used in health systems in unit dose packages or, when applicable, in packaging that optimizes medication safety, improves operational efficiency, and reduces medication waste; further,

To urge that the Food and Drug Administration require pharmaceutical manufacturers to provide stability data to support the repackaging of medications outside of their original manufacturer bulk containers in the interest of public health, healthcare worker and patient safety, and reduced waste.

Note: This policy would supersede ASHP policy 2253.

Optimizing the Medication-Use Process (96.0%)
Source: Council on Pharmacy Management
To discontinue ASHP policy 9903, Optimizing the Medication-Use Process, which reads:

> To urge health-system pharmacists to assume leadership, responsibility, and accountability for the quality, effectiveness, and efficiency of the entire medication-use process (including prescribing, dispensing, administration, monitoring, and education) across the continuum of care; further,
>
> To urge health-system pharmacists to work in collaboration with patients, prescribers, nurses, and other health care providers in improving the medication-use process.

POLICY RECOMMENDATIONS NOT APPROVED

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

Independent Prescribing Authority (56.2%)
Source: Council on Pharmacy Practice
To affirm that prescribing is a collaborative process that includes patient assessment, understanding of the patient's diagnoses, evaluation and selection of available treatment options, monitoring to achieve therapeutic outcomes, patient education, and adherence to safe and cost-effective prescribing practices; further,

To recognize that pharmacists are highly trained medication experts on the interprofessional care team capable of making independent and autonomous evidence-based decisions on medication therapy management; further,

To advocate that pharmacists have independent and autonomous authority to initiate, modify, and deprescribe all schedules and classes of medications; further,

To advocate that healthcare delivery organizations establish credentialing and privileging

processes for pharmacists that delineate scope of practice, support pharmacist prescribing, and ensure that pharmacists who prescribe are accountable, competent, and qualified to do so; further,

To advocate that all pharmacists have a National Provider Identifier that is recognized by payers.

Note: This policy would supersede ASHP policies 2236 and 2251.

Pharmacist's Role on Ethics Committees (73.4%)
Source: Council on Pharmacy Practice
To advocate that pharmacists should be included as members of, or identified as a resource to, hospital and health-system ethics committees; further,

To encourage pharmacists to actively seek ethics consultations or solicit input from their institution's ethics committee, as appropriate; further,

To encourage pharmacists serving on ethics committees to seek advanced training in healthcare ethics.

Note: This policy would supersede ASHP policy 1403.

Safe Handling and Administration of Hazardous Drugs (62.2%)
Source: Council on Pharmacy Practice
To advocate that pharmaceutical manufacturers eliminate surface contamination on packages and vials of hazardous drugs (HDs); further,

To inform pharmacists and other personnel of the potential presence of surface contamination on the packages and vials of HDs; further,

To advocate that all healthcare settings proactively conduct an interprofessional assessment of risk for exposure to HDs during handling and administration, including the use of closed-system transfer devices (CSTDs); further,

To advocate for pharmacist involvement in the development of policies, procedures, and operational assessments regarding administration of HDs, including when CSTDs cannot be used; further,

To advocate that the Food and Drug Administration require standardized labeling and package design for HDs that would alert handlers to the potential presence of surface contamination, including development of CSTD-compatible, ready-to-administer HD products; further,

To encourage healthcare organizations, wholesalers, and other trading partners in the drug supply chain to adhere to published standards and regulations.

Note: This policy would supersede ASHP policies 1615 and 1902.

Order Verification (55.4%)
Source: Council on Public Policy
To advocate that a prescriber should not be solely responsible for medication ordering, dispensing, and administration as well as any patient monitoring and evaluation, except when a double check would limit patient access to care.

Liability Protection (62.5%)
Source: Council on Public Policy
To advocate that pharmacists be able to provide evidence-based dispensing and care to patients without fear of criminal or civil legal consequences, harassment, or liability; further,

To advocate that protection against liability extend to referrals for out-of-state care and for dispensing to patients from another state.

State Prescription Drug Monitoring Programs (62.9%)
Source: Council on Public Policy
To support continued state implementation of prescription drug monitoring programs that collect real-time, relevant, and standard information from all dispensing outpatient entities about controlled substances and monitored prescriptions; further,

To advocate that such programs seek adoption into health information exchanges to best integrate into electronic health records and to allow prescribers, pharmacists, and other practitioners to proactively monitor data for appropriate assessment and dispensing; further,

To advocate that such programs improve their interstate data integration to enhance clinical decision-making and end-user satisfaction; further,

To encourage policies that allow practicing pharmacists to gain access to databases without holding licensure in each state; further,

To promote research on the effects of prescription drug monitoring programs and electronic health record programs on opioid prescribing, dispensing, misuse, morbidity, and mortality.

Note: This policy would supersede ASHP policy 1408.

Nonprescription Status of Rescue and Reversal Medications (67.3%)
Source: Council on Therapeutics
To support the over-the-counter (OTC) status of medications intended for evidence-based rescue use or reversal of potentially fatal events; further,

To work with federal, state, and local governments and others to improve the rescue and reversal medication development and supply system to ensure an adequate and equitably distributed supply of these medications; further,

To advocate that all insurers and manufacturers maintain coverage and limits on out-of-pocket expenditure so that patient access to rescue and reversal medications is not compromised; further,

To support and foster standardized education and training on the role of rescue and reversal medications and their proper administration, safe use, and appropriate follow-up care.

Pharmacy Residency Training (73.4%)
Source: Council on Education and Workforce Development
To continue efforts to increase the number of ASHP-accredited pharmacy residency training programs and positions available; further,

To promote efforts to increase recruitment and retention of residents in ASHP-accredited pharmacy residency programs; further,

To encourage stakeholders to evaluate priority areas within pharmacy for future residency training needs.

Note: This policy would supersede ASHP policy 0917.

NOTES ON VOTING

Ninety-four percent (203) of delegates to the virtual House of Delegates participated in the voting, with 94% (153) of state delegates voting. All registered past presidents voted, and 85% of state delegations had 100% participation by their delegates.

HOUSE OF DELEGATES

Melanie A. Dodd, Chair
Paul C. Walker, Vice Chair

As of March 22, 2024

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Leigh A. Briscoe-Dwyer, President-Elect
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Christene M. Jolowsky, Treasurer
Paul W. Abramowitz, Chief Executive Officer
Kim W. Benner, Board Liaison, Council on Pharmacy Management
Melanie A. Dodd, Chair of the House
Kristine K. Gullickson, Board Liaison, Council on Education and Workforce Development
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Pamela K. Phelps, Board Liaison, Commission on Affiliate Relations
Vickie L. Powell, Board Liaison, Council on Therapeutics
Jennifer E. Tryon, Board Liaison, Council on Pharmacy Practice

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Bruce Canaday	Marianne Ivey	Bruce Scott	
Kevin Colgan	Thomas Johnson	Steven Sheaffer	
Debra Devereaux	Stan Kent	Janet Silvester	
Fred Eckel	Robert Lantos	Kelly Smith	

STATE	**DELEGATES**	**ALTERNATES**
Alabama (3)	Nancy Bailey Danna Nelson Megan Roberts	Nathan Pinner
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Nebraska (3)	Tiffany Goeller Katie Reisbig David Schmidt	Jolyn Merry
Nevada (2)	Adam Porath Kate Ward	
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U.S. Public Health Service	CDR Christopher McKnight	
Veterans Affairs	Heather Ourth	Tera Moore Anthony Morreale

House of Delegates

REPORT ON THE VIRTUAL HOUSE OF DELEGATES

May 10-16, 2024

RESULTS OF THE VOTING

Between May 10 and 16, the ASHP House of Delegates (roster attached as Appendix A) voted on three policy recommendations. Delegates approved two 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.

POLICY RECOMMENDATIONS APPROVED

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

Supporting High Reliability in Pharmacy Practice (85.0%)
Source: Council on Pharmacy Management
To state that a commitment to the principles and science of high reliability, with the goals of zero medication errors and zero harm, are foundational to pharmacy excellence; further,

To encourage hospitals and health systems to commit to high-reliability principles; further,

To encourage research that informs the creation of best practices in high reliability and progress toward implementation of high-reliability principles in all pharmacy services.

ASHP Statement on the Community Pharmacist's Role in the Care Continuum (94.5%)
Source: Section of Community Pharmacy Practitioners
To approve the ASHP Statement on the Community Pharmacist's Role in the Care Continuum (Appendix B).

POLICY RECOMMENDATIONS NOT APPROVED

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

Prehospital Management of Medications (54.7%)
Source: Council on Pharmacy Practice
To assert that variation in the prehospital management and use of medications is a risk to patient safety and continuity of care; further,

To advocate for pharmacy workforce involvement in clinical and operational decision-making for prehospital management and utilization of medications; further,

To encourage the pharmacy workforce to assume responsibility for medication-related aspects of ensuring the continuity of care as patients transition from prehospital care to other care settings; further,

To collaborate with stakeholders involved in prehospital medication-use cycle decisions to improve patient safety, minimize variation, and reduce inefficiencies.

NOTES ON VOTING

Ninety-two percent (204) of delegates to the virtual House of Delegates participated in the voting, with 93% (152) of state delegates voting. Ninety-three percent of registered past presidents voted, and 81% of state delegations had 100% participation by their delegates.

HOUSE OF DELEGATES

Melanie A. Dodd, Chair
Paul C. Walker, Vice Chair

As of May 10, 2024

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Washington State (4)	Lauren Bristow Chris Greer Karen White	
West Virginia (2)	Chris Fitzpatrick Derek Grimm	
Wisconsin (4)	John Muchka Sarah Peppard William Peppard Kate Schaafsma	Monica Bogenschutz Edward Conlin Carmen Gust David Reeb
Wyoming (2)	Linda Gore Martin Jessica Papke	
SECTIONS AND FORUMS	**DELEGATES**	**ALTERNATES**
Ambulatory Care Practitioners	Brody Maack	Sara Panella
Clinical Specialists and Scientists	Nancy MacDonald	Megan Musselman
Community Pharmacy Practitioners	Ashley Storvick Boedecker	Courtney Isom
Inpatient Care Practitioners	Allison King	Lucas Schulz
Pharmacy Educators	Cher Enderby	Jennifer Arnoldi
Pharmacy Informatics and Technology	Hesham Mourad	Jeffrey Chalmers
Pharmacy Practice Leaders	Lindsey Kelley	Katherine Miller
Specialty Pharmacy Practitioners	Denise Scarpelli	Erica Diamantides
New Practitioners Forum	Justin Moore	Alfred Awuah
Pharmacy Student Forum	Heather Howell	Charbel Aoun
Pharmacy Technician Forum	Tyler Darcy	Daniel Nyakundi
FRATERNAL	**DELEGATES**	**ALTERNATES**
U.S. Air Force	Lt Col Rohin Kasudia	Maj. Elizabeth Tesch
U.S. Army	LTC Victoria O'Shea	MAJ Danielle Zsido
U.S. Navy	LT Staci Jones	LCDR Chirag Patel
U.S. Public Health Service	CDR Christopher McKnight	
Veterans Affairs	Heather Ourth	Tera Moore Anthony Morreale

ASHP Statement on the Community Pharmacist's Role in the Care Continuum

Position

The American Society of Health-System Pharmacists (ASHP) believes that community pharmacists are skilled clinicians who play an important role in the care continuum as equal, essential, and valued members of the healthcare team. Community pharmacists provide direct patient care, advance team-based care, manage patient-centered clinical services, and serve as leaders within their communities and health systems. Community pharmacists optimize care by providing educational consultations, medication safety and optimization services, chronic condition management, patient empowerment, wellness services, care coordination, and other services.

Community pharmacists lead teams that support patient access and safety through clinical care, medication preparation and dispensing services, regulatory compliance, operational efficiency, and integration services across settings of care. Further, community pharmacists lead, manage, and contribute to innovative practices and operations that advance pharmacy practice and contribute to financial sustainability.

The purpose of this statement is to recognize the patient-centered care services provided by community pharmacists and encourage healthcare leaders to utilize community pharmacists to the full extent of their expertise by continuing to integrate them across the continuum of care. This statement will describe current practice of health-system-based community pharmacy and identify future opportunities for practice advancement, though the patient-centered core responsibilities described are generalizable to all community pharmacy practice settings.

Community pharmacists should be recognized as medication experts and accountable partners for optimal health outcomes. ASHP urges community pharmacists and leaders to advocate for the value of community pharmacists to internal and external stakeholders so their outcomes-oriented clinical and business expertise is recognized.

Background

Community pharmacies are found across an array of practice areas, including health systems, traditional retail sites, clinics, independent pharmacies, and integrated within ambulatory care settings. Community pharmacy ranks among the most frequent patient touch points in healthcare. More than 90% of Americans live within 5 miles of a pharmacy,[1] and patients visit their community pharmacist 12 times more frequently than their primary care provider.[2]

Patients can benefit from convenient access to healthcare services, and community pharmacy practitioners are uniquely positioned to take an active role in improving therapeutic outcomes and providing comprehensive and longitudinal patient-centered care. According to the Centers for Disease Control and Prevention, nearly half of Americans use at least one prescription medication each month,[3] and 40% of U.S. adults are managing two or more chronic conditions.[4] Innovative community pharmacy practices have the potential to significantly impact outcomes, such as reducing hospital readmission rates, preventing drug-induced harm, and increasing medication access and adherence.[5-7] Studies have also shown that community pharmacist–led interventions have a positive impact on a wide range of chronic diseases, including diabetes, cardiovascular disease, hyperlipidemia, and HIV/AIDS, and have

demonstrated a decrease in medical and healthcare costs.[8-10] As the healthcare landscape shifts toward a value-based framework, there is general agreement on the favorable impact of community pharmacists in increasing access to care and providing preventive health services.[11-16]

Core responsibilities

Patient care. Pharmacists practicing in community settings can both integrate into specific patient care teams and act as health and wellness advocates in their practice setting. Health-system-based community pharmacists have uniquely integrated tools, including electronic health record (EHR) access and communication methods, that facilitate these patient care activities. Community pharmacists are critical in ensuring that patients in the outpatient setting receive the medications they need through patient-centered dispensing, while also providing clinical services that optimize patient care and outcomes. The following encompasses many of the core clinical responsibilities of community pharmacists.

1. ***Medication utilization reviews:*** Patients may routinely seek care from many different sources and may or may not choose to use a single pharmacy for prescriptions. Community pharmacists are well positioned to utilize the information from their own system as well as information obtained from the patient and other pharmacy locations to compile a comprehensive medication list. Community pharmacists can then use this information to optimize the patient's medication therapies. Optimization includes, but is not limited to, utilizing this list to ensure that each medication is an appropriate agent, prescribed at an appropriate dose and for an appropriate duration. Information elucidated in this broad-spectrum patient care approach can then be communicated to the patient's entire healthcare team, reducing the risk for adverse outcomes related to incomplete understanding of the patient's medication regimen.
2. ***Medication access:*** Community pharmacists identify and help resolve medication access barriers. No other care setting offers the opportunity to routinely identify and overcome barriers to medication access and appropriate use such as cost, availability, harm reduction (e.g., providing naloxone), and dosage form modifications. During dispensing and at the point of sale, community pharmacists have the opportunity to engage the patient in a discussion regarding affordability of and access to their medications. These discussions often incorporate a variety of resources, including manufacturer discount programs, therapeutic interchanges, and use of charitable resources. In some settings, community pharmacists assist with the prior authorization process as well. Programs offered by community pharmacies (e.g., medication bedside delivery in acute care settings and home delivery in ambulatory care settings) can overcome transportation-related access barriers. These services are part of a broader effort to improve health equity.
3. ***Comprehensive medication management:*** Community pharmacists are trained to assess and improve medication regimens. Community pharmacists provide cognitive services to patients that go beyond the dispensing-focused prospective drug utilization reviews, including comprehensive medication reviews, medication reconciliation, and chronic disease management. These services can be especially impactful for patients

experiencing transitions between acute and ambulatory care with a significant change in health status. In addition, community pharmacists integrate targeted services such as medication adherence support, therapeutic optimization, reversal agent access, and duplicative therapy adjustments into their daily workflow.

4. ***Point-of-care testing and treatment:*** Advances in technology have increased the availability of testing that can be done outside laboratories, increasing access and convenience for patients. The advent of direct-to-consumer testing, in addition to CLIA-waived testing, has spurred a need for healthcare professionals to assist in providing and/or interpreting test results, formulating next steps, and in some cases initiating appropriate treatment. Community pharmacists perform and/or interpret point-of-care testing, including patient-initiated pharmacogenomics testing, and assist patients in understanding their test results. This service may lead to provision of targeted treatment for acute infections or recommendations to modify medication regimens that can be shared with the patient's other healthcare providers. Recognizing that not all patients with healthcare needs may be able to come to a pharmacy, community health screening events offer a mechanism for community pharmacists to identify patients in need of additional assessment and treatment for previously undiagnosed conditions (e.g., high blood pressure, hyperlipidemia, diabetes, chronic kidney disease).
5. ***Preventive care provision:*** Community pharmacists support patient wellness, both in a usual or daily setting and when patients can be exposed to new or potentially hazardous conditions. Wellness care involves preventive interventions (e.g., Medicare Wellness Visits, health screenings) or travel consultations to prepare travelers for pathogens and adverse conditions they may encounter abroad. Other preventive and wellness services may include provision of pre- or post-exposure prophylaxis against HIV infection or oral contraceptives. In addition, access to many different vaccines with different payer models is a unique aspect of community pharmacy that has increased patient access to vaccines. The COVID-19 pandemic highlighted the value of community pharmacists in ensuring that patients could easily receive recommended vaccines, and rates of routine immunizations have increased as community pharmacists have expanded vaccination services.[17,18]
6. ***Patient and community education:*** Community pharmacists have chosen to practice in a setting that enables them to be a resource for patient education on many different levels. This role includes not only patient education and counseling regarding specific medications, over-the-counter products, and complementary and alternative medicines, but also more comprehensive medication education (e.g., storage, appropriate administration, safe combinations with other medications or supplements, recommended disposal). Many community pharmacists and pharmacies offer programs that provide education and support for specific conditions, such as the Diabetes Self-Management Education and Support (DSMES) program.[19] Community pharmacists may be involved in identifying patients who struggle with substance use disorders and can offer resources and referrals to additional care providers. Pharmacists in this setting can also serve as educational resources for the broader community during health screenings, drug take-back events, and community wellness and outreach events. The

community pharmacist provides this education in a manner that is tailored to each patient's educational needs, including language and health-literacy barriers.

7. ***Medication safety:*** Community pharmacists serve as advocates for the safe use of medications in many ways. The interventions of community pharmacists are highly impactful on patient safety, whether this is in implementation of the Institute for Safe Medication Practices Community Pharmacy Action Agenda items,[20] recognition and mitigation of dangerous drug-drug or drug-disease interactions, or ensuring a patient's understanding of their medication regimen. Community pharmacists also support safe use of medications by working on a broader scale within their organizations or locations to perform continuous quality improvement processes and providing medication safety resources for other healthcare disciplines. Outreach to the community can raise awareness of the risks associated with medication misuse and can prevent harm.

Operations. In addition to core patient care responsibilities, community pharmacists are responsible for day-to-day operations of the pharmacy and ensuring compliance with state and federal laws and regulations, as well as accreditation standards. The following encompasses the core operations of the community pharmacy that the pharmacist manages or supports.

1. ***Team supervision:*** Community pharmacists oversee daily operations, including day-to-day staffing levels and maintaining appropriate pharmacist-to-technician staffing ratios, developing workstation and workflow expectations and optimizations, and supervising learners.
2. ***Regulatory compliance:*** Community pharmacists ensure compliance with all regulations, including all state and federal laws, Drug Enforcement Administration regulations, applicable United States Pharmacopeia (USP) standards (e.g., USP 795), 340B program compliance as applicable, and additional requirements of accreditation and governing bodies.
3. ***Record-keeping:*** Community pharmacists maintain all records (e.g., inventory, dispensing) in compliance with the Health Insurance Portability and Accountability Act of 1996, state, and federal regulations.
4. ***Inventory management:*** Community pharmacists manage the pharmacy's inventory to ensure the needs of the patients are served while preventing a surplus of inventory. Inventory management includes examination of inventory turns, proper security and storage of medications, and proper inventory management practices as it relates to the 340B program. Additionally, community pharmacists navigate drug shortages.
5. ***Fiscal management:*** Community pharmacists manage billing, revenue cycles, inventory costs, labor, and operational expenses in a fiscally responsible way. Pharmacy leaders also develop annual budgets and create volume projections for the pharmacy.
6. ***Compounding:*** Compounding services can be offered to patients when individualized pharmaceutical products are not commercially available. If the community pharmacy is part of a health system, compounded nonsterile preparations available to patients when admitted to the hospital can be made available in the community pharmacy for continuation of therapy. Many community pharmacists are able to refer patients to sterile compounding facilities if needed.

7. ***Program and protocol development:*** Community pharmacies offer relevant services such as vaccination and meds-to-beds services as applicable. Additional clinical services may also be provided, such as medication synchronization, medication adherence packaging, and medication delivery programs. Clinical services such as hormonal contraception prescribing, smoking cessation, COVID therapeutics, and immunizations may be provided through standing orders or collaborative practice agreements as allowed by state and federal laws.
8. ***Customer service:*** Community pharmacists provide excellent customer service not only to patients and customers but also to internal providers and stakeholders in the organization. Pharmacists can connect with the patient's providers to determine alternatives in the event of a drug shortage, to navigate insurance restrictions as needed, and to accommodate financial restrictions limiting patient access.
9. ***Access to health data:*** Community pharmacists utilize the patient's EHR to ensure comprehensive care for patients. Where EHR access is not available, community pharmacists may pursue access to health information exchange platforms. Similarly, community pharmacies may integrate their dispensing records into the patient's EHR.
10. ***Health literacy:*** Community pharmacists promote health equity by recognizing and accommodating the health literacy of their patients. Community pharmacists can provide prescription labels and care notes in the patient's preferred language or in the preferred modality for visually or hearing-impaired patients, at an appropriate reading level, and utilizing the patient's preferred name.
11. ***Drug disposal:*** With the rise of the opioid epidemic and overdoses, some community pharmacies serve as drug disposal sites, allowing patients to safely dispose of unwanted medications.

Expanded roles

While the clinical and operational functions described above are fundamental in today's practice for community pharmacists, there are many opportunities to expand how community pharmacists demonstrate value in providing direct patient care. Community pharmacists are poised to expand their roles due to their accessibility, in-depth knowledge of the medication-use process, and ability to quickly pivot and adapt to the changing healthcare landscape (Table 1).

Table 1. Domains of opportunity for expanded community pharmacist roles.

Impacting Health Outcomes	• Expand the use of and design new collaborative practice agreements. • Provide access to point-of-care testing for a variety of disease states (e.g., influenza, group A *Streptococcus*, human immunodeficiency virus, hepatitis C, coronaviruses, oral contraceptives, and chronic diseases). • Engage patients in health and wellness initiatives (e.g., smoking cessation, weight management, asthma, chronic heart failure,

	chronic obstructive pulmonary disease, diabetes, hyperlipidemia, hypertension, anticoagulation, medication adherence). • Promote preventive care such as establishing a primary provider and health screenings.
Education	• Incorporate learners at all levels by expanding opportunities for clinical rotation experiences and residency programs. • Continue to support technician education and advancement initiatives. • Encourage practitioners to meet the needs of evolving patient populations through gaining advanced clinical knowledge.
Health Equity	• Overcome barriers that cause health inequities in patient care.
Technology	• Identify how technology can be leveraged to create operational efficiencies in practice. • Expand or partner in developing precision medicine and pharmacogenomics opportunities. • Develop and evaluate artificial intelligence and cognitive support tools. • Support patients in their wellness journey by use of technology such as health apps, wearable devices, and other tools.
Patient-centric Models	• Perform ongoing evaluations of the patient-centered medical home model or hospital-at-home services. • Leverage technology to offer clinical services through in-person care, health applications, patient portals, and telehealth options.
Innovation	• Collaborate with clinicians to increase pharmacy-offered clinical services to alleviate provider burnout. • Enhance the patient experience by offering a team-based approach to the continuum of care. • Identify opportunities that not only advance patient care but also increase the pharmacy department's financial contribution to the organization. • Continue to advocate for billing avenues and recognition of services by payers.
Public Health	• Evaluate and investigate community health issues. • Educate the community about public health. • Engage in organizational efforts to prepare and respond to emergencies which may include leadership roles on emergency managements teams. • Develop and implement programs related to medication and vaccine access. • Offer wellness, disease prevention, and treatment services (e.g. immunizations, antimicrobial stewardship, HIV prevention,

	diabetes prevention programs, hormonal contraception education, substance abuse prevention/treatment). • Support disease surveillance and monitoring initiatives (e.g. antiviral dispensing rates for infectious disease data trending, asthma inhaler use and environmental or air quality concerns)
Population Health	• Participate in the development of metrics to identify and care for specific patient populations. • Promote vaccine confidence within communities. • Extend services to virtual care and video visits. • Partner with clinicians, health plans, and health system leaders to understand value-based payment models and associated metrics. • Ensure effective chronic disease management that includes evidence-based medication optimization and monitoring. • Identify associated quality measures and develop initiatives to support or address open care gaps (e.g., order routine lab testing, ensure appropriate statin usage, and encourage eye exams for patients with diabetes). • Promote medication adherence and support initiatives to improve medication access. • Promote health equity by identifying and addressing Social Determinants of Health (SDOH) to reduce health care disparities. • Participate in transition of care services to reduce readmissions in target patient populations. • Support and promote cost-effective medication usage to control cost of healthcare
Research	• Pursue opportunities to participate in investigational drug research, including dispensing and counseling for commercial and investigational drugs within clinical trials. • Contribute to the body of literature by sharing results of outcomes-based research. • Encourage patient and clinician participation in research. • Contribute to research through data collection.

To be successful in the development of expanded roles for community pharmacy practitioners, all pharmacy team members must be trailblazers, early adopters of practice change, and actively advocating for pharmacy practice advancement.

Practice challenges

Although community pharmacists are well equipped to improve therapeutic outcomes and patient care, practice challenges exist. Declining reimbursements to pharmacies by insurance plans have become increasingly problematic. Since the establishment of performance-based pharmacy contracts by Medicare Part D plans in 2012, price concessions charged to pharmacies

by insurance plans and pharmacy benefit managers increased 170%.[21] Further, limited payment of pharmacists for clinical services has led to serious financial strains on community pharmacies, forcing closures, and has resulted in lack of access to community pharmacy services in rural settings. Studies showed that 1 in 8 pharmacies closed between 2009 and 2015, a statistic that disproportionally affected independent pharmacies and low-income neighborhoods.[22]

The lack of ready access to a pharmacy, a phenomenon labeled "pharmacy deserts," is a persistent practice challenge. In rural areas, travel time to the nearest pharmacy may hinder access. And although more than 90% of Americans live within 5 miles of a pharmacy, proximity does not guarantee access.[23] Patients may still be stymied by lack of public transportation, limited pharmacy hours, or mobility issues. To promote health equity, patients should be provided easy access to community pharmacy services. Telepharmacy is one option that has been shown to increase patient access to pharmacy services.[24]

Limited revenue for community pharmacies has further been aggravated by a changing economy and workforce. In a recent report by the National Community Pharmacy Association, 93% of community pharmacists noted their business was affected by inflation. Concurrently, 80% of respondents indicated being affected by supply chain shortages, and more than three quarters of community pharmacists have experienced staffing shortages recently.[25]

Access to patients' health information also presents a challenge to optimal care, as community pharmacies often do not have access to the patient's complete electronic medical record. To combat this, community pharmacies should pursue access to health information exchange platforms. Similarly, community pharmacy dispensing records should be accessible in the EHR.

Staffing shortages in the community pharmacy and financial strains impact care. Despite increasing evidence favoring community pharmacist involvement in advanced clinical services, uptake is slow. The 2019 National Pharmacist Workforce Study[26] found that services such as vaccinations, medication assistance programs, medication therapy management, and medication synchronization are offered in most community pharmacy sites. However, only 43% of community pharmacy respondents indicated that they provide comprehensive medication management, 25%, opioid deprescribing; 24%, disease state management; 20%, point-of-care testing; 19%, injection administration; and 4%, pharmacogenomics testing. The study also identified high workload and inadequate staffing as the top two stressors for pharmacists.

The public perception of the range of roles of pharmacists may also pose a challenge. Though pharmacists provide a myriad of clinical and operational services, patients are often unaware of the extent of the role of the pharmacist in the medication-use process.[27] Patients visiting their local community pharmacy may not see the clinical decisions that pharmacists make daily and may not be aware that pharmacists act as a part of their interprofessional care team.

Leveraging pharmacy technicians

As community pharmacists face increased workload demands and limited time, advanced pharmacy technicians can be utilized as pharmacist extenders, furthering pharmacy practice and patient care.[28-30]

Traditional community pharmacy technician roles include entering prescriptions into the pharmacy dispensing system, counting medications, compounding, managing inventory, dealing with billing issues and insurance, and providing customer service at the point of sale. Limiting pharmacy technicians to only these roles does not utilize their full potential.[29] An advanced pharmacy technician is an individual who has responsibilities and tasks that go beyond the traditional duties of a standard pharmacy technician and requires a higher level of training, expertise, and often additional certifications. Nontraditional and advanced roles for pharmacy technicians can contribute to the overall impact of community pharmacy practice in patient care.[28,31-34] Some of these advanced pharmacy technician responsibilities are listed in Table 2. The role of pharmacy technicians is variable depending on the laws of each state and responsibilities highlighted may not encompass all technicians.

Table 2. Advanced pharmacy technician responsibilities in community pharmacy.

Patient care responsibilities	Operational responsibilities
• Administer immunizations and promote vaccine confidence. • Collect medication history. • Conduct point-of-care tests. • Identify and resolve barriers to medication access or care. • Enroll patients in patient assistance programs. • Serve as patient advocate. • Assist with patient adherence efforts. • Leverage patient relationships to promote preventive and essential health services. • Obtain additional training (e.g., as a community health worker).	• Engage in technician product verification and tech-check-tech programs. • Coordinate 340B activities. • Manage billing, prior authorizations, and financial affairs. • Manage pharmacist schedules and consultations. • Supervise ancillary staff. • Provide peer education and training. • Gather data and generate metrics and reports. • Oversee medication inventory and surveillance. • Assist in pharmacy workflow optimization. • Contribute to continuous quality improvement and patient safety efforts.

By redesigning the pharmacy workflow and using pharmacy technicians as pharmacist extenders, community pharmacies can optimize the pharmacists' accessibility and provide quality healthcare to their communities. Community pharmacists and leaders should support advanced community pharmacy technician training opportunities, which will allow pharmacy technicians to elevate their practice and contribute to advanced roles.

Professional obligations of community pharmacists

Community pharmacists have a long-standing commitment to make a tremendous, positive impact in patient care and the communities they serve. To overcome the financial and

workforce challenges currently impacting care, community pharmacists have a professional obligation to be advocates for the pharmacy profession and their practice in the following ways.

Community pharmacists should

- Engage in advocacy efforts, through state and national partners, to advance and protect the interests of patient care and the pharmacy profession.
- Continue to pursue educational and training opportunities that further their clinical and professional skills.
- Seek opportunities to engage in advanced roles that optimize patient outcomes, patient safety, operational efficiencies, and fiscal health for their patients and organizations.
- Commit to being innovators, who adapt to and lead contemporary models of care.
- Act as positive and ethical role models for their patients, colleagues, and the community.
- Serve as mentors and educators for student pharmacists and pharmacy residents, contributing to succession planning for a diverse and healthy workforce.
- Encourage the advancement and recognition of pharmacy technician partners.
- Participate in research evaluating the services that they provide.

Conclusion

The role of community pharmacists has evolved significantly. Pharmacists in community-based settings are operational leaders for the financial sustainability of healthcare institutions as well as valuable clinicians in providing comprehensive management of patient's medication therapy in collaboration with other healthcare colleagues.

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Disclosures

The authors have declared no potential conflicts of interest.

Additional information

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House of Delegates

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REPORT OF THE

COMMITTEE ON NOMINATIONS

June 9, 2024

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ASHP COMMITTEE ON NOMINATIONS

Madam Chair, Fellow Delegates:

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

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

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

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

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

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

The Committee’s year-long process of receiving nominations and screening candidates is designed to solicit extensive membership input and, ultimately, to permit the Committee to candidly and confidentially assess which candidates best fit ASHP’s needs. The Committee has met three times since the last session of the House of Delegates: on December 5, 2023, at the ASHP Midyear Clinical Meeting; on February 23, 2024, via teleconference; and in person on April 17, 2024, at ASHP Headquarters. Review of nominees’ materials was conducted continuously between March and April 2024 solely via secure electronic transmissions. This process has been reviewed for quality improvement and will be repeated for the 2024–2025 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 849 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: 7 accepted
BOARD OF DIRECTORS: 17 accepted
CHAIR, HOUSE OF DELEGATES: 8 accepted

A list of candidates that were slated was provided to delegates following the Committee's meeting on April 17, 2024.

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 (2025-2026)

Melanie A. Dodd, PharmD, PhC, BCPS, FASHP (Albuquerque, NM)
Stephen F. Eckel, PharmD, MHA (Chapel Hill, NC)

Board of Directors (2025-2028)

Marie A. Chisholm-Burns, PharmD, PhD, MPH, MBA, FACHE, FASHP, FAST (Portland, OR)
Todd W. Nesbit, PharmD, MBA, CPEL, FASHP (Baltimore, MD)
Mollie A. Scott, PharmD, BCACP, CPP, FASHP, FNCAP (Asheville, NC)
Majid R. Tanas, PharmD, MHA, MS, FASHP (Portland, OR)

Chair, House of Delegates (2024-2027)

Jesse H. Hogue, PharmD (Kalamazoo, MI)
Martin J. Torres, PharmD, FCSHP (Orange, CA)

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

CANDIDATES FOR PRESIDENT-ELECT 2025–2026

Melanie A. Dodd, PharmD, PhC, BCPS, FASHP (mdodd@salud.unm.edu) is associate dean for clinical affairs and professor, The University of New Mexico (UNM) College of Pharmacy, Albuquerque. She graduated from Purdue University and UNM and completed her residency at Presbyterian Healthcare Services. Dodd oversees innovative clinical models and faculty clinical services, including credentialing, contracting, billing and reimbursement. She provides key pharmacy professional advocacy and serves on academic and health-system leadership committees. Dodd is a pharmacist clinician in geriatric primary care with broad prescriptive authority at the UNM Hospitals Senior Health Clinic and is a consultant pharmacist for 340B-eligible and other ambulatory clinics. She is responsible for extensive didactic and clinical teaching activities in the UNM PharmD program and Health Sciences Center, including geriatric syndromes, pharmacy law, interprofessional education, and serves as a residency preceptor. Her research includes geriatric syndromes, advanced practice pharmacist models, and scholarship of teaching.

Dodd's ASHP service includes member of the Board of Directors and chair, ASHP House of Delegates (2021-2024), chair of the Council on Public Policy, chair of the Section of Ambulatory Care Practitioners (SACP), member, Pharmacy Forecast Advisory Committee, and NM delegate to the House of Delegates for 14 years. She is past president of NMSHP and faculty advisor for the UNM SSHP. She has received numerous awards for her service to the profession, including the ASHP Pharmacy Champion Award, SACP Distinguished Service Award, Fellow of ASHP, and NMSHP Dorothy Dillon Memorial Lecture Award.

Statement:
Access to optimal, safe, and effective healthcare is a cornerstone of a thriving community. My vision is to ensure pharmacists are recognized as direct patient care providers for all people, in all communities, throughout the continuum of care in all healthcare settings and future models of care. Pharmacist leaders need to always be at the table for key discussions regarding medication use and global issues affecting healthcare such as health equity, access to primary care, financing, evolving technology, and workforce shortages.

In alignment with the ASHP Practice Advancement Initiative, we must embrace and advocate for expanding roles of pharmacists, technicians, and students, including prescriptive authority. These new roles will require changes in education and training.

Lastly, in order for ASHP to achieve its mission into the future, we need to continue to focus on engaging new and mid-career members in activities that support leadership development and role advancement, and provide professional resources. ASHP's leadership in professional policy development and advocacy and collaboration with key stakeholders is essential to advance pharmacy practice change and address contemporary issues like drug shortages and artificial intelligence. ASHP must continue to be nimble to address the quickly changing healthcare and technological environment and new generational needs, including workforce wellness. I am humbled and honored by this nomination and am committed to providing leadership to continue to advance the pharmacy profession.

Stephen F. Eckel, PharmD, MHA (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 Master of Science in pharmaceutical sciences with a specialization in health-system pharmacy administration. This degree collaborates with 16 different health systems across nine states who sponsor the residency. It also has 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 health care 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, ACCP, NCAP, and NAP.

Statement:
One constant of healthcare is change. While many pharmacists do not like change, it creates opportunities to take leadership roles during stressful and uncertain situations. Our profession needs to fill those gaps. One prime opportunity, I believe, is for pharmacists to take responsibility for the medication-use process and in so doing, will make patient care better, safer, more efficient, and less expensive. It will also increase our involvement in the patient-centric practice of pharmacy. To do this, 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 someone outside of the profession will do it.

I have focused my career on providing novel and creative ideas to solve the challenges that face our profession and leveraging the uncertainty of change in helping us meet our professional ideals. I have also educated and mentored pharmacists as they take increasing responsibilities within their workplace.

I am passionate and committed that our professional society remains diverse and inclusive for all. 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.

CANDIDATES FOR BOARD OF DIRECTORS 2025–2028

Marie A. Chisholm-Burns, PharmD, PhD, MPH, MBA, FACHE, FASHP, FAST (chishmar@ohsu.edu) is the executive vice president and provost of Oregon Health & Science University (OHSU) and the J.S. Reinschmidt Endowed Professor in the OHSU School of Medicine. She is also founder and director of the Medication Access Program, which has helped thousands of solid-organ transplant recipients receive more than $119 million in prescription medications.

Chisholm-Burns received her BS in pharmacy and Doctor of Pharmacy degrees from the University of Georgia, Master of Public Health degree from Emory University, Master of Business Administration degree from the University of Memphis, and PhD degree from the University of South Dakota. She completed her residency at Piedmont Hospital in Atlanta, Georgia. She has also achieved FACHE certification and practiced in several regions of the U.S.

Chisholm-Burns has been an active member of ASHP for over 30 years. She previously served in several ASHP leadership positions; for example, she served as the inaugural chair of the ASHP Section of Pharmacy Educators Executive Committee, as director-at-large of the ASHP Section of Clinical Specialists and Scientists Executive Committee, as a member of the Center for Health-System Pharmacy Leadership Advisory Panel, and as a member of the *AJHP* editorial board. She is a member of the Pharmacy Forecast Advisory Committee and contributed to several Forecasts over the years, including 2024 (public health priorities), 2023 (health disparities), and 2021 (healthcare access). Additionally, Chisholm-Burns has received several awards from ASHP, including the 2022 Board of Directors' Distinguished Leadership Award.

Statement:
Equitable healthcare access and delivery are of utmost importance to the health of our communities. Access and success are central to my vision for pharmacy practice – specifically, access to healthcare and success in achieving health equity and optimizing patient outcomes. I have illuminated the value of pharmacists in advancing access and success in patient care throughout my career, including documenting extensive evidence of the beneficial effects of pharmacist-provided direct patient care, with the support of ASHP and its members. Such evidence supports inclusion of pharmacists in interprofessional healthcare delivery models as a strategy to increase access, improve outcomes, and reduce healthcare costs.

To achieve this vision of access and success, we must recognize and respond to challenges facing the profession, including drug shortages, technological advances, financial sustainability, and workforce shortages, stress, and burnout. We must work together to build bridges to success in each of these areas. Further, we should amplify equitable healthcare for all patients and communities we serve. And we should strive to promote access and success by:

- *Advocating for pharmacists to practice at the top of their license and for improved reimbursement mechanisms.*
- *Supporting the well-being of patients and the pharmacy workforce, including reducing burnout and stress.*
- *Facilitating growth of the pharmacy technician workforce.*
- *Expanding practice and care delivery, including greater participation on interprofessional healthcare teams.*
- *Eliminating healthcare disparities and advancing equity for all.*

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

Todd W. Nesbit, PharmD, MBA, CPEL, FASHP (tnesbit@jhmi.edu) serves as chief pharmacy officer for The Johns Hopkins Hospital and vice president for pharmacy services for Johns Hopkins Health System in Baltimore, Maryland. As executive pharmacy leader, he is responsible for directing hospital and health-system practice, research, and education, and implementing system-wide pharmacy services across the continuum. He is the residency program director for the HSPAL residency program at The Johns Hopkins Hospital and has served as preceptor and mentor to pharmacy students and residents for more than 30 years.

Nesbit received his BS in pharmacy degree from Ohio Northern University, his Doctor of Pharmacy degree from The Ohio State University, and his MBA degree in medical services management from Johns Hopkins University. Through positions of increasing responsibility held in diverse hospitals and academic medical centers, he has worked to promote and advance the role of the pharmacist and clinical pharmacy in health systems.

He has extensive experience serving ASHP and state affiliates, including ASHP Forecast Advisory Committee member and chapter author; Pharmacy Competency Assessment Center Advisory Board member and section editor; co-chair of the Maryland Society of Health-System Pharmacy (MSHP) Practice Model Task Force; voting member of the inaugural Pharmacy Practice Model Summit; and delegate to the Pharmacy Stakeholders Conference on MTM Services. Nesbit has been recognized as a Fellow of ASHP and has achieved the status of Certified Pharmacy Executive Leader by the organization. Nesbit received the MSHP W. Arthur Purdum Award for significant contributions to health-system pharmacy.

Statement:
My philosophy begins with the belief that the patient must always be at the center of our individual and collective decision-making. Medication-use systems must be designed to ensure that the needs of our patients are met holistically within and across all care settings for which we are responsible. Meeting these needs necessitates ownership and accountability by all pharmacists and pharmacy technicians alike, to directly manage drug therapy and ensure the safety and quality of medication use. Professional staff should be empowered through credentialing and privileging and engagement in collaborative practice agreements with other professional colleagues, for optimal efficiency and effectiveness. Leveraging the collective expertise of our technicians is critical to extend their scope and impact the care of more patients. We should deploy automation and robotic systems to reduce the burden of repetitive tasks, optimizing the work to be completed by scarce human resources. Robust analytic frameworks are also essential to validate the patient care impact and outcomes that we intend. We should embrace new and evolving approaches for data management and knowledge generation, through expanded use of artificial intelligence and machine learning. It is imperative that we continue to foster a culture of innovation through research, to support new understanding of disease processes and advances in treatment options for our patients such as genetic and cellular therapies. Lastly, it is crucial that we foster supportive and diverse learning environments, to ensure the availability of the future pharmacy workforce that will be needed to care for our patients.

Mollie A. Scott, PharmD, BCACP, CPP, FASHP, FNCAP (mollies@email.unc.edu) is regional associate dean and clinical professor at UNC Eshelman School of Pharmacy and chair of pharmacotherapy at Mountain Area Health Education Center (MAHEC). She practices as a clinical pharmacist practitioner in an interprofessional osteoporosis clinic. Mollie received her BS degree in biology from Meredith College and her Doctor of Pharmacy degree from UNC Eshelman School of Pharmacy before completing a specialty pharmacy residency in geriatrics at the Durham VA Medical Center. She has practiced in inpatient internal medicine, long-term care, and ambulatory care and for the past 20 years has focused on ambulatory care, administration, and academia.

Mollie served as vice chair and chair for the Section of Ambulatory Care Practitioners (SACP) Section Advisory Group on Clinical Practice Advancement, where she led the development of an Ambulatory Care Career Tool. She served six years on the SACP Executive Committee, first as director-at-large, and later, as chair, and co-authored the ASHP Statement on the Role of Pharmacists in Primary Care. She is currently a member of the House of Delegates and the Advocacy and PAC Advisory Committee. Mollie led the North Carolina Association of Pharmacists (NCAP) Task Force on Hormonal Contraception, which resulted in new legislation allowing pharmacists to prescribe a variety of medications, including contraception. She is the recipient of multiple awards for contributions to the profession of pharmacy, including the NCAP Don Blanton Award, ASHP SACP Distinguished Service Award, and Bowl of Hygeia. She has been recognized as a Fellow of NCAP and ASHP.

Statement:
Pharmacists are members of a distinguished and honored profession who serve as medication experts and improve the health of patients through medication optimization. Upon graduation, we promise to consider the welfare of humanity and relief of suffering our primary concerns, and providing patient-centered care is a cornerstone of our profession. It has been a joy to serve my patients and community as a pharmacist for the past 31 years.

The American healthcare system is currently challenged by a shortfall of primary care physicians, closure of rural hospitals and community pharmacies, medication shortages, high costs of care, the impact of social determinants of health, and a post-pandemic world. I believe that the profession of pharmacy can increase access, equity, and quality of care and create healthy communities by:

1. *Leading policy efforts to overcome barriers that prevent pharmacists from practicing at the top of our licenses.*
2. *Incorporating social determinants of health into education, research, and practice to improve delivery of equitable and holistic care.*
3. *Creating best practices for incorporating artificial intelligence into pharmacy practice and education.*
4. *Advocating for financial sustainability of rural and small health systems and independent community pharmacies to improve access to care.*
5. *Partnering with healthcare leaders in medicine, nursing, social work, health policy, government, and professional organizations to create collaborative solutions to healthcare problems.*

ASHP is at the forefront of advocating for our profession and our patients, and it is an honor to be slated for the Board of Directors.

Majid R. Tanas, PharmD, MHA, MS, FASHP (mtanas@lhs.org) is the vice president of pharmacy and chief pharmacy officer at Legacy Health, an eight-facility, 1,200-bed community health system ranging from a Level 1 trauma center to Critical Access Medical Center, including pediatric and psychiatric specialty services. Tanas earned a BS in biochemistry from Whitworth University, an MS in biotechnology from Washington State University, and a Doctorate in pharmacy from Washington State University. He earned a Master of Health Administration as a part of his two-year pharmacy administration residency at the University of Washington.

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

- New Practitioners Forum Advisory Groups:
  - Communications and Public Affairs (2007)
  - Leadership and Career Development (2008)
- New Practitioners Forum Executive Committee (2009):
  - Pharmacy Practice Advisory Group – Executive Liaison
  - Science and Research Advisory Group – Executive Liaison
- Council of Pharmacy Practice (2010, 2011, 2012)
- House of Delegate: Alternate (2014), Member (elected in 2015)
- Board of Canvassers (2019-2022)
- Section Advisory Group on Multi-Hospital Pharmacy Executives: Member (2021), Vice-Chair (2022), Chair (2022-2023), Chair (2022-2024)

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

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

With nearly three million nurses and one million physicians, the 300,000 pharmacists that make up our profession may be few in comparison, but our voice and impact in healthcare are far-reaching. Health systems must rapidly adapt from established business practices due to diminishing reimbursement. The members of ASHP stand at the crossroads to advance health-system pharmacy and healthcare. We must forge ahead to find new ways to meet our community's needs.

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

Let's not wait for an operational plan to be handed to our profession. Instead, we must preemptively identify how health-system pharmacy provides stability in uncertain times, how we can provide readily

accessible services to our patients, and how pharmacy can create a safe and healing environment. We will go farther and are better…together.

CANDIDATES FOR CHAIR, HOUSE OF DELEGATES 2024–2027

Jesse H. Hogue, PharmD (hoguej@bronsonhg.org) is the pharmacy education coordinator, the postgraduate year 1 pharmacy residency director and an emergency department pharmacist at Bronson Methodist Hospital in Kalamazoo. He also serves as an affiliate preceptor for the Ferris State University (FSU) College of Pharmacy. Hogue received his Doctor of Pharmacy degree from FSU and completed residency training at Bronson Methodist Hospital. After residency, he worked in trauma and orthopedics, then had the opportunity to establish pharmacy services in the emergency department, where he worked for several years prior to assuming his current role.

Hogue currently serves on the ASHP Commission on Credentialing and has been a Michigan delegate to the ASHP House of Delegates for 15 years. He has previously served on the ASHP Council on Education and Workforce Development. Hogue has also been very engaged on the state level, having served as president, treasurer, and executive board member for the Michigan Society of Health-System Pharmacists (MSHP), as an executive board member for the Michigan Pharmacists Association (MPA), as a delegate in the MPA House of Delegates for many years, and as a member on numerous MSHP and MPA committees and taskforces. He has been recognized in Michigan for his contributions to the profession as a Fellow of MPA and a member of the MPA Hall of Honor. Additionally, he has received the MSHP Pharmacist of the Year Award, the MSHP Joseph A. Oddis Leadership Award, and the MPA Distinguished Young Pharmacist of the Year Award.

Statement:
"We are better together."
- Paul Walker, ASHP past-president

The pharmacy workforce continues to innovate and move the practice and delivery of healthcare forward. Pharmacists play a vital role in both leadership and on the front lines. Even for non-medication-related issues, we are often called upon to contribute - and even lead - due to our demonstrated proficiency and valued perspectives.

To support that, ASHP joins us together as a unified profession, providing forums for education and idea sharing, establishing best practices, and crafting practice resources. When combined with initiatives to promote and grow our profession and ensure a diverse and inclusive workforce, ASHP's efforts help us improve care and expand access to pursue our mission to help people achieve optimal health outcomes.

But we face challenges. Drug shortages. Decreasing pharmacy school enrollment. Technician shortages. 340B and CMS pass-through funding. Opposition from groups such as the American Medical Association. ASHP is helping us meet and overcome these challenges through advocacy efforts and media campaigns, often directed by our professional policy positions. Therefore, it is critical that the House of Delegates Chair, for which I am honored to have been nominated, ensures decisions on policy statements are made in an equitable way - prioritizing open communication and making sure everyone is allowed to share their views without being dominated by others in those conversations. The ASHP policy process must ensure that viewpoints of our diverse membership are

considered, regardless of role or practice area. Because we are one pharmacy profession – better together.

Martin J. Torres, PharmD, FCSHP (martit3@hs.uci.edu) is a director of pharmacy at UC Irvine Medical Center in Orange, California with administrative oversight of quality, safety, education, and research. He is also an adjunct professor of pharmacology at the Southern California College of Optometry in Fullerton in addition to serving as a volunteer faculty member at the UCI School of Pharmacy and Pharmaceutical Sciences. He received his PharmD from the USC School of Pharmacy, completed a 1-year residency in clinical pharmacy, and began his career establishing an ICU satellite pharmacy and multiple clinical programs in a community hospital. After initially providing direct patient care for seven years, he has had the opportunity to lead teams both in acute care and outpatient settings in developing patient services across multiple transitions of care.

His ASHP service includes member, Council on Affiliate Relations (2022-current), and California delegate to the ASHP House of Delegates (2018-2021). He has been very active with the California Society of Health-System Pharmacists as chair of the House of Delegates (2018-2021), co-chair/member, Committee on Professional Affairs (2014-2017), president, Orange County Society of Health-Systems Pharmacists (2017-2018), and a member of multiple seminar planning and Pacific Coast Patient Safety Conference committees.

He has developed additional insights into organizational leadership through volunteer activities as a board chair/member of multiple community organizations, including a community foundation board, technology committee, chair of a parks and recreation committee, and others. His goal in every community engagement was to be "the pharmacist" for the organization and its members.

Statement:
Dear Friends and Colleagues,

As I share my thoughts, I want to first thank those who made time to model and mentor during my journey. As a profession, we have much to celebrate yet so much more to accomplish, all for the care of our patients. There are many priorities which must be addressed, but taking control of how we are represented should have a sense of urgency. The pharmacists I support do not "verify" orders, they "evaluate" orders. Evaluate better represents the cognitive application of our medication management expertise, whereas "verify" might simply imply the click of a mouse. Let's use the power of words and images consistently in our messaging, where every reference to our wonderful profession conveys caring for patients. Yes, OUR patients!

A pharmacist with a spatula "saving lives counting by fives"? Pharmacy directors or pharmacy executives? Pharmacy departments or pharmacy enterprises? Pharmacy leaders or leaders in healthcare? If there are opportunities for incremental improvement, let's have a renewed focus on how we represent ourselves through every policy we draft and every position statement issued.

If we don't control the narrative, who knows, we may end up being the only patient care profession that is reimbursed based on issuing a product. Imagine that. Better yet, reimagine that! I look forward to learning from you and working together with you not only for the benefit of our profession, but for our patients.

I would love to hear your thoughts if you are willing to share. Thank you.

House of Delegates

Board of Directors Report: Policy Recommendations for the June 2024 House of Delegates

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.

Jennifer Tryon, *Board Liaison*

1. Prehospital Management of Medications

To assert that variation in the prehospital management and use of medications is a risk to patient safety and continuity of care; further,

To advocate for pharmacy workforce involvement in clinical and operational decision-making for prehospital management and utilization of medications; further,

To encourage the pharmacy workforce to assume responsibility for medication-related aspects of ensuring the continuity of care as patients transition from prehospital care to other care settings; further,

To collaborate with stakeholders involved in prehospital medication-use cycle decisions to improve patient safety, minimize variation, and reduce inefficiencies.

Rationale

ASHP advocates that the pharmacy workforce "assume responsibility for medication-related aspects of ensuring the continuity of care as patients move from one care setting to another" (ASHP policy 2205). Prehospital management and utilization of medications varies greatly through patient emergency services, transport, and transfers. The pharmacy workforce has established clinical and operational expertise across the spectrum of medication use, which would add value and safety measures to the prehospital management and utilization of medications. That expertise could inform decision-making regarding standardization, management of medication shortages, and prevention of medication errors, among other things. Ensuring pharmacy workforce involvement in these medication-related activities and decisions would optimize medication use, improving prehospital care and patient safety during emergent situations and patient transfers.

Background

The Council examined this topic in response to a recommendation from the 2023 House of Delegates. Council members noted that a similar gap in ASHP policy led to the development of ASHP policy 2317, Emergency Medical Kits, and agreed that an ASHP policy position was needed to fill this gap.

2. Role of Artificial Intelligence in Pharmacy Practice

To recognize artificial intelligence (AI) as a tool with tremendous potential to improve patient care and the medication-use process, which should be implemented with caution due to potential unforeseen risks; further,

To encourage healthcare organizations to develop policies, procedures, and guidelines to determine which care settings, medications, and patient populations are appropriate candidates for the use of AI; further,

To advocate for pharmacy workforce involvement and transparency in the decision-making, design, implementation, and ongoing evaluation of AI-related applications and technologies that affect medication-use processes and tasks; further,

To oppose any use of AI that compromises human interaction or replaces ethical decision-making, professional judgment, or critical thinking or is implemented solely to reduce healthcare staffing and resources; further,

To advocate for regulations and standards that permit the use of AI in circumstances in which it has proven safe and effective.

Rationale

Artificial intelligence (AI) is an emerging technology described as intelligent computer programs or software capable of learning human cognition and processes. AI falls under two categories: machine learning (ML) for data set analysis and natural learning processes for information extraction from existing data. In recent years, AI technology has evolved at an immense speed, and healthcare has been increasingly digitizing data, raising two questions: how to best use both to improve patient-specific care on a grand scale without compromising patient safety and outcomes, and how to retain the expertise, autonomy, and humanity (e.g., empathy and compassion) of the interprofessional care team.

The healthcare community recognizes the potential benefit and risk of AI in patient care. Examples of opportunities include but are not limited to optimizing patient health, reducing variation in patient care services, translating evidence to practice, streamlining workflows and creating efficiencies, and reducing cognitive load on the interprofessional care team. Risks may include potential for breaches in patient privacy and safety; failure to incorporate ethical and moral decision-making; lack of transparency; automation biases; and narrow algorithm development that does not account for diverse populations, widening health disparities in undeserved or underrepresented patient populations. Given these risks, pharmacists and other healthcare professionals must retain oversight of AI applications and their implementation. Even if there comes a time when AI technology can account for every possible variable, the healthcare team must retain the right to make the final decisions on patient care to mitigate its inherent risks.

Pharmacy should take a leading role on the interprofessional healthcare team to research, develop, implement, and improve the quality of AI/ML-based clinical models that affect medication-use processes and tasks. The potential for improvement of care, lower costs, and comprehensive medication management could significantly impact healthcare, but healthcare providers must recognize the need for sufficient purview and monitoring to guarantee patient safety and effective therapy. Pharmacists, as leaders in AI health technology, can guide healthcare professionals and future generations on the implementation of AI in healthcare.

Background

The Council discussed AI following the Joint Council and Commission Meeting on the Role of Artificial Intelligence in Pharmacy. Their initial focus was on the ethical considerations in AI; however, the Council felt there was a need to discuss how AI impacts pharmacy practice more broadly. The Council agreed on the need for new ASHP policy. The Council also agreed that the ASHP Statement on the Use of Artificial Intelligence in Pharmacy should be revised to address ethical considerations for AI in healthcare and pharmacy practice, such as what tasks should always be performed by a human and never be replaced by AI, and what ethical considerations are needed for initial evaluation, implementation, and ongoing quality assurance of AI technologies.

3. Independent Prescribing Authority

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

To recognize that pharmacists are highly trained medication experts on the interprofessional care team capable of making independent and autonomous evidence-based decisions on medication therapy management; further,

To advocate that pharmacists have independent and autonomous authority to initiate, modify, and deprescribe all schedules and classes of medications; further,

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

To advocate that all pharmacists have a National Provider Identifier that is recognized by payers.

Note: This policy would supersede ASHP policies 2236 and 2251.

Rationale

Pharmacists are highly trained medication experts skilled in providing comprehensive medication management (CMM) services across the continuum of care. Nearly all states include pharmacist prescribing authority within their state practice acts, although those acts differ in how pharmacist prescribing authority is described, terminology used, and the degree of prescribing autonomy (i.e., autonomous or collaborative). Regulations at the state level are critical to ensuring that pharmacists can seamlessly provide CMM services within the interprofessional team and to the top of their skills and abilities. Pharmacists are a core healthcare team member, well-positioned to provide high-quality, cost-effective care that increases patient access and reduces the burden on other healthcare providers. Hundreds of studies published in peer-reviewed literature, conducted throughout a variety of organizations and health systems, have consistently demonstrated the benefits of pharmacist-directed patient care across a variety of clinical practice settings. A 2010 comprehensive systematic review of 298 studies of U.S. pharmacists' effect as a member of the patient care team found positive results on therapeutic and safety metrics (Chisholm-Burns MA, Kim Lee J, Spivey CA, et al. US pharmacists' effect as team members on patient care: systematic review and meta-analyses. *Med Care.* 2010; 48:923-33).

Autonomous prescribing allows pharmacists to be fully optimized as a part of the

interprofessional healthcare team and ensures that their skills are used to the fullest potential to allow them to be responsible and accountable and fully execute CMM treatment plans. Pharmacist prescribing is implicit to interprofessional care delivery, but the form and manner of pharmacist prescribing varies among health systems and organizations. Independent and autonomous drug therapy decision-making by pharmacists is already common and accepted by other licensed practitioners (e.g., physicians, physician assistants, and nurse practitioners). Practitioners participating in interprofessional teams that include pharmacists rely on the knowledge, demonstrated competency, and expertise of those pharmacists for CMM. Pharmacists in specialty practice areas such as anticoagulation management, solid organ transplant, and nutrition support have long functioned in roles in which autonomous prescribing authority has improved clinical outcomes in the management and monitoring of medication therapy. In settings such as the Indian Health Service and Veterans Health Administration systems, prescribing authority for pharmacists providing CMM services has been in place for over 40 years and has demonstrated positive clinical impact and increased patient access across the continuum of care.

Many health systems authorize pharmacists to manage drug therapy by enacting pharmacy and therapeutics committee policies that require use of medical staff protocols and physician oversight for pharmacist-initiated orders. While this model works effectively for specific scenarios (e.g., management of population-specific patients), it does not allow the pharmacist to fully function and fulfill the CMM needs of their patients. Depending on the patient, medication, and degree of trust with the pharmacist, physicians often delegate therapeutic decision-making and medication treatment planning to pharmacists, based on the trust relationship developed through the interprofessional team and shared experiences in successfully dealing with challenging clinical situations, rather than through formal collaborative practice agreements. Common examples of pharmacist prescribing include independently managing symptoms and adverse events 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. Further, there are settings of care and pharmacy practice models that allow for autonomous and accountable prescribing authority by pharmacist practitioners as core component of CMM, without the need for collaborative practice authority for specific patients or populations. Pharmacist autonomous prescribing authority should be the gold standard for practice, especially when appropriate credentialing and privileging is in place and there is a separation of duties to ensure that a prescribing pharmacist is not responsible for the processing and dispensing of that medication order.

Pharmacists who prescribe must be recognized by payers and receive equitable payment for performing these advanced practice services. All pharmacist prescribers on the interprofessional team must possess a National Provider Identifier to monitor the care provided as well as reimburse for services rendered. Credentialing and privileging of individual healthcare providers is essential for determining who is authorized to prescribe and should ensure the appropriate evaluation of the quality of care provided. The credentialing procedures used 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 similar or higher-level peers (i.e., pharmacist prescribers or other licensed practitioners 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. The practice of credentialing and privileging should be consistent between hospitals health systems, accountable care organizations, and other organizations where the pharmacists function as a part of the interprofessional team. Finally, interdisciplinary health professional training programs should incorporate the concept of pharmacist prescribing in a standard way to ensure consistency amongst pharmacists practicing in similar practice settings and with similar levels of responsibilities.

Background

The Council examined this topic in response to a recommendation from the 2023 House of Delegates to consolidate and harmonize ASHP policies related to pharmacist prescribing authority. The Council consolidated ASHP policies 2251, Qualifications and Competencies Required to Prescribe Medications, and 2236, Pharmacist Prescribing in Interprofessional Patient Care, and updated them for readability and consistency as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To affirm that prescribing is a collaborative process that includes patient assessment, understanding of the patient's diagnoses, evaluation and selection of available treatment options, monitoring to achieve therapeutic outcomes, patient education, and adherence to safe and cost-effective prescribing practices; further, **[from policy 2251]**
>
> ~~To affirm that safe prescribing of medications, performed independently or collaboratively, requires competent professionals who complement each others' strengths at each step.~~ **[from policy 2251]**
>
> To recognize that pharmacists are highly trained medication experts on the interprofessional care team capable of making independent and autonomous evidence-based decisions on medication therapy management; further,
>
> To advocate that pharmacists have independent and autonomous authority to initiate, modify, and deprescribe all schedules and classes of medications; further,
>
> To advocate that healthcare delivery organizations establish credentialing and privileging processes for pharmacists that delineate scope of practice, support pharmacist prescribing, and ensure that pharmacists who prescribe are accountable, competent, and qualified to do so; further, **[from policy 2236]**

~~To advocate for comprehensive medication management that includes autonomous prescribing authority for pharmacists as part of optimal interprofessional care; further,~~ **[from policy 2236]**

To advocate that all pharmacists ~~on the interprofessional team~~ have a National Provider Identifier ~~(NPI); further,~~ that is recognized by payers. **[from policy 2236]**

~~To advocate that payers recognize pharmacist NPIs~~. **[from policy 2236]**

The Council drafted the new second clause ("To recognize that pharmacists are highly trained medication experts…") to emphasize that pharmacists have the skills to make decisions regarding medication therapy management, including prescribing. The Council drafted the new third clause ("To advocate that pharmacists have independent and autonomous authority…") to capture the intent of the clause struck from policy 2236 and to more clearly define the scope of pharmacists' prescribing authority.

4. Pharmacist's Role on Ethics Committees

To advocate that pharmacists should be included as members of, or identified as a resource to, hospital and health-system ethics committees; further,

To encourage pharmacists to actively seek ethics consultations or solicit input from their institution's ethics committee, as appropriate; further,

To encourage pharmacists serving on ethics committees to seek advanced training in healthcare ethics.

Note: This policy would supersede ASHP policy 1403.

Rationale

Many hospitals have a committee or other process by which they consider ethical decisions related to patient care. Many issues that face these committees involve medications, yet often pharmacists do not serve on the committee or are not directly involved in the decision-making process. The number of ethical issues involving medications is expected to increase, given many new and unique drug products coming into the market. These include patient access to high-cost medications, considerations during medication shortages, and other ethical considerations that surface as part of the formulary process. Pharmacist involvement would better inform these committees and consultations. To effectively contribute to decision-making on ethics, pharmacists will require advanced education on the subject.

Background

The Council reviewed ASHP policy 1403, Pharmacist's Role on Ethics Committees, as part of

sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To advocate that pharmacists should be included as members of, or identified as a resource to, hospital and health-system ethics committees; further,
>
> To encourage pharmacists to actively seek ethics consultations or solicit input from their institution's ethics committee, as appropriate; further,
>
> To encourage pharmacists serving on ethics committees to seek advanced training in healthcare ethics.

This policy was last reviewed in 2019 by the Council on Pharmacy Practice. The Council determined the policy needed to be revised to capture pharmacists serving as an expert or resource to ethics committees. Council members also indicated that ASHP needs to offer more education and resources in ethics and ethical decision-making. In particular, the Council felt more programming is needed related to ethical decisions specific to medication use, medication shortages, and high-cost medications.

5. Safe Handling and Administration of Hazardous Drugs

To advocate that pharmaceutical manufacturers eliminate surface contamination on packages and vials of hazardous drugs (HDs); further,

To inform pharmacists and other personnel of the potential presence of surface contamination on the packages and vials of HDs; further,

To advocate that all healthcare settings proactively conduct an interprofessional assessment of risk for exposure to HDs during handling and administration, including the use of closed-system transfer devices (CSTDs); further,

To advocate for pharmacist involvement in the development of policies, procedures, and operational assessments regarding administration of HDs, including when CSTDs cannot be used; further,

To advocate that the Food and Drug Administration require standardized labeling and package design for HDs that would alert handlers to the potential presence of surface contamination, including development of CSTD-compatible, ready-to-administer HD products; further,

To encourage healthcare organizations, wholesalers, and other trading partners in the drug supply chain to adhere to published standards and regulations.

Note: This policy would supersede ASHP policies 1615 and 1902.

Rationale

Hazardous drugs (HDs) present well-known risks to healthcare workers who handle them. Most HDs are administered orally or intravenously; however, other routes of administration are sometimes used, such as intrathecal, intraventricular, or intravesicular administration, or perfusion into a vessel or organ cavity. These procedures are becoming more common. Healthcare providers are required to use personal protective equipment and other protective devices, such as closed-system transfer devices (CSTDs), when the dosage form allows. The protective precautions required for administration through these routes is well described in United States Pharmacopeia (USP) General Chapter 800, the ASHP Guidelines on Handling Hazardous Drugs, the Oncology Nursing Society's Safe Handling of Hazardous Drugs, and other sources.

HDs are sometimes administered through other routes (e.g., Ommaya reservoirs, intraperitoneal infusion) for which protective precautions are not as well described or CSTD use is not possible. ASHP encourages all healthcare settings to conduct an interprofessional, proactive assessment of the risk of such procedures to assess the potential exposure risks for healthcare providers and identify mitigating measures. Given their depth of knowledge

regarding the handling of HDs, pharmacists should be involved in the development of policies, procedures, and operational assessments regarding administration of HDs in such circumstances. To reduce the risks to healthcare providers, ASHP encourages device and pharmaceutical manufacturers and the Food and Drug Administration (FDA) to deploy new production and processing standards to mitigate exposures, including labeling and package design that alerts handlers to the possibility of contamination. In addition, manufacturers and the FDA should develop CSTD-compatible, ready-to-administer HD drug products with the goal that CSTDs be utilized for all routes of administration of HD products as a best practice. However, when such use is not possible, an assessment of risk could identify gaps and ensure there are pharmacy-guided policies to address the handling, compounding, and administration for all healthcare staff coming into contact with HDs during administration via nontraditional routes. Such policies could also address any specialized training for staff in procedural areas, or the availability of a HD-specialized trained staff member to assist in the administration of the drug (e.g., a "chemo nurse").

The outer surfaces of vials of hazardous drugs have been shown to be contaminated with hazardous substances, and pharmacy and other personnel handling those vials may unknowingly be exposed. ASHP advocates that individuals involved in drug distribution, receiving, and inventory control adhere to safe handling guidelines, including ASHP guidelines and United States Pharmacopeia Chapter 800, to avoid undue exposure to hazardous substances but recognizes the limits of these best practices. Pharmaceutical manufacturers have a responsibility to provide vials that are devoid of surface contamination by ensuring adequate vial-cleaning procedures such as using decontamination equipment and protective sleeves during the manufacturing process.

Background

The Council reviewed ASHP policy 1902, Safe Administration of Hazardous Drugs, as part of sunset review, and voted to recommend consolidating it with ASHP policy 1615, Protecting Workers from Exposure to Hazardous Drugs, as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To advocate that pharmaceutical manufacturers eliminate surface contamination on packages and vials of hazardous drugs (HDs); further, **[from policy 1615]**
>
> To inform pharmacists and other personnel of the potential presence of surface contamination on the packages and vials of HDs ~~hazardous drugs~~; further, **[from policy 1615]**
>
> To advocate that all healthcare settings proactively conduct an interprofessional assessment of risk for exposure to ~~hazardous drugs (~~HDs~~)~~ during handling and administration, including the use of ~~when~~ closed-system transfer devices (CSTDs)~~ cannot be used~~; further, **[from policy 1902]**
>
> To advocate for pharmacist involvement in the development of policies, procedures, and operational assessments regarding administration of HDs, including when CSTDs

cannot be used; further, **[from policy 1902]**

To advocate that the Food and Drug Administration require standardized labeling and package design for HDs ~~hazardous drugs~~ that would alert handlers to the potential presence of surface contamination~~; further~~, **[from policy 1615]**

~~To encourage device and pharmaceutical manufacturers and the Food and Drug Administration to foster~~ including development of CSTD-compatible, ready-to-administer HD products; further, **[from policy 1902]**

To encourage healthcare organizations, wholesalers, and other trading partners in the drug supply chain to adhere to published standards and regulations~~, such as ASHP guidelines and United States Pharmacopeia Chapter 800, to protect workers from undue exposure to hazardous drugs~~. **[from policy 1902]**

COUNCIL ON PUBLIC POLICY
POLICY RECOMMENDATION

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.

Sam Calabrese, *Board Liaison*

1. Order Verification

To advocate that a prescriber should not be solely responsible for medication ordering, dispensing, and administration as well as any patient monitoring and evaluation, except when a double check would limit patient access to care.

Rationale

As pharmacy practice has evolved to include more direct patient care services, oversight of these services has not kept pace. This trend was exacerbated by the COVID-19 pandemic, which ushered in new test-to-treat models for pharmacy teams and introduced new flexibilities into telehealth. As care has shifted, pharmacists may be placed in situations in which they are overseeing many aspects of medication use, from independent prescribing to dispensing, without any additional verification checks. Other clinicians, including physicians and nurse practitioners, may also be in similar positions. Regardless of setting, without adequate patient safety safeguards (e.g., high-reliability process, technology and/or human review), placing one clinician in charge of the elements of medication-use process related to ordering, dispensing and administration, as well as any patient evaluation and monitoring, increases the risk for errors and adverse outcomes. While human checks are preferable for high-risk drugs, nothing in this policy should be considered to oppose appropriate autoverification of orders.

Background

The Council discussed how independent prescribing authority has shifted pharmacy practice, resulting in situations in which a single pharmacist is responsible for all patient-focused elements of the medication-use process (e.g., ordering, administration, dispensing, and evaluation and/or monitoring). The Council noted that this is also the case for physicians and certain nonphysician practitioners, but agreed that regardless of clinician type, checks are needed to ensure patient safety. The Council reviewed both ASHP policies 2133, Optimal Pharmacy Staffing Levels, and 2246, Autoverification of Medication Orders, and concluded that this issue merited its own policy rather than inclusion in an existing policy.

The Council discussed the Board's recommended edits to the policy, but felt that they did not fully capture the Council's intent. Specifically, the Council reiterated its concerns that no clinician, including pharmacists, should be placed in a position in which they maintain responsibility for the entire medication-use process without any checks. The Council agreed that checks could be provided by technology and should not be the basis for limiting patient access to treatment when such checks were unavailable (particularly in rural and/or underserved areas). The Council reworked the original policy language to incorporate the last portion of the Board's revisions and suggested some edits to the rationale, as indicated above. The Council felt strongly that this policy would not impede uptake of test-to-treat models, given that the language is inclusive of all providers and makes allowances for situations in which additional checks are not feasible.

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.

Vivian Bradley Johnson, *Board Liaison*

2. Liability Protection

To advocate that pharmacists be able to provide evidence-based dispensing and care to patients without fear of criminal or civil legal consequences, harassment, or liability; further,

To advocate that protection against liability extend to referrals for out-of-state care and for dispensing to patients from another state.

Rationale

In some states, pharmacists face potential civil or criminal liability for providing certain evidence-based patient care, including services related to reproductive health, gender-affirming care, and prevention and post-prophylaxis for HIV. Subjecting pharmacists to such liability for providing evidence-based patient care not only inappropriately infringes on the practice of pharmacy, it increases risks to patients. Given the chilling effect of the laws impeding evidence-based patient care services, patient access to services may be reduced or eliminated. Treatment delays, particularly for time-sensitive care related to reproductive health and provision of post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP), adversely impact patient care and outcomes and may result in patient or fetal mortality. Further, fear of prosecution could unduly limit not only the number of pharmacists willing or able to provide

these services, but also significantly hinder training and specialization in these areas in the next generation of clinicians, damaging our nation's clinical pipeline.

Background

The Council reviewed ASHP policy 2250, Access to Reproductive Health Services, to ensure that no changes were needed to address state law shifts following the Dobbs decision. The Council felt that no changes to policy 2250 were needed, but voiced concern about the growing threat of prosecution or civil liability for pharmacists providing evidence-based reproductive health, gender-affirming care, and PEP and PrEP. The Council felt that ASHP should provide education and analysis of new state laws to avoid chilling effects related to fear of prosecution or liability. Further, the Council recommended some edits to the rationale of policy 2250 to note the need for education related to potential areas of liability (e.g., reproductive health, PEP and PrEP, and gender-affirming care).

3. State Prescription Drug Monitoring Programs

To support continued state implementation of prescription drug monitoring programs that collect real-time, relevant, and standard information from all dispensing outpatient entities about controlled substances and monitored prescriptions; further,

To advocate that such programs seek adoption into health information exchanges to best integrate into electronic health records and to allow prescribers, pharmacists, and other practitioners to proactively monitor data for appropriate assessment and dispensing; further,

To advocate that such programs improve their interstate data integration to enhance clinical decision-making and end-user satisfaction; further,

To encourage policies that allow practicing pharmacists to gain access to databases without holding licensure in each state; further,

To promote research on the effects of prescription drug monitoring programs and electronic health record programs on opioid prescribing, dispensing, misuse, morbidity, and mortality.

Note: This policy would supersede ASHP policy 1408.

Rationale

ASHP recognizes the important contributions to public health made by state prescription drug monitoring programs (PDMPs). To be effective, these programs need to be mandatory; must

collect standardized, relevant, and real-time information for analysis and comparison among states; and need to be universal.

All states have implemented PDMPs, with the final state, Missouri, implementing its on January 20, 2023. While this is a great step forward, continued improvement of PDMP utilization is required. A recent review of PDMP reviews by Tay et al. in the Journal of Drug and Alcohol Dependence identified the following barriers still exist: PDMP system-related (i.e., usability, data quality), end-user related (i.e., satisfaction, workflow efficiency), and broader issues (i.e., electronic health record (EHR) integration, data sharing). More importantly, not all states mandate provider use of PDMP prior to controlled substance prescribing, and states that due mandate its use are slow to hold providers/pharmacists accountable for not using it. Due to these factors, it is difficult for practitioners to make relevant clinical decisions.

For states to see improvement in PDMP~~s~~ there needs to be improved data sharing between different jurisdictions, enhanced interoperability with EHRs and information exchanges, and increased evidence of PDMPs' impacts on patient outcomes to increase utilization. Finally, adequate state and federal funding is essential to sustain the viability of these programs and to encourage research, education, and implementation of best practices in PDMPs.

Background

The Council reviewed ASHP policy 1408, State Prescription Drug Monitoring Programs as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To ~~advocate for mandatory, uniform~~ support continued state implementation of prescription drug monitoring programs that collect real-time, relevant, and standard information from all dispensing outpatient entities about controlled substances and monitored prescriptions; further,
>
> ~~To advocate that the design of these programs should balance the need for appropriate therapeutic management with safeguards against fraud, misuse, abuse, and diversion; further,~~
>
> To advocate that such programs seek adoption into health information exchanges to best integrate into ~~be structured as part of~~ electronic health records and ~~exchanges~~ to allow prescribers, pharmacists, and other practitioners to proactively monitor data for appropriate assessment and dispensing; further,
>
> ~~To advocate for full interstate integration to allow for access by prescribers, pharmacists, and other qualified designees across state lines; further,~~
>
> ~~To advocate for federal and state funding to establish and administer these programs; further,~~

~~To promote research, education, and implementation of best practices in prescription drug monitoring programs.~~

To advocate that such programs improve their interstate data integration to enhance clinical decision-making and end-user satisfaction; further,

To encourage policies that allow practicing pharmacists to gain access to databases without holding licensure in each state; further,

To promote research on the effects of prescription drug monitoring programs and electronic health record programs on opioid prescribing, dispensing, misuse, morbidity, and mortality.

The Council updated the wording of the policy to reflect the fact that all states have now adopted PDMPs. It also updated language around integration of PDMP usage into EHRs and information exchanges to better reflect current technology and usage.

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.

1. Testing for Pregnancy Status

To affirm that pregnancy testing should occur only with informed consent and only when the test results would change medical management; further,

To affirm that a positive pregnancy test should not compromise the integrity of evidence-based, patient-centered care.

Rationale

Screening and testing for the pregnancy status of patients prior to admission to a hospital or surgical center or before initiation of a teratogenic drug therapy has long been a routine practice, as the pregnancy status of a patient has many ethical and legal considerations when medical management is considered for patient care. Chief pharmacy officers often oversee laboratory medicine departments, and pharmacists are often involved in creating protocols and order sets in which pregnancy testing and screenings are embedded and as a result are key stakeholders.

It is important to note that this policy pertains to testing without informed consent when therapy may need to be changed due to a positive test. The balance between unnecessary testing and testing when initiating a medication therapy is supported by a 2015 study that found that pregnancy assessment was underutilized in the emergency department when patients were prescribed a pregnancy category D or X drug. This policy does not advocate

that healthcare professionals should not include pregnancy screening as a part of a patient history, only that pregnancy testing should occur only with informed consent and not be a requirement for care. The incidence of unknown pregnancy in adult women presenting to a hospital for surgical procedures varies from 0.125 to 1.2%, depending on the procedure.

This policy also aligns ASHP with the American Society of Anesthesiologists statement that recommends "pregnancy testing may be offered to female sex patients of childbearing age and for whom the result would alter the patient's management, but testing should not be mandatory. Informed consent or assent of the risks, benefits, and alternatives related to preoperative pregnancy testing should ideally be obtained. Best practice may employ shared decision-making between patients and providers."

Background

The Council reviewed and discussed ASHP policy positions 2315, Responsible Medication-Related Clinical Testing and Monitoring; 0013, Patient's Right to Choose; and 2320, Pharmacoequity, in their discussion about this topic, and concluded that a standalone policy is needed.

2. 5-HT_2 Agonist, Entactogen, and Empathogen (Psychedelic) Assisted Therapy

To recognize that psychedelic-assisted therapy (PAT) has demonstrated therapeutic potential and should be further researched; further,

To recognize that in PAT there is not a standardized product subject to the same regulations as a prescription drug product, and to support the development of standardized formulations of psychedelics that would provide consistent potency and quality; further,

To encourage state boards of pharmacy, regulatory agencies, and safety bodies with an interest in PAT to promote research best practices and regulatory standards for medication preparation, compounding, and administration to ensure safety and quality; further,

To advocate that when psychedelics are used for PAT, healthcare providers, including pharmacists, should assess patients for medical, pharmacologic, and psychosocial contraindications prior to use and provide medical assistance as needed.

Rationale

There has been growing interest in the therapeutic potential of psychedelic drugs for use in the treatment of conditions such as depression, posttraumatic stress disorder, substance use disorders, and other conditions. The U.S. Food and Drug Administration (FDA) includes among these psychedelic drugs the "classic psychedelics," typically understood to be 5-HT_2 agonists

such as psilocybin and lysergic acid diethylamide (LSD), as well as entactogens or empathogens such as 3,4 methylenedioxymethamphetamine (MDMA). As a result of the growing interest, the FDA issued guidance that provides general considerations to sponsors developing psychedelic drugs for treatment of medical conditions.

Many studies report that psychedelic compounds are associated with few adverse events in trials, but the populations studied are not generalizable to the larger population. Psychological safety is a potential concern, and psychological distress is common, though not necessarily harmful in the long term. Increased blood pressure and heart rate due to the distress experienced during the administration session may put individuals with uncontrolled blood pressure or coronary artery disease at risk of ischemic events and may be considered a relative contraindication. Psychiatric illnesses, including schizophrenia, psychosis, and bipolar disorder, are considered a likely contraindication to psychedelic therapy. Drug-drug interactions of psilocybin, including tricyclic antidepressants, monoamine oxidase inhibitors, selective serotonin reuptake inhibitors, and QT interval-prolonging medications, are of concern and underscore the importance of pharmacists in the management of policies and practices related to the use of psychedelic compounds. Small sample sizes, a lack of diversity in enrollment, a lack of effective blinding, varied doses studied, and selective enrollment are just some of the critiques of trials assessing the use of psychedelic compounds. Psilocybin has been studied mainly in the treatment of psychological distress associated with life-threatening illnesses and major depressive disorder, while MDMA has been studied most extensively in the treatment of posttraumatic stress disorder. Despite promising results of some of the studies, the limitations of the studies prevent firm conclusions from being drawn.

In 2023, the American Medical Association also released new Current Procedural Terminology (CPT) III codes for Continuous In-Person Monitoring and Intervention During Psychedelic Medication Therapy. The code will provide a mechanism to track and report on the delivery of psychedelic treatments and will cover multiple psychedelic compounds with psychological support models, if approved, as well as various staffing structures, and numbers and credentials of qualified healthcare professionals.

Currently, psychedelic compounds with proposed therapeutic benefit, including psilocybin and MDMA, remain Schedule I substances, with no recognized therapeutic uses. Two states, Oregon and Colorado, have passed laws allowing the legal consumption of psychedelic compounds. Medical organizations have expressed concern about state efforts to circumvent federal laws through this approach, particularly when in the guise of medical treatment. In Oregon, for example, the administration of psychedelics is accompanied by assisted psychotherapy to maximize the possible therapeutic benefits. Prior to administration of the psychedelic compound, the individual will meet with a facilitator in a “preparation” session to review safety and support planning, transportation, and expectations for the administration of the psychedelic compound. The individual is then administered the dose under the supervision of the facilitator. Although these individuals are encouraged to share their past medical histories with the facilitator, it is not required, and the screening needed to ensure an appropriately selected client may fail to detect contraindications or significant drug-drug interactions. Furthermore, facilitators are required to have only a high school diploma and are not required to undergo medical training. This lack of training is of particular concern because individuals who are not trained medical professionals are likely unable to distinguish between

medical emergencies and the side effects of the psychedelic compounds.

ASHP policy also aligns with the American Psychiatric Association position that recognizes the emerging scientific evidence for using psychedelic drugs within the context of approved investigational studies and that "clinical treatments should be determined by scientific evidence in accordance with applicable regulatory standards and not by ballot initiatives or popular opinion."

It is important to recognize that mushrooms containing psilocybin have long been used for rituals and religious ceremonies around the world. As this use is falls within indigenous cultural and religious traditions and is not intended as a medical treatment, this policy does not address those uses.

Background

The Council reviewed the current evidence supporting the use of psychedelics along with the federal and state laws surrounding their use. Council members also discussed the trend of state law circumventing federal law for Schedule I substances and acknowledged that, despite promising results, the state approach to permitting use is concerning. The Council also recognized that although the ideal approach to PAT would be through controlled studies, PAT outside of investigational studies is already expanding, so the policy is written to reflect this reality and to encourage the presence of a medical professional at sites where PAT is provided. The Council also suggested that since more states are enacting legislation permitting the use of psychedelics, ASHP could provide resources on drug-drug interactions, toxicology, and education on PAT.

3. Nonprescription Status of Rescue and Reversal Medications

To support the over-the-counter (OTC) status of medications intended for evidence-based rescue use or reversal of potentially fatal events; further,

To work with federal, state, and local governments and others to improve the rescue and reversal medication development and supply system to ensure an adequate and equitably distributed supply of these medications; further,

To advocate that all insurers and manufacturers maintain coverage and limits on out-of-pocket expenditure so that patient access to rescue and reversal medications is not compromised; further,

To support and foster standardized education and training on the role of rescue and reversal medications and their proper administration, safe use, and appropriate follow-up care.

Rationale

As part of public health initiatives, certain medications used for rescue and reversal have

moved from prescription to over-the-counter (OTC) status. The opioid reversal agent naloxone is the most recent approval, with naloxone nasal spray approved in March of 2023 to help combat the opioid epidemic in the United States. Rescue and reversal medications such as naloxone and epinephrine require an additional level of action from patients and caregivers because they are used to initially treat life-threatening conditions, in contrast to other OTC agents. These patients will often require an additional level of care to monitor for safety and potential adverse events in the event of an opioid overdose or anaphylactic reaction. Therefore, it is important that rescue and reversal medications considered for OTC status have evidence that supports their use.

As barriers to access are removed, patient demand for these life-saving agents will almost certainly skyrocket, aligning with the intended purpose of such initiatives. To forestall the possibility of counterproductive market shortages, efforts to support and enhance manufacturing processes should be bolstered, with the U.S. Food and Drug Administration (FDA) likely being the most effective entity for these interventions. These interventions may include new drug application (NDA) provisions that require a certain threshold of product availability prior to OTC approval or a mandate that all manufacturers of an approved product transition their agent-specific supply chain to OTC distribution. Further, the FDA should optimize the NDA process itself, which may include a fast track for rescue and reversal medications, subsidies for all or part of the process, or standardized product labeling — which may serve the dual purpose of also supporting patient education initiatives — and other such measures.

Similarly, pricing for rescue and reversal medications should be minimized as much as possible, including efforts to eliminate patient cost entirely. OTC status often results in loss of third-party payer coverage, although there are notable exceptions to this trend (e.g., aspirin, vitamin D). The Affordable Care Act established a precedent for requiring insurer coverage of preventive drugs, and similar provisions could be made for rescue and reversal agents. Government efforts could include other related efforts, such as developing manufacturing cost subsidies, supporting tax-exempt status designations, and augmenting the wholesale distribution process and related infrastructure.

Finally, because the use of rescue and reversal medications often occurs in an emergency situation, easy-to-understand instructions on how to use these drugs and how to escalate if a person does not respond should be encouraged by all manufacturers. These instructions should be designed, tested, and validated in a similar design to the Drug Fact Label created by the FDA, which is designed to assess whether all the components of the product with which a user would interact could be used safely and effectively as intended.

Background

The Council discussed the approval of naloxone spray as an OTC agent and the potential for other rescue and reversal medications to become OTC. In light of the FDA announcement of naloxone's change to OTC status, the Council reviewed ASHP policy position 2211, Naloxone Availability, for potential updates and found that, even with the recent change to OTC status, the policy language is still relevant and did not require updating. When discussing other drugs, injectable epinephrine was the next drug that was considered. OTC inhaled epinephrine is OTC as the branded Primatene Mist HFA, which is indicated for treatment of mild to intermittent

asthma but is not a part of any treatment guideline. Its approval in 2018 was the cause of much concern in the medical community. Due to this experience, the Council expressed a desire to ensure that FDA approvals for rescue and reversal medication are evidence-based and guideline-driven, given the emergent nature of their use. Council members also noted that in Massachusetts there is a push to change albuterol to OTC, which reinforced the need for a clause that speaks to evidenced-based and guideline-driven approvals. The Council also discussed their concern of supply chain shortages, as occurred with prescription epinephrine in 2018, and therefore included language about ensuring that supply can keep up with demand for rescue and reversal medications.

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.

Kristi Gullickson, *Board Liaison*

Council Members
Joshua Blackwell, *Chair* (Texas)
Michelle Estevez, *Vice Chair* (Florida)
Aliyah Cruz (Wisconsin)
Stacy Dalpoas (North Carolina)
Sandeep Devabhakthuni (Maryland)
Johnnie Early II (Florida)
Glen Gard, *Pharmacy Technician* (Illinois)
Devon Hess, *Student* (North Carolina)
Tera Moore (Federal Service)
Vipul Patel (California)
Jennifer Robertson (Tennessee)
Kate Taucher (Colorado)
Ted Walton (Georgia)
Sophia Chhay, *Secretary*

1. Opposition to Pharmacy Jurisprudence Examination Requirement

To advocate the removal of a standalone examination of federal or state pharmacy law as a requirement for licensure; further,

To advocate that employers provide initial and ongoing education of the pharmacy workforce on pertinent federal and state pharmacy laws; further,

To acknowledge that it is a professional obligation of a pharmacist to practice in compliance with federal and state laws.

Rationale

National pharmacy associations have recently joined in advocacy for a more portable pharmacist license. Pharmacist interstate movement and practice are inhibited by the state-specific nature of the pharmacy jurisprudence examination. The pharmacist's licensing process includes one clinical knowledge exam (the NAPLEX), and in 48 states a jurisprudence exam is required, typically the Multistate Pharmacy Jurisprudence Examination (MPJE) — a 2.5-hour, adaptive, and proctored test. In contrast, physicians take three clinical knowledge exams, and only Texas, Oklahoma, Maine, and Oregon require a jurisprudence exam, which is taken online and is open-resource. Nurses are required to take one clinical knowledge exam (the NCLEX),

and only Texas and Kentucky require a jurisprudence exam, which is also online and open-resource. A 2017 working paper from the National Bureau of Economic Research found that pharmacists ranked among the lowest in terms of between-state migration, at -47%, compared to nurses (+5.5%) and physicians (+33%). While licensure in multiple states has always been almost a prerequisite for practitioners whose systems are in multi-state areas (e.g., VA, MD, DC), the advances in telehealth have made multistate licensure compulsory for many more pharmacists.

Accreditation Council for Pharmacy Education accreditation standards require pharmacy law as part of the curriculum, but student pharmacists may not practice in the state in which they receive their education, and employers should provide training on pertinent federal and state pharmacy laws. Even absent the state law exams, continuing education requirements and professional responsibility require pharmacists to know the laws in the state(s) in which they are licensed.

Background

The Council reviewed licensing requirements across states and professions, the relevance of continued law examination for pharmacists, and potential outcomes of eliminating the MPJE, and determined that ASHP needs a policy advocating the removal of a standalone examination of federal or state pharmacy law as a requirement for licensure. The Council felt eliminating this requirement would allow for greater flexibility regarding interstate movement and practice and align pharmacy with other healthcare professions.

2. Pharmacy Technician Education Requirements

To recognize that highly trained and skilled pharmacy technicians working in advanced roles regularly perform complex and critical medication-use procedures, and that a safe and effective medication-use process depends significantly on the skills, knowledge, and competency of those pharmacy technicians to perform those tasks; further,

To reaffirm that all pharmacy technicians should complete an ASHP-accredited training program, be certified by the Pharmacy Technician Certification Board, and be licensed by state boards of pharmacy; further,

To advocate that beyond those requirements, pharmacy technicians working in advanced roles should complete at a minimum an associate of science degree and demonstrate ongoing competencies specific to the tasks to be performed; further,

To advocate that expansion of pharmacy technician duties into expanded, advanced roles should include consideration of potential risk to patients and that ongoing quality assurance metrics should be established to assure patient safety.

Note: This policy would supersede ASHP policy 1203.

Rationale

Pharmacy technician roles have undergone a significant transformation within health systems throughout the years. In today's intricate healthcare landscape, these pharmacy technicians take on advanced responsibilities beyond their traditional duties. These extended roles include managing information systems, sterile product preparation, handling logistics, and implementing cutting-edge technology. According to the 2022 ASHP National Survey, more advanced pharmacy technician roles are emerging, including 340B Drug Pricing Program management, responsibility for USP chapter 797 (USP <797>) compliance, initiation of medication reconciliation, and supervision of other technicians. Pharmacy administrators have also reported a range of functions that health-system technicians perform, including sterile and nonsterile compounding, inventory management, purchasing, hazardous drug handling, controlled substance system management, medication order distribution, supervisory responsibilities, billing and reimbursement, and technician education and training. These advanced roles will require different skills and competencies, and pharmacy technicians should demonstrate competency before being allowed to perform such tasks, which will require additional, task-specific training.

The advancement of the pharmacy technician workforce includes credentialing, licensing, and on-the-job training. Moreover, engaging in formal education such as an associate of science degree equips pharmacy technicians with the necessary skill set to excel in these multifaceted roles, aids human resources departments in assigning an appropriate job code and pay grade, and elevates the pharmacy profession more broadly. Furthermore, other technical personnel in the healthcare sector (e.g., radiology technicians, respiratory therapist, laboratory technicians) are moving towards requiring a minimum of an associate degree and completion of an accredited training program, and aligning pharmacy technician requirements with other professions provides another pathway for enhanced remuneration. In addition, these measures would promote recruitment and retention of the pharmacy technician workforce within hospitals and health systems.

Background

The Council reviewed ASHP policy 1203, Qualifications of Pharmacy Technicians in Advanced Roles, as part of the discussion of pharmacy technician formal education requirements for health systems. The Council voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To recognize that highly trained and skilled pharmacy technicians working in advanced roles regularly perform complex and critical medication-use procedures, and that a safe and effective medication-use process depends significantly on the skills, knowledge, and competency of those pharmacy technicians to perform those tasks; further,
>
> To reaffirm that all pharmacy technicians should complete an ASHP-accredited training program, be certified by the Pharmacy Technician Certification Board, and be licensed by state boards of pharmacy; further,
>
> To advocate that beyond those requirements, pharmacy technicians working in

advanced roles should ~~have additional training~~ complete at a minimum an associate of science degree and ~~should~~ demonstrate ongoing competencies specific to the tasks to be performed; further,

To advocate that expansion of pharmacy technician duties into expanded, advanced roles should include consideration of potential risk to patients and that ongoing quality assurance metrics should be established to assure patient safety.

3. Implications of Artificial Intelligence for Professional Integrity

To encourage hospitals, health systems, and colleges of pharmacy to adopt policies regarding the appropriate use of artificial intelligence and ongoing surveillance of these tools.

Rationale

The rapid advancement of generative artificial intelligence (AI) technologies, such as ChatGPT, has introduced new possibilities and challenges across society, particularly in the realm of education. These technologies appear to offer innovative ways to assist learners, enhance educational experiences, and streamline administrative processes. However, the integration of AI tools raises concerns about academic integrity, plagiarism, and the potential for unethical use that could undermine the educational process. As such, hospitals, health systems, and colleges of pharmacy should adopt policies regarding the appropriate use of AI across the continuum of learning from didactic to experiential and within the clinical learning environment.

AI tools require extensive education and ongoing surveillance about their potential utility and limitations. Ethical and regulatory implications must be considered, as AI is increasingly incorporated into practice, education, and training. Furthermore, pharmacists must be prepared to engage in the development, validation, and implementation of AI to ensure such tools are being leveraged appropriately to support optimal patient care.

Background

At its Policy Week meeting, the Council reflected on the implications of ChatGPT and AI for academic integrity and guidance to student pharmacists, pharmacy residents, educators, and preceptors. The Council identified a need for ASHP policy on this issue.

4. Pharmacy Residency Training

To continue efforts to increase the number of ASHP-accredited pharmacy residency training programs and positions available; further,

To promote efforts to increase recruitment and retention of residents in ASHP-accredited pharmacy residency programs; further,

To encourage stakeholders to evaluate priority areas within pharmacy for future residency training needs.

Note: This policy would supersede ASHP policy 0917.

Rationale

ASHP is committed to achieving the goal that "pharmacists who provide direct patient care should have completed an ASHP-accredited residency or have attained comparable skills through practice experience" and advocates that "the completion of an ASHP-accredited postgraduate year one residency be required for all new college or school of pharmacy graduates who will be providing direct patient care." (ASHP policy position 2027) Furthermore, in the Practice Advancement Initiative (PAI) 2030, recommendation B4 states, "Health systems should require completion of ASHP-accredited residency training as a minimum credential for new pharmacist practitioners." There are opportunities to evaluate recruitment and retention of residents to increase the number who successfully complete residency training programs. In addition, key stakeholders (e.g., colleges of pharmacy, academic medical centers, healthcare organizations, and government agencies) should evaluate priority areas within pharmacy for future training needs, which may include health-system pharmacy administration and leadership, population health management and data analytics, pain and palliative care, medication-use safety and policy, pharmacy informatics, and others.

Background

The Council reviewed ASHP policy 0917, Pharmacy Residency Training, as part of the discussion of pharmacy residency trends. The Council voted to recommend amending it as follows (underscore indicates new text):

> To continue efforts to increase the number of ASHP-accredited pharmacy residency training programs and positions available; further,
>
> To promote efforts to increase recruitment and retention of residents in ASHP-accredited pharmacy residency programs; further,
>
> To encourage stakeholders to evaluate priority areas within pharmacy for future residency training needs.

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.

Kim Benner, *Board Liaison*

Council Members
Christy Norman, *Chair* (Georgia)
Jennifer Miles, *Vice Chair* (Florida)
Thomas Achey (South Carolina)
Timmi Anne Boesken, *Pharmacy Technician* (Ohio)
Elissa Chung, *Student* (Washington)
Rox Gatia (Michigan)
Davey Legendre (Georgia)
Ryan Naseman (Kentucky)
Rebecca Ohrmund, *Pharmacy Technician* (Illinois)
Daniel O'Neil (West Virginia)
Joseph Pinto (New York)
Ellen Revak (Wisconsin)
Kate Schaafsma (Wisconsin)
Tara Vlasimsky (Colorado)
Jason Wong (Oregon)
Eric Maroyka, *Secretary*

1. Documentation of Patient-Care Services in the Permanent Health Record

To advocate for public policies that support documentation of patient-care services provided by the pharmacy workforce in the permanent patient health record; further,

To promote inclusion of the pharmacy workforce in organization-based credentialing and privileging processes and in collaboration with an organization's clinical informatics team to ensure accurate and complete documentation of the care provided to patients and to validate the impact of patient care provided by the pharmacy workforce on patient outcomes and cost of care; further,

To advocate that electronic health records be designed with a common documentation space to accommodate all healthcare team members and support the communication needs of pharmacy.

Note: This policy would supersede ASHP policy 1419.

Rationale

Documentation in the patient record is critical for a complete record for patient care and communication among members of the healthcare team. Documentation should be done within an electronic health record (EHR). Organization-based privileging is the process used by a healthcare organization, after evaluating a practitioner's credentials, to assure stakeholders that the healthcare professional has the competencies and experience to provide certain direct patient care services. Privileging grants that individual practitioner permission to deliver those patient care services and document the rendering of those services in the permanent health record. ASHP supports the use of use of post-licensure credentialing, privileging, and competency assessment, in a manner consistent with other healthcare professionals, to practice pharmacy as a direct patient-care practitioner (see ASHP policies 2011, Credentialing and Privileging by Regulators, Payers, and Providers of Collaborative Practice, and 1415, Credentialing, Privileging, and Competency Assessment). Pharmacy technicians, within their scope of practice, have documented activities (e.g., medication history documentation) in the record as part of team-based care documentation. When documenting electronically, use of standardized and coded formats allows for improved measurement of patient outcomes.

Background

The Council reviewed ASHP policy 1419, Documentation of Patient-Care Services in the Permanent Health Record, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To advocate for public ~~and organizational~~ policies that support ~~pharmacist~~ documentation of patient-care services provided by the pharmacy workforce in the permanent patient health record; further,
>
> To promote inclusion of the pharmacy workforce in organization-based credentialing and privileging processes and in collaboration with an organization's clinical informatics team to ensure accurate and complete documentation of the care provided to patients and to validate the impact of ~~pharmacist~~ patient care provided by the pharmacy workforce on patient outcomes and ~~total~~ cost of care; further,
>
> To advocate that electronic health records be designed with a common documentation space to accommodate all healthcare team members and support the communication needs of pharmacy.

The Council discussed the lengthy first clause in the existing policy and felt advocating for public policies seems reasonable but not so for organizational policies. Promoting incorporation in an organization-based credentialing and privileging process and in collaboration with an organization's clinical informatics team seem practical and actionable. There is some crossover with ASHP policy 2137, Documentation of Pharmacist Patient Care, but that policy focuses more on documentation, billing, and attribution for services rendered. There was some discussion

about a need for advocacy to support documentation of activities by pharmacy technicians within their scope of practice (e.g., medication history documentation) as part of team-based care documentation.

2. Safe Medication Sourcing, Preparation, and Administration in All Sites of Care

To advocate that all sites of care be required to meet the same regulatory standards for medication sourcing, preparation, and administration to ensure safety and quality.

Note: This policy would supersede ASHP policy 1914.

Rationale

Globally, health spending as a share of the overall economy has been steadily increasing since the 1980s, as spending growth has outpaced economic growth across all high-income countries, the United States included. This growth is multifactorial but is largely due to advances in medical technologies, including specialty medications; exponential and disparate price increases in the health sector across all markets; and higher demand for services, especially from a growing, aging population (Commonwealth Fund, Peterson-KFF). Based on data from 2021, the United States spent 18.3% of gross domestic product (GDP) on healthcare, nearly twice as much as the average country in the Organisation for Economic Co-operation and Development (Peterson-KFF, CMS). Over 2022-2031, average growth in national health expenditures (5.4%) is projected to outpace that of average GDP growth (4.6%), resulting in an increase in the health spending share of GDP, from 18.3% in 2021 to 19.6% in 2031 (CMS). This increasing cost of healthcare in the United States has motivated stakeholders across the care paradigm to search for strategies to curtail costs. Over the last decade, payers have implemented strategies that fragment providers' comprehensive care management of the patient. These strategies include but are not limited to site-of-care (SOC) optimization, which shifts care away from hospitals, and payer-directed drug distribution models (see ASHP policy 2309, Payer-Directed Drug Distribution Models), which undermine hospitals' patient safety protections and jeopardize patient care. The payers' overarching goal is cost containment, while maintaining access to the prescribed therapy. Cost containment efforts have shifted beyond the traditional pharmacy point-of-sale management intended for self-administered medications under the pharmacy benefit, such as formulary tiering, prior authorization requirements, drug exclusions, and step therapy implementation. These newer payer strategies targeting provider-administered medications under the medical benefit present risks to patient care and safety. Patients are increasingly being required to receive care at lower-cost nonhospital SOCs, rather than at traditional venues, such as hospital outpatient infusion centers. Alternative or nonhospital SOCs include nonhospital-affiliated outpatient infusion centers, physician's offices, ambulatory infusion centers, or patients' homes. Payer-imposed SOC restrictions and policies

jeopardize the continuity of care for the patient by introducing incongruent providers and systems (see ASHP policy 2031, Continuity of Care in Insurance Payer Networks). These same policies also create additional logistical challenges for the patient to navigate and can impede timely access to care for patients who require additional special assistance or services, such as access to emergency staff in the event of an adverse reaction. Further, the level of infrastructure required to adequately address regulatory and accreditation requirements focused on quality and safety (e.g., United States Pharmacopeia Chapters 797 and 800, state board of pharmacy regulations, and the standards of accreditors such as The Joint Commission and Det Norske Veritas Healthcare) varies across SOCs, with hospitals carrying the greatest administrative burden and costs. As a result, health systems should collaborate with pharmacy leadership when exploring ways to optimize medication access and appropriate utilization in nonhospital SOCs.

Background

The Council reviewed ASHP policy 1914, Safe Medication Preparation, Compounding, and Administration in All Sites of Care, as part of sunset review and in response to recommendations made by an ASHP member advisory panel and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To advocate that all sites of care be required to meet the same regulatory standards for medication sourcing, preparation, ~~compounding,~~ and administration to ensure safety and quality.

The Council discussed opportunities to make the policy recommendation and associated rationale reflective of current practice, healthcare trends, and pharmacy opportunities to ensure optimal patient care. The Council proposed ASHP continue advocacy in opposition to specific payer strategies that restrict access points, interfere with shared provider-patient decision-making, and jeopardize patient care.

2024 Report of the ASHP Treasurer

Christene M. Jolowsky

The Treasurer has the responsibility to report annually on ASHP's financial condition to the membership. ASHP's fiscal year is from June 1 through May 31, coinciding with our policy development process and timetable. This report describes ASHP's actual financial performance for fiscal year FY2023, projected financial performance for FY2024, and an FY2025 budget status update.

Fiscal Year 2023 Ending May 31, 2023—Actual

ASHP's FY2023 financial statement audit for the year ending May 31, 2023, was performed by Aprio, LLP. The audit resulted in ASHP receiving the best opinion available, an unmodified opinion.

ASHP's core operations[1] experienced a strong post-COVID recovery. Core gross revenue was $58.8 million (Figure 1), up by $15.0 million compared to FY2022. The gross revenue increase was primarily attributable to the Midyear Clinical Meeting & Exhibition (MCM) being held in person versus a virtual meeting during FY2022. In addition, we held the Summer Meetings for the first time after a two-year hiatus due to COVID and had successes with membership, *American Journal of Health-System Pharmacy* (*AJHP*), special publishing, professional certificates, accreditation services, and the Health and Human Services Administration grant. Core net income was a surplus of $4.4 million. Net program development, capital budget, and investments[2] were a net loss of $1.9 million, which is attributable to short-term investment losses. In total, FY2023 resulted in a favorable $2.5 million net change in ASHP's reserves/net assets.

Finally, the building fund[3] had a loss of $4.9 million, primarily due to short-term investment losses. With significant positive returns in previous years, the building fund remains on track to continue supporting ASHP's office space expenses and reach its long-term financial target. ASHP's total net assets at the end of FY2023 were $134.6 million (Figure 2). Our year-end balance sheet remained strong, with an asset-to-liability ratio of 3.95:1. ASHP remains well-prepared for the future.

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

[2]Includes investments in ASHP's program development and capital budget, building sale reserve funds, reserves/net assets spending, and investment gains/(losses). The Board of Directors approves spending during ASHP's annual budget development process. Expenditures are typically (1) associated with new, enhanced, and expanded programs; (2) associated with time-limited programs; (3) capital asset purchases; or (4) supplemental operating expenses. These expenditures are primarily funded by investment income from reserves/net assets and the building sale reserve funds.

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

Report of the ASHP Treasurer

Fiscal Year 2024 Ending May 31, 2024—Projected

Fiscal year 2024 core operations are shaping up to have another record year, with projected core gross revenue of $61.0 million. As of February 29, 2024, we anticipate that ASHP's FY2024 core net income will be in the range of $1.7 million (Figure 1). Assuming the financial markets remain steady for the remainder of the fiscal year, we are projecting a deficit of $443,000 for program development expenses, capital budget, and investments. This deficit is primarily due to ASHP's current year $1.5 million investment in a national public awareness campaign to educate the public about the roles of pharmacists and pharmacy personnel in hospitals, health systems, and clinics. This results in a projected positive net change in reserves/net assets of $1.3 million. Finally, we anticipate the building fund will have a surplus in the range of $17,000.

ASHP accomplished a great deal during FY2024, including maintaining a strong and active membership and launching The Pharmacy Technician Society (TPTS), a stand-alone 501(c)6 membership organization for pharmacy technicians. Initial interest and engagement with TPTS has been strong. The aforementioned national public awareness campaign launched to a strong positive reaction. We continue to build back our in-person meetings and remain at the forefront of pharmacy training and education.

ASHP's engaged and growing membership is a testament to our efforts to help pharmacy practitioners address today's most pressing challenges and prepare for dynamic changes ahead. As the largest and most influential professional pharmacy organization in the United States, ASHP remains dedicated to addressing the individualized and evolving needs of our members in every practice setting and at every step of their careers.

Fiscal Year 2025 Ending May 31, 2025—Budget

ASHP's Board of Directors has thoughtfully considered our FY2025 budget. There are many positive signs for the future.

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

Considering these and other factors, ASHP's FY2025 budgeted net change in reserves/net assets is a deficit of $559,000, with $60.4 million in core gross revenue. The deficit is primarily attributable to ASHP's continued investment in the national public awareness campaign. The building fund, which is designed to pay for ASHP's headquarters office space, is budgeted to have a $323,000 surplus.

Conclusion

As ASHP works to support our members, the profession, and the patients we serve through this transformative era, we have experienced sustained financial stability and membership growth. ASHP proudly represents the diversity and vibrancy of the pharmacy profession. Effective financial stewardship, innovative thinking, and a collaborative spirit ensure that we have a strong pipeline of products, programs, and services to enhance practice, foster career

development, and most importantly, positively impact safe and effective medication use and improved patient outcomes. The Board of Directors, Chief Executive Officer, and staff are wholly dedicated to ASHP's mission, vision, and strategic plan and supporting our members. We look forward to another successful year, and I am proud to serve this organization as your Treasurer!

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

	Actual Fiscal Year 2022 Ended May 31, 2022	Actual Fiscal Year 2023 Ended May 31, 2023	Projection* Fiscal Year 2024 Ended May 31, 2024	Budget Fiscal Year 2025 Ended May 31, 2025
CORE OPERATIONS				
Gross Revenue	43,848	58,775	61,015	60,370
Total Expense	(47,996)	(54,384)	(59,295)	(60,367)
CORE NET INCOME/(LOSS)	(4,148)	4,391	1,720	3
NET PROGRAM DEVELOPMENT EXPENSES, CAPITAL BUDGET, AND INVESTMENTS GAIN/(LOSS)	(4,227)	(1,929)	(443)	(562)
NET CHANGE IN RESERVES/NET ASSETS	(8,375)	2,462	1,277	(559)
BUILDING FUND	(8,671)	(4,867)	17	323

*Projection as of February 29, 2024

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

	Actual as of May 31, 2022	Actual as of May 31, 2023
ASSETS		
Current assets	12,496	22,204
Fixed assets	4,644	3,851
Investments	150,601	141,424
Other assets	478	12,850
Total Assets	168,219	180,329
LIABILITIES		
Current liabilities	22,615	27,783
Long-term liabilities	8,556	17,903
Total Liabilities	31,171	45,686
RESERVES/NET ASSETS		
Total Net Assets	137,048	134,643
Total Liabilities and Net Assets	168,219	180,329

2024 Joint Address from the ASHP President and the Chief Executive Officer

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Our collective successes only raise the bar as we strive to continue to support pharmacy's evolving needs. We will continue to be inventive and transformative, to lead by example, to harness the potential of change, and to spearhead innovation.

Editor's note: The following is adapted from comments delivered during the House of Delegates session of the ASHP Pharmacy Futures 2024 meeting, held in June 2024 in Portland, OR.

Each year in June, the CEO and the President of ASHP present joint remarks at the annual gathering of our House of Delegates. These remarks provide an overview of ASHP initiatives, activities, and accomplishments supporting our profession, members, and the patients they serve.

For the first time ever, in 2024, the live remarks have been delivered at the House of Delegates via a prerecorded, multimedia presentation[1] as a new and exciting way to help bring this in-depth written version to life.

A year ago in Baltimore, the theme for the presidential inaugural address was "Be the Change," asking how we, the pharmacy workforce, can be the change in this digital healthcare revolution. This theme has been exceedingly relevant to ASHP's work over the last 12 months, culminating in the reimagined Pharmacy Futures 2024 meeting, which featured our first-ever Artificial Intelligence (AI) Summit and provided exceptional educational programming to help our members harness the power of innovation to improve patient care and transform the practice of pharmacy.

It is truly astounding how quickly our profession is evolving and changing, driven by a dramatic influx of new thinking and advanced technologies. The prioritization of digital healthcare is critical to the future of our profession, and ASHP, the largest professional pharmacy organization in the US, will be leading the way.

ASHP is committed to supporting our 60,000 members, our profession, and the patients we serve with tools and resources to meet the dynamic demands of pharmacy today and tomorrow. And we are equally committed to addressing today's challenges head-on.

National public awareness campaign

Last month, ASHP embarked on one of the most anticipated initiatives in our storied history—the launch of *We're Your Pharmacist*, our national public awareness campaign. The vision for this campaign is simple: The public will be aware of, seek, and value hospital and health-system pharmacists as essential patient care providers. To get there, we are partnering with our members to tell their stories, spotlighting real hospital and health-system pharmacists through their own words and those of their colleagues and patients to demonstrate their value and impact on patient care. We are leveraging the power of multimedia to bring member stories to life and using multiple channels and platforms to reach our target audiences. We are also making the campaign local, with multimedia tool kits to empower partner organizations—hospitals and health systems, colleges of pharmacy, and ASHP state affiliates—to spread campaign messages in communities across the country.

The ASHP Board of Directors approved initial funding of $3 million over 3 to 5 years, a testament to our organization-wide commitment to making a real impact with the campaign. Earlier this year, the ASHP Foundation made its own statement

of support and approved $1 million in campaign funding over 5 years to bolster sustained campaign success.

The campaign is just getting started, and we are beyond excited to see the stories of pharmacists across settings and specialties come to life.

Advocacy

ASHP is the leading advocacy voice in the halls of Congress in Washington, DC, and in the states on the issues that matter most to our patients and pharmacy practitioners in hospitals, clinics, and in community practices in health systems. ASHP has engaged in remarkable advocacy efforts in the past year to advance pharmacy practice and protect patient access to affordable medications. On a state level, we have witnessed significant progress in expanding pharmacist payment authority, with Medicaid programs in 47 states now providing payment for various levels of pharmacist care. We continue to advocate for the passage of legislation in Congress to recognize pharmacist provider status on a federal level to ensure patient access to essential pharmacist services for seniors, rural populations, and other underserved populations.

One of ASHP's most influential advocacy tools is providing model legislation to pharmacy professionals. Model legislation is standardized language that can be adopted in statehouses nationwide as legislators develop laws that influence pharmacy practice. ASHP's model legislation has helped states enact pharmacy-centric laws on white bagging and comprehensive medication management. ASHP developed model legislation prohibiting insurers from discriminating against 340B-covered entities, which has helped us reach 28 states that prohibit this discrimination. Earlier this year ASHP partnered with 340B Health to draft model legislation to protect 340B contract pharmacy relationships. We also published model legislation enabling pharmacists to prescribe medications for opioid use disorder (MOUD), with 11 states now allowing this practice. Most recently, we published model legislation for pharmacy technician product verification, part of a larger advocacy initiative to authorize pharmacy technician product verification in all states.

On a federal level, key congressional committees are actively considering two pharmacist provider status bills: the Equitable Community Access to Pharmacist Services Act[2] and the Pharmacy and Medically Underserved Areas Enhancement Act.[3] This is the most concrete sign of congressional interest in provider status, and ASHP continues to lead efforts calling on Congress to pass these bills.

In the area of drug shortages, ASHP testified before the House Energy and Commerce Committee, participated in White House discussions, and released policy solutions to address the drug shortage crisis. The attention garnered on Capitol Hill is a testament to our collective efforts, and we will continue to advocate and provide expertise and recommendations to address this pressing issue.

Another area of focus was our opposition to site-neutral payments, which threaten to undermine fair reimbursement practices and the quality of patient care. ASHP collaborated with the American Hospital Association to create and disseminate an infographic advocating against site-neutral payments and explaining how they threaten patient safety.

And we actively worked with the White House and other federal entities to address the fallout from the Change Healthcare cyberattack. We participated in a discussion with Department of Health and Human Services (HHS) Secretary Xavier Becerra, emphasizing the need to ensure that pharmacies will be made whole for medications dispensed, and cost sharing collected, based on good faith efforts to ensure continuity of patient care. ASHP also called on HHS to ensure pharmacists and other providers will be held harmless for data breaches attributable to the cyberattack. We met with the Optum Rx CEO to discuss the need to restore claims and reimbursement quickly and provide financial support and flexibility to patients, hospitals, and pharmacies disrupted by the attack. In addition, we ensured our members had the latest information and resources for recovery efforts.

Supporting pharmacy technicians

The pharmacy technician workforce is foundational to optimal patient care. In 2023, ASHP took the bold step of creating an independent membership organization for pharmacy technicians, to be led by pharmacy technicians. The Pharmacy Technician Society (TPTS) is a new, national membership organization devoted exclusively to the needs of pharmacy technicians. TPTS supports the career advancement and professionalization of the pharmacy technician workforce through education, networking, policy development, and advocacy. Early response to the new organization has been overwhelmingly positive, with a growing membership of more than 10,500 technicians.

The recently appointed inaugural TPTS Board of Directors will have the critical job of developing the TPTS mission, vision, and first strategic plan. ASHP recently concluded an in-depth survey of the quickly growing TPTS membership, which will help inform the organization's strategic direction and plans for the development of tools and resources. Initial response to the comprehensive TPTS website and the technician-specific job board launched earlier this year has been strong and points to much success ahead.

ASHP Leadership Center

As pharmacy practice evolves, being a leader means an expanded sphere of influence and countless opportunities to influence the future. ASHP is committed to promoting growth at all pharmacy and health-system leadership levels, including clinical and executive leaders. Two years ago, we launched the ASHP Leadership Center, which has been instrumental in providing leadership development for clinical

and executive members through professional growth opportunities such as networking, mentorship, and verification of leadership competence and knowledge.

Our Certified Pharmacy Executive Leader program, or CPEL, celebrated its first anniversary in late 2023. To date, more than 94 pharmacy clinical and administrative executive leaders have achieved certification. CPELs represent more than 35 US states and 4 countries. It is a thriving community, and we look forward to the program's continued growth in 2024 and beyond.

As part of a 2-year research effort funded by the ASHP Foundation, ASHP recently sent a survey to members to assess various aspects of formal leadership roles for pharmacists, including job satisfaction of existing pharmacists in leadership roles, interest in pursuing leadership roles by students, residents, and junior and mid-level pharmacists, opportunities, and challenges in filling leadership vacancies, and more. Stay tuned for more information about this exciting project.

The Pharmacists in C-Suites (PICS) membership home is a hub for pharmacists who have risen to executive roles beyond traditional pharmacy settings, including chief executive officers, chief operating officers, presidents and vice presidents, and other C-suite level positions. The PICS Advisory Panel gathered for the first time in June 2023, and over 50 hospital and health-system executives attended the inaugural PICS virtual event last fall. This event provided a platform for discussions on executive-level topics, including strategic partnering with postacute care providers for improved bed utilization, challenges posed by insurers, optimized patient throughput, and ideas for leading and supporting health systems' workforces.

ASHP's Pharmacy Executive Leadership Alliance, or PELA, provides opportunities for pharmacy executives and chief pharmacy officers to share insights on critical topics through exclusive events that help advance pharmacy leadership and practice. PELA recently convened a virtual conference focused on drug policy, formulary management, and P&T decisions for our nation's multihospital systems and large hospitals.

The Pharmacy Administration and Leadership Residents' Collaborative (PALRC) is a home within ASHP for unique offerings for the health-system pharmacy administration and leadership (HSPAL) resident community. In the last year, PALRC has organized several events, including an open forum at the ASHP Conference for Pharmacy Leaders, a networking session at the Midyear Clinical Meeting, presentations at pharmacy schools, and the production of leadership-focused podcasts.

The ASHP Student Leadership Development Program is available as a resource for use as an elective course by schools and colleges of pharmacy as well as a stand-alone learning experience for students interested in improving their professional and leadership skills. It enables pharmacy students to be better prepared to serve as effective leaders, helping establish a legacy of future leaders to continue advancing pharmacy practice.

Diversity, equity, and inclusion (DEI)

ASHP continues to take significant steps toward strengthening an inclusive culture for all pharmacy practitioners.

ASHP's Guided Mentorship Program connects seasoned practitioners with aspiring student pharmacists of color. Fostering these connections strengthens the pharmacy workforce by creating a diverse and skilled community of new pharmacy practitioners. The success of our third cohort, with more than half of the students and a significant number of mentors identifying as Black, Indigenous, and people of color (BIPOC), is a testament to the power of mentorship in cultivating a new generation of pharmacy leaders.

The ASHP Foundation continues its critical work in supporting DEI initiatives. The Pharmacy Leadership Scholars program, which provides up to $10,000 for research projects examining race and ethnicity's impact on patient outcomes and pharmacy education, is now in its third cycle. Last year, the program awarded $40,000 in grants.

The ASHP Foundation has also taken tangible steps to support students from underrepresented communities. Last year, the Pharmacy Student Scholarship program distributed $25,000 to third- and fourth-year pharmacy students from historically black colleges and universities (HBCUs). The Foundation will offer these scholarships again this year.

The Midyear Travel Awards, offered by the ASHP Foundation in partnership with #PharmGradWishlist, provided $500 stipends and registration fees for 50 PharmD candidates who self-identify as racial and ethnic minorities to attend our 2023 Midyear Clinical Meeting. Plans are underway to offer the awards for the 2024 Midyear meeting in New Orleans, LA.

We are incredibly proud of the new tools, education, networking, and other resources that ASHP produces to spotlight and enhance the pharmacy community's diversity. From articles to podcasts and webinars commemorating Black History Month, Women's History Month, and Pride Month, we shine a light on the vibrant and engaging pharmacists who are not only part of our community but are vital members of our nation's healthcare leadership. We encourage you to visit ASHP's Inclusion Center at ashp.org to learn more.

World-class education, information, and resources

ASHP remains at the forefront of pharmacy education and training, creating and delivering valuable resources and content in multiple formats to support professional development and practice advancement. We issued 671,250 statements of continuing education credit across our educational offerings in 2023. We continue to grow and enhance our professional

certificates (now with 35 titles), board certification resources (in partnership with the American College of Clinical Pharmacy), competency assessment products, publications, and more. ASHP's robust offerings of programs, products, and services are too comprehensive to catalog in full, but some notable highlights include:

- In response to the elimination of the X waiver, ASHP launched the Medications for Opioid Use Disorder (MOUD) Training Program. Created for pharmacists, physicians, and other advanced healthcare professionals, it meets the Substance Abuse and Mental Health Services Administration training requirements for the Medication Access and Training Expansion Act of 2023.
- ASHP's Practice Advancement Initiative 2030, or PAI 2030, provides pharmacy teams with guidance for advancing healthcare and pharmacy practice through 59 recommendations. Since its launch, more than 650 individuals and organizations have used the PAI 2030 Self-Assessment Tool to identify areas in one's practice or organization where PAI 2030 recommendations could have the biggest impact. This year, we kicked off a virtual collaborative learning cohort that followed the 9-step implementation process outlined in the ASHP PAI 2030 State Affiliate Toolkit. It involved a series of brief, monthly presentations to help states adopt the recommendations. We also offered programming at the 2023 Midyear Clinical Meeting related to the PAI 2030 focused initiatives and each of the 5 PAI 2030 recommendation domains.
- ASHP developed the Certified Centers of Excellence (COE) in Medication-Use Safety and Pharmacy Practice program to recognize hospitals and health systems that demonstrate the highest levels of pharmacy practice. This certification signifies operational and practical excellence and bolsters the reputation and impact of pharmacy services within the institution. Legacy Salmon Creek Medical Center in Vancouver, WA, recently earned this certification and is the first community hospital to obtain this distinction. Several additional organizations are currently in pursuit of this prestigious certification.
- The 2024 Commission on Goals focused on transforming primary care delivery through the convergence of evolving patient and provider expectations, changing workforce dynamics, technological advancements, and innovative business models. Common themes that spanned these areas included the need to rapidly adopt innovative tools, constrain unnecessary administrative burdens and complexity, forge productive connections among all primary care team members, improve the patient care experience, and retain patients in care. Keep your eye out for an in-depth report about the Commission's conclusions and recommendations in an upcoming issue of *AJHP*.

Another way ASHP is at the forefront of preparing the pharmacy workforce for the future is right here at Pharmacy Futures 2024. As pharmacy professionals face new opportunities and challenges with rapid advances in diagnostics and therapeutics, personalized medicine, and AI, we transformed our annual Summer Meeting into a new event that will now be known as ASHP Pharmacy Futures.

This meeting offers cutting-edge educational sessions and a collaborative environment where pharmacy professionals can come together to share practice insights and influence the future direction of healthcare. Attending Pharmacy Futures 2024 equips the attendees with the forward-looking perspective and innovative tools necessary to stay ahead in a rapidly evolving healthcare environment. It prepares participants not just to adapt to the future but to actively participate in creating it, ensuring that pharmacy practice remains at the cutting edge of patient care and technological progress.

In addition, we held our first-ever AI Summit. It offered an intensive exploration into AI's pivotal role in healthcare and showcased the latest AI innovations revolutionizing pharmacy practice.

Information and resources to keep pace with an evolving healthcare landscape

ASHP is the trusted voice of our profession on the full range of issues that impact our patients throughout the entire spectrum of care in health systems, including hospitals, clinics, and community practices.

Another way ASHP supports members is by providing timely and essential information. As the leading provider of education and resources on opioids, nonopioid analgesics, and MOUD, ASHP launched the Pain Management and MOUD Resource Center, which offers in-depth information about opioid pharmacology, counseling techniques for patients with opioid use disorder, guidance documents, and the latest legislative updates. We also updated our comprehensive Compounding Resource Center to help members achieve compliance with updated requirements in USP Chapters <797> and <795>.

The ASHP News Center is a digital content hub for all ASHP news, including press releases, full-length stories, feature articles, statements, multimedia content, and breaking news alerts. It provides an exciting, dynamic forum to spotlight ASHP expertise, proprietary news, and unique perspectives, and the News Center is a significant differentiator for ASHP among pharmacy organizations.

And ASHP continues to increase its presence in media nationwide, a testament to our growing thought leadership. Over the past year, ASHP has been mentioned in more than 8,000 news stories, generating an estimated 20 billion media impressions, a 50% increase from the prior year. Our ASHPOfficial

Podcast continues to grow its reach and influence. To date, ASHP has produced 980 episodes, with 1.3 million downloads.

New experiences for members

In our ongoing commitment to enhance the ASHP member experience, we've recently launched a dynamic member engagement platform called ASHP Navigator. This digital portal provides members with a centralized location for all of their member, career, and professional development information. The platform connects and displays information in an easy-to-navigate dashboard format and can be tailored to each member's interests and needs. In the coming months and years, we will continue to add functionality and features to make ASHP Navigator a one-stop shop for all career-related information and activities for members.

Conclusion

Over the past year, we have seen firsthand just how hard ASHP works to support our members, your practice, and your patients. Pharmacy Futures 2024 and the AI Summit are just one example of how ASHP is rising to meet the pharmacy practice challenges of today and tomorrow.

Our collective successes only raise the bar as we strive to continue to support pharmacy's evolving needs. We will continue to be inventive and transformative, to lead by example, to harness the potential of change, and to spearhead innovation.

On behalf of ASHP, we thank you for being members and for all you do for your patients and our profession.

Disclosures

The authors have declared no potential conflicts of interest.

References

1. American Society of Health-System Pharmacists. *Joint Address from the ASHP CEO & President*. Video. Accessed July 8, 2024. https://www.ashp.org/about-ashp/joint-address
2. Equitable Community Access to Pharmacist Services Act. Congress.gov. Accessed July 8, 2024. https://www.congress.gov/bill/118th-congress/house-bill/1770
3. Pharmacy and Medically Underserved Areas Enhancement Act. Congress.gov. Accessed July 8, 2024. https://www.congress.gov/bill/117th-congress/house-bill/2759

House of Delegates

2024 NEW BUSINESS SUBMISSION FORM

PLEASE RETURN BY 4PM ON MONDAY, JUNE 10, TO THE
EXECUTIVE OFFICE IN ROOM A104, OREGON CONVENTION CENTER

Delegates may submit items of new business several ways. Delegates may submit a new business item online using the form on HOD Calls, Forms, and Rosters page of the ASHP House of Delegates website (https://www.ashp.org/house-of-delegates/hod-calls-forms-and-rosters) or by completing this form and submitting it by 4 p.m. Phoenix time (MST) to the Executive Office in Room A104.

ASHP
HOUSE OF DELEGATES
JUNE 11, 2024
PORTLAND, OREGON

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

Date Submitted: 6/10/2024

Time Submitted: 2:35 PM

INTRODUCED BY (NAME):
Jesse Hogue (MI), Tyler Vest* (NC), Ashley Duty (OH), Cynthia King (OH), Kellie Musch (OH), Dan Lewis (OH), Lindsey Kelley (Section of Pharmacy Practice Leaders), Justin Moore (New Practitioners Forum), Rebecca Maynard (MI), Lama Hsaiky (MI), Josh Blackwell (TX), Chris Scott (IN), Tate Trujillo (IN), Andrew Lodolo (IN), Dale English (KY), John Hamiel (IA), Christy Norman (GA), Arpit Mehta (PA), Caroline Sierra (CA), Elaine Law (CA), Joel Hennenfent (MO), Amy Sipe (MO), Mel Smith (MO), Kelly Smith (Past President), Lt Col Rohin Kasudia* (USAF), Rachel Root* (MN), Scott Hayes* (KY), Cheri Briggs* (DE), Cassie Schmitt* (MN-alt), Allison King (Section of Inpatient Care Practitioners)

*** Council on Public Policy members**

SUBJECT:
Reconsideration of the Council on Public Policy Liability Protection Policy Proposal

MOTION:
To advocate that pharmacists be able to provide evidence-based dispensing and care to patients without fear of criminal or civil legal consequences, harassment, or liability; further,

To advocate that protection against liability extend to referrals for out-of-state care and for dispensing to patients from another state.

BACKGROUND:
While we recognize the language was not perfect in the view of all delegates, given the urgent need to have a policy on the books to support advocacy efforts and the seeming misunderstanding of the proceedings at

the Sunday session of the House of Delegates, we move to approve the original Council on Public Policy Liability Protection policy proposal rather than referring it back to Council. That language is captured as the motion above.

SUGGESTED OUTCOMES:
In addition to having a policy on the books for near-term advocacy efforts, the Council on Public Policy should revisit this policy in consideration of the rich discussion on Connect and at the House of Delegates for the purpose of further optimizing it and addressing the concerns with the current language.

House of Delegates

2024 NEW BUSINESS SUBMISSION FORM

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ASHP
HOUSE OF DELEGATES
JUNE 11, 2024
PORTLAND, OREGON

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

Date Submitted: 6/10/2024

Time Submitted: 3:53 PM

INTRODUCED BY (NAME):
Andrew Kaplan (FL), Heather Maturin (LA), Amisha Arya (NY)

SUBJECT:
Re-classification of reproductive health medications as controlled substances

MOTION:
To amend ASHP policy 2250, Access to Reproductive Health Services, be revised by addition of a new clause 4, reading:

To advocate that states should not re-classify medications related to reproductive health, such as misoprostol and mifepristone, as controlled substances, given the low likelihood of personal abuse or physiological dependence; further,

BACKGROUND:
Louisiana re-classified misoprostol and mifepristone as Schedule IV controlled substances (https://www.legis.la.gov/Legis/BillInfo.aspx?i=246533) - this law will go into effect October, 2024.

We believe ASHP policy should advocate against this restriction and similar restrictions which may be entertained in other states.

While several states place medications into more restrictive schedules than the federal level, this additional oversight is typically intended for medications which have potential for abuse and that abuse may lead to physical dependence or psychological dependence - examples being Kentucky classifies gabapentin as a Schedule V controlled substance, and New York treats benzodiazepines like Schedule II controlled

substances.

There is no evidence that either misoprostol or mifepristone have a likelihood of abuse or have demonstrated risk of physical dependence. Placing these medications into a controlled substance schedule creates unnecessary burdens on providers, pharmacists, nurses and patients which can impede access to reproductive health efforts, with seemingly little benefit to public health.

Further, scheduling these medications creates a false impression among patients, practitioners, and the public that these medications are dangerous and require additional restrictions.

Finally, with these medications being treated as controlled substances, they will required to be reported through state prescription drug monitoring programs (PDMP's). We believe this information could be potentially used inappropriately to surveil use of medications used in reproductive health, empowering the state(s) to monitor the termination of pregnancies, even across state lines (since many states share PDMP data).

SUGGESTED OUTCOMES:

That ASHP policy 2250, Access to Reproductive Health Services, be revised to read, in its entirety (proposed new language italicized):

> **To recognize that reproductive healthcare includes access to and safe use of medications; further,**
>
> **To recognize that reproductive health services include pre-conception, conception, post-conception, and termination of pregnancies; further,**
>
> **To advocate for access to safe, comprehensive reproductive healthcare for all patients, including historically underserved patient groups such as patients of color, those with limited means, and those living in rural areas; further,**
>
> ***To advocate that states should not re-classify medications related to reproductive health, such as misoprostol and mifepristone, as controlled substances, given the low likelihood of personal abuse or physiological dependence; 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.**

Delegate Recommendations from the 2024 House of Delegates

The delegate[s] who introduced each Recommendation is [are] noted. Each Recommendation is forwarded to the appropriate person or body within ASHP for assessment and action as may be indicated. ASHP actions on the recommendations are recorded and reported to the House the following year.

	Recommendation Title/Text/Background	Sponsor(s)
1	**Policy on the Role of the Pharmacy Workforce in Trauma Informed Care** ASHP should develop a policy on the role of the pharmacy workforce in trauma-informed care. **Background:** Trauma informed care is directly related to DEI and increases risk of SUD, morbidity, and mortality.	Terri Jorgenson (MD)
2	**Include other organizations in HOD** Consider inviting other pharmacy organizations to participate in HOD (e.g., APhA, ACCP). **Background:** See ASHP Strategic Plan – our members and partners. Goal 5, Objectives 1 and 2.	Sarah McBane (CA)
3	**Just Culture & Medical Errors** ASHP should consider policy language addressing just culture and criminal prosecution for medical errors. **Background:** See for example cases of Eric Cropp (RPh) and Radonda Vaught (Nurse), and KY House Bill 159	Sarah McBane (CA)
4	**Defining Evidence-based Medicine (EBM) for Future Policy Direction** ASHP should define evidence-based medicine so it has official language for what that means for the previous 42 policies in which this terminology is used. **Background:** Implementation of EBM remains a foundational element of high-quality healthcare despite the challenges in its definition and practice. By addressing these challenges organizations can support healthcare professionals in delivering care. The implementation of EBM remains a foundational element of high-quality healthcare, despite the challenges in its definition and practice. The issues of information overload, variable research quality, increasing involvement of AI, and the need for specialized skills underscore the complexities of implementing EBM in clinical practice. For many healthcare organizations, these challenges necessitate a thoughtful approach to policy and protocol development, emphasizing accessibility, education, and the dynamic nature of medical evidence. By addressing these challenges, such organizations can support healthcare	Brian Gilbert (KS)

	professionals in delivering care that is truly evidence-based, ultimately improving patient outcomes.	
5	**Add Music and Dancing to the Whitney Dinner** Recommend that ASHP add a dance and DJ/band to further escalate the celebration of the Whitney Award recipient following dinner. **Background:** ASHP members would appreciate the opportunity to continue celebrating the Whitney Award recipient following dinner.	Jackie Boyle (SACP), Allison King (SICP), Kim Benner (BOD), Nish Kaskebar (President)
6	**To Reaffirm Good Policy Structure and Wording to Combat Policy Bloat** ASHP should develop a policy on policies to clearly outline good policy structure and ideal actions. **Background:** ASHP is facing a significant issue with policy bloat, and this may soon result in unmanageable work on behalf of the councils and the ASHP staff. Policy makers should make every effort to create and update policies that are: 1) No longer than three clauses in length, 2) Not duplicative or contradictory of existing ASHP policy (i.e., should not reaffirm or restate existing policies). The ASHP charter includes educate, research, publish and, therefore those actions do not need to be included as potential actions of the policies moving forward as it is understood ASHP will carry those actions out.	Chris Scott and Tate Trujillo (IN)
7	**Peer Review** Recommend ASHP develops a standalone policy that addresses the peer review process for pharmacists. **Background:** Motion that ASHP consider developing a policy related to peer review in any setting where pharmacists are providing direct patient care.	Jackie Boyle (SACP), Brody Maack (SACP), Sara Panella (FL)
8	**Minimum Standards for Community Pharmacy Services within Health Systems** To provide guidance and supplement the new SCPP - ASHP Statement on the Community Pharmacist's Role in the Care Continuum. **Background:** Guidance and best practices on how to expand health system services into the Community Pharmacy space. Including, but not limited to, employee and patient pharmacy services, medication reconciliation, meds to beds, increased access to immunizations and medication education on high-risk disease rates (e.g., heart failure, diabetes, etc.).	Victoria Wallace (ID)
9	**Recent Regulatory Changes to the 505(b)(2) Approval Process** We are asking ASHP to review recent regulatory changes to the 505 (b)(2) FDA and CMS approval process. **Background:** The Centers for Medicare & Medicaid Services (CMS) clarified that 505(b)(2) products will only be assigned to the reference product healthcare Common Procedure Coding System (HCPS) J-Code if they are deemed therapeutically equivalent by	Martha Roberts (RI), Ryan Gibbard (OR)

	the FDA. This new decision is a change from previous practice which typically listed 505(b)(2) products under the reference products J-code. Current EHR functionalities, drug databases, and purchasing platforms do not clearly or readily distinguish 505(b)(2) drugs from generics. This can result in patient safety risks, claim denials, and regulatory non-compliance.	
10	**ASHP Policy for Lactation Support and Resources within the Pharmacy Workforce** ASHP should develop a policy advocating for lactation support and resources within the pharmacy workforce. **Background:** The World Health Organization and the American Academy of Pediatrics recommend breastfeeding (chestfeeding) as the sole source of nutrition in infants under six months of age and continued breastfeeding for one to two years or longer if desired by mother and baby. Currently, only 30 states have laws related to chestfeeding in the workplace. Lactation policies should refer to the Fair Labor Standards Act (FLSA) guidelines and clearly delineate the roles of the employer and employee regarding lactation support.	Cindy King (OH), Jackie Boyle (SACP), Karen White (WA), Chris Greer (WA), Ashley Duty (OH), Kellie Musch (OH), Kembral Nelson (OH), Dan Lewis (OH), Dale English (KY), Brody Maack (SACP), Josh Blackwell (TX), Jodi Taylor (TN), Ryan Wargo (OR), Michael Lanning (OR), Edward Saito (OR)
11	**Lactation Support and Resources at ASHP Sponsored Events** ASHP should provide sufficient support and resources for members and attendees at AHSP sponsored events. **Background:** ASHP is the largest national pharmacy organization with various attendees from the pharmacy workforce and industry. ASHP should provide sufficient resources and number of spaces to support lactation needs for their members/attendees at all events. These needs include sufficient lactation space (private, secure, space with chair); access to an outlet; sink to clean supplies; clean, designated cold storage location; and cleaning supplies.	Cindy King (OH), Jackie Boyle (SACP), Karen White (WA), Chris Greer (WA), Ashley Duty (OH), Kellie Musch (OH), Kembral Nelson (OH), Dan Lewis (OH), Dale English (KY), Brody Maack (SACP), Josh Blackwell (TX), Jodi Taylor (TN), Ryan Wargo (OR), Michael Lanning (OR), Edward Saito (OR)
12	**Implementation Science to Drive Sustainable Pharmacy Practice Expansion and Innovation** Recommend ASHP work to increase education in the field of Implementation Science and consider policy development that advocates for the utilization of Implementation Science. **Background:** Implementation Science is a field that uses theories, models, and frameworks to identify contextual factors that influence barriers and facilitators to implementation of clinical services. Using these concepts help to streamline the time it takes to implement evidence-based practices and elements of pharmacist provider status. ASHP should work to explore education initiatives and applicable policy that advocates for increasing adoption of Implementation Science in research, quality improvement practices, and pharmacy practice expansion efforts.	Brody Maack, Jaclyn Boyle, Sara Panella (SACP)
13	**ASHP consideration of adding more Specialty content during the Futures Meeting**	Denise Scarpelli (SSPP)

	The section of Specialty Pharmacy Practitioners is recommending on behalf of their members to add more Specialty Pharmacy content programming during the Future Meetings to help foster growth of Specialty Pharmacy within health systems. **Background:** The Section of Specialty Pharmacy Practitioners would like to submit a request for ASHP to consider reinstating a Specialty Pharmacy focused educational programming for the summer session in whatever form it remains (Pharmacy Futures or Summer Meeting). When the SSPP started, Section leadership and members promoted the summer session specialty track to colleagues in the field as a valuable and worthwhile venue to share and learn best practices for specialty pharmacy with other health systems and as an opportunity for members to network with other Specialty Pharmacy leaders and practitioners. The Section found great value to these in-person, focused gatherings, leading to increased engagement in the Section. These meetings uniquely met the need of providing health system specialty pharmacy focused and driven content, which filled a large gap when compared to other professional meetings attended by specialty pharmacy practitioners and leaders. Over the past 6 years, the Section has continued to grow reaching several thousand highly engaged members, and our members have expressed the need for a Specialty specific programming within the summer meeting to serve as a home for health system specialty pharmacies to reliably meet, network, and develop. We believe this is vital to continued growth and engagement in our Section and that there is an opportunity to continue to grow attendance from ASHP members as well as external stakeholders such as vendors, payers, and manufacturers. Additionally, if the Summit at Pharmacy Futures formatting remains, we would like to request that the 2025 Summit be focused on Specialty Pharmacy given that it has been 5 years since the previous ASHP Specialty Pharmacy Summit, and the field and Section membership needs have continued to change during this time.	
14	**Include PGY2 programs that will accept early commit candidates as part of the Residency Directory to improve pharmacy student advising** With new rules related to the early commit process, a more transparent way to see which programs allow early commit to PGY2s will better inform student advising. **Background:** Now that programs can commit within health systems instead of institutions, it is not clear if all PGY1s within the system will be accepted for early commit to specific PGY2 programs. We feel this is unlikely for some very large systems, and updating the directory to include that information will be super helpful as candidates select programs to apply for PGY1 residency and faculty advise students in the process.	Jodi Taylor (TN)

15	**Separating the timing of the ASHP-PAC Contributors Luncheon and the Meet the Candidates sessions at Pharmacy Futures** ASHP staff and leadership should time the ASHP-PAC Contributors Luncheon and the Meet the Candidates session at the Pharmacy Futures conference so they don't overlap, allowing members to fully attend both. **Background:** Members who attend these two sessions tend to be highly engaged. It is frustrating to have to choose which to attend, or to have to either leave one early to attend the other or join the latter session halfway through.	Jesse Hogue (MI), Liz Wade (NH), Paul Driver (ID), Becky Maynard (MI), Chris Scott (IN), Tate Trujillo (IN), Amy Sipe (MO)
16	**Policy on DEA Scheduling of Marijuana** Recommend ASHP develop policy on the potential implications to pharmacy if the DEA reschedules Marijuana to Schedule III. **Background:** On May 16th, 2024, the DEA issued a proposed rule to move Marijuana from Schedule I to Schedule III. This has the potential to require marijuana to be dispensed from a pharmacy.	Adam Porath (NV)
17	**PGY-2 Programs in Transitions of Care** ASHP should consider reinstating Transitions of Care PGY-2 specialty residency programs. **Background:** During the 2015-2016 residency application cycle, there were eight Transitions of Care (TOC) PGY-2 programs that either accredited or had pre-candidate status. However, in the fall of 2016, ASHP's Commission on Credentialing ceased future accreditation of TOC PGY-2 Programs. There has been significant growth in TOC, requiring knowledge in regulatory and clinical skills and expertise in ambulatory, acute care, and community settings. The current PGY2-2 pharmacy residency programs do not fully prepare pharmacists to be fully competent in this field.	Sara Panella, Brody Maack, Jaclyn Boyle, (SACP)
18	**Review/Update of ASHP Statement of Use of AI in Pharmacy** Recommend the review and update of ASHP Statement on the Use of Artificial Intelligence in Pharmacy **Background:** There currently exists a Statement by ASHP on its stance on the Use of AI in Pharmacy Practice. Given all of the updates to AI since the statement's publication in 2020, I recommend review and revision of the statement to reflect these technological advancements be completed.	Kelly Mullican (DC)
19	**Adoption of sustainable practices at ASHP meetings through elimination of printing, utilization of electronic alternatives, and increasing recycling options.** Prior to ASHP meetings, members receive several home paper mailers that are redundant of email, social media, and online advertising. At ASHP meetings, registrants are provided with fliers, handouts are provided at education sessions, programs are printed for receptions or events, and a number of papers are included at each caucus and session of the House of Delegates (including duplicates available at every delegate's seat).	Kellie Musch (OH), Cindy King (OH), Ashley Duty (OH), Joshua Musch (OH-Alt)

	Sometimes the mix of electronic and paper formats introduce confusion in attendees. ASHP should embrace electronic pathways for content delivery. This can include the ASHP LIVE! App, ASHP website, ASHP Connect, or even exploration of a SharePoint/OneDrive (or similar). **Background:** Sustainability is the practice of using natural resources responsibly and efficiently to meet the needs of the present and future generations. Sustainability is important for preserving the planet, protecting habitats, reducing pollution, and ensuring the well-being of humans and other living beings. Sustainability is also a crucial element for any organization's success, as it can enhance profitability, growth, retention, and reputation. Printing unnecessarily or inefficient printing processes can consume a lot of paper, which accounts for 23% of the total waste in landfills from municipalities that don't have a good recycling program or from individuals that don't recycle. While paper is recyclable and renewable, many still look for alternative ways for traditional printing to reduce waste even further.	
20	**Continued advocacy for Medicare reimbursement of pharmacist clinical services in ambulatory care settings** Recommend ASHP continue efforts to seek recognition from CMS as pharmacists on the interdisciplinary healthcare team to ensure adequate reimbursement for clinical services provided. **Background:** Pharmacists provide ambulatory clinical pharmacy services to patients in ambulatory care settings (and other settings not listed here). These services are provided without consideration of patient insurance; however, pharmacists are not recognized by CMS as providers and are unable to bill for these services in the same way as we bill Medicaid and commercial insurance. We should continue to demand CMS recognize the services provided by pharmacists and adequately reimburse for these services.	Karen White (WA)
21	**Pharmacy Futures Meeting Location – Salt Lake City, UT** ASHP hold the Pharmacy Futures Meeting in Salt Lake City, UT. **Backgrounds:** Salt Lake City is preparing to host the Winter Olympics in 2030. We offer new and convenient conference space with unparalleled scenery.	Krystal Moorman-Bishir (UT), Utah Delegation, Karen White (WA), Travis Dick (NJ)
22	**Cellular Therapy Products** ASHP create a policy on the safe and appropriate manipulation, dispensing, and handling of cellular therapy products, both investigational and commercial, for health systems. **Background:** Cellular therapy commercial products and investigational products have historically been approved or studied for oncology / hematology indications. However, there are many new trials with these products, starting in development for non-oncology conditions in adult and pediatric populations. The	Elyse MacDonald (UT), Utah Delegation, Travis Dick (NY), Ashley Duty (OH), Janet Mighty (MD), John Pastor (MN), Rachel Root (MN)

	safe and appropriate dispensing and handling of these agents is paramount and may or may not be within the scope of health system pharmacy. It may also not be appropriate for a health-system pharmacy to handle these products.	
23	**Increased Collaboration between State Affiliates and Councils to proactively align or propose policies based on state legislature climate** From approved law in Louisiana, to reclassifying medications related to reproductive health, to proposed law in Ohio (4B73) which essentially compromises the practice of pharmacy, there is urgency for increased collaborations between state affiliates to ASHP. That would allow us to have 1) unified voice, 2) timely responses, 3) stakeholder engagement tool, 4) increased prevention and law traction, 5) tools for immediate advocacy.	Kembral Nelson (OH)
24	**Increasing Health-System Pharmacist Engagement in NAPB & Boards of Pharmacy** ASHP should develop & implement a strategy to increase health system pharmacists on staff boards of pharmacy and seek increased engagement with and in NABP. **Background:** Health system pharmacists are under-represented on SBOPs. NABP is dominated by retail pharmacists – to facilitate practice change we must influence staff practice laws, regulations and actions by SBOPs and NABP policies.	Steve Sheaffer (Past President), Christine Roussez (PA)
25	**Creation of an ASHP sponsored Skillbridge Program for Separating Medical Servicemen** ASHP should support separating pharmacist and technician servicemen transition to the civilian workforce. **Background:** The DoD sponsored program lets AD servicemen spend their last 6 months of time in service at a civilian organization to gain skills and bridge knowledge gaps to improve job prospects.	Lt Col Rohin Kasudia (USAF)
26	**CPEL capstone information on ASHP website** That the capstone information on the ASHP website is more descriptive of what it entails. **Background:** The current three bullet points related to the capstone are vague as is the statement about facilitated group case discussions based on CPEL competencies. An example of the schedule for the multi-day program would be helpful for giving those interested in the CPEL a better understanding of the capstone.	Andy Donnelly (IL)
27	**Unfunded Mandates Task Force** ASHP create a task force to review evidence supporting the creation of unfunded mandates (e.g., DSCSA, USP 795, USP 797, etc.) as well as define metrics to measure their impact on patient safety and financial return on investment. **Background:** A number of unfunded mandates have been imposed on health-systems with limited evidence such as USP Standards	Kim Zammit (NY), Krystal Moorman-Bishir (UT), Elyse MacDonald (UT), David Schmidt (NE), Josh Blackwell (TX), Arpit Mehta (PA), Stan Kent (Past President), Thomas

	and DSCSA. These mandates have significant impact on resources and may or may not impact patient/staff safety.	Thielke (Past President), Terri Jorgensen (MD), Christy Norman (GA), Rachel Root (MN), Amisha Arya (NY), Paul Green (NY), Mark Sinnett (NY), Jennifer Sternbach (NJ)
28	**ASHP Policy 2023** ASHP should consider sunsetting or revising ASHP Policy 2023. **Background:** ASHP is a long-standing supporter of advancing the pharmacy workforce. Advancement of pharmacy technician career paths can be stifled by varying educational paths/training, limited career paths, and a lack of professionalization. Revisiting the structure of the pharmacy workforce could contribute to improvement in patient care and medication safety as practice transformation and upskilling occurs.	Daniel Nyakundi (PTF), Sara Panella (FL), Jackie Boyle (SACP), Brody Maack (SACP)
29	**College credit during technician training** ASHP should work with other stakeholders to ensure technician training programs provide college credit toward degree conferment and count toward pre-requisites for furthering participants pharmacy education. **Background:** Technician training programs are often the first step that technicians take in higher education. These programs should help lay a foundation for technicians to continue their education beyond just obtaining a certification. This may lead to the development of an associate degree with an emphasis on pharmacy practice, contribute toward a bachelors in science pharmaceutical science program, and toward prerequisites for PharmD programs. This aspirational development would be a large step forward in helping to professionalize the career of pharmacy technicians.	Christopher J. Edwards (AZ), Melinda Burnsworth AZ), Kelly Erdos (AZ)
30	**Summer Meeting 2028 Location** The Missouri delegation recommends, for consideration by ASHP, Kansas City, Missouri, The City of Fountains, home of the best BBQ, Mr. Taylor Swift, and the World Champion Kansas City Chiefs as host city for Summer Meeting 2028. **Background:** With ample convention space, new airport, walkable dining and entertainment opportunities, new hotel spaces and centrally located geographically, Kansas City is the obvious choice. The people of Kansas City would welcome all ASHP members and attendees with Midwest kindness and hospitality. Come check out our new women's soccer stadium and amenities!	Amy Sipe, Mel Smith, Joel Hennenfent (MO)
31	**Optimization of Billing by Complexity** ASHP should develop a policy regarding the optimization of billing based on patient complexity. **Background:** CMS allows for higher billing levels based on administration and monitoring of narrow therapeutic index drugs.	Nancy MacDonald (SCSS), Christopher Edwards (AZ), Megan Musselman (SCSS), Megan Corrigan (SCSS), Christi Jenn (SCSS)

	Narrow index drugs are not standardized, frequently defined by individual entities such as state boards of pharmacy, and current lists used by billing departments are outdated. ASHP should develop and maintain a list of narrow therapeutic index drugs used to identify patients considered higher complexity for the purposes of billing. Best practices for optimization of billing optimization based on complexity and pharmacist involvement should be disseminated amongst ASHP membership.	
32	**National Strategies to Elevate and Sustain Compensation for Pharmacy Technician Roles** Develop National Strategies to Elevate and Sustain Compensation for Pharmacy Technician Roles. **Background:** Over the past two decades, pharmacy leaders have been challenged to support the elevation for pharmacy technicians completing advanced roles and compensation for all pharmacy technician roles. Institutions and states have pursued successful strategies, but lack of a national standardized approach has failed to support sustainable elevation and compensation.	Kate Schaafsma (WI)
33	**Define core roles and responsibilities of advanced pharmacy technicians** Define core roles and responsibilities of advanced pharmacy technicians to allow for clear and attainable skills, knowledge and experiences that may be translated into a degreed program. **Background:** See many ASHP policies and other documents related to pharmacy technician training. Concerted efforts to define core roles and responsibilities of advanced pharmacy technicians would allow for clear definition of skills, knowledge and experiences that could then be translated into defined education and a degree conferring program.	Kate Schaafsma (WI)
34	**Transparency of carbon impact of medication** ASHP should advocate for FDA to require information about the lifecycle carbon impact on product labeling to allow formulary decision makers and other stakeholders to consider carbon impact in their therapeutic decision making. **Background:** Understanding the carbon impact of anesthetic gasses has helped to improve decision making, leading to a reduction in the use of gasses most associated with carbon emissions. There are likely other examples of therapeutically comparable drugs with wildly different life cycle impacts on the environment. By requiring this information be included in the product labeling/package insert, decision makers would be able to incorporate this information into their decision making.	Christopher J. Edwards (AZ)

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Inaugural Address of the Incoming President: Our Service, Our Stories

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Look for that one moment, that one person, and know that the impact you had on them that day was their everything. That is your why. Believe it. Celebrate it.

Editor's note: The following is adapted from comments delivered by Dr. Briscoe-Dwyer during the ASHP Pharmacy Futures 2024 meeting, held in June in Portland, OR.

Thank you, everyone. It is certainly the honor of a lifetime to stand before you today as your next President. I am grateful for the opportunity to serve this great profession and for the people who have made today possible.

You have heard the quote that "it takes a village." Well, for me, it took an entire state. Thank you to the membership of the New York State Council of Health-System Pharmacists for your support, enthusiasm, and excitement as we shared this journey. Serving at the local and state level was the beginning of my passion for being involved in ASHP, and I will always be proud of being a past president of the New York State Council.

I stand before you as your 81st President. It has been over 60 years since someone from New York was elected President of ASHP. Dr. Lou Jeffrey was ASHP President from 1962 to 1963. As one of ASHP's youngest presidents, Lou went on to do incredible things for the profession after his presidency, including serving as president of the Massachusetts College of Pharmacy. Sadly, we lost Lou in 2002, but I am very happy that his son Dr. Paul Jeffrey—also a pharmacist—is here with us today.

One of the greatest gifts I have received from this profession is the people it has brought into my life. To my Pharmacy Family—you are the people I never knew I needed. You have made my life richer in knowledge, love, and laughter, and I am a better person for having known you. Thank you.

My husband Kevin remains my greatest love, my staunchest supporter, best friend, and confidant. I am beyond grateful to share my life with you. Your love and strength get me through every day. Days like today—when we are celebrating—are the easy ones, but you have been there for the hard days too, times when I just needed someone to believe in me.

Finally, I am incredibly grateful to my parents, Alton and Mary Jane Briscoe, who showed me what living a life of service meant. Early one morning when I was 7 or 8 years old, a man drove off the road and hit a tree in front of our rural home. My parents were awoken by the sound of his head lying on the horn. After they called for a rescue squad, it took nearly 45 minutes for them to arrive. I remember them talking later that morning and saying, "What if that had been one of our kids?"

A few weeks later, there was a meeting in our home and the first volunteer ambulance squad in our small town of Laurens, NY, was born right at our kitchen table. This was the first time I saw in action the words of Margaret Mead: "Never doubt that a small group of committed citizens can change the world; indeed it's the only thing that ever has."

It was because of their example of service that I answered the call to join this profession. Service is the foundational premise on which our profession was built.

It is the first line in the Oath of a Pharmacist: "I promise to devote myself to a lifetime of service to others through the profession of pharmacy." I want you to remember that because later on I'm going to ask you to say it with me: "I promise to devote myself to a lifetime of service to others through the profession of pharmacy." As we talk about the future and all that is to come, we must ensure our foundation, our call to service—the thing that *unites* us—remains strong.

One way we can accomplish this is by telling our stories. You have just heard *how* I became a pharmacist—everyone has that story. More important are the stories about *why* we became pharmacists.

The two most important days of our lives are the day that we're born and the day we find out why. How lucky we are that we get to live that "why" every single day There is joy in living our why every day. Let us take the time to acknowledge and celebrate that.

Last October, Becca, a specialty pharmacy liaison, was living *her* why. While trying to contact a patient with diabetes to arrange for delivery of her insulin, she discovered that the patient was at that moment living in her car with her 9-year-old son. Without judgement or pity, Becca arranged to meet the patient in a public place to deliver her insulin. After delivering the medication, Becca asked if there was anything the patient needed, and the patient stated that she had money and food but it was getting cold and she didn't have a coat. Becca immediately went to her car, got her fleece jacket, and gave it to the patient.

None of this was included in Becca's orientation to the job. It was a human response by an individual who focused on providing the best service possible for a single patient at that point in time. Things like this happen every day, and these are the stories we need to tell.

When we examine stories in the media about pharmacy and pharmacists, we hear terms like "unsung heroes," the "invisible ingredient," and (I hate this term) "ancillary." This is what happens when you let other people tell your story. No one else can speak the words from your lips. Starting today, let us make it a priority to tell our own stories. We are pharmacy, it is our story to tell, and *we* get to decide how this story unfolds.

A dear friend was recently hospitalized for a CABG procedure complicated by COVID-19. After 78 days of hospitalization and cardiac rehab, Tom was ready to go home. The only thing he needed was to complete two more days of treatment for a UTI. His physician wrote his discharge orders and sent the prescriptions to the local chain pharmacy. I received a panicked call from his daughter, who reported that no pharmacy in 150 miles was able to get the antibiotic and Tom could not be discharged without it. The antibiotic was an IM dose of amikacin. I asked to have the prescription sent to one of my outpatient pharmacies and obtained the doses and supplies necessary to administer it. I then delivered it to their home and oversaw the administration of the first dose.

We have been given an opportunity to remarkably reframe the perception of our profession. Our journey will be defined by how well we tell our story.

Now, I may not have received 4 years of postgraduate education, plus 3 to 7 years of residency, and 12,000 to 16,000 hours of clinical training like Tom's physician did.[1] But I didn't need to know how to diagnose his UTI to know how to treat it.

My point here is that healthcare is a team sport. When we focus on service that is truly patient-centered, not profession-centric, everyone wins. Let pharmacists be true disrupters in healthcare and lead the way in spending less time focusing on practicing at the top of our *scope* and concentrate instead on practicing at the top of our *mission*.

And that, exactly, is the point of the ASHP's public awareness campaign. *We're Your Pharmacist* is designed to demonstrate to the public the positive contribution that we have on patient care; that care is better and safer when we are part of the care team. This campaign is not just an opportunity to tell our story but also an obligation to step up and do the things we say we can do. This campaign will only be successful if we all put actions behind those words.

As we look to the future, we will see transformation occurring with a speed unlike anything we have ever seen before. There is data to support the fact that it takes 17 years for practice changes to be fully adopted and implemented. We don't have 17 years—in some cases we don't have 17 weeks. We no longer have the luxury of time to be comfortable with the changes we need.

We want pharmacy's story to be that we adapted and evolved our profession to keep pace with the rapid changes in healthcare. We are leveraging opportunities in AI, pharmacogenomics, robotics, and digital health to improve patient care.

And ASHP is there every step of the way, enabling us to tell these stories through meetings like this, the Pharmacogenomics Accelerator, and the Section of Digital and Telehealth Practitioners. Pharmacy technicians now have The Pharmacy Technician Society as an outlet to share their stories.

The ASHP Office of Government Relations needs our stories to demonstrate to politicians, and the people who elect them, that we are not the unsung heroes, we are not invisible, and we most certainly are not ancillary. So, *let's do that!*

By telling our stories we can weave together the tapestry that is our history, our future, and our right. Stories built on a foundation of service. Stories that unite us. Stories that capture the powerful voice of this profession. And your voice matters. If you haven't done it already, stop by the ASHP booth and sign up to tell your story. You all have one. I know you do.

Having a united voice is something we all want. What better way to create that united voice than by looking at all we have in common? What we all have in common is our oath. Regardless of where you practice now or how you got there, we all started on this path by reciting our oath. I am asking you all to take a step toward unity by standing with me now and uniting our voices in reaffirming our call to service. Please stand and join me in reciting our Oath of a Pharmacist. The words will appear on the screen behind me.

I promise to devote myself to a lifetime of service to others through the profession of pharmacy. In fulfilling this vow:

- *I will consider the welfare of humanity and relief of suffering my primary concerns.*

- *I will promote inclusion, embrace diversity, and advocate for justice to advance health equity.*
- *I will apply my knowledge, experience, and skills to the best of my ability to assure optimal outcomes for all patients.*
- *I will respect and protect all personal and health information entrusted to me.*
- *I will accept the responsibility to improve my professional knowledge, expertise, and self-awareness.*
- *I will hold myself and my colleagues to the highest principles of our profession's moral, ethical, and legal conduct.*
- *I will embrace and advocate changes that improve patient care.*
- *I will utilize my knowledge, skills, experiences, and values to prepare the next generation of pharmacists.*

I take these vows voluntarily with the full realization of the responsibility with which I am entrusted by the public.[2]

That, my friends, is the sound of unity. The sound of strength. Like each one of us, the oath has undergone transformation over the years but, also like us, stands stronger today ready to face the future.

As we conclude, I would like to highlight some things for you to leave here with:

There is joy to be found in pharmacy. The profession is strong and poised to forge new paths, with all of us together leading the way.

Tell people your stories. Be proud of what you do. There is no story too small to tell because there is a patient and a family behind each one. And listen to your brothers and sisters in pharmacy because they have stories too. Once we put our stories out there, they forever become part of our history and our foundation becomes stronger.

Live your service with arms wide open. Define your mission and practice to achieve it. *Find. Your. Why. Every. Day.* Look for that one moment, that one person, and know that the impact you had on them that day was their everything. That is your why. Believe it. Celebrate it.

We have been given an opportunity to remarkably reframe the perception of our profession. Our journey will be defined by how well we tell our story. I am excited to join you on this journey and have never been more proud to stand before a group of people and proclaim: "My name is Leigh Briscoe-Dwyer and *I am a pharmacist*."

Disclosures

The author has declared no potential conflicts of interest.

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