House of Delegates

Consolidated Documents:

2026 ASHP Regional Delegate Conferences:

Baltimore, Denver, Rosemont

Contents

House of Delegates

AGENDA

2026 ASHP
Regional Delegate Conferences

Note: **Day One** runs from 1:30 to 5:30 p.m., followed by dinner from 7:00 to 9:00 p.m. The agenda is completed on **Day Two**, which runs from 8:30 to 11:00 a.m.

Day One

A. Welcome, Introductions, and Antitrust Notice

B. Regional Delegate Conference (RDC) Objectives

C. Review of RDC Agenda

D. Responsibilities of Delegates

E. Characteristics of Good Policy and Substantive Amendments

F. Summary of Virtual House of Delegates

G. Review of Policy Recommendations

H. Dinner and Discussion

Day Two

OPTIONAL SESSION ON HOUSE OF DELEGATES PROCEDURES (8:00 - 8:30 a.m.)

A. Review of Remaining Policy Recommendations and Resolutions

B. Treasurer's Report

C. Open Discussion of Issues

D. Keeping the Discussion Going via ASHP Connect and With Your Constituents

E. Review of Important Events for Delegates

1. Summer Meetings Registration
   - Delegates and Alternate Delegates to the House must register to attend the ASHP Pharmacy Futures 2026 Meeting.
2. House of Delegates Registration
3. Delegate Primer on House of Delegates Processes (open to all delegates)
4. Open Forum for Members
5. First Delegate Caucus*
6. Other Caucuses -- Small and Rural; Federal Pharmacists
7. First House of Delegates Meeting*
8. ASHP-PAC Donors Event
9. Meet the Candidates
10. Delegate Reception
11. Second Delegate Caucus*
12. Second House of Delegates Meeting*
13. Collecting Information from and Reporting to Constituents on the RDC and House

**Attendance at these events is an expectation of delegate service.*

F. Evaluation of the RDC

G. Adjournment

House of Delegates

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

COUNCIL ON EDUCATION AND WORKFORCE DEVELOPMENT POLICY RECOMMENDATIONS

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

Dawn Moore, *Board Liaison*

1. Optimizing Career Fulfillment in Pharmacy

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

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

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

Rationale

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

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

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

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

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

Background

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

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

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

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

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

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

This policy would supersede ASHP policy 1108.

Rationale

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

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

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

Background

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

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

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

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

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

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

COUNCIL ON PHARMACY MANAGEMENT POLICY RECOMMENDATIONS

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

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

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

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

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

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

This policy would supersede ASHP Policy 2406.

Rationale

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

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

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

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

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

Background

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

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

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

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

2. Standard of Care Regulatory Model

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

Rationale

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

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

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

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

Background

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

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

COUNCIL ON PHARMACY PRACTICE
POLICY RECOMMENDATIONS

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

Todd Nesbit, *Board Liaison*

1. Promoting Environmental Sustainability in Healthcare

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

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

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

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

Rationale

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

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

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

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

Background

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

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

2. Body Size Inclusivity

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

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

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

Rationale

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

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

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

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

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

Background

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

3. Pharmacy Workforce Leadership in Improving Vaccine Access

The pharmacy workforce is the leader in increasing patient access to vaccinations to improve public health; further,

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

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

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

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

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

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

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

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

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

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

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

To advocate for payer coverage guarantees without cost sharing of vaccines recommended by recognized state and federal organizations and in accordance with clinical practice norms; further,

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

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

This policy would supersede ASHP policy 2247.

Rationale

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

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

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

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

programs, and training vaccination providers.

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

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

Background

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

> ~~affirm that~~ The ~~the~~ pharmacy workforce is the leader ~~has a role~~ in ~~improving public health and~~ increasing patient access to vaccinations to improve public health ~~by promoting and administering appropriate vaccinations to patients and employees in all settings~~; further,
>
> To collaborate with key stakeholders to support the public health role of the pharmacy workforce in the administration of adult and pediatric vaccinations; further,
>
> To advocate that states grant pharmacists and appropriately supervised student pharmacists the authority to initiate and administer all adult and pediatric vaccinations; further,
>
> To advocate that states grant appropriately supervised pharmacy technicians the authority to prepare and administer all adult and pediatric vaccinations; further,
>
> To advocate for pharmacist-provided vaccination training in college of pharmacy curricula and pharmacy technician-provided vaccination training in technician training programs; further,
>
> To advocate that members of the pharmacy workforce who have completed a training and certification program acceptable to state boards of pharmacy and meeting the

standards established by the Centers for Disease Control and Prevention may provide such vaccinations; further,

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

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

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

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

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

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

To advocate for payer coverage guarantees without cost sharing of vaccines recommended by recognized state and federal organizations and in accordance with clinical practice norms; further,

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

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

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

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

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

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

To support the principle that a member of the pharmacy workforce exercising the right of conscience must be respectful of, and serve the legitimate health care needs and desires of, the patient, and shall provide a referral without any actions to persuade, coerce, or otherwise impose on the patient the pharmacist's values, beliefs, or objections.

This policy would supersede ASHP policy 0610.

Rationale

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

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

Background

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

> To affirm the value of shared decision-making that balances the pharmacy workforce's and other healthcare professionals' rights of conscience with safeguards to protect patient well-being; further,
>
> To recognize the right of the pharmacy workforce ~~pharmacists, as health care providers, and other pharmacy employees~~ to decline participation ~~to participate~~ in non-emergent care delivery scenarios for which ~~therapies~~ they consider to be morally, religiously, or ethically troubling; further,
>
> To support ~~the proactive establishment of timely and convenient~~ systems ~~by pharmacists and their employers~~ that protect ~~the~~ patient~~'~~s' access ~~right~~ to ~~obtain~~ legally prescribed and medically necessary ~~indicated~~ treatments while reasonably accommodating members of the pharmacy workforce's right of conscience in a nonpunitive manner ~~the right of conscience~~; further,
>
> To support the principle that a member of the pharmacy workforce ~~pharmacist~~ exercising the right of conscience must be respectful of, and serve the legitimate health care needs and desires of, the patient, and shall provide a referral without any actions to persuade, coerce, or otherwise impose on the patient the pharmacist's values, beliefs, or objections.

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

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

5. Safe and Effective Extemporaneous Compounding

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

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

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

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

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

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

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

This policy would supersede ASHP policy 2139

Rationale

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

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

Background

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

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

sufficient facilities and equipment that meet technical and professional standards to ensure the quality of compounded medications; further,
To encourage USP to develop drug monographs for commonly compounded preparations; further,

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

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

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

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

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

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

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

To collaborate with key partners to combat disinformation and misinformation..

Rationale

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

A longstanding area of concern related to disinformation and misinformation is with vaccines and vaccine preventable diseases. Maintaining public trust in vaccine evidence-based recommendations is essential to protecting patient and public health, and that trust depends

on transparent, rigorous processes grounded in scientific evidence. The pharmacy workforce needs to remain steadfast in their commitment to science-driven decision making related to vaccines and patient education in order to support shared clinical decision making.

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

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

Background

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

COUNCIL ON PUBLIC POLICY
POLICY RECOMMENDATIONS

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

Vickie Powell, *Board Liaison*

1. FDA's Public Health Role

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

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

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

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

This policy would supersede ASHP policy 0012.

Rationale

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

Background

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

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

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

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

2. Protecting the Healthcare Workforce Against Artificial Intelligence Deepfakes

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

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

Rationale

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

Background

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

COUNCIL ON THERAPEUTICS
POLICY RECOMMENDATIONS

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

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

Jennifer Tryon, *Board Liaison*

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

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

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

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

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

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

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

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

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

This policy would supersede ASHP Policy 2125

Rationale

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

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

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

Background

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

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

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

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

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

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

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

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

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

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

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

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

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

Rationale

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

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

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

Background

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

3. Dosing of Combination Antibiotics

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

To support the reduction of available formulations; further,

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

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

Rationale

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

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

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

Background

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

4. Evidence-Based Medicine

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

Rationale

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

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

Background

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

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

House of Delegates

ashp pharmacists advancing healthcare®

REPORT OF THE

COMMITTEE ON RESOLUTIONS

June 14, 2026

St. Louis, Missouri

Melanie A. Dodd, Chair
Kim W. Benner, Vice Chair
Leigh A. Briscoe-Dwyer
Lisa M. Gersema
Marie A. Chisholm-Burns
Jesse H. Hogue
Dawn M. Moore
Todd W. Nesbit
Vickie L. Powell
Douglas C. Slain
Jennifer E. Tryon
Douglas J. Scheckelhoff, Interim Executive Vice President and Chief Executive Officer

Article 7.2.2.1 of the ASHP Rules of Procedure for the House of Delegates states:

> Resolutions not voluntarily withdrawn by the submitter that meet the requirements of the governing documents shall be presented to the House of Delegates by the Committee on Resolutions at the first meeting and acted upon at the second meeting. They shall be submitted to delegates with one of the following recommendations: (a) recommend adoption, (b) do not recommend adoption, (c) recommend referral for further study, or (d) presented with no recommendation of the Committee on Resolutions.
>
> Action by the House of Delegates shall be on the substance of the resolutions and not on the recommendation of the Committee on Resolutions.

Pursuant to the above article, the Committee on Resolutions presents the attached resolutions (Appendices A, C, and E) to the House of Delegates.

For the first resolution, which is to affirm evidence-based medicine (EBM) as a foundational principle of pharmacy practice, patient care, and the development of ASHP professional policies and advocacy positions, including clinical decision-making and public health guidance, the recommendation of the Committee is to **refer the resolution to the Council on Therapeutics for further study and consideration in September 2026**. The Committee noted that the content of the resolution could be incorporated as a second clause of the policy recommendation, *Evidence-Based Medicine* (Appendix B), which will be considered by the House of Delegates in June. Also, the Committee acknowledge the prevalence of the term *"evidence-based"* throughout ASHP policies.

Delegates are reminded that they are voting on the substance of the resolution, which is approval of the motion as follows:

> To affirm evidence-based medicine (EBM) as a foundational principle of pharmacy practice, patient care, and the development of ASHP professional policies and advocacy positions, including clinical decision-making and public health guidance.

The options for House action on the resolution, to be taken at the second meeting, are to (a) approve the motion; (b) defeat the motion; (c) refer the motion for further study by a committee or task force to be determined by the Board of Directors **(the option recommended by the Committee on Resolutions)**; or (d) amend the resolution, which would then require due consideration by the Board of Directors at its next meeting in September.

For the second resolution, which is to advocate that state boards of pharmacy and regulatory bodies recognize and accept a valid pharmacist license from any U.S. state or territory for the provision of non-dispensing telehealth pharmacy services across all U.S. states, regardless of patient or provider location, the recommendation of the Committee is to **refer the resolution to the Council on Public Policy for further study and consideration in September 2026.** The Committee noted that policy 1310, *Regulation of Telepharmacy Services* (Appendix D) serves as a strong foundation for incorporating provision of non-dispensing telehealth services across state lines by pharmacists. The Committee concluded that the ASHP policy committee process, with its studied reflection and multiple layers of review, would be the best way to arrive at policy that expresses a comprehensive, contemporary view on pharmacist provision of telehealth across state lines.

Delegates are reminded that they are voting on the substance of the resolution, which is approval of the motion as follows:

> To advocate that state boards of pharmacy and regulatory bodies recognize and accept a valid pharmacist license from any U.S. state or territory for the provision of non-dispensing telehealth pharmacy services across all U.S. states, regardless of patient or provider location.

The options for House action on the resolution, to be taken at the second meeting, are to (a) approve the motion; (b) defeat the motion; (c) refer the motion for further study by a committee or task force to be determined by the Board of Directors **(the option recommended by the Committee on Resolutions)**; or (d) amend the resolution, which would then require due consideration by the Board of Directors at its next meeting in September.

For the third resolution, which is to advocate for legislative and regulatory policies that would oppose alternative funding program policies, the recommendation of the Committee is to **refer the resolution to council for further study and consideration in September 2026.** The Committee noted that ASHP policy 1809, *Health Insurance Policy Design* (Appendix F), serves as a strong foundation for considering concepts such as alternative funding programs. The Committee questioned whether adoption of this resolution as written could result in unintended consequences for ASHP by appearing to unduly influence payer business practices at a time when health systems are facing increased scrutiny related to rising healthcare costs. At the same time, the Committee recognized concerns that alternative funding programs may disrupt continuity of care provided through the pharmacy home. The Committee concluded that the ASHP policy committee process, with its studied reflection and multiple layers of review, is the most appropriate mechanism to develop policy that reflects a comprehensive and balanced view of the use of alternative funding programs, particularly as a means by which self-funded employers exclude specialty medications from coverage.

Delegates are reminded that they are voting on the substance of the resolution, which is approval of the motion as follows:

> To advocate for legislative and regulatory policies that would oppose alternative funding program policies.
>
> To educate about alternative funding programs and their negative impacts on patient access to treatment.
>
> To advocate that plan benefits are transparently communicated to covered patients.
>
> To advocate for equitable patient access to treatment and oppose practices that rely on patient financial assistance programs or international sourcing of medications.
>
> To oppose mandatory use of power of attorney contracts between patients and alternative funding programs as a component of the medication access process.

The options for House action on the resolution, to be taken at the second meeting, are to (a) approve the motion; (b) defeat the motion; (c) refer the motion for further study by a committee or task force to be

determined by the Board of Directors **(the option recommended by the Committee on Resolutions)**; or (d) amend the resolution, which would then require due consideration by the Board of Directors at its next meeting in September.

Appendix A
Resolution for the 2026 ASHP House of Delegates: Evidence-Based Medicine as a Foundational Principle of Pharmacy Practice

Submitted by:
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Subject: Evidence-Based Medicine as a Foundational Principle of Pharmacy Practice
Received: March 5, 2026

Motion
To affirm evidence-based medicine (EBM) as a foundational principle of pharmacy practice, patient care, and the development of ASHP professional policies and advocacy positions, including clinical decision-making and public health guidance.

Background
Although many ASHP policies refer to EBM, ASHP does not have an overarching policy-level commitment to EBM as a foundational principle for informing pharmacy practice, patient care, advocacy and policy making. EBM integrates the best available scientific evidence with clinical expertise to optimize health outcomes. In an era of rapid therapeutic innovation, proliferating health information (including misinformation), and evolving public health challenges, the consistent application of EBM is essential to maintain the scientific integrity of pharmacy practice and ASHP's policy positions. This resolution underscores EBM's central role in guiding clinical, educational, advocacy, public health and collaborative activities across the pharmacy workforce. It aligns with and reinforces ASHP's broader commitment to rigorous, data-driven standards in all aspects of health-system pharmacy.

Suggested Outcome
Adoption of this resolution will reinforce EBM as a core tenet underlying ASHP's professional policies, educational programming, and external advocacy. It will promote widespread integration of evidence-based principles into daily pharmacy practice, interprofessional collaboration, and interactions with public health authorities, payers, and policymakers.

Appendix B: Related ASHP Policy/Materials

The related policies are organized into Sections A, B, and C. Section A includes proposed policies aligned with the intent of this resolution but not yet fully considered by the House. Section B contains approved ASHP policies that are similar in intent to the resolution. Section C links to policies that are not necessarily aligned with the resolution's intent but use the terms "evidence-based" or "evidence-based medicine," which occur 52 times in ASHP policies, making them relevant to this review.

A. Proposed policies that are not yet fully considered by the House of Delegates but are aligned with the intent of the resolution.

Evidence-Based Medicine (Proposed policy to be considered during House of Delegates June 2026)
Source: Council on Therapeutics

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

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

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

Background
The Council discussed the term evidence-based medicine as a part of the evolution of the amount and quality of information and its role in medication misinformation, clinical decision making, and the practice of pharmacy as well as its use in ASHP Policies. Review found there are 52 references to the term evidence-based in ASHP Policies and rationales. The Council also discussed how other professional organizations use this term, how ASHP should define the term EBM as it pertains to developing professional policy, and the impact of removing

this term from ASHP policy. The Council decided that a policy affirming ASHP's position would be in the organization's best interest.

Role of the Pharmacy Workforce to Combat Public Health Disinformation and Misinformation (Proposed policy to be considered during the House of Delegates June 2026)
Source: Council on Pharmacy Practice

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

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

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

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

To collaborate with key partners to combat disinformation and misinformation.

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

A longstanding area of concern related to disinformation and misinformation is with vaccines and vaccine preventable diseases. Maintaining public trust in vaccine evidence-based recommendations is essential to protecting patient and public health, and that trust depends on transparent, rigorous processes grounded in scientific evidence. The pharmacy workforce needs to remain steadfast in their commitment to science-driven decision making related to vaccines and patient education in order to support shared clinical decision making. Clinical decisions often require nuance, and pharmacists may reasonably differ in how they interpret evolving evidence, weigh risks and benefits, or apply guidelines to individual patients. Differences in evidence informed professional opinions, including vaccine recommendations based on patient factors or emerging data, are not the same as misinformation. Good faith interpretation of available evidence, even when it does not fully align with a guideline, is an essential part of professional practice. Efforts to address disinformation must distinguish intentional or reckless spread of falsehoods from legitimate clinical judgment that reflects the complexity of real world care.

ASHP, state affiliates, and its members have a professional duty to recognize and combat disinformation and misinformation with their constituencies and in their communities. It is imperative that the pharmacy workforce serve as a source of truth for scientific and evidence-based information. Many leading health professional organizations, including the American Medical Association and the American Nurses Association, have advanced policy statements that outline key elements for addressing disinformation and misinformation

such as conveying clear definitions, reinforcing professional responsibility, providing trusted education and communication, creating accountability, and collaborating with other partners with similar goals and policy positions. ASHP should align and collaborate with peer pharmacy and medical organizations to reinforce shared principles and support critical public health initiatives that uphold scientific integrity and patient safety.

Background

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

B. Approved ASHP policies that are similar in intent to the resolution.

1822 RATIONAL USE OF MEDICATIONS

Source: Council on Therapeutics

To promote evidence-based prescribing and deprescribing for indication, efficacy, safety, duration, cost, and suitability for the patient; further,

To advocate that pharmacists lead interprofessional efforts to promote the rational use of medications, including engaging in strategies to monitor, detect, and address patterns of irrational medication use in patient populations.

This policy supersedes ASHP policy 1312.

This policy was reviewed in 2023 by the Council on Therapeutics and by the Board of Directors and was found to still be appropriate.

Rationale

The World Health Organization (WHO) identifies that rational use of medications requires that "patients receive medications appropriate to their clinical needs, in doses that meet their own individual requirements, for an adequate period of time, and at the lowest cost to them and their community." The overuse, underuse, or misuse of medicines results in wastage of scarce resources and widespread health hazards. Examples of irrational use of medicines include use of too many medicines per patient, inappropriate use of antimicrobials, inadequate dosage, overuse of injections when oral formulations would be more appropriate, failure to prescribe in accordance with clinical guidelines, inappropriate self-medication, decreased access to medicines, and nonadherence to dosing regimens. These actions can negatively affect the quality of patient care, raise

healthcare costs, and increase the number of adverse reactions and events, and may cause adverse reactions or negative psychosocial effects.

Strategies to address irrational medication use can be characterized as educational, managerial, economic, or regulatory in nature. Furthermore, the WHO advocates 12 key interventions to promote more rational use of medications:

- establishment of a multidisciplinary national body to coordinate policies on medication use;
- use of clinical guidelines;
- development and use of national essential medications list;
- establishment of drug and therapeutics committees in districts and hospitals;
- inclusion of problem-based pharmacotherapy training in undergraduate curricula;
- continuing in-service medical education as a licensure requirement;
- supervision, audit, and feedback;
- use of independent information on medications;
- public education about medications;
- avoidance of perverse financial incentives;
- use of appropriate and enforced regulation; and
- sufficient government expenditure to ensure availability of medications and staff.

These recommendations are echoed by the Joint Commission of Pharmacy Practitioners, whose tenets of the pharmacists' patient care process include the collection of necessary subjective and objective information about the patient in order to understand the relevant medical/medication history and clinical status of the patient; assessment of information collected and analysis of the clinical effects of the patient's therapy in the context of the patient's overall health goals in order to identify and prioritize problems and achieve optimal care; development of an individualized patient-centered care plan, in collaboration with other healthcare professionals and the patient or caregiver that is evidence-based and cost-effective; implementation of the care plan in collaboration with other healthcare professionals and the patient or caregiver; and monitoring and evaluation of the effectiveness of the care plan and modification of the plan in collaboration with other healthcare professionals and the patient or caregiver as needed. ASHP also supports the use of stewardship programs with pharmacists in a lead role, as these have been shown to demonstrate the rational use of medications.

2208 PHARMACIST'S ROLE IN TEAM-BASED CARE

Source: Council on Pharmacy Practice

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

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

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

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

This policy supersedes ASHP policy 1215.

Rationale

There is a growing consensus among healthcare providers and payers that patient-centered care by a collaborative team is the optimal model of care. A collaborative care model provides pharmacists with an opportunity to contribute their expertise in medication use to improving patient outcomes.

The pharmacy profession appears to be struggling, however, with implementation of this care model. Not unexpectedly, there is a wide variation in the way "team-based care" is interpreted and applied. Therefore, states currently in the process of rewriting practice acts have been challenged to find guidance on the fundamental roles and responsibilities of pharmacists in various care settings. This policy recommendation builds on concepts in ASHP policy 1114, Pharmacist Accountability for Patient Outcomes; sets the expectation for other providers that teams with pharmacists will improve the quality, safety, and efficiency of care; and supports advocacy to the broader healthcare community on the value of care delivery by teams that include pharmacists.

C. Existing ASHP policies using terms "evidence-based" are linked here.

Appendix C
Resolution for the 2026 ASHP House of Delegates: Recognition of Pharmacist Licensure in Non-Dispensing Telehealth Pharmacy Services

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Subject: Recognition of Pharmacist Licensure in Non-Dispensing Telehealth Pharmacy Services

Received: March 16, 2026

Motion
To advocate that state boards of pharmacy and regulatory bodies recognize and accept a valid pharmacist license from any U.S. state or territory for the provision of non-dispensing telehealth pharmacy services across all U.S. states, regardless of patient or provider location.

Background
By advocating for the recognition of valid pharmacist licenses in the provision of non-dispensing telehealth pharmacy services, regardless of patient or provider location, ASHP can empower pharmacists to optimize their contributions to patient care and address the healthcare needs of diverse populations across the nation. This approach is particularly beneficial for pharmacists practicing in large multi-state health systems or networks, as it enables them to deliver care efficiently across state boundaries without regulatory delays. Additionally, pharmacists serving rural communities can leverage streamlined licensure recognition to provide timely and consistent access to pharmaceutical care, helping to bridge gaps in medication management and reduce care fragmentation. Allowing pharmacists to provide non-dispensing telehealth services across state lines would expand patient access to high-quality medication management and reduce care fragmentation.

While existing ASHP policy broadly addresses interstate licensure (2507,1310, 0909, and ASHP Statement on Telehealth Pharmacy Practice), focused efforts to recognize non-dispensing telehealth pharmacy services across state lines will help advance practice while comprehensive interstate licensure models continue to be pursued.

This policy should address:

1. Recognition of Licensure: uniform recognition of pharmacist licensure that enables pharmacists to provide non-dispensing telehealth services (audio and video) without the impediment of state-specific regulations that may hinder their practice.
2. Scope of Practice: Pharmacists should be permitted to engage in telehealth services, including medication therapy management, patient consultations, and chronic disease management, irrespective of the state in which the patient resides, as long as the pharmacist holds a valid license, in good standing, in at least one state.

3. Patient-Centered Care: This recognition will support the delivery of patient-centered care by ensuring that qualified pharmacists can leverage telehealth technologies to enhance access to pharmaceutical care, improve health outcomes, and facilitate adherence to treatment regimens.
4. Interstate Collaboration: collaboration among state boards of pharmacy, telehealth organizations, and other stakeholders to establish best practices and frameworks that sustain the quality and integrity of non-dispensing telehealth pharmacy services while ensuring patient safety.
5. Advocacy for Legislative Measures: support of legislative efforts and policy initiatives that promote the recognition of pharmacist licensure and the establishment of a flexible regulatory environment conducive to telehealth practices.

Suggested Outcome

Adoption of this resolution as professional policy would strengthen advocacy to allow pharmacists to provide non-dispensing telehealth services across state lines, therefore expanding patient access to medication management and reducing care fragmentation. Modernizing regulatory frameworks to recognize pharmacist licensure for non-dispensing telehealth services across all U.S. states would strengthen continuity of care, regardless of geographic barriers.

Appendix D: Related ASHP Policy/Materials

1310 REGULATION OF TELEPHARMACY SERVICES

Source: Council on Public Policy

To advocate that state governments adopt laws and regulations that standardize telepharmacy practices across state lines and facilitate the use of United States-based telepharmacy services; further,

To advocate that boards of pharmacy and state agencies that regulate pharmacy practice include the following in regulations for telepharmacy services: (1) education and training of participating pharmacists; (2) education, training, certification by the Pharmacy Technician Certification Board, and licensure of participating pharmacy technicians; (3) communication and information systems requirements; (4) remote order entry, prospective order review, verification of the completed medication order before dispensing, and dispensing; (5) direct patient-care services, including medication therapy management services and patient counseling and education; (6) licensure (including reciprocity) of participating pharmacies and pharmacists; (7) service arrangements that cross state borders; (8) service arrangements within the same corporate entity or between different corporate entities; (9) service arrangements for workload relief in the point-of-care pharmacy during peak periods; (10) pharmacist access to all applicable patient information; and (11) development and monitoring of patient safety, quality, and outcomes measures; further,

To identify additional legal and professional issues in the provision of telepharmacy services to and from sites located outside the United States.

This policy was reviewed in 2023 by the Council on Public Policy and by the Board of Directors and was found to still be appropriate.

Rationale

In light of continuing advances in technology, there an increasingly urgent need for state board of pharmacy regulation of the provision of pharmacist care services from offsite locations through electronic technology, which is often referred to, especially in regulation, as *telepharmacy*. In the ASHP Statement on Telehealth Pharmacy Practice, ASHP explains why it prefers the term *telehealth pharmacy practice* to describe both the provision of team-based patient care and oversight of aspects of pharmacy operations (e.g., remote dispensing, order verification, supervision of staff) by pharmacists using electronic information and telecommunications technology.

It is important to acknowledge the regulatory purview of state boards of pharmacy regarding the use of telepharmacy and recognize that the intent of such regulations should be to balance protection of the public health with the increased patient access to the patient care services of pharmacists provided by telepharmacy. Although such regulations should allow for various arrangements across state borders and within or between health systems, they all need to address a number of common concerns.

ASHP advocates that the provision of medication therapy management and other direct patient care services be addressed in any regulation of telepharmacy services and that patient safety, quality, and outcomes measures for these services be developed and monitored. Further, ASHP urges state governments to harmonize the practice of pharmacy across state lines and to require that pharmacy technicians providing telepharmacy services be certified by the Pharmacy Technician Certification Board and licensed by the state

board of pharmacy. Finally, ASHP recognizes the need to continue efforts to identify additional legal and professional issues in the provision of international telepharmacy services.

2227 ASHP STATEMENT ON TELEHEALTH PHARMACY PRACTICE

Source: Section of Pharmacy Informatics and Technology

To approve the ASHP Statement on Telehealth Pharmacy Practice

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

2507 INTERSTATE PHARMACIST LICENSURE

Source: Council on Public Policy

To advocate for improved timeliness of the pharmacist licensure application approval process; further,

To advocate for interstate pharmacist licensure; further,

To support streamlined reciprocity processes, including temporary licensure mechanisms, as progress toward interstate licensure.

This policy supersedes ASHP policy 1621.

Rationale

Pharmacists sometimes face challenges from delays in obtaining licensure by transfer or reciprocity when moving their practice from one jurisdiction to another. Such delay may be due to the need for boards to review pharmacists' licensure records in all jurisdictions in which they are licensed, administer a state pharmacy law exam, complete a criminal background check, and, in some cases, schedule an interview with the board. To address these challenges, boards of pharmacy should allow pharmacists in good standing to immediately practice in a different jurisdiction when they change employment or enter a residency program. Granting pharmacists a temporary license for a period of up to six months while the board completes its review would help meet workforce demands while continuing to safeguard the public health. In some cases, pharmacists who are unable to obtain a license in a timely manner are unable to fully use the skills in which they have been trained. Without a license, the pharmacist may temporarily have to function as a technician or perform other tasks. For pharmacists participating in residency programs outside their jurisdiction of licensure, several months of their residency program can elapse before they receive licensure transfer or reciprocity. Upon completion of a year-long residency program, many residents move to another jurisdiction to practice and have to start the transfer or reciprocity process again.

Members in several states have reported that in recent years boards of pharmacy have been slow to issue pharmacy licenses. This delay is especially problematic for pharmacy residents from another jurisdiction who rely on boards to grant them a license prior to performing in a clinical capacity. Given that the licensing period can take several months, this delay has presented a problem for pharmacy residents who have a limited timeframe to successfully complete their duties, typically one year. In some cases, state boards are urging residents to obtain a pharmacy technician license; however, this is inappropriate given the

expertise and education residents have and the level of practice they're expected to engage in. Given its national scope, NABP is well-positioned to explore a broad solution to this problem rather than the current, incremental, state-by-state approach.

0909 REGULATION OF INTERSTATE PHARMACY PRACTICE
Source: Council on Public Policy

To advocate that state governments, including legislatures and boards of pharmacy, adopt laws and regulations that harmonize the practice of pharmacy across state lines in order to provide a consistent, transparent, safe, and accountable framework for pharmacy practice.

This policy was reviewed in 2024 by the Council on Public Policy and by the Board of Directors and was found to still be appropriate.

Rationale
With the emergence of new technology, state borders are becoming more artificial and coordination between states is increasingly needed. To achieve the highest level of patient safety possible, state regulatory bodies need to work closely together to provide a consistent and transparent regulatory framework for pharmacy practice. Dialogue between the National Association of Boards of Pharmacy and individual state boards can help harmonize the practice of pharmacy across state lines by producing model language that can be adopted by individual states.

2220
PROMOTING TELEHEALTH PHARMACY SERVICES
Source: Council on Pharmacy Practice

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

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

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

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

Rationale
The definitions and terminology used to describe telehealth vary. Many refer to virtual health, telehealth, telemedicine, and/or telepharmacy interchangeably. The Centers for Medicare & Medicaid Services (CMS) describes telemedicine as a means for improving a patient's health by permitting two-way, real-time, interactive communication between a patient and a healthcare provider who are geographically separated.

ASHP defines telehealth as a method used in pharmacy practice in which a pharmacist utilizes telecommunications technology to oversee aspects of pharmacy operations or provide patient care services.

Telehealth is part of a larger digital transformation in healthcare. Patients are increasingly making decisions about who delivers their care and engaging in the delivery of that care digitally. As a result, hospitals and health systems need a strategy for their own digital transformation and to meet patient demands. In general, telehealth includes a broader scope of remote healthcare services than telemedicine and telepharmacy; therefore, ASHP considers telehealth to be the overarching term for the remote delivery of patient care services.

The availability of telehealth services in rural areas facilitates greater access to care by eliminating the need to travel long distances to see a qualified healthcare provider. It promises to save patients time and money, reduces patient transfers, emergency department and urgent care center visits, and delivers savings to payers (American Hospital Association [AHA]. Fact Sheet: Telehealth; AHA. Optimizing Pharmacy Services: Managing your hospital pharmacy during the COVID-19 pandemic and beyond). Pharmacists' role in telehealth is instrumental, as telehealth serves are a valuable tool for the profession of pharmacy to extend its reach to patients for the provision of medication management and complex patient care (AHA. Optimizing Pharmacy Services: Managing your hospital pharmacy during the COVID-19 pandemic and beyond; ASHP Statement on Telepharmacy). Telehealth services have grown significantly over recent years, especially during the COVID-19 pandemic. Telehealth services have the potential to improve patient access to care, cost efficiencies, and quality while meeting consumer demand. They also offer patients the convenience of remote drug therapy monitoring, authorization for prescriptions, patient counseling, and monitoring patients' compliance with prescriptions, and they can be offered remotely to patients with diabetes, congestive heart failure, and other chronic diseases. Pharmacists may also use telehealth when suitable to remotely verify sterile compounding, offer pre- and postoperative medication order review, provide interactive postoperative patient medication counseling, or deliver drug information to a facility that is geographically isolated (ASHP Statement on Telemedicine). To ensure the best patient care outcomes and most efficient use of healthcare resources, additional research will be needed to compare telehealth pharmacy services with those offered in person.

Appendix E
Resolution for the 2026 ASHP House of Delegates: Alternative Funding Programs

Submitted by:
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Subject: Alternative Funding Programs

Received: March 5, 2026

Motion
To advocate for legislative and regulatory policies that would oppose alternative funding program policies; further,

To educate about alternative funding programs and their negative impacts on patient access to treatment; further,

To advocate that plan benefits are transparently communicated to covered patients; further,

To advocate for equitable patient access to treatment and oppose practices that rely on patient financial assistance programs or international sourcing of medications; further,

To oppose mandatory use of power of attorney contracts between patients and alternative funding programs as a component of the medication access process.

Background

Alternative funding programs (AFPs) have emerged as a controversial solution aimed at reducing the financial burden of high-cost specialty medications for employer-sponsored health plans. While these programs may seem beneficial to employers, they introduce complexities and unintended consequences that significantly impact patient care and the broader healthcare system.

There are distinct differences between Alternative Funding Programs (AFPs) and Patient Assistance Programs (PAPs), Foundation Support, and Copayment Programs:

- Alternative Funding Programs (AFPs): These programs shift the cost of expensive drugs from health plans by seeking to procure medication through non-traditional fill methods such as patient assistance programs or international pharmacies by labeling these medications as "non-essential health benefits." In turn, these drugs are removed from the list of covered medications, leaving patients without insurance coverage for their prescribed treatments.

- Patient Assistance Programs (PAPs): Sponsored by pharmaceutical manufacturers, PAPs provide low-income and uninsured individuals access to their medications at reduced rates or for free. PAPs aim to support patients who cannot afford their medications, ensuring they receive necessary treatments without incurring prohibitive costs.
- Foundation Support: Similar to PAPs, foundation grants are supported by non-profits and often are disease-specific. They are designed to be used by qualifying patients who are uninsured or severely underinsured. There are typically income restrictions to foundation support, similar to PAP programs.
- Copayment Programs: Copayment is the portion of the medication cost that patients must pay out-of-pocket, even with insurance coverage. Manufacturer copay assistance programs help patients cover these copayments, reducing the patient's financial burden.

Alternative Funding Programs (AFPs) impact patients and the healthcare system in four primary ways:

- Treatment Delays: Procuring medication through an AFP is a complex and unclear process. AFPs often lack clarity and infrequently provide a clear process for how medication will be obtained for patients and healthcare staff helping patients navigate access. The enrollment process is time-consuming and labor-intensive, often resulting in treatment delays that can span weeks. Many patients do not qualify for PAPs due to income requirements. Increasingly, manufacturer PAPs are able to identify patients as being enrolled in an AFP or are closing PAPs to commercial patients altogether to combat AFP practices.
- Added Complexity/Workload for Accessing Treatment: Patients are required to enroll in the AFP, including providing financial information and clinically-sensitive details about their condition/treatment. This process is labor-intensive and often results in treatment delays.
- Unsafe and Potentially Illegal Medication Procurement Procedures: Another increasingly common method of medication procurement by AFPs is international pharmacy use. Often if patients are denied PAP, the AFP will pivot to seek medication internationally, most often from Canada and Mexico. Other tactics seen in practice include changing patients to a medication covered on their medical benefit or using preferred (often small) retail pharmacies for fulfillment.
- Suboptimal Treatments and Poor Outcomes: AFPs inadvertently create an "income gap trap". Many working individuals earn too much to qualify for patient assistance programs or government-funded insurance but not enough to afford their medications out-of-pocket. This scenario forces patients into a prolonged and uncertain process to access their necessary treatments, exacerbating their health risks and financial burdens. Some patients have already been stabilized on therapies. Due to long wait times, some patients risk developing antibodies to treatments and losing the clinical benefit from the therapy.

The financial implications of AFPs extend beyond treatment delays. Even when patients qualify for assistance, the support provided often has a cap, leaving patients to cover substantial costs once this threshold is reached. This situation undermines the fundamental purpose of health insurance, which is to protect patients from unmanageable financial obligations when they require expensive healthcare treatments. Instead, AFPs cause patients' insurance to fail them precisely when they need it most.

Reliance on third-party vendors to manage AFPs introduces another layer of complexity and potential risk. These vendors may resort to importing medications from international sources outside the secure drug supply chain, exposing patients to drugs that may lack safety and efficacy guarantees. This practice jeopardizes patient health and undermines the integrity of the healthcare system.

The broader implications of AFPs are equally concerning. By diverting resources intended for vulnerable populations, AFPs create a zero-sum game where insured patients compete with low-income and uninsured individuals for limited assistance funding. This diversion risks leaving both groups without access to their necessary medications, defeating the purpose of patient assistance programs. Additionally, manufacturers are changing the requirements for their programs and excluding these patients altogether, further complicating access to necessary medications.

Employers face challenges with AFPs as well. While these programs promise cost savings, the reality is that the administrative costs and bureaucratic complexities often offset these savings. Moreover, the health complications and treatment disruptions caused by AFPs can lead to increased absenteeism, presenteeism, and staff turnover, ultimately affecting organizational productivity and employee well-being. Research indicates that employers incur substantial costs due to absenteeism and reduced productivity associated with chronic diseases and uncontrolled symptoms. Changes in insurance coverage for medications force many patients to stop receiving their medication, leading to increased absenteeism, presenteeism, and staff turnover. For many patients, these medications were what allowed them to be physically able to re-enter the workforce in the first place.

Conclusion: Alternative funding programs, while intended to reduce costs for employer-sponsored health plans, often result in significant harm to patients and the broader healthcare system. By implementing policies that promote transparency, protect patient access to necessary medications, and ensure the integrity of health insurance, the negative impacts of these programs can be mitigated, thereby improving patient outcomes.

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Suggested Outcome

Changes in legislative and regulatory policies to oppose alternative funding program policies.

Appendix F: Related ASHP Policy/Materials

1809
HEALTH INSURANCE POLICY DESIGN
Source: Council on Pharmacy Management

To advocate that all health insurance policies be designed and coverage decisions made in a way that preserves the patient–practitioner relationship; further,

To advocate that health insurance payers and pharmacy benefit managers provide public transparency regarding and accept accountability for coverage decisions and policies; further,

To oppose provisions in health insurance policies that interfere with established drug distribution and clinical services designed to ensure patient safety, quality, and continuity of care; further,

To advocate for the inclusion of hospital and health-system outpatient and ambulatory care services in health insurance coverage determinations for their patients.

This policy supersedes ASHP policy 1520.

This policy was reviewed in 2023 by the Council on Pharmacy Management and by the Board of Directors and was found to still be appropriate.

Rationale

Evolving practices by health insurers are negatively affecting patient care decisions and impacting the relationships between patients and their care providers. One common health insurance practice restricts management of and access to certain drugs to specialty suppliers. Another problematic practice is that certain drugs are not reimbursed by the insurer when used as part of the patient's hospital or health-system care. Medicare, for example, deems certain drugs as self-administered drugs, which are not reimbursed when provided to a patient because they are not considered integral to the reason for admission. These practices increase the number of patients that "brown bag" medications when they are admitted to a hospital to avoid being charged personally for the uncovered medications. ASHP has identified a number of concerns about these practices, including impact on continuity of care, integrity of the drug supply, patient satisfaction, and public perception of healthcare organizations.

It is the responsibility of the pharmacist to ensure the integrity of drugs used in the care of patients in the healthcare facility in which he or she practices. Having to verify products that patients bring with them from multiple suppliers disrupts the care process. Having patients go unreimbursed for a medication because it was administered in and supplied by the healthcare organization is confusing to the patient and damaging to the patient–provider relationship. More broadly, lack of understanding of the differing payment systems in different care settings leads to public relations challenges. In addition, the lack of transparency regarding how payers make certain coverage determinations and apply performance penalties (e.g., direct and indirect remuneration fees) creates a significant challenge for healthcare providers as they care for patients.

ASHP advocates reforming these insurance practices. Coverage of medications should not interfere with the safe and effective provision of care and should recognize the responsibility of pharmacists to ensure product integrity for care provided where they practice. In addition, ASHP advocates that the Centers for

Medicare & Medicaid Services, commercial payers, and others include hospital and health-system outpatient and ambulatory care services in health insurance coverage determinations for their patients.

2320
ACCESS TO MEDICATIONS
Source: Council on Pharmacy Practice

To raise awareness that lack of access to medications in clinical practice negatively impacts healthcare outcomes; further,

To recognize the impact of social determinants of health on patient outcomes; further,
To advocate for drug availability, drug pricing structures, pricing transparency, and insurance coverage determinations that promote fair access to medications; further,

To advocate that the pharmacy workforce identify and address risks and vulnerabilities to access as part of comprehensive medication management services; further,

To advocate for resources, including technology, that improve access to care for all populations where pharmacy access is limited; further,

To encourage the pharmacy workforce to identify and mitigate biases in healthcare decision-making that compromise access to medications.

This policy supersedes ASHP policy 9820.

This policy was revised in 2025 by the ASHP Board of Directors on April 3, 2025, to ensure compliance with federal law.

Rationale
Barriers contributing to the lack of access to medications include decreased access to care, increased costs of care, and differences in care based on provider bias. Decreased access to care may be due to insufficient prescription drug coverage or residing in a pharmacy desert. The current trends in the price of prescription drugs, combined with lack of insurance or underinsurance, results in lower use of prescribed medications and nonadherence. Ensuring that all individuals have access to the highest quality medications required to meet their needs will require a multifaceted approach.

2239
DRUG PRICING PROPOSALS
Source: Council on Public Policy

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

Rationale

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

2508

PATIENT'S RIGHT TO CHOOSE

Source: Council on Public Policy

To acknowledge that patients or their representative have the right to be fully informed about their medication options and to be involved in the decision-making process; further,

To support the right of patients or their representative to have their preferences considered respectfully, within the limits of clinical appropriateness, formulary considerations, safety, and legal requirements; further,

To recognize the right of the patient or their representative to refuse care and have those decisions respected.

This policy supersedes ASHP policy 0013.

Rationale

ASHP supports the right of the patient, or their representative as allowed under law to make informed decisions regarding the patient's care plan. The patient's right to choose includes being entitled to be informed of their health status, involved with care and treatment, allowed to request or refuse treatment, execute advance directives, and have healthcare practitioners adhere to those directives.

2016

MEDICATION FORMULARY SYSTEM MANAGEMENT

Source: Council on Pharmacy Management

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

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

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

This policy supersedes ASHP policies 9601 and 1805.

This policy was reviewed in 2025 by the Council on Pharmacy Management and by the Board of Directors and was found to still be appropriate.

2019
ACCESS TO AFFORDABLE HEALTHCARE
Source: Council on Public Policy

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

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

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

This policy supersedes ASHP policy 1001.

This policy was reviewed in 2025 by the Council on Public Policy and by the Board of Directors and was found to still be appropriate.

Rationale
This policy expresses ASHP's stance on access to healthcare in the United States. The policy emanated from ASHP policies dealing with affordability and accessibility of pharmaceuticals. ASHP believes that it is important to address the larger issue of healthcare access, particularly due to the impact of the cost of medications on the nation's overall healthcare budget as well as pharmacy budgets in hospitals and health systems. The cost of healthcare is high throughout the United States, for people across all income groups and backgrounds, but even more so for vulnerable and underserved populations. Healthcare should be affordable, but also sufficient to ensure patient access to services.

1806
MANUFACTURER-SPONSORED PATIENT ASSISTANCE PROGRAMS
Source: Council on Pharmacy Management

To advocate that pharmaceutical manufacturers extend their patient assistance programs (PAPs) to serve the needs of both uninsured and underinsured patients, regardless of distribution channels; further,

To advocate expansion of PAPs to inpatient settings; further,

To advocate that pharmaceutical manufacturers and PAP administrators enhance the efficiency of PAPs by standardizing application criteria, processes, and forms; further,

To advocate that pharmaceutical manufacturers and PAP administrators enhance access to and visibility of PAPs to pharmacy personnel and other healthcare providers; further,

To encourage pharmacy personnel, other healthcare providers, and pharmaceutical manufacturers to work cooperatively to ensure PAPs include the essential elements of pharmacist patient care, are patient-centered, and are transparent; further,

To develop education for pharmacy personnel and other healthcare providers on the risks and benefits of PAPs.

This policy supersedes ASHP policy 1420.

This policy was reviewed in 2023 by the Council on Pharmacy Management and by the Board of Directors and was found to still be appropriate.

Rationale

ASHP recognizes the value of patient assistance programs (PAPs) in improving continuity of care while controlling costs and advocates expanded use of these programs for uninsured and underinsured patients in ambulatory and inpatient care settings. Some organizations have demonstrated success in achieving the benefits of these programs through dedicated resources and a mastery of the many programs available. Simplification of these programs (similar eligibility criteria, a common data format) would reduce the resources required to participate and improve access and utilization. Other barriers for enrolling patients in PAPs include annual out-of-pocket spend requirements to re-enroll, confusing forms, and inability to renew in advance of new year. ASHP notes that while the number of PAPs in ambulatory care settings has increased, there has been little growth in programs for inpatients. Hospitals must then absorb the costs of patient care, which results in fewer resources in the overall healthcare system. ASHP believes that expansion of PAPs to indigent inpatients would significantly offset some of the costs to hospitals and ultimately improve care. In addition, interprofessional cooperation will be needed to support patients in accessing drug products when the PAP doesn't cover the cost of the drug product due to high deductibles or co-pays. To ensure that these programs achieve their objectives, ASHP advocates that development of these programs ensure that they contain the elements of pharmacist patient care to enhance access to and visibility of PAPs.

1521

IDENTIFICATION OF PRESCRIPTION DRUG COVERAGE AND ELIGIBILITY FOR PATIENT ASSISTANCE PROGRAMS

Source: Council on Pharmacy Management

To advocate that pharmacists or pharmacy technicians ensure that the use of patient assistance programs is optimized and documented to promote continuity of care and patient access to needed medications; further,

To advocate that patient assistance programs should incorporate the pharmacist-patient relationship, including evaluation by a pharmacist as part of comprehensive medication management; further,

To support the principle that medications provided through manufacturer patient assistance programs should be stored, packaged, labeled, dispensed, and recorded using systems that ensure the same level of safety as prescription-based programs that incorporate a pharmacist-patient relationship.

This policy was reviewed in 2025 by the Council on Pharmacy Management and by the Board of Directors and was found to still be appropriate.

Rationale

Ensuring accurate medication histories and continuity of medication therapies are critical pharmacists' roles in monitoring and documenting patient transition through the healthcare system. Additionally, pharmacists have an important role in ensuring patients have means to access their medications, both upon hospital admission and discharge. With the numerous channels patients use to obtain their medications, it has become increasingly difficult to verify this information and, in some cases, obtain the medications needed to care for a patient.

Patient assistance programs (PAPs) present a unique challenge for healthcare providers. Documentation of the utilization of a PAP by a patient is important information for providers accessing the patient electronic health record and improving that documentation should be a priority for healthcare providers. Additionally, pharmacists need to provide leadership in facilitating the utilization of PAPs to ensure continuity of care, the patient's ability to access needed medications when appropriate, and a comprehensive pharmacist-patient relationship.

1301

PAYER PROCESSES FOR PAYMENT AUTHORIZATION AND COVERAGE VERIFICATION

Source: Council on Pharmacy Management

To advocate that public and private payers collaborate with each other and with health care providers to create standardized and efficient processes for authorizing payment or verifying coverage for care; further,

To advocate that payment authorization and coverage verification processes (1) facilitate communication among patients, providers, and payers prior to therapy; (2) provide timely payment or coverage decisions; (3) facilitate access to information that allows the pharmacist to provide prescribed medications and medication therapy management to the patient; and (4) foster continuity in patient care.

This policy was reviewed in 2023 by the Council on Pharmacy Management and by the Board of Directors and was found to still be appropriate.

Rationale

Patients and health care providers are required to navigate an array of payment requirements from private and public payers. Private insurers enforce their own prior authorization procedures, state Medicaid programs have their individual program requirements, and Medicare has its local and national coverage determinations. These payment authorization and verification processes vary considerably from payer to payer and are time consuming and needlessly complex. The required data, forms of documentation required, submission processes, coverage verification procedures, and delivery of approval vary widely among payers. These processes are often not integrated into the patient-care process and require manual documentation and submission. The lack of timely review and approval may delay patient care. Payment authorization and verification processes should effectively facilitate communication among both patients and providers, should be standardized and automated, and should result in timely decisions that do not disrupt patient care.

House of Delegates

Important Dates for Proposed Policy Amendments, May-June 2026

May 4: Chair's email message to delegates sent urging those interested in amending policy recommendations to complete a survey (email includes list of policy recommendations going to May virtual House, if held).

May 13: Deadline for delegates to submit contact info and description of proposed amendment (or draft language, if available) through interest survey.

May 14-15: Emails (one for each policy for which amendments are proposed) will be sent to amending delegates (identified through the survey and ASHP Connect posts), council/section/forum chairs and vice chairs, TPTS President, and council secretaries and section or forum directors. These emails are designed to facilitate collaboration and provide further direction.

May 27: Target date for posting proposed amending language on ASHP Connect and submitting consensus amending language through the amending language form on the Calls, Forms, and Rosters page of the House of Delegates website.

June 12: Deadline for submitting consensus amending language through the amending language form on the Calls, Forms, and Rosters page of the House of Delegates website for consideration at the First Delegate Caucus.

House of Delegates

2026 ASHP HOUSE OF DELEGATES MEETINGS AT A GLANCE

America's Center Convention Complex
St. Louis, Missouri

- **House of Delegates Registration**
  Saturday, June 13, 10:00 a.m. – 6:00 p.m.
  Sunday, June 14, 7:00 a.m. – 11:00 a.m.
  (After then, delegates may register in the Executive Office, Level 3, Room 360)
  Level 1
  Washington Lobby

- **Delegate Primer on HOD Processes**
  (For all delegates and alternate delegates)
  Saturday, June 13, 2:30 – 3:30 p.m.
  Level 2
  Room 241

- **Open Forum for Members**
  Saturday, June 13, 3:30 – 5:30 p.m.
  Level 2
  Room 231

- **First Delegate Caucus**
  Sunday, June 14, 9:30 – 11:30 a.m.
  Level 2
  Room 231

- **Second Delegate Caucus**
  Tuesday, June 16, 12:15 – 2:00 p.m.
  Level 2
  Room 231

- **Other Caucuses**
  Small & Rural Hospital Caucus, Sunday, June 14, 7:30 – 8:30 a.m.
  Federal Pharmacist Caucus, Sunday, June 14, 8:30 – 9:30 a.m.
  Level 2
  Room 230

- **First House of Delegates Meeting**
  Sunday, June 14, 1:00 – 5:00 p.m.
  Level 1, Hall 3

- **Meet the Candidates**
  Monday, June 15, 12:15 – 1:45 p.m.
  Level 2
  Room 231

- **Delegate Reception**
  Monday, June 15, 5:30 – 6:30 p.m.
  Majestic Ballroom D
  2nd Fl via Gateway
  Marriott St. Louis Grand

- **Second House of Delegates Meeting**
  Tuesday, June 16, 4:00 – 6:00 p.m.
  Level 1, Hall 3

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House of Delegates

Agenda

ASHP House of Delegates
St. Louis, Missouri

Presiding – Jesse H. Hogue
Chair, House of Delegates

FIRST MEETING

America's Center Convention Complex
Sunday, June 14, 2026
1:00 – 5:00 p.m.

1. CALL TO ORDER
2. ROLL CALL OF DELEGATES
3. REPORT ON PREVIOUS SESSION
4. RATIFICATION OF PREVIOUS ACTIONS
5. REPORT OF COMMITTEE ON NOMINATIONS
6. REPORT OF COMMITTEE ON RESOLUTIONS
7. BOARD OF DIRECTORS REPORTS ON POLICY RECOMMENDATIONS
   a. COUNCIL ON EDUCATION AND WORKFORCE DEVELOPMENT
      Dawn Moore, Board Liaison
   b. COUNCIL ON PHARMACY MANAGEMENT
      Marie Chisholm-Burns, Board Liaison
   c. COUNCIL ON PHARMACY PRACTICE
      Todd Nesbit, Board Liaison
   d. COUNCIL ON PUBLIC POLICY
      Vickie Powell, Board Liaison
   e. COUNCIL ON THERAPEUTICS
      Jennifer Tryon, Board Liaison
8. REPORT OF THE TREASURER
9. RECOMMENDATIONS OF DELEGATES
10. ANNOUNCEMENTS
11. ADJOURNMENT OF FIRST MEETING

SECOND MEETING

America's Center Convention Complex
Tuesday, June 16, 2026
4:00 – 6:00 p.m.

1. CALL TO ORDER
2. QUORUM CALL
3. REPORT OF THE COMMITTEE ON RESOLUTIONS
4. UNFINISHED AND NEW BUSINESS
5. REPORT OF THE PRESIDENT AND THE CEO

   Melanie A. Dodd and Samuel V. Calabrese
6. RECOMMENDATIONS OF DELEGATES
7. INSTALLATION OF OFFICERS AND DIRECTORS
8. ANNOUNCEMENTS
9. ADJOURNMENT OF SECOND MEETING

House of Delegates

AGENDA

First Delegate Caucus

June 14, 2026
9:30 – 11:30 a.m.
America's Center Convention Complex, Level 2, Room 231

The First Delegate Caucus has two purposes:

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

1. Review of Agenda

1. Call to Order
2. Roll Call of Delegates
3. Report on Previous Session
4. Ratification of Previous Actions
5. Report of Committee on Nominations
6. Report of Committee on Resolutions
7. BOARD OF DIRECTORS REPORTS ON POLICY RECOMMENDATIONS
    A. Council on Education and Workforce Development
    B. Council on Pharmacy Management
    C. Council on Pharmacy Practice
    D. Council on Public Policy
    E. Council on Therapeutics
8. Report of the Treasurer
9. Recommendations of Delegates
10. Announcements
11. Adjournment of First Meeting

2. Amendments to Policy Recommendations

House of Delegates

AGENDA

Second Delegate Caucus

June 16, 2026
12:15 – 2:00 p.m.
America's Center Convention Complex, Level 2, Room 231

The Second Delegate Caucus has four purposes:

1) To review the agenda for the second meeting of the House of Delegates and answer any questions delegates have about the agenda.
2) To review the Report of the Committee on Resolutions and provide an opportunity for delegate discussion of the resolutions and the Committee's recommendations.
3) To present the Board's actions on policy recommendations amended by the House ("unfinished business").
4) To present new business items coming before the House.

1. Review of Agenda

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

2. Report of the Committee on Resolutions

3. Unfinished Business

4. New Business

ASHP Regional Delegate Conferences
April 25–28, 2026

Antitrust Statement

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

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

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

Characteristics of Good ASHP Professional Policy

Professional Policy Definition

ASHP's official stance on an issue related to pharmacy practice or use of medications in society.

Optimal Characteristics

Optimally, an individual policy position of ASHP will

- Deal with an important issue in health-system pharmacy or societal medication use (consistent with the purposes of ASHP).
- Generally target a distinct, sharply-defined issue rather than a diffuse, multifaceted issue.
- Be based on a thorough, balanced analysis of the issue and policy options.
- Be clear, efficient, and precise in its wording.
- Be direct in its wording. (It is permissible to be opposed to something.)
- Identify the desired outcome or situation to give ASHP a clear basis for advocacy.
- Generally be expressed in sufficiently broad language to give ASHP latitude in pursuing the desired outcome.
- Foster the ability of health-system pharmacists to optimize the application of their knowledge, skills, and abilities in practicing their profession.
- Be consistent with broad national goals in healthcare delivery, including goals related to healthcare access, value, and quality.
- Be motivated by broad public interest rather than narrow self-interest.
- Focus on the "right thing to do" (from the public's perspective) rather than on the "easy thing to do" (from a practitioner's perspective).
- Avoid redundancy with or contradiction of other ASHP policy.

(Note: Published titles of policy positions are considered an editorial matter; staff is receptive to suggestions for title changes.)

Implementing ASHP Policy

ASHP has four options in advocating a policy. The Board of Directors and staff decide after a policy is adopted which combination of options to apply in implementing a particular policy position.

1. Actively and directly pursue implementation of the policy.
2. Collaborate with other stakeholders in actively pursuing implementation of the policy.
3. Communicate the policy to others who have a stake in the issue and who may be working on the issue.
4. Maintain the policy as general guidance and look for opportunities to communicate the policy to interested stakeholders or to collaborate with others on implementation.

In general, the level of effort devoted to implementing a new policy is determined by its alignment with ASHP's top advocacy priorities.

ASHP Policy Development Process

1. The primary policy process is indicated by heavy arrows.

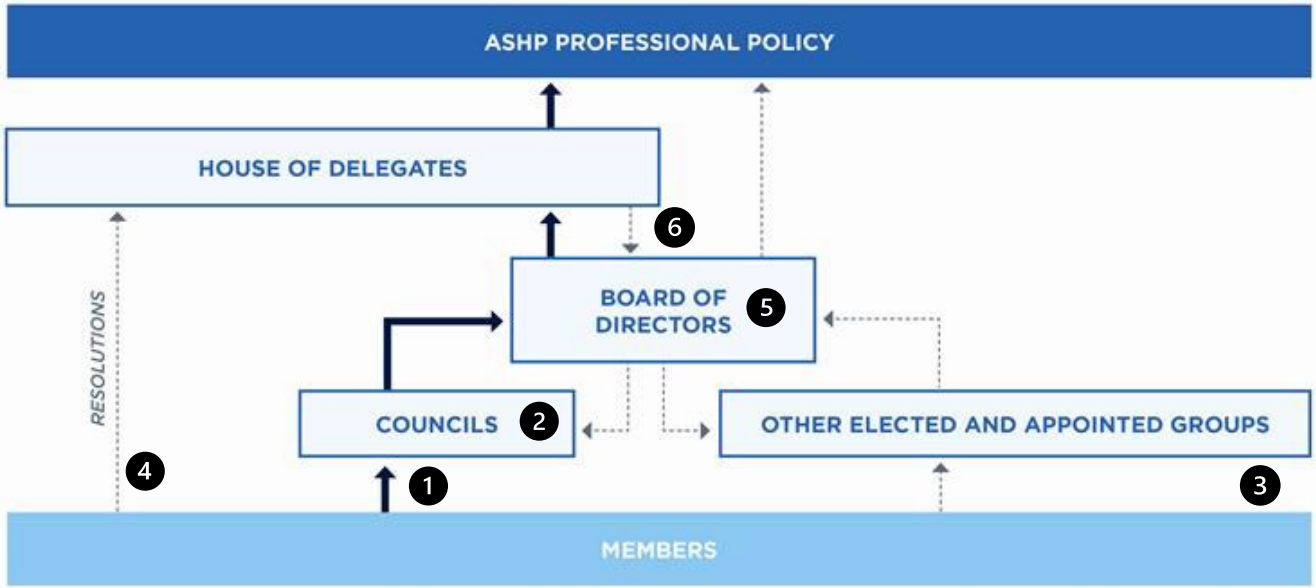
2. There are five councils: Education and Workforce Development, Pharmacy Management, Pharmacy Practice, Public Policy, and Therapeutics. The councils are the primary policy-recommending groups.

3. Standing committees, commissions, advisory groups, TPTS President, task forces, ad hoc committees, and the executive committees of the Sections and Forums.

4. Resolutions are submitted directly to the House of Delegates by active ASHP members.

5. The Board of Directors has final authority over most practice standards, and it may adopt interim professional policies on any issue when the House of Delegates is not in session.

6. The House of Delegates also has a role in identifying issues for policy development, which are referred to the Board of Directors. The Board, in turn, may refer an issue to a specific council.



Note: The Board of Directors has authority over matters of governance and operational policy, including financial management.

Substantive versus Non-Substantive Amendments

Words added are in *italics*; words deleted have a ~~strikethrough~~ mark.

Examples of Substantive Amendments

Medication Management for Patient Assistance Programs
To support the principle that medications provided through manufacturer patient assistance programs should be stored, packaged, labeled, dispensed, and recorded using systems that ensure the same level of safety as *prescription-based programs incorporating a pharmacist-patient relationship.* ~~in traditional medication use systems.~~

Influenza Vaccination Requirements to Advance Patient Safety and Public Health
To advocate that hospitals and health systems require health care workers ~~with direct patient care responsibilities~~ to receive an annual influenza vaccination except when (1) it is contraindicated, or (2) the worker has religious objections, or (3) the worker signs an informed declination; further, ...

Medicare Prescription Drug Benefit
…
To advocate that essential requirements in the program include (1) appropriate product reimbursement based on transparency of drug costs; (2) affordability for patients, including elimination of coverage gaps; (3) payment for indirect costs and practice expenses related to the provision of pharmacist services, based on a study of those costs; (4) appropriate coverage and payment for patient care services provided by pharmacists; (5) open access to the pharmacy provider of the patient's choice; ~~and~~ (6) formularies with sufficient flexibility to allow access to medically necessary drugs; *and* (7) *well-publicized, unbiased resources to assist beneficiaries in enrolling in the most appropriate plan for their medication needs.*

Examples of Non-Substantive Amendments

To *encourage* ~~advocate~~ that ....

To *support* ~~encourage~~ that ....

To *strongly* advocate that ....

To *foster* ~~promote~~ the role ....

To *strongly encourage* ~~urge~~ health policy makers ....

. . .. schools *and* colleges of pharmacy ....

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

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

House of Delegates

April 22, 2026

MEMORANDUM

TO: Delegates and Alternate Delegates
2026 ASHP House of Delegates

FROM: Douglas J. Scheckelhoff, MS, FASHP
Interim Executive Vice President and Chief Executive Officer

SUBJECT: Candidates for ASHP Offices

The ASHP Committee on Nominations met on April 22, 2026, and prepared a slate of candidates for President and Board of Directors. The following slate will be presented to the House of Delegates on Sunday, June 14, 2026.

President, 2027-2028

Kristi K. Gullickson, PharmD, MBA, CPEL, DPLA, FASHP, FMSHP
Vice President of Pharmacy Operations
Allina Health
Minneapolis, MN

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

Board of Directors, 2027-2030

Daniel H. Good, MS, RPh, FASHP
Vice President, Pharmacy
Mercy Health System
Springfield, MO

Todd D. Lemke, PharmD, CPEL, DPLA, FASHP
Director of Regional Pharmacy Services
CentraCare
St. Cloud, MN

Katherine (Kat) A. Miller, PharmD, MHA, CPEL, DPLA, FASHP, FKCHP
Senior Director Acute Care Pharmacy and Clinical Nutrition
The University of Kansas Health System
Kansas City, KS

Ian P. Orensky, PharmD, MS, CPEL
Manager, Pharmacy Business Services and 340B Program
VCU Health
Richmond, VA

Members are invited to "Meet the Candidates" on Monday, June 15, 12:15 – 1:45 pm, in Room 231 of the America's Center Convention Complex. Election of the ASHP President 2027-2028 and members of the Board of Directors will occur during the annual balloting in June.

2026 Report of the ASHP Treasurer

Lisa M. Gersema

The Treasurer is responsible for reporting annually on ASHP's financial condition to the membership. ASHP's fiscal year (FY) is from June 1 through May 31, aligned with our policy development process and timetable. This report describes ASHP's actual financial performance for FY2025, projected financial performance for FY2026, and highlights of FY2027 budget planning and outlook.

Fiscal Year 2025 Ending May 31, 2025—Actual

ASHP's FY2025 financial statement audit for the year ending May 31, 2025, was performed by Aprio, LLP. The audit resulted in ASHP receiving the best opinion available, an unmodified opinion.

ASHP's core operations[1] remained strong. Core gross revenue was $61.2 million (Figure 1), essentially flat year over year compared to FY2024. Core net income was a surplus of $3.2 million, which was primarily due to expense management and savings. Net program development, capital budget, and investments[2] generated a gain of $1.6 million, which is primarily attributable to investment gains. In total, FY2025 resulted in a favorable $4.8 million net change in ASHP's reserves/net assets.

The building fund[3] recorded a gain of $1.6 million, primarily due to investment gains. The building fund remains on track to continue supporting ASHP's office space expenses and to reach its long-term financial target. ASHP's total net assets at the end of FY2025 were $148.7 million (Figure 2). Our year-end balance sheet remained strong, with an asset-to-liability ratio of 4.8:1. ASHP remains well-prepared for the future.

Fiscal Year 2026 Ending May 31, 2026—Projected

Fiscal year 2026 core operations are shaping up to have another favorable year, with projected core gross revenue of $61.6 million. As of February 28, 2026, we anticipate that ASHP's FY2026 core net income will be in the range of $91,000 (Figure 1). We are projecting a deficit of $925,000 for program development expenses, capital budget, and investments. This deficit is primarily due to ASHP's current year $750,000 investment in a national public awareness

[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.

campaign designed to educate and inform the public about the patient care impact of pharmacists in hospitals and health systems, as well as executive vice president and chief executive officer transition expenses. This results in a projected negative net change in reserves/net assets of $834,000. Finally, we anticipate the building fund will have a surplus in the range of $250,000. However, since we have conservatively projected investment returns, if the financial markets remain strong through May 31, 2026, ASHP's net change in reserves/net assets and building fund could end the fiscal year with a significant surplus.

In addition, ASHP transferred $3 million to ASHP Foundation for the Paul W. Abramowitz Fund to Enhance Public Awareness of Pharmacy & Inspire the Next Generation of Practitioners, a campaign to elevate the health-system pharmacy profession, enhance public understanding of pharmacists' roles in optimizing patient care, and inspire and prepare the next generation to join the pharmacy workforce.

ASHP accomplished a great deal during FY2026, including achieving record membership of over 65,000 members, and nurturing The Pharmacy Technician Society (TPTS), which has grown to more than 17,000 members in its third year of existence.

ASHP's national public awareness campaign has surpassed expectations, generating more than 100 million media impressions and engaged millions with compelling stories from pharmacists, physicians, nurses, patients and more. At the end of the year, the campaign launched a new set of ads targeted to students to inspire a new generation of pharmacy professionals.

ASHP's growing and engaged membership underscores our deep commitment to empowering pharmacy practitioners to navigate today's challenges and shape the future of care. As our nation's largest and most influential professional pharmacy organization, ASHP is dedicated to meeting the evolving needs of members across all practice settings and career stages, while advocating to advance pharmacy practice, elevate the role of pharmacists and technicians, and improve patient care.

Fiscal Year 2027 Ending May 31, 2027—Budget

In preparing the FY2027 budget, we continue to build on our successes while thoughtfully assessing financial performance and long-term priorities. The budget includes growing our membership and achieving new milestones as we invest in and enhance our meetings and conferences, publications, professional development offerings, accreditation services, and other initiatives. As the workforce and healthcare landscape evolves, the Board of Directors remains committed to positioning ASHP for the future, ensuring we provide our members and the profession with timely and valuable resources, products, and services.

Considering these and other factors, ASHP's FY2027 budgeted net change in reserves/net assets is a deficit of $42,000, with a record $63.4 million in core gross revenue. The deficit is 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 $609,000 surplus. Finally, the budget includes $899,000 in support provided to the ASHP Foundation.

Report of the ASHP Treasurer

Conclusion

In a rapidly evolving healthcare environment, ASHP remains committed to financial strength and sustainability. Our disciplined approach ensures we can continue advancing our mission, supporting our members, advocating for the profession, and improving the care and outcomes of the patients we serve.

ASHP proudly represents the breadth and growing impact of pharmacists and pharmacy technicians across the full continuum of care. Through prudent financial stewardship, we are well positioned to invest strategically, foster collaboration, and drive innovation. These efforts enable a strong portfolio of products, programs, and services that elevate practice, support professional growth, and advance the safe, effective, and accessible use of medications. The ASHP Board of Directors and staff remain deeply committed to our mission and vision. Under the leadership of a new CEO and guided by a new strategic plan, we look forward to building on our momentum and continued success in year ahead. I am truly honored to serve as your Treasurer.

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

	Actual Fiscal Year 2024 Ended May 31, 2024	Actual Fiscal Year 2025 Ended May 31, 2025	Projection* Fiscal Year 2026 Ended May 31, 2026	Budget Fiscal Year 2027 Ended May 31, 2027
CORE OPERATIONS				
Gross Revenue	61,499	61,176	61,568	63,363
Total Expense	(57,455)	(58,007)	(61,477)	(63,362)
CORE NET INCOME/(LOSS)	4,044	3,169	91	1
NET PROGRAM DEVELOPMENT EXPENSES, CAPITAL BUDGET, AND INVESTMENTS GAIN/(LOSS)	1,860	1,608	(925)	(43)
NET CHANGE IN RESERVES/NET ASSETS	5,904	4,777	(834)	(42)
BUILDING FUND	1,788	1,572	250	609

* Projection as of February 28, 2026

Report of the ASHP Treasurer

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

	Actual as of May 31, 2024	Actual as of May 31, 2025
ASSETS		
Current assets	20,590	19,723
Fixed assets	3,211	2,823
Investments	150,934	157,737
Other assets	10,108	7,520
Total Assets	184,843	187,803
LIABILITIES		
Current liabilities	28,267	27,977
Long-term liabilities	14,242	11,143
Total Liabilities	42,509	39,120
RESERVES/NET ASSETS		
Total Net Assets	142,334	148,683
Total Liabilities and Net Assets	184,843	187,803