



# House of Delegates Session—2019

June 9 and 11, 2019  
Boston, Massachusetts

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Proceedings of the 71st annual session  
of the ASHP House of Delegates,  
June 9 and 11, 2019

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### **Paul W. Abramowitz, Secretary**

The 71st annual session of the ASHP House of Delegates was held at the Hynes Convention Center, in Boston, Massachusetts, in conjunction with the 2019 Summer Meetings.

### **First meeting**

The first meeting was convened at 1:00 p.m. Sunday, June 9, by Chair of the House of Delegates Casey H. White. Chair White introduced the persons seated at the head table: Paul W. Bush, Immediate Past President of ASHP and Vice Chair of the House of Delegates; Kelly M. Smith, President of ASHP and Chair of the Board of Directors; Paul W. Abramowitz, Chief Executive Officer of ASHP and Secretary of the House of Delegates; and Susan Eads Role, Parliamentarian.

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

The roll of official delegates was called. A quorum was present, including 211 delegates representing 50 states and the District of Columbia (no delegates from Puerto Rico), as well as the federal services, chairs of ASHP sections and forums, ASHP officers, members of the Board of Directors, and ASHP past presidents (see Appendix I for a complete roster of delegates).

Chair White reminded delegates that the report of the 70th annual session of the ASHP House of Delegates had been published on the ASHP Web site and had been distributed to all delegates. Delegates had been advised earlier to review this report. The proceedings of the 70th House of Delegates session were received without objection.

### **Report of the Committee on Resolutions.**

President Smith presented the Report of the Committee on Resolutions (Appendix II). Debate and action on the Report took place at the second meeting of the House.

### **Report of the Committee on Nominations for Treasurer.**

President Smith presented the Report of the Committee on Nominations for Treasurer (Appendix III). Debate and action on the Report took place at the second meeting of the House.

### **Report of the Committee on Nominations.**

Chair White called on Kimberley Benner for the report of the Committee on Nominations (Appendix IV).<sup>a</sup> Nominees were presented as follows:

### ***President 2020-2021***

**Lea S. Eiland, Pharm.D., BCPPS, BCPS, FASHP, FPPAG**, Clinical Professor and Associate Department Head of Pharmacy Practice, Auburn University Harrison School of Pharmacy, and Clinical Professor of Pediatrics, University of Alabama at Birmingham School of Medicine, Auburn, AL

**Thomas J. Johnson, Pharm.D., M.B.A., BCCCP, BCPS, FASHP, FCCM**, Assistant Vice President of Hospital Pharmacy, Avera Health, Sioux Falls, SD

### *Treasurer 2019-2022*

**Roger W. Anderson, M.S., Dr.P.H., FASHP**, Retired, McKinney, TX  
**Christene M. Jolowsky, B.S.Pharm., M.S., FASHP**, Director, Hennepin Healthcare System, Minneapolis, MN.

### *Board of Directors, 2020-2023*

**Leigh A. Briscoe-Dwyer, Pharm.D., B.S.Pharm., BCPS, FASHP**, Vice President of Network Pharmacy, Westchester Medical Center Health Network, Valhalla, NY

**Dan D. Degnan, Pharm.D., M.S., CPPS, FASHP**, Associate Director, Professional Program Laboratory, and Clinical Assistant Professor of Pharmacy Practice (Courtesy) at Purdue University College of Pharmacy, West Lafayette, IN.

**Rafael Saenz, Pharm.D., M.S., FASHP**, Administrator, Pharmacy Services for the University of Virginia, Assistant Dean of VCU School of Pharmacy, Charlottesville, VA

**Jamie S. Sinclair, M.S., R.Ph., FASHP**, Director, Pharmacy Services for Mercy Medical Center, Cedar Rapids, IA

A “Meet the Candidates” session to be held on Monday, June 10, was announced. Chair White announced the candidates for the executive committees of the five sections of ASHP.

**Policy committee reports.** Chair White outlined the process used to generate policy committee reports (Appendix V). He announced that the recommended policies from each council would be introduced as a block. He further advised the House that any delegate could raise questions and discussion without having to “divide the question” and that a motion to divide the question is

necessary only when a delegate desires to amend a specific proposal or to take an action on one proposal separate from the rest of the report; requests to divide the question are granted automatically unless another delegate objects. Chair White reminded delegates that policies not separated by dividing the question would be voted on en bloc before the House considered the separated items.

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

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

*The ASHP Bylaws [Section 7.3.1.1] require the Board of Directors to reconsider an amended policy before it becomes final. The Board reported the results of its “due consideration” of amended policies during the second meeting of the House; the double underlined type indicates material added during the Board’s due consideration and the double ~~strikethrough~~ marks indicate material deleted by the Board.)*

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Kelly M. Smith, Board Liaison to the **Joint Council**, presented the Council's Policy Recommendation.

### 1. Suicide Awareness and Prevention

To support the goal of zero ~~patient or healthcare worker~~ suicides; further,

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

To acknowledge that optimal suicide awareness and prevention efforts focus both on ~~preventing patients suicides and on maintaining the health and well-being of the healthcare workforce~~; further,

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

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

To provide education that assists the pharmacy workforce in their continuing professional development efforts related to suicide awareness and prevention; further,

To support the inclusion of suicide awareness and prevention principles throughout pharmacy curricula and postgraduate educational and training programs; further,

To encourage ~~state-based~~ efforts that support universal education and training of healthcare providers in suicide awareness and prevention; further,

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

To enhance awareness of local, state, and national suicide awareness and prevention resources, including the National Suicide Prevention Lifeline funded by the Substance Abuse and Mental Health Services Administration; further,

To foster education and research on suicide awareness and prevention.

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Paul C. Walker, Board Liaison to the **Council on Pharmacy Practice**, presented the Council's Policy Recommendations 1 and 2.

### 1. Safe Administration of Hazardous Drugs

To advocate that ~~health systems all sites of care~~ healthcare settings proactively conduct an interprofessional assessment of risk for exposure to hazardous drugs (HDs) during administration, including when closed-system transfer devices (CSTDs) cannot be used; further,

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

To encourage device and pharmaceutical manufacturers and the Food and Drug Administration to foster development of CSTD-compatible, ready-to-administer HD products.

### 2. Compounded Sterile Preparation Verification

To advocate that health systems adopt automation and information technology to

facilitate in-process and final verification of compounded sterile preparations (CSPs) to ensure CSP quality; further,

To advocate that, until such time as automation or technology can be implemented, independent in-process and final verification of CSPs be performed; further,

To oppose the use of the syringe pull-back method or other proxy methods of CSP verification.

*This policy supersedes ASHP policy 1617.*

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Todd A. Karpinski, Board Liaison to the **Council on Public Policy**, presented the Council's Policy Recommendations 1 through 6.

### **1. Notification of Drug Product Price Increases**

To advocate for manufacturers to provide ~~advance~~ notice and justification to the public and healthcare providers in advance of drug price increases; further,

To advocate for transparency in drug product pricing decisions.

### **\*2. Mitigating Drug Product Shortages**

To advocate for ongoing federal evaluation of ~~whether~~ how drug product shortages present risks to national security and public health; further,

To advocate that drug product manufacturers be required to disclose manufacturing sites and sources of active pharmaceutical ingredients (APIs) to facilitate such a risk assessment; further,

To recommend that the Food and Drug Administration (FDA) require drug product

manufacturers to have contingency plans for maintaining drug supplies; further,

To advocate that drug product manufacturers be required to provide a specific reason for a shortage and an estimated timeline for resolution in their Food and Drug Administration Safety and Innovation Act notifications to FDA; further,

To advocate that the FDA be required to publicly provide quality ratings for 503B outsourcing facilities preparing copies of drug products under the exemption for products on FDA's shortage list; further,

To advocate that the Federal Trade Commission be required to evaluate the potential for drug product supply chain interruptions when considering manufacturer consolidations.

### **\*3. Emergency Supplies of Drug Products**

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

### **4. Credentialing and Privileging by Regulators, Payers, and Providers for Collaborative Practice**

To advocate expansion of collaborative practice agreements in which the prescriber and ~~the licensed~~ pharmacist agree upon the conditions under which the pharmacist initiates, monitors, and adjusts a patient's drug and non-drug therapy; further,

~~To acknowledge that as a step toward the goal of universal recognition of and payment for pharmacist medication management services, public or private third-party payers may require licensed pharmacists to demonstrate their competence to provide medication management services, before the payers~~

~~authorize them to engage in or be paid for such clinical services; further,~~

To support (1) the development (as a professional initiative by pharmacist associations rather than as a government activity) of national standards for determining a pharmacist's competence to provide medication management services and (2) the appropriate use of these standards by clinical privileging systems, government authorities, and public or third-party payers; further,

To advocate pharmacists be included as providers in medical staff bylaws; further,

To support the use of credentialing and/or clinical privileging by hospitals, and health systems, and payers in a manner that is consistent with other healthcare professionals to assess a ~~licensed~~ pharmacist's competence to engage in medication management services within the hospital or health system; ~~further,~~

~~To advocate that state boards of pharmacy apply the principles of continuous quality improvement in assessing the quality, safety, and outcomes of medication management services.~~

(Note: This policy would supersede ASHP policy 0905.)

### **5. 340B Drug Pricing Program Sustainability**

To affirm the intent of the federal drug pricing program (the "340B program") to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services; further,

To advocate ~~legislation or regulation to ensure~~ for continued access to the 340B program in accordance with the intent of the program; further,

To advocate that reimbursement and contracting policies promote 340B program stability and to oppose reimbursement and savings reductions to covered entities; further,

To advocate for clarification and simplification of the 340B program and any future federal discount drug pricing programs with respect to program definitions, eligibility, and compliance measures to ensure the integrity of the program; further,

To encourage 340B participants to provide appropriate stewardship of the 340B program; further,

To educate pharmacy leaders and health-system administrators about the internal partnerships and accountabilities and the patient-care benefits of program participation; further,

To educate health-system administrators, risk managers, and pharmacists about the resources required to support 340B program compliance and documentation; further,

To encourage communication and education concerning the value of the 340B program; further,

To advocate that the Health Resources & Services Administration Office of Pharmacy Affairs have sufficient regulatory authority to enforce compliance for all stakeholders with the 340B program.

(Note: This policy would supersede ASHP policy 1817.)

### **6. Pharmacist Authority to Provide Medication-Assisted Treatment**

To advocate for the role of the pharmacist in medication-assisted treatment (MAT) for opioid use disorder, including patient assessment, education, ~~and~~ prescribing, and monitoring of pharmacologic therapies; further,

To pursue the development of federal and state laws and regulations that recognize pharmacists as providers of MAT for opioid use disorder; further,

To foster additional research on clinical outcomes of pharmacist-driven MAT; further,

To advocate for the removal of barriers for all providers to be able to provide MAT to patients.

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Linda S. Tyler, Board Liaison to the **Council on Therapeutics**, presented the Council's Policy Recommendation.

### 1. Therapeutic Use of Cannabidiol

To support continued research ~~on the therapeutic uses of cannabidiol (CBD); further,~~

~~and to provide education on the therapeutic uses, adverse effects, and drug interactions of cannabidiol (CBD); further,~~

To oppose use of CBD-containing products not approved regulated by the Food and Drug Administration; further,

To advocate for enhanced public education regarding safe use of ~~CBD and unapproved~~ CBD-containing products.

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Stephen F. Eckel, Board Liaison to the **Council on Education and Workforce Development**, presented the Council's Policy Recommendations 1 and 2.

### 1. Pharmacy Expertise in Sterile Compounding

To support colleges of pharmacy in providing sterile compounding and aseptic technique instruction in didactic and experiential curricula that reflect the needs of the workforce; further,

To promote the use of sterile compounding training programs to foster an increase in the number of pharmacists and pharmacy technicians with sterile compounding expertise; further,

To advocate that pharmacists and pharmacy technicians who work in sterile compounding attain compounded sterile preparations advanced certifications.

*This policy supersedes ASHP policy 0915.*

### 2. Pharmacy Technician Training and Certification

To advocate for adoption of a national standard for accreditation of pharmacy technician education and training programs; further,

To advocate that ~~the completion of~~ a pharmacy technician education and training program accredited by ASHP and the Accreditation Council for Pharmacy Education (ACPE) be required for all new pharmacy technicians by the year 2022; further,

To advocate that all pharmacy technicians be required to obtain and maintain Pharmacy Technician Certification Board certification; further,

To foster expansion of ASHP/ACPE-accredited pharmacy technician education and training programs.

(Note: This policy would supersede ASHP policy 1609.)

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Jennifer M. Schultz, Board Liaison to the **Council on Pharmacy Management**, presented the Council's Policy Recommendations 1 through 4.

## 1. Pharmaceutical Distribution Systems

To support drug distribution business models that meet the requirements of hospitals and health systems with respect to availability and timely delivery of products, minimizing short-term outages and long-term product shortages, managing and responding to product recalls, fostering product-handling and transaction efficiency, preserving the integrity of products as they move through the supply chain, and maintaining affordable service costs; further,

To oppose manufacturers, distributors, and wholesalers restricting or making availability of drug products contingent on how those products are used; further,

To encourage selection of a wholesale distributor that (1) purchases products only from a manufacturer before distribution to the purchasing end user; (2) is licensed in the state where it is conducting business; (3) complies with the requirements of the Drug Supply Chain Security Act; ~~and~~ (4) is accredited under the National Association of Boards of Pharmacy Verified-Accredited Wholesale Distributors program; and (5) ~~is~~ uses information systems that are interoperable with common types of pharmacy systems.

## 2. Safe Medication Preparation in All Sites of Care

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

## 3. Pharmacy Department Business Partnerships

To recognize that a key objective of pharmacy departments is to provide medication management services across the continuum of patient care, and that pharmacy leaders should proactively evaluate potential business partnerships against this objective; further,

To recognize that hospitals and health-system pharmacy leaders must ensure that business partners meet all applicable patient safety and accountability standards; further,

To provide education and tools for pharmacy leaders to aid in the evaluation of and development of business partnerships; further,

To educate health-system administrators on the importance of pharmacy leadership in evaluating and developing pharmacy-related business partnerships; further,

To encourage health-system pharmacy leaders to consider evolving healthcare financing systems when evaluating and developing business partnerships.

*This policy supersedes ASHP policy 1416.*

## 4. Intimidating or Disruptive Behavior

To affirm the professional responsibility of the pharmacist to ensure patient and workplace safety by communicating with other healthcare personnel to clarify and improve medication management; further,

To advocate that hospitals and health systems adopt zero-tolerance policies for intimidating or disruptive behaviors in their institutions; further,

To encourage hospitals and health systems to develop and implement education and training programs for all healthcare personnel to encourage effective communication, set expectations for standards of conduct, promote use of de-escalation techniques, and discourage intimidating or disruptive behaviors; further,

To encourage colleges of pharmacy and residency training programs to incorporate training in communications and managing intimidating or disruptive behaviors; further,



To collaborate with other organizations to advocate codes of conduct that minimize do not allow intimidating or disruptive behavior in hospitals and health systems; further,

To encourage hospitals and health systems to adopt processes for identification and reporting of intimidating or disruptive behaviors to evaluate and mitigate unacceptable behaviors in a timely and effective manner.

(Note: This policy would supersede ASHP policy 0919.)

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Kathy S. Pawlicki, Board Liaison to the **Pharmacy Technician Forum**, presented the Forum's Policy Recommendation.

### 1. Pharmacy Technician Student Drug Testing

To advocate for the use of pre-enrollment, random, and for-cause drug testing as a mandatory component throughout any accredited or unaccredited pharmacy technician training program and practice experience, based on defined criteria with appropriate testing validation procedures; further,

To encourage pharmacy technician training programs to develop policies and processes to identify impaired individuals; further,

To encourage pharmacy technician training programs to facilitate access to and promote programs for treatment and to support recovery; further,

To encourage pharmacy technician training programs to use validated testing panels that have demonstrated effectiveness detecting commonly misused, abused, or illegally used substances.

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Paul C. Walker, Board Liaison to the **Section of Inpatient Care Practitioners**, presented the Section's Policy Recommendation.

### 1. ASHP Statement on the Role of the Medication Safety Leader

#### *Page 2, Background:*

The medication safety leader may report to the organization's pharmacy, risk-management department, its office of, or quality departments, or a to senior administrator administration (e.g., hospital vice president, chief medical officer, chief executive officer). Reporting outside the pharmacy department may foster interdisciplinary approaches to medication safety. The medication safety leader should be positioned on the organizational chart where it will best enhance his or her "ability to affect change and advocate that the position remains targeted on medication safety."<sup>9</sup>

9. Institute for Safe Medication Practices. "The Case for Medication Safety Officers (MSO): A White Paper." Aug 2018. <https://www.ismp.org/resources/white-paper-case-medication-safety-officers-mso> (accessed 2019 June 8).

#### *Page 5, Leadership:*

**Leadership.** To provide leadership, the medication safety leader will

1. Develop a vision of an ideal safe medication-use system for the organization.
2. Oversee the planning, creation, review, and refinement of a medication safety plan.
3. Proactively develop and lead implementation of error-prevention strategies based on practice standards, best practice guidelines (or recommendations), literature review, external error reports, medication safety tools, and analysis of the organization's medication safety data.
4. Ensure medication management and patient safety are core components of overall organization quality and outcomes initiatives.

45. Participate in the planning, design, and implementation of the organization's medication-use technology and automation systems.

56. Build a culture of safety through "lesson learned" education and communication across the entire organization.

67. Oversee processes to collect information on the organization's medication errors and system failures to ensure that they are captured and barriers to reporting are addressed.

78. Ensure compliance with state and federal regulatory and legal requirements relating to medication safety and assist in the accreditation process by ensuring that the organization's medication-use processes meet applicable medication management standards and NPSGs.

9. Support the development and implementation of a second victim/care-for-the-caregiver program.

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**Report of Treasurer.** Thomas J. Johnson presented the report of the Treasurer. There was no discussion, and the delegates voted to accept the Treasurer's report (Appendix VI).

The meeting adjourned at 5:00 p.m.

### **Second meeting**

The second and final meeting of the House of Delegates session convened on Tuesday, June 11, at 4:00 p.m. A quorum was present.

**Resolution.** President Smith presented the Resolution from Christopher Ellison (VA) and Robert Brucher (MD), titled "Minimum Educational Qualification Standards for Pharmacists." Following discussion, the Resolution was adopted. It reads as follows:

To support minimum educational qualification standards for pharmacists to practice pharmacy that are consistent

with the licensing standards of state boards of pharmacy; further,

To oppose the basic education requirement within the Office of Personnel Management Classification & Qualifications - General Schedule Qualification Standards - Pharmacy Series, 0660, requiring a Doctor of Pharmacy or Doctor of Philosophy degree as the minimum qualification to practice pharmacy.

### **Report of President and Chair of the Board.**

President Smith updated and elaborated upon various ASHP initiatives. There was no discussion, and the delegates voted to accept the report of the Chair of the Board (Appendix VII).

**Report of Chief Executive Officer.** Paul W. Abramowitz presented the report of the Chief Executive Officer (Appendix VIII).

### **Board of Directors duly considered matters.**

Pursuant to Bylaws section 7.3.1.1, the Board met on the morning of June 10 to "duly consider" the policies amended at the first meeting. Four policy recommendations were approved without amendment. Thirteen policy recommendations were amended by the House of Delegates and suggested nonsubstantive editorial changes to one policy recommendation. The Board agreed with the nonsubstantive editorial changes to one policy recommendation and amendments of 11 of the policies with minor editorial changes to two of amended policies to increase their clarity or provide consistency with other ASHP policies.

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**New Business.** Chair White announced that, in accordance with Article 7 of the Bylaws, there was one item of New Business to be considered. Chair White called on Mollie Scott (SACP) to introduce the item of New Business, "Pharmacists Can Mitigate the Primary Care Physician Shortage" (Appendix IX). Following

discussion, the item was approved for referral to the Council on Pharmacy Practice. It reads as follows:

### *Pharmacist Can Mitigate the Primary Care Physician Shortage*

#### *Motion:*

We recommend that ASHP create a new statement on the physician shortage and the important role that pharmacists play on interprofessional teams. Specific recommendations for elements for such a statement include:

1. To recognize the shortage of primary care physicians; further,
2. To advocate that pharmacists are direct care providers who increase access to care and unburden the interprofessional team through comprehensive medication management, population health, and prevention and wellness services; further,
3. To partner with interprofessional stakeholders at the state and national level to develop solutions to the primary care provider shortage that include the incorporation of pharmacists into primary care models of care.

#### *Background:*

The Association of American Medical Colleges recently published an updated report in April 2019 entitled “Complexities of Physician Supply and Demand: Projections from 2016-2030” that projected a shortage of up to 122,000 physicians by the year 2032, including a shortfall of up to 55,200 primary care physicians. Population growth and aging are the most important contributing factors for increased demand in healthcare services. The shift from fee-for-service to value-based care as part of the U.S. healthcare system transformation places an increased emphasis on population health initiatives that achieve the quadruple aim of healthcare including lowering

costs, improving quality, and improving the patient and provider experience. Increases in chronic disease, mental health concerns, and the opioid epidemic have impacted on the number of patients needing care, and improving access to care is a goal of the Affordable Care Act. Rural and underserved communities are particularly impacted by the primary care provider shortage, leading to health disparities and poorer outcomes.

Pharmacists are considered our nation’s medication experts, and multiple organizations including the National Governors’ Association, the Patient Centered Primary Care Collaborative (PCPCC), and Get the Medications Right Institute advocate for recognizing pharmacists as providers, embedding pharmacists into primary care practices and creating financial sustainability for the provision of comprehensive medication management by pharmacists. ASHP has long championed the role of the pharmacist on interprofessional teams, the development of collaborative practice agreements, and served as a leader in developing best practices in ambulatory care. Pharmacists across the country provide a wide variety of services in interprofessional teams including but not limited to, annual wellness visits, disease management, transitions of care, comprehensive medication management, immunizations, medication assistance, medication adherence programs, and many others. In order to increase uptake of these models, ASHP developed the Ambulatory Care Self-Assessment as part of the Practice Advancement Initiative, and partnered with the A3 Collaborative to support pharmacists and health systems with the development of innovative care models that increase access to care and improve patient care outcomes. Despite all that the profession of pharmacy does to improve patient care outcomes through the provision of direct patient care services, the AAMC report focuses primarily on the role that physician assistants and nurse practitioners play to mitigate the primary care physician

shortage. As the national grapples with the how to care for an aging population and provide comprehensive, accessible, patient-centered care for a growing population, it is paramount that pharmacists are seen as a profession who can mitigate the primary care provider shortage. Collaboration with medical, physician assistant, and nurse practitioner professional organizations as well as groups such as Get the Medications Right Institute, the A3 Collaborative, PCPCC, CMS, and others, is warranted so that the profession of pharmacy is at the table when solutions to the primary care shortage are developed.

### **SUGGESTED OUTCOMES:**

1. Pharmacists are nationally recognized as a viable and integral solution for addressing the primary care shortage.
2. Creation of an ASHP Statement on “How Pharmacists Can Mitigate the Primary Care Shortage” that is endorsed by interprofessional external stakeholders.

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

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

As a token of appreciation on behalf of the Board of Directors and members of ASHP,

Chair White presented Immediate Past President Smith with an inscribed gavel commemorating her term of office.

Chair White then installed the chairs of ASHP’s sections and forums: Zachary A. Weber, Section of Ambulatory Care Practitioners; Aaron L. Steffenhagen, Section of Clinical Specialists and Scientists; Douglas A. Meyer, Section of Inpatient Care Practitioners; Samm V. Anderegg, Section of Pharmacy Informatics and Technology; Samuel V. Calabrese, Section of Pharmacy Practice Managers; Tyler Vest, New Practitioners Forum; Sara Bonenfant, Pharmacy Student Forum; and Tara McNulty, Pharmacy Technician Forum. Chair White then recognized the remaining members of the executive committees of sections and forums.

**Installation.** Chair White then installed Kathy S. Pawlicki as President of ASHP, Kristina A. Butler and Nishaminy Kasbekar as members of the Board of Directors (Appendix XI). (See Appendix XII for the Inaugural Address of the Incoming President.)

**Adjournment.** The 71st annual June meeting of the House of Delegates adjourned at 6:00 p.m.

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<sup>a</sup>The Committee on Nominations consisted of Kimberley Benner, Chair (AL); Lisa Gersema, Vice Chair (MN); Noelle Chapman (IL); Steven Riddle (WA); Kethen So (CA); Meghan Swarhout (MD); and Lanita White (AR).

## DELEGATES to the 2019 Session of the House

### OFFICERS OF THE HOUSE

Casey White, *Chair*  
Paul Bush, *Vice Chair*  
Paul Abramowitz, *Secretary*

### OFFICERS AND BOARD OF DIRECTORS

Kelly Smith, *President*  
Kathleen Pawlicki, *President-Elect*  
Paul Bush, *Immediate Past President*  
Casey White, *Chair, House of Delegates*  
Thomas Johnson, *Treasurer*  
Paul Abramowitz, *Chief Executive Officer*  
Todd Karpinski, *Board Liaison, Council on Public Policy*  
Linda Tyler, *Board Liaison, Council on Therapeutics*  
Jennifer Schultz, *Board Liaison, Council on Pharmacy Management*  
Paul Walker, *Board Liaison, Council on Pharmacy Practice*  
Julie Groppi, *Board Liaison, Commission on Affiliate Relations*  
Stephen Eckel, *Board Liaison, Council on Education and Workforce Development*

### PAST PRESIDENTS

Roger Anderson  
John Armitstead  
Daniel Ashby  
Jannet Carmichael  
Kevin Colgan  
Debra Devereaux  
Rebecca Finley  
Lisa Gersema  
Diane Ginsburg  
Harold Godwin  
Marianne Ivey  
Christene Jolowsky  
Stan Kent  
Jill Martin Boone  
Gerald Meyer  
Bruce Scott  
Steven Sheaffer  
Thomas Thielke<sup>2</sup>  
Sara White  
T. Mark Woods

### STATE DELEGATES

**Alabama (3)**  
Thomas Cobb  
Lea Eiland  
April Yarbrough

**Alaska (2)**  
Ursula Iha

**Arizona (3)**  
Melinda Burnworth  
Christi Jen  
Carol Rollins

**Arkansas (2)**  
Rayanne Story  
Lanita White

**California (8)**  
Kathleen Besinque  
Daniel Dong  
Steven Gray<sup>2</sup>  
Lisa Gunther Lum  
Brian Kawahara  
Victoria Serrano-Adams  
Kethen So

Martin Torres

**Colorado (3)**  
Jennifer Davis  
Michelle Hilaire

**Connecticut (3)**  
David Goffman  
Molly Leber  
Lorraine Lee

**Delaware (2)**  
Michael Dejos

**Florida (5)**  
Gary Dalin  
Michael DeCoske  
Sandy Estrada  
Bill Kernan  
Dave Lacknauth

**Georgia (3)**  
Trisha Branan  
Collin Lee  
Jennifer Sterner-Allison

**Hawaii (2)**  
Joy Matsuyama<sup>2</sup>

**Idaho (2)**  
Arielle Arnold  
Paul Driver

**Illinois (5)**  
Andy Donnelly  
Bernice Man  
Bryan McCarthy  
Jennifer Phillips  
Carrie Sincak

**Indiana (3)**  
Christopher Lowe  
Christopher Scott  
Tate Trujillo

**Iowa (3)**  
Lisa Mascardo  
Jamie Sinclair  
Dave Weetman

**Kansas (3)**  
Jeffrey Little  
Lindsay Massey<sup>1</sup>  
Jennifer Mckenna  
Katherine Miller<sup>2</sup>

**Kentucky (3)**  
Kimber Boothe  
Scott Hayes  
Rachel Swope

**Louisiana (3)**  
Monica Dziuba  
Joseph "Gary" LeBlanc  
Kyana Stewart

**Maine (2)**  
Matthew Christie  
Kathryn Sawicki

**Maryland (4)**  
Tara Feller  
Janet Lee  
Molly Wascher

**Massachusetts (4)**  
Caryn Belisle  
Karl Gumpfer  
Jackie MacCormack-Gagnon  
Erin Taylor

**Michigan (4)**  
Ryan Bickel  
Jesse Hogue  
James Lile  
Michael Ruffing

**Minnesota (4)**  
Kevin Dillon  
Matthew Ditmore  
Paul Krogh

Brandon Ordway

**Mississippi (2)**  
Anastasia Jenkins<sup>2</sup>  
Joshua Fleming<sup>2</sup>  
Wes Pitts<sup>1</sup>

**Missouri (3)**  
Laura Butkievich<sup>2</sup>  
Joel Hennenfent  
Amy Sipe<sup>1</sup>  
Emily Owen

**Montana (2)**  
Jeffery Ferber  
Jason Nickisch

**Nebraska (2)**  
Michele Faulkner  
Jerome Wohleb

**Nevada (2)**  
Adam Porath  
Katherine Ward

**New Hampshire (2)**  
Staci Hermann  
Elizabeth Wade

**New Jersey (3)**  
Luigi Brunetti  
Paul Goebel  
Julie Kalabalik

**New Mexico (2)**  
Melanie Dodd  
Davena Norris

**New York (5)**  
Heide Christensen  
Leigh Briscoe-Dwyer  
Joseph Pinto  
Lisa Voigt  
Kim Zammit

**North Carolina (4)**  
Susan Bear  
Michael Melroy  
Jacqueline Olin  
Mary Parker

**North Dakota (2)**  
Maari Loy

**Ohio (5)**  
Amanda Hansen  
Karen Kier  
Scott Knoer  
Katie McKinney  
Jason Milner

**Oklahoma (3)**  
Kiya Harrison  
Kari McCracken  
Edna Patatanian

**Oregon (3)**  
Andrew Gibler  
Kathryn Norton

**Pennsylvania (5)**  
Jennifer Belavic  
Lawrence Carey  
Christine Roussel  
Jean Scholtz  
David Zimmerman

**Rhode Island (2)**  
Karen Nolan  
Mark Rogers

**South Carolina (3)**  
Lynn Etheridge  
Natasha Nicol

**South Dakota (2)**  
Jaclynn Chin  
Andrea Darr

**Tennessee (4)**  
Kelly Bobo  
Don Branam

Justin Griner  
Jodi Taylor

**Texas (6)**  
Tammy Cohen  
Steven Knight  
Tricia Meyer  
Katie Morneau  
Sidney Phillips  
Jeffrey Wagner

**Utah (3)**  
Kavish Coudhary  
Erin Fox  
Elyse MacDonald

**Vermont (2)**  
Joseph Aloï  
Kevin Marvin

**Virginia (4)**  
Scott Anderson  
Katelyn Hipwell  
Craig Kirkwood  
Natalie Nguyen

**Washington, D.C. (2)**  
Carla Cabanilla Darling  
Michelle Eby

**Washington State (4)**  
Cyndy Clegg  
Steven Riddle  
Megan Wilson  
Roger Woolf

**West Virginia (2)**  
Doug Slain  
Carol Woodward

**Wisconsin (4)**  
Terry Audley  
David Hager  
Justin Konkol  
Lucas Schulz

**Wyoming (2)**  
Shawn Dalton  
Tonja Woods

### SECTIONS AND FORUMS DELEGATES

**Ambulatory Care Practitioners**  
Mollie Scott

**Clinical Specialists and Scientists**  
Kimberly Benner<sup>2</sup>  
Aaron Steffenhagen<sup>1</sup>

**Inpatient Care Practitioners**  
Todd Lemke

**Pharmacy Informatics and Technology**  
Maritza Lew

**Pharmacy Practice Managers**  
Kristine Gullickson

**Specialty Pharmacy Practitioners**  
JoAnn Stubbings

**New Practitioners Forum**  
Tyler Vest

**Pharmacy Student Forum**  
Sara Loftus

**Pharmacy Technicians Forum**  
Tara McNulty

### FRATERNAL DELEGATES US Air Force

Jin Kim

**US Navy**  
Jason Galka

**US Public Health Svc**  
Jeffrey Gidlow

**Veterans Affairs**  
Heather Ourth

<sup>1</sup>Sat in Sunday House Meeting only

<sup>2</sup>Sat in Tuesday House Meeting only

# House of Delegates

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## REPORT OF THE COMMITTEE ON RESOLUTIONS

June 9, 2019

Boston, Massachusetts

Kelly M. Smith, Chair  
Kathleen S. Pawlicki, Vice Chair  
Paul W. Bush  
Stephen F. Eckel  
Julie A. Groppi  
Thomas J. Johnson  
Todd A. Karpinski  
Jennifer M. Schultz  
Linda S. Tyler  
Paul C. Walker  
Casey H. White  
Paul W. Abramowitz, 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 resolution to the House of Delegates. The recommendation of the Committee is to **adopt the resolution**. The Committee supports the substance of the resolution, which is to oppose the Office of Personnel Management (OPM) [Classification and Qualifications - General Schedule Qualification Standard - Pharmacy Series, 0660](#) requirement of a Doctor of Pharmacy or Doctor of Philosophy degree as a minimum qualification to practice pharmacy in the federal service. ASHP policy aligns with the minimum education standards of all state boards of pharmacy, which do not distinguish between entry-level degrees (e.g., B.S.Pharm., Pharm.D., and various non-U.S. degrees). The Committee recognizes that according to the 2014 National Pharmacist Workforce Study, only 38% of pharmacists have earned a Pharm.D., and that the OPM requirement would not only limit the career options of B.S.Pharm.-degreed pharmacists but could also present a challenge to building a strong federal pharmacist workforce.

The Committee understands that limiting the policy's language to the specific OPM requirement could create a gap in ASHP policy when addressing similar actions by other nonlicensing agencies. The Board of Directors has asked the appropriate ASHP councils to explore potential broader policy on the topic.

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

To support minimum educational qualification standards for pharmacists to practice pharmacy that are consistent with the licensing standards of state boards of pharmacy; further,

To oppose the basic education requirement within the Office of Personnel Management Classification & Qualifications - General Schedule Qualification Standards - Pharmacy Series, 0660, requiring a Doctor of Pharmacy or Doctor of Philosophy degree as the minimum qualification to practice pharmacy.

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

## Resolution for 2019 ASHP House of Delegates: Minimum Educational Qualification Standards for Pharmacists

### Submitted By:

Christopher Ellison  
Falls Church, VA  
christopher.w.ellison.mil@mail.mil

Robert Brutcher  
Points of Rocks, MD  
robert.e.brutcher.mil@mail.mil

### Subject: Minimum Educational Qualification Standards for Pharmacists

Received: March 8, 2019

### Motion

To support minimum educational qualification standards for pharmacists to practice pharmacy that are consistent with the licensing standards of state boards of pharmacy; further,

To oppose the basic education requirement within the Office of Personnel Management Classification & Qualifications - General Schedule Qualification Standards - Pharmacy Series, 0660, requiring a Doctor of Pharmacy or Doctor of Philosophy degree as the minimum qualification to practice pharmacy.

### Background

In September 2017, the U.S. Office of Personnel Management (OPM) issued a new [qualification standard](#) for pharmacists, GS-0660. The new standard lists the basic educational requirement for pharmacists as a Doctor of Pharmacy (Pharm.D.) or Doctor of Philosophy (Ph.D.) degree. To set this requirement, OPM must have determined that pharmacy cannot be performed by persons without one of these degrees, because [Title 5 U.S.C. 3308](#) permits the establishment of minimum educational requirements only when OPM has determined that the work cannot be performed by persons who do not possess the prescribed minimum education.

All 50 states currently allow pharmacists with a bachelor's degree in pharmacy (B.S.Pharm.) to obtain licensure and practice pharmacy, which indicates that all state legislatures or regulators have concluded that pharmacists with a B.S.Pharm. degree can practice pharmacy safely and effectively. In the U.S., the B.S.Pharm. degree was awarded until 2005; in 2006, the Pharm.D. degree became the only entry-level degree awarded. A 2014 survey of the pharmacy workforce found that only 40% of pharmacists had earned a Pharm.D. The minimum educational requirements set by OPM would automatically disqualify 60% of pharmacists from entering the federal government workforce, an inequitable practice not seen outside the federal sector. The OPM minimum educational requirement also creates a monumental challenge to building and maintaining the pharmacist workforce the Department of Defense needs to support U.S. warfighting efforts and take care of veterans. ASHP recognizes that pharmacists must possess the education, training, and experience required to effectively, efficiently, and responsibly fulfill their roles. Further, ASHP supports licensure by a state



board of pharmacy as the minimum requirement for pharmacy practice in its [Minimum Standard for Pharmacies in Hospitals](#).

**Suggested Outcome**

For ASHP to support minimum educational qualification standards for pharmacists to practice pharmacy that are consistent with the licensing standards of state boards of pharmacy. Further, for ASHP to oppose the basic education requirement within the Office of Personnel Management Classification & Qualifications - General Schedule Qualification Standards - Pharmacy Series, 0660, requiring a Doctor of Pharmacy or Doctor of Philosophy degree as the minimum qualification to practice pharmacy.



# House of Delegates

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

June 9, 2019

Boston, Massachusetts

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

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

To facilitate selection of the nominees, the Board formed a committee consisting of Todd Karpinski (Chair), Kathleen S. Pawlicki, Linda S. Tyler, Paul C. Walker, and Paul W. Abramowitz. The committee met on March 13, 2019, via teleconference and reviewed the qualifications of members who had agreed to be considered as candidates, and selected two candidates. The Board of Directors approved the slated candidates on April 11.

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

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

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

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

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

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

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

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

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

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

**Roger W. Anderson, M.S., Dr.P.H., FASHP** ([anderson.roger183@gmail.com](mailto:anderson.roger183@gmail.com)) was Head of the Division of Pharmacy, MD Anderson Cancer Center, 1978–2004. He was Senior Vice President and Chief Pharmacist, Medco, 2004–2009, and Chief Pharmacy Officer, US Oncology, 2009–2012.

He received his pharmacy degree from Ferris State University in 1964, obtained an M.S. from The Ohio State University in 1968, and completed his residency at Grant Hospital in 1967. He earned a Dr.P.H. from The University of Texas in 1997.

Anderson has served ASHP in several roles, including President, COSHP (1970); President, OSHP (1973); ASHP Board of Directors (1983–86); and President, ASHP (1987–88). He was President of the Texas Board of Pharmacy in 2002. He was awarded the Harvey A.K. Whitney Award in 1992 and an Honorary ASHP Membership in 2015 and currently serves on the ASHP Foundation Board.

**Statement:**

*Throughout my practice career, and continuing today, I believe in and strive for excellence in well-managed pharmacy operations and patient-oriented clinical patient care. I fully support the granting of provider status for pharmacists. I support the process of pharmacists obtaining BPS certification in the variety of specialty areas. While my specific career positions have been in the administrative area, I have focused an equal priority on building high-impact practice and clinical programs. Throughout my career, and continuing today, I support and continue to be involved with residency training — both administrative and clinical. I also support and participate in a variety of clinical and practice research. Based on my past early research on occupational exposure to hazardous drugs, I continue involvement with ongoing research with a*

*passion to further improve the handling of hazardous drugs. I fully support and have a personal history of membership and leadership in professional organizations on a local, state, and national level. I have a passion for and current role in the development of future leaders in health-system administrative and clinical practice. This includes the increased involvement and future roles for pharmacy technicians.*

**Christene M. Jolowsky, B.S.Pharm., M.S., FASHP** ([cjolowsky@gmail.com](mailto:cjolowsky@gmail.com)) is Director, Hennepin Healthcare System, Minneapolis. She completed her B.S.Pharm. and M.S. in Pharmacy Administration at the University of Minnesota, along with an ASHP-accredited administrative residency at the University of Minnesota Hospital. She is an Assistant Professor at the University of Minnesota College of Pharmacy.

Jolowsky has led teams around patient safety and clinical service initiatives. Her expertise is in clinical and operational performance improvement. Key accomplishments include promoting technicians, student and residency training, and expanding the roles and scope of pharmacy practice.

Jolowsky's service to ASHP includes serving as President and on the Board of Directors; President, MSHP; and chairing several councils, committees, and task forces for ASHP and local and state health-system chapters. Jolowsky received the 2009 Distinguished Service Award for ASHP's Section of Pharmacy Practice Managers and MSHP's Hallie Bruce Award in 2005.

**Statement:**

*"Describe yourself in three words ..." This provides insight into how a person thinks, their priorities, and how others see them. The responses can help decide a candidate's fit with the team. These are words I would use —*

*As a Candidate: Passionate. Persistent. Optimistic.*

- *My focus is on obtaining the resources needed to support pharmacy's role in care. This means continually advocating for and constantly looking at opportunities. I seek to expand pharmacist and technician roles in all areas that impact our patients.*

*As your Treasurer: Alignment. Advancement. Resourcefulness.*

- *Our decisions around resources must align with the goals and direction of the organization. Thoughtful deliberations will assure resources meet current needs, maintain flexibility for new opportunities, and support a sustainable foundation.*

*As an ASHP Leader: Patients. Members. People.*

- *This is the core of ASHP's strategic plan. Our work connects directly to the patient; we as members provide the care; and ASHP's staff support this work.*

*Today's decisions impact our organization's and profession's future. Our Board deliberations must align with strategic goals, to assure balance with financial resources and demands. Thank you for the opportunity to serve the ASHP team as Treasurer. I am optimistic about pharmacy's future!*

# House of Delegates

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## **HOUSE OF DELEGATES**

### **REPORT OF THE**

### **COMMITTEE ON NOMINATIONS**

June 9, 2019

Boston, Massachusetts

Kimberley Benner (Chair), Alabama  
Lisa Gersema (Vice Chair), Minnesota  
Noelle Chapman, Illinois  
Steven Riddle, Washington  
Kethen So, California  
Meghan Swarthout, Maryland  
Lanita White, Arkansas  
Molly Leber (1st Alternate), Connecticut  
James Hoffman (2nd Alternate), Tennessee  
Christopher Fortier (3rd Alternate), Massachusetts

## ASHP COMMITTEE ON NOMINATIONS

Mister Chair, Fellow Delegates:

The Committee on Nominations consists of seven members of ASHP who were members of the House of Delegates at the time of their appointment. The Committee is appointed by the Chair of the House of Delegates and is charged with the task of presenting to you our best judgments about those persons who possess the tangible and intangible attributes of leadership that qualify them to serve as our officers and directors.

Selection of nominees for ASHP office involves a series of very challenging decisions on the part of the Committee. Ultimately, those decisions are intended to permit the membership to select leaders with the professional, intellectual, and personal qualities of leadership that will sustain the dynamism and pioneering spirit that have characterized both ASHP and its nearly 50,000 members who provide patient care service across the entire spectrum of care.

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

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

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

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

The Committee's year-long process of receiving nominations and screening candidates is designed to solicit extensive membership input and, ultimately, to permit the Committee to candidly and confidentially assess which candidates best fit ASHP's needs. The Committee has met twice in person since the last session of the House of Delegates: on December 4, 2018, at the Midyear Clinical Meeting in Anaheim, California; and on April 24, 2019, at ASHP headquarters; and met once via teleconference. Review of nominees' materials was conducted continuously between March and April 2019 solely via secure electronic transmissions. This process has been reviewed for quality improvement and will be repeated for the 2019–2020 nomination cycle.

As in the past, the Committee used various means to canvass ASHP members and state affiliates for candidates who they felt were most qualified to lead us. All members were invited via announcements in ASHP News and Daily Briefing, social media, online ASHP NewsLink bulletins, and the ASHP website to submit nominations for the Committee's consideration. Nominations from affiliated state societies were solicited through special mailings and the "state affiliate" edition of the online NewsLink service. At the 2018 Midyear Clinical Meeting, the Chair and ASHP Chief Executive Officer made themselves available to receive nominations personally in a location and at a time that were publicized in ASHP news publications and correspondence.

Based upon recommendations from membership, state affiliates, and ASHP staff, the Committee contacted over 625 individuals identified as possible candidates. Some individuals were invited to accept consideration for more than one office. Of the nominees who responded to the invitation to place themselves in nomination, the breakdown by office is as follows:

PRESIDENT-ELECT: 6 accepted

BOARD OF DIRECTORS: 18 accepted

A list of candidates that were slated was provided to delegates following the Committee's meeting on April 24, 2019.

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

#### **President-Elect**

Lea S. Eiland, Pharm.D., BCPPS, BCPS, FASHP, FPPAG (Auburn, AL)

Thomas J. Johnson, Pharm.D., M.B.A., BCCCP, BCPS, FASHP, FCCM (Sioux Falls, SD)

#### **Board of Directors**

Leigh A. Briscoe-Dwyer, Pharm.D., B.S.Pharm., BCPS, FASHP (Valhalla, NY)

Dan D. Degnan, Pharm.D., M.S., CPPS, FASHP (West Lafayette, IN)

Rafael Saenz, Pharm.D., M.S., FASHP (Charlottesville, VA)

Jamie S. Sinclair, M.S., R.Ph., FASHP (Cedar Rapids, IA)

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



**CANDIDATES FOR PRESIDENT 2020–2021**

**Lea S. Eiland, Pharm.D., BCPPS, BCPS, FASHP, FPPAG** ([eilanls@auburn.edu](mailto:eilanls@auburn.edu)) is a Clinical Professor and Associate Department Head of Pharmacy Practice, Auburn University Harrison School of Pharmacy, and Clinical Professor of Pediatrics, University of Alabama at Birmingham School of Medicine. She received her Pharm.D. from The University of Texas at Austin and completed an ASHP-accredited pediatric specialty residency at Texas Tech University. Her practice experience includes the pediatric ICU, general pediatric inpatient, and pediatric ambulatory care settings.

Eiland's service to ASHP includes the Board of Directors; Chair and Director-at-Large of the SCSS; Chair, Council on Education and Workforce Development; Women in Pharmacy Leadership Steering Committee; EVP/CEO Search and Screen Committee; Task Force on Pharmacy's Changing Demographics; and as a state delegate. Eiland is an Auburn SSHP faculty advisor, is a Past President of ALSHP, and received the ALSHP Pharmacist of the Year Award.

**Statement:**

*ASHP's tagline is "Pharmacists advancing healthcare." From an organizational level to the member level, we advance healthcare by improving medication utilization and patient outcomes. Healthcare is rapidly changing in structure, technology, patient populations, and relationships in part due to the consumerization of medicine and wellness care models. To support our patients and members as well as lead during this healthcare transformation, ASHP must:*

- *Advocate for our patients and profession.*
- *Anticipate potential changes to the profession and transparently adapt to the evolving needs of our members and patients.*
- *Continually assess members' needs in order to support their responsibilities and well-being.*
- *Support future roles in the profession by providing innovative services and resources for our members' growth as pharmacists, students, and technicians.*
- *Continue seeking strong collaboration with other organizations regarding healthcare activities to benefit our patients, members, and profession.*
- *Remain the paramount pharmacy organization others seek for input and partnership in pharmacy-related opportunities or concerns.*

*I am grateful for this nomination and would be honored to serve as your ASHP President. I thank each of you for your contributions to ASHP, our profession, and the advancement of healthcare today.*

**Thomas J. Johnson, Pharm.D., M.B.A., BCCCP, BCPS, FASHP, FCCM** ([thomas.johnson@avera.org](mailto:thomas.johnson@avera.org)) is Assistant Vice President of Hospital Pharmacy, Avera Health, Sioux Falls, S.D. He earned his Pharm.D. from North Dakota State University and completed an ASHP-accredited residency at St. Alexius Medical Center/NDSU in Bismarck, N.D. He has served in multiple roles over his professional career including clinical practice, academia, research, and leadership. Johnson has consistently championed advancing optimal patient outcomes through the progressive use of pharmacy staff within healthcare teams. His current role at Avera spans from rural through tertiary settings.

Johnson has served ASHP in multiple roles including Treasurer (2016–2019); Board of Directors (2011–2014); Council on Education and Workforce Development; Council on Therapeutics; Committee on Nominations; Task Force on Organizational Structure; Practitioner Recognition Committee; and as a state delegate for many years. Johnson is a Past President of SDSHP and 2005 SDSHP Pharmacist of the Year.

**Statement:**

*The future of the pharmacy profession is dependent upon our ability to make a difference. Can we make a difference in the lives and health of patients — both for individuals and populations as a whole? Can we make a difference in the financial bottom line of our local health systems or the national health system? Can we effectively convince others that we make a difference? I believe the answer is “Yes!”, but there remain significant opportunities for us to do even more.*

*Let’s take advantage of these opportunities to make a difference for our patients and our healthcare system through our common membership and engagement in ASHP.*

*Specifically, we should:*

- *Embrace technology in a thoughtful and purposeful way to simplify and streamline our professional practice.*
- *Leverage our skills as the medication experts to fully integrate into patient care teams across our health systems.*
- *Advocate for legislation and regulation that enhances and expands our ability to provide optimal patient care.*
- *Tell our story — clearly, concisely, and convincingly — to the public, payers, administrators, and other providers so that everyone is requesting our services.*

*I would be honored and thrilled to serve as your President. Let’s make a difference together!*

**CANDIDATES FOR BOARD OF DIRECTORS 2020–2023**

**Leigh A. Briscoe-Dwyer, Pharm.D., B.S.Pharm., BCPS, FASHP** ([Leigh.Briscoe-Dwyer@WMCHealth.org](mailto:Leigh.Briscoe-Dwyer@WMCHealth.org)) is the Vice President of Network Pharmacy for the Westchester Medical Center Health Network, a 10-hospital system located in Valhalla, N.Y.

She received her Bachelor of Science in Pharmacy from Albany College of Pharmacy and her Doctor of Pharmacy degree from St. John's University. She is a certified pharmacist immunizer, is a Board Certified Pharmacotherapy Specialist, and has been named a Fellow of ASHP.

Briscoe-Dwyer is a Past President of both the Long Island Society of Health-system Pharmacists and New York State Council of Health-system Pharmacists. She has served ASHP in a number of capacities, including the FASHP Recognition Committee, Council on Public Policy, Committee on Nominations (including a term as Chair), and the PAC Advisory Committee. She has served as a member of the House of Delegates for 14 years.

**Statement:**

*The only thing that is higher than a purpose is a shared purpose — and it is clear that the problems facing the profession today can no longer be solved by individuals. Thus, the role of ASHP in providing guidance and advocacy is more important than ever. The fact that ASHP has a seat at the table when discussing key issues such as drug shortages, drug pricing, and the opioid epidemic signifies that the organization has credibility. ASHP speaks for all pharmacists who want to practice at the top of their license, regardless of practice setting. We need to continue developing advocacy as a professional obligation and provide guidance for members so we can share a consistent message.*

*Medications touch nearly every patient in health systems, and no healthcare system can truly be successful without active, engaged pharmacist participation. I have worked for over 30 years to ensure that pharmacists are visible members of the healthcare team, that they take accountability for outcomes, and that they continuously work to advance the role of the profession in the tumultuous world of healthcare today.*

*It would be an honor to serve the profession I love on the Board of Directors of ASHP.*

**Dan D. Degnan, Pharm.D., M.S., CPPS, FASHP** ([ddegnan@purdue.edu](mailto:ddegnan@purdue.edu)) currently serves as Associate Director for the Professional Program Laboratory and is a Clinical Assistant Professor of Pharmacy Practice (Courtesy) at Purdue University College of Pharmacy. Degnan has an appointment with Regenstrief Center for Healthcare Engineering at Purdue as a Clinical Research Associate with research interests in the areas of pharmacy automation and high-reliability healthcare. Before coming to Purdue, Degnan served as the Medication Safety Officer at Community Health Network in Indianapolis.

Degnan earned his Pharm.D. from Purdue University. He completed a specialty residency in pharmacy administration and an M.S. in Pharmacy Administration at the University of Wisconsin.

Degnan's service to ASHP includes Chair, Council on Organizational Affairs; Chair, Committee on Nominations; Chair, Section of Inpatient Care Practitioners; and state delegate to ASHP from Indiana for many years. Degnan has served in many state affiliate roles, including President of the Indiana Society.

**Statement:**

*Embracing the issues that face our profession and curating effective and meaningful ways to improve them should be the work of all of us, including ASHP. Moving forward, ASHP should enhance its efforts to move the profession forward in the following areas:*

- *Aligning pharmacist care delivery with patient needs and matching reimbursement schemes.*
- *Promoting a rich environment for innovation and growth in postgraduate residency programs.*
- *Focusing on development of robust clinical well-being, resilience, and burnout mitigation resources, including profession-specific research on the issue.*
- *Developing the concepts of professionalism, ethics, and caring in pharmacy so that the narrative and context around a patient's care are viewed as critical to the provision of care.*

*My personal and professional philosophy includes a longstanding commitment to the principles of servant leadership, lifelong learning, and demonstrating an empathetic approach to helping others. These principles have been applied throughout my career and lend themselves to the concept of a constant pursuit of excellence. ASHP and our profession deserve no less.*

*It is an honor to be on the slate of candidates for the ASHP Board of Directors. I would truly appreciate the opportunity to serve on the ASHP Board of Directors.*

**Rafael Saenz, Pharm.D., M.S., FASHP** ([rsaenz@virginia.edu](mailto:rsaenz@virginia.edu)) is the Administrator, Pharmacy Services for the University of Virginia, Assistant Dean of VCU School of Pharmacy, and RPD for the UVA M.S./HSPA residency. He received his Pharm.D. from VCU and completed the M.S./HSPA residency from the University of Wisconsin Hospital and Clinics.

Saenz's service to ASHP includes member and Chair, Council on Education and Workforce Development; Section of Pharmacy Practice Managers Programming Committee; ASHP Advisory Group on International Residency Accreditation; Task Force on Organizational Restructuring; Pharmacy Technician Stakeholder Group; and Pharmacy Forecast Advisory Group. He has served as President of VSHP. Rafael was appointed to the Virginia Board of Pharmacy in 2015 and is currently serving as Chair.

**Statement:**

*In health-system pharmacy, change is inevitable. While the practice is rewarding and enriching, recent developments pose new threats to the profession. Drug shortages, payment models, and workforce issues that challenge health-system executives can be addressed through proactive and creative action by health-system pharmacy leaders. Despite posing risks to the profession, these threats have provided us an opportunity for practice to evolve. ASHP should continue to focus on clinical and practice-based research, providing member guidance for emerging challenges, and direct advocacy efforts to advance contemporary and meaningful legislation that will secure the future of our profession.*

*Further, I believe that ASHP should expand its efforts to establish pharmacy technician training standards across the country. A strong pharmacy technician workforce is crucial to our ability to provide patient care. Close partnerships with state affiliates to address boards of pharmacy and disparities in practice acts will lead to us achieving our goals. Helping states learn from each other will vastly improve the outcomes desired by those attempting to make a positive change for patients.*

**Jamie S. Sinclair, M.S., R.Ph., FASHP** ([jsinclair@mercyare.org](mailto:jsinclair@mercyare.org)) is Director, Pharmacy Services for Mercy Medical Center, Cedar Rapids, Iowa, and Adjunct Assistant Professor at the University of Iowa College of Pharmacy. Sinclair earned her B.S.Pharm. from Massachusetts College of Pharmacy and M.S. from the University of Minnesota. She completed an ASHP-accredited residency at Methodist Hospitals of Memphis. Sinclair has practiced in academic and community-based settings, beginning as a critical care pharmacist, and has held health-system leadership positions for over 20 years. Her passions include developing technicians, pharmacist practitioners, and leaders; implementing/optimizing technologies; and fostering interprofessional relationships.

Sinclair's service to ASHP includes Council on Pharmacy Practice; Chair, Commission on Affiliate Relations; Committee on Nominations; Women in Pharmacy Leadership Steering Committee; ASHP/ISMP Medication Safety Certificate Faculty; and state delegate (Iowa and Minnesota). She is a member of the Iowa Pharmacy Association and Past Treasurer and President of the Minnesota Society of Health-System Pharmacists.

**Statement:**

*As experts and leaders in medications and medication-use systems, we have a responsibility to:*

- *BEND — alter something that exists into a new creation to better serve the profession.*
- *BREAK — take something that is whole and reassemble in a more functional way.*
- *BLEND — combine two or more current models in a transformative way to support a paradigm shift.*

*Opportunities I see for our profession and ASHP include:*

- *Bend credentialing frameworks and expand them to pharmacists. We can move closer to provider status, increasing patient access to pharmacists' cognitive skills and improve the well-being of patients.*
- *Break industry models to improve transparency related to medication costs and shortages.*
- *Blend our knowledge with artificial intelligence to develop the future roles of pharmacists and technicians.*

*As we bend, break, and blend we must:*

- *Maintain our patient-centric values.*
- *Enhance and expand our interprofessional relationships.*
- *Foster well-being and adaptability within our pharmacy workforce to manage ambiguity and "bounce forward" during adversity.*

*I am grateful for my ASHP home and the people I have met who have challenged me and fulfilled me. I am humbled to be slated and would be honored to serve the ASHP Board and advocate for our patients, membership, and profession.*



# House of Delegates

## First Board of Directors Report: Policy Recommendations for the June 2019 House of Delegates

### First of Two Reports

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# JOINT COUNCIL POLICY RECOMMENDATION

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*Council on Education and Workforce Development, Council on Pharmacy Management, Council on Pharmacy Practice, Council on Public Policy, and Council on Therapeutics*

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## 1. Suicide Awareness and Prevention

- 1 To support the goal of zero patient or healthcare worker suicides; further,
- 2 To collaborate with key stakeholders in support of suicide awareness and prevention;
- 3 further,
- 4 To acknowledge that optimal suicide awareness and prevention efforts focus both on
- 5 preventing patient suicides and on maintaining the health and well-being of the
- 6 healthcare workforce; further,
- 7 To recognize that pharmacists, as key providers on the patient care team, are integral to
- 8 suicide awareness and prevention efforts, and to acknowledge the vital role of other
- 9 members of the pharmacy workforce in those efforts; further,
- 10 To foster development of standardized tools to aid pharmacists in assessing the influence
- 11 of medications and environmental and physiological factors on suicidality; further,
- 12 To provide education that assists the pharmacy workforce in their continuing
- 13 professional development efforts related to suicide awareness and prevention; further,
- 14 To support the inclusion of suicide awareness and prevention principles throughout
- 15 pharmacy curricula and postgraduate educational and training programs; further,
- 16 To encourage state-based efforts that support universal education and training of
- 17 healthcare providers in suicide awareness and prevention; further,
- 18 To advocate for adequate government and healthcare organization funding for suicide
- 19 awareness and prevention; further,
- 20 To enhance awareness of the National Suicide Prevention Lifeline funded by the
- 21 Substance Abuse and Mental Health Services Administration; further,
- 22 To foster research on suicide awareness and prevention.



**Rationale**

The high and increasing number of suicides in the U.S. has created a call for national action. The U.S. Surgeon General and the National Action Alliance for Suicide Prevention, in the 2012 National Strategy for Suicide Prevention, provided general guidance for various societal approaches, including public awareness and development of effective clinical practices targeting suicide prevention. The National Strategy set an aspirational zero suicides goal for healthcare services, which will require a systemwide effort to improve healthcare's approach to suicide prevention, including clinician training and implementation of better referral systems.

The responsibility for healthcare professionals to become involved in suicide prevention extends beyond those specializing in mental health services, as suicide may be viewed as a response to multiple biological, psychological, interpersonal, environmental, and societal influences that interact with one another and may change over time. Suicide prevention, when viewed as the collective efforts of government, public and private organizations, and care providers to reduce the incidence of suicide, requires a correspondingly broad response by healthcare professionals. In 2016, the Joint Commission published a Sentinel Event Alert urging healthcare organizations to develop policies, staff education, and comprehensive care plans to utilize suicide risk assessment tools and support patients with suicide risk factors. The Joint Commission urged all healthcare organizations to develop clinical environment readiness by identifying, developing, and integrating comprehensive behavioral health, primary care, and community resources to assure continuity of care for individuals at risk for suicide.

In addition, concern over drug-associated suicidal ideation and behavior has been increasing over the last decade. In 2012, the Food and Drug Administration (FDA) issued draft guidance on assessing the occurrence of suicidal ideation and behavior in clinical drug trials. Over 800 drugs have been linked to an increased risk of suicidal thoughts and depression, from central nervous system agents to antimicrobials. The ASHP Medications and Suicidality Web Resource Center contains guidelines and publications concerning drug-associated suicidality and maintains links to information on individual drugs associated with depression and suicidality. ASHP encourages continued research on suicidal ideation and behavior in clinical trials and supports safety measures by manufacturers and the FDA (e.g., risk evaluation and mitigation strategies, boxed warnings) when appropriate.

Given the leading role of pharmacists in overseeing safe medication use, the dangers of medications relating to suicide risk, and the high degree of pharmacist interaction with patients, pharmacists are well positioned to play a key role in suicide awareness and prevention efforts. The pharmacist's role could include, for example, ensuring appropriate use of medications in management of mental health and other medical conditions; identifying patients at risk for suicide, and evaluating that suicide risk; and recommending care, making referrals, and following up on referrals with patients and providers. Strategies could range from evaluating patients' prescribed medications and identifying those that increase risk for suicidality; to counseling patients, caregivers, and other healthcare providers about those risks; to educating the public about the dangers of unused medications and the need for proper disposal. Clinical pharmacy specialists trained in behavioral health could also be incorporated into behavioral health programs to serve as a resource to the healthcare team. Other pharmacy practitioners (student pharmacists and pharmacy technicians) could perform vital services in suicide awareness and prevention efforts as well, such as medication reviews. The goal of zero

patient or healthcare worker suicides will also require a combined effort from individual healthcare workers and the healthcare system as a whole to sustain clinician well-being and resilience, as further described in ASHP policy 1825, Clinician Well-Being and Resilience. To ensure that pharmacy practitioners have the competence and confidence to properly fill these key roles, ASHP is committed to providing education and tools to assist pharmacy practitioners in suicide awareness and prevention efforts. Further, ASHP advocates inclusion of suicide awareness and prevention in college of pharmacy curricula and postgraduate educational and training programs, through a multimodal approach. ASHP also advocates universal, state-based suicide awareness and prevention training for healthcare providers, including pharmacists. Adequate government and private-sector funding of suicide awareness and prevention efforts will be required to promote the success of suicide awareness and prevention efforts. ASHP joins other organizations in supporting efforts to promote awareness of the National Suicide Prevention Lifeline (1-800-273-TALK [8255]), with the ultimate goal of making the Lifeline number as memorable as the 911 emergency hotline. The Lifeline, accessible via phone and chat (<https://suicidepreventionlifeline.org/>), is a national network of 150 local crisis centers that provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week. Finally, ASHP urges research on suicide awareness and prevention, including research on patient assessment tools, the role of genomic testing in drug approval and patient care, and practice models and strategies to identify and manage patients at risk for suicide.

### ***Background***

In response to a recommendation from the House of Delegates regarding the pharmacist's role in suicide awareness and prevention, ASHP convened a joint meeting of all councils and the Commission on Affiliate Relations during its 2018 Policy Week to consider the topic. On Tuesday, September 25, members of all councils and the Commission were asked to suggest elements of ASHP policy on suicide awareness and prevention as well as ASHP programmatic activities relating to the pharmacist's role in suicide awareness and prevention. Those suggestions were collated for presentation on Thursday, September 27. On Thursday, members of all councils and the Commission met to hear a presentation from Dr. Daina L. Wells, Pharm.D., BCPS, BCPP, National Program Manager, Academic Detailing Service, VACO Pharmacy Benefits Management. Dr. Wells provided an overview of suicide awareness and prevention, the role of pharmacists in suicide awareness and prevention, and lessons learned from the Veterans Administration's efforts on suicide prevention. Council and Commission members were then presented with the results of the card-storming exercise and engaged in a brief discussion. Council and Commission members then returned to committee deliberation to reflect on current scientific evidence, best practices, the presentation from Dr. Wells, background reading, the meeting discussion, and personal experience to consider the need for new or revised ASHP professional policy and related ASHP programmatic activities related to topics within its purview. The policy recommendations from all the councils were consolidated into the policy recommendation above, which was approved by all the councils as a joint recommendation.

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# COUNCIL ON PHARMACY PRACTICE

## POLICY RECOMMENDATION

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*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.*

Paul C. Walker, *Board Liaison*

### **Council Members**

Joseph Slechta, *Chair* (Kansas)  
Jennifer Burnette, *Vice Chair* (Texas)  
Jason Bergsbaken (Wisconsin)  
Rachel Cartus, *Student* (Pennsylvania)  
Noelle Chapman (Illinois)  
Michael Dickens (Idaho)  
Karl Gumper (Massachusetts)  
Molly Leber (Connecticut)  
Abhay Patel, *New Practitioner*  
(Pennsylvania)  
Brittany Riley (West Virginia)  
Jamielynn Sebally (North Carolina)  
Andrew Stivers (Georgia)  
Anna L. Dopp, *Secretary*

### **1. Safe Administration of Hazardous Drugs**

- 1 To advocate that health systems proactively conduct an interprofessional assessment of
- 2 risk for exposure to hazardous drugs (HDs) during administration when closed-system
- 3 transfer devices (CSTDs) cannot be used; further,
  
- 4 To advocate for pharmacist involvement in the development of policies, procedures, and
- 5 operational assessments regarding administration of HDs when CSTDs cannot be used;
- 6 further,
  
- 7 To encourage device and pharmaceutical manufacturers and the Food and Drug
- 8 Administration to foster development of CSTD-compatible, ready-to-administer HD
- 9 products.

### **Rationale**

Hazardous drugs (HDs) present well-known risks to healthcare workers who handle them. Most HDs are administered orally or intravenously, however non-traditional routes of administration such as, but not inclusive to, intrathecal, intraventricular, intravesicular, and perfusion into a vessel or organ cavity. These procedures are becoming more common. It is mandated that healthcare providers use personal protective equipment (PPE) and other protective devices,

such as closed-system transfer devices (CSTDs) when the dosage form allows. The protective precautions required for administration through these routes is well described in United States Pharmacopeia (USP) General Chapter 800, the [ASHP Guidelines on Handling Hazardous Drugs](#), the Oncology Nursing Society's *Safe Handling of Hazardous Drugs*, and other sources.

HDs are sometimes administered through other routes (e.g., Ommaya reservoirs, intraperitoneal infusion) for which protective precautions are not as well described or CSTD use is not possible. ASHP encourages health systems to conduct an interprofessional, proactive assessment of risk of such procedures to assess the potential exposure risks for healthcare providers and identify mitigating measures. Given their depth of knowledge regarding the handling of hazardous drugs, pharmacists should be involved in the development of policies, procedures, and operational assessments regarding administration of HDs in such circumstances. To reduce the risks to healthcare providers, ASHP encourages device and pharmaceutical manufacturers and the Food and Drug Administration to foster the development of CSTD-compatible, ready-to-administer HD drug products. The goal would be that CSTD's be utilized for all routes of administration of HD products as a best practice; however if this is not possible then an assessment of risk can identify gaps and assure there are pharmacy guided policies that can address the handling, compounding, and administration for all healthcare staff coming into contact with HDs during these non-traditional routes of administration. This would also include any specialized training for staff in procedural areas, or the availability of a HDs specialized trained staff member whom can assist in the administration of the drug (e.g., a "chemo nurse").

### **Background**

The 2018 the [ASHP Guidelines on Handling Hazardous Drugs](#) acknowledge that administration of hazardous drugs "in nontraditional locations, such as the operating room" presents "challenges in training of personnel and in proper containment of drugs and drug residue." The Council noted that CSTDs are often used to protect healthcare providers administering HDs but recognized that CSTDs and other standard precautions may not be suitable for atypical or unusual administration procedures. The intent of this policy is to encourage health systems to consider such situations and develop policies and procedures to protect healthcare workers involved in them, as well as to encourage device and pharmaceutical manufacturers to develop CSTD-compatible, ready-to-administer HD drug products to help address this issue.

## Board Actions

### Sunset Review of Professional Policies

As part of sunset review of existing [ASHP policies](#), the following were reviewed by the Council and Board and found to be still appropriate. (No action by the House of Delegates is needed to continue these policies.)

- Standardization of Oral Liquid Medication Concentrations (1401)
- Safe Use of Radiopharmaceuticals (1402)
- Pharmacist's Role on Ethics Committees (1403)
- Pharmacist's Role in Providing Care for an Aging Population (0902)
- Pharmaceutical Waste (0903)
- Use of Use of Color To Identify Drug Products (9608)

## Other Council Activity

### Joint Meeting: Pharmacist's Role in Suicide Awareness and Prevention

On Tuesday, September 25 members of all councils and the Commission on Affiliate Relations were asked to suggest through a card-storming exercise potential elements of ASHP policy on as well as ASHP programmatic activities relating to the pharmacist's role in suicide awareness and prevention. Those suggestions were collated for presentation on Thursday, September 27. On Thursday, members of all councils and the Commission on Affiliate Relations met to hear a presentation from Dr. Daina L. Wells, Pharm.D., BCPS, BCPP, National Program Manager, Academic Detailing Service, VACO Pharmacy Benefits Management. Dr. Wells provided an overview of suicide awareness and prevention, the role of pharmacists in suicide awareness and prevention, and lessons learned from the VA's efforts on suicide prevention. Council and Commission members were then presented with the results of the card-storming exercise and engaged in a brief discussion. Council and Commission members then returned to committee deliberation to reflect on current scientific evidence, best practices, the presentation from the outside expert, background reading, the meeting discussion, and personal experience to consider the need for new or revised ASHP professional policy and related ASHP programmatic activities related to topics within its purview.

The Council considered the need for new or revised ASHP professional policy related to topics within its purview, including the responsibilities of pharmacy practitioners, practitioner care for individual patients, practitioner activities in public health, pharmacy practice standards and quality, professional ethics, and interprofessional and public relations. Topics identified for consideration in advance of the Joint Meeting included counseling of patients taking prescription and nonprescription drugs that present a risk of suicidality, practitioner interventions to identify and treat patients at risk of suicide, and the quality of pharmacy practice standards related to suicide awareness and prevention. The Council developed draft policy language that was incorporated into the joint council policy recommendation on suicide

awareness and prevention. The Council also to develop an ASHP statement on the pharmacist's role in suicide awareness and prevention.

The Council concluded that the broad scope of topics within its purview (the responsibilities of pharmacy practitioners, practitioner care for individual patients, and practitioner activities in public health) were better suited to the longer format of an ASHP statement, similar to that of other [ASHP statements on the pharmacist's role](#) in other activities. The tentative outline for the statement follows the four recommendations outlined by Dr. Wells:

- Ensure appropriate management of mental health and medical conditions
- Recognize and identify patients at risk for suicide
- Evaluate suicide risk
- Recommend care, make referrals, and follow-up

## Naloxone Distribution at Discharge

The Council discussed the pharmacist's responsibility to assess whether a patient who receives an opioid prescription or who has a history of opioid overdose requires naloxone upon discharge from the hospital or an ambulatory care setting. The Council noted that due to the severity of the opioid epidemic, several states have taken action during the recent years to provide naloxone to patients at risk of overdose. The Substance Abuse and Mental Health Services Administration (SAMSHA) describes three prescription models: 1) traditional doctor-to-patient prescription, 2) third-party, and 3) non-patient-specific. Currently there are four processes that states can utilize for non-patient-specific dispensing: 1) standing orders pre-approved by a provider, 2) protocol orders, 3) collaborative practice agreements, and 4) pharmacist prescriptive authority. As of 2018, 49 states and D.C. permit some model of non-patient-specific prescription process; the only state that doesn't is Nebraska. A few states and the VA health system allow prescriptive authority to pharmacists, which would include naloxone. Recently, some states have passed laws that allow non-patient-specific prescriptions that authorize naloxone distribution to individuals or organizations that meet specific criteria (e.g., family members or community members).

The Council discussed the need for new or revised ASHP professional topic regarding naloxone distribution at discharge and concluded that the topic is adequately addressed by ASHP policy 1510, Naloxone Availability, which reads:

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

To support efforts to safely expand access to naloxone; further,

To advocate that individuals other than licensed healthcare professionals be permitted access to naloxone after receiving education; further,

To foster education on the role of naloxone in opioid reversal and its proper administration, safe use, and appropriate follow-up care; further,

To support state efforts to authorize pharmacists' prescribing authority for naloxone for opioid reversal.

### **Organizational Policy on Pharmacy Inventory**

The Council discussed the challenge of pharmacy storage of nonpharmaceutical items (e.g., dietary formulas and supplements, IV solutions without additives, blood products, leeches, and biological hazardous substances such as fecal material for fecal transplants). The Council observed that many pharmacy departments are asked to purchase and store such products. These items can add significant costs to a pharmacy's budget, reduce inventory space, and add special storage requirements. It was the Council's opinion that hospitals should review items and have a policy that reflects current hospital practices of how to deal with such products, including physical location, departmental budget breakdown, and any training or additional education needed by staff that may come in contact and dispense the products. The Council noted that ASHP policy 0232, Pharmacist's Role in Drug Procurement, Distribution, Surveillance, and Control, provides the policy needed to address this issue but suggested that an ASHP web resource center, FAQ sheet, or *AJHP* commentary would better fill the needs of members.

### **Ready-To-Use Packaging for All Settings**

The Council discussed ASHP policy 0402, Ready-To-Use Packaging for All Settings, as part of sunset review but deferred action to further consider what approach ASHP should take regarding ready-to-use and ready-to-administer packaging.

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# COUNCIL ON PUBLIC POLICY

## POLICY RECOMMENDATIONS

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*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.*

Todd A. Karpinski, *Board Liaison*

### **Council Members**

Chris Fortier, *Chair* (Massachusetts)  
Jeff Little, *Vice Chair* (Kansas)  
Emily Dyer (Virginia)  
Erin Fox (Utah)  
Roy Guharoy (Alabama)  
Mark Hamm (Ohio)  
Charzetta James (Florida)  
Lois Kim, *Student* (Texas)  
Janet Lee (Maryland)  
Bernice Man, *New Practitioner* (Illinois)  
Mike Powell (Iowa)  
Steve Riddle (Washington)  
Jillanne Schulte Wall, *Secretary*

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### **1. Notification of Drug Product Price Increases**

- 1 To advocate for manufacturers to provide advance notice and justification to the public
- 2 and healthcare providers in advance of drug price increases; further,
- 3 To advocate for transparency in drug product pricing.

### **Rationale**

Many factors contribute to high drug product costs, and addressing the problem is made difficult by lack of knowledge about the marketplace for those products. For example, rebates negotiated by pharmacy benefit managers (PBMs) and discounts to other buyers make it difficult to determine the actual price of a drug product. ASHP advocates for more publicly accessible information on drug product pricing, such as an annual report on increases in drug product prices. Such information would provide patients and their healthcare providers with the information needed to make drug product purchasing choices. The purpose of this policy is to advocate for laws and regulations that would require drug product manufacturers to publicly report price increases in advance and provide justification for those increases, as well as to advocate for transparency regarding drug product pricing decisions. The policy is intended to increase public knowledge concerning pricing decisions made by different parties in the drug product supply chain (e.g., manufacturers, distributors, PBMs, group purchasing organizations) who may influence drug product prices.



**Background**

In 2017, the ASHP Formulary Review Panel recommended that the Council revise ASHP policy 0814 to advocate that drug product manufacturers be required to provide public notification in advance of significant price increases. At the Regional Delegate Conferences and the 2018 House of Delegates meetings, delegates expressed concern that the addition did not align with the intent of policy 0814, which is to advocate for federal review of anticompetitive practices by drug product manufacturers. Although delegates agreed that the new language should be ASHP policy, the amendment to policy 0814 was not approved by the House. Delegates recommended that the Council develop new, stand-alone policy on the topic. The 2018 Council crafted the policy recommendation above, removing the word “significant” from the Formulary Review Panel’s proposed amendment to address the concern that the term was subject to interpretation and would need to be defined.

In addition, the Council discussed the role of pharmacists in educating the public about factors that drive up drug product costs. The sense of the Council is that the general public is not aware of the complexities of the drug product marketplace and how those complexities impact drug product prices. Pharmacists have an important role in educating consumers about the complex marketplace, as well as options consumers may have in their purchases. For example, the Council cited a recently passed law that bans so-called “gag clauses” that prevent a pharmacist from notifying patients when an out-of-pocket payment is lower than the cost when the same product is purchased through their insurance or PBM coverage. Pharmacists also have a role in identifying cheaper generic alternatives and assisting patients in enrolling in manufacturer-sponsored drug discount programs.

**2. Preventing Drug Product Shortages**

- 1 To advocate for ongoing federal evaluation of whether drug product shortages present
- 2 risks to national security; further,
  
- 3 To advocate that drug product manufacturers be required to disclose manufacturing sites
- 4 and sources of active pharmaceutical ingredients (APIs) to facilitate such a risk
- 5 assessment; further,
  
- 6 To recommend that the Food and Drug Administration (FDA) require drug product
- 7 manufacturers to have contingency plans for maintaining drug supplies; further,
  
- 8 To advocate that drug product manufacturers be required to provide a specific reason for
- 9 a shortage and an estimated timeline for resolution in their Food and Drug
- 10 Administration Safety and Innovation Act notifications to FDA; further,
  
- 11 To advocate that FDA be required to provide quality ratings for 503B outsourcing
- 12 facilities preparing copies of drug products under the exemption for products on FDA's
- 13 shortage list; further,

- 14 To advocate that the Federal Trade Commission be required to evaluate the potential for
- 15 drug product supply chain interruptions when considering manufacturer consolidations.

### **Rationale**

In November 2017, ASHP convened a [meeting of healthcare professional organizations](#) to review and identify new opportunities to address the ongoing supply chain and patient care challenges associated with drug product shortages. Participants at the meeting examined how the 2012 FDA Safety and Innovation Act (FDASIA) has impacted drug product shortages and made recommendations to prevent and mitigate future shortages. One of those recommendations was that the federal government undertake an evaluation of the risks drug product shortages could present to national security. Such an evaluation would need to consider the risks posed by sourcing of APIs and excipients, as well as by the location of manufacturing sites.

The FDA's [Strategic Plan for Preventing and Mitigating Drug Shortages](#) recommends that drug product purchasers consider quality in making purchasing decisions. Information that purchasers would find helpful in prospectively assessing drug product quality includes the production and compliance history of a manufacturer, the specific name and location of the manufacturing plant, and the source of raw materials. Because approximately 80 percent of APIs used in U.S. drug product manufacturing comes from foreign sources, the FDA has limited ability to inspect and certify that those APIs are unadulterated. In addition, although FDA publishes some quality information about manufacturers, it is sometimes difficult to know who the actual manufacturer is and which specific plant location produced the product, because drug companies may rely on contract manufacturers to produce drug products through licensing agreements. Requiring manufacturers to disclose that information would allow for improved evaluation of a manufacturer's integrity and alignment with current good manufacturing processes. Detailed knowledge of manufacturing sites would also allow the government and healthcare systems to plan for or avoid disruptions to the supply chain like those that followed Hurricanes Irma and Maria in 2017, when supplies of 40 critical pharmaceutical products went into shortage, in part because of disruption to the large number of pharmaceutical manufacturing facilities in Puerto Rico. Lack of information about such disruptions can also lead to hoarding, which exacerbates an existing shortage. To avoid similar disruptions, the FDA should require manufacturers to have contingency plans for maintaining drug product supplies during events that could disrupt production, such as natural and manmade disasters (e.g., hurricanes, cyber-attacks, electricity failures, shipping disruptions).

FDASIA requires that drug product manufacturers submit a notification of a production disruption to FDA. Manufacturers should also be required to provide in these notices a specific reason for the shortage and an estimated timeline for resolution. This information would be helpful not only to those affected but also in the federal evaluation of the risks posed by drug product shortages. Healthcare providers addressing drug product shortages also need information to evaluate the quality of copies of drug products produced by 503B outsourcing facilities under the exemption for products on FDA's shortage list. Congress should require the FDA to provide quality ratings for those manufacturers.

Finally, to avoid future drug product shortages, the Federal Trade Commission should be

required to evaluate the potential for drug product supply chain interruptions when considering manufacturer consolidations.

### **Background**

The purpose of this policy is to advocate for solutions to prevent drug product shortages. In November 2017, ASHP convened a meeting of healthcare professional organizations — the American Hospital Association (AHA), the FDA, and the Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR) — to review and identify new opportunities to address the ongoing supply chain and patient care challenges associated with drug product shortages. The meeting served as an opportunity to examine how the FDA Safety and Innovation Act (FDASIA), enacted in 2012, has impacted shortages, and to address whether there is a need to build on the law with new recommendations. Held at ASHP headquarters, the meeting featured attendees that represented not only a large part of the clinician community, but also the AHA, the Pew Charitable Trusts, and the University of Utah Drug Information Services. At the meeting, representatives from the American Society of Anesthesiologists, the American Society of Clinical Oncology, the American Medical Association, the American Society of Parenteral and Enteral Nutrition, the Institute for Safe Medication Practices, and the Society of Critical Care Medicine discussed the ongoing challenges of drug product shortages and their impact on patient care. In addition, the FDA and the ASPR's Office of Emergency Management were in attendance. The meeting resulted in a number of new recommendations to prevent and mitigate drug shortages. Attendees of the roundtable discussed various policy options that build upon existing law, in terms of reporting, as well as new requirements. The Council developed this new policy recommendation based on the recommendations from that meeting.

### **3. Emergency Refills**

- 1 To advocate for state laws to allow any pharmacist, during a declared emergency, to
- 2 dispense without a prescription refills of a drug product in quantities that meet the needs
- 3 of patients.

### **Rationale**

Many states allow pharmacists to provide emergency supplies of prescription drug products during or in the immediate aftermath of a declared emergency. States such as Florida allow this practice for up to 72 hours after an emergency has been declared (i.e., a patient can obtain a 72-hour supply during an emergency or disaster). However, the long duration of events like hurricanes demonstrates the need to expand the 72-hour window. Hurricanes, for example, typically generate an emergency declaration prior to the storm, and the impact can last until days after the storm, when flood waters crest. Several states, including California and Texas, allow pharmacists to adequately provide prescription drug products, excluding controlled substances, during disasters, emergencies, or catastrophic events. In California, pharmacists are empowered to use their professional judgment when determining the appropriate quantity of a fill. In these situations, patients without a prescription may use an empty pill bottle or other

documentation to demonstrate their need for a drug product. In addition, states sometimes require appropriate follow-up by the pharmacist with the patient's prescriber and supporting documentation of the provision of care under an emergency declaration. American Medical Association policy H-120.933, Emergency Prescription Drug Refills, calls for emergency refills beyond the 72-hour period and excludes controlled substances.

### **Background**

The intent of this policy is to advocate for states to expand access to prescription drug products during declared emergencies. The Council reviewed several state laws and American Medical Association policy H-120.933 in drafting this policy recommendation. The Council concluded that ASHP policy should not specify whether controlled substances should be excluded, leaving that decision to the states. Similarly, the Council concluded that ASHP policy should not take a stance on expanding the emergency supply beyond 72 hours but rather leave the limit to the discretion of the states.

#### **4. Credentialing and Privileging by Regulators, Payers, and Providers for Collaborative Practice**

- 1 To advocate expansion of collaborative practice agreements in which the prescriber and  
2 the licensed pharmacist agree upon the conditions under which the pharmacist initiates,  
3 monitors, and adjusts a patient's drug therapy; further,
  
- 4 To acknowledge that as a step toward the goal of universal recognition of and payment  
5 for pharmacist medication management services, public or private third-party payers  
6 may require licensed pharmacists to demonstrate their competence to provide  
7 medication management services, before the payers authorize them to engage in or be  
8 paid for such clinical services; further,
  
- 9 To support (1) the development (as a professional initiative by pharmacist associations  
10 rather than as a government activity) of national standards for determining a  
11 pharmacist's competence to provide medication management services and (2) the  
12 appropriate use of these standards by clinical privileging systems, government  
13 authorities, and public or third-party payers; further,
  
- 14 To support the use of clinical privileging by hospitals and health systems to assess a  
15 licensed pharmacist's competence to engage in medication management services within  
16 the hospital or health system; further,
  
- 17 To advocate that state boards of pharmacy apply the principles of continuous quality  
18 improvement in assessing the quality, safety, and outcomes of medication management  
19 services.

(Note: This policy would supersede ASHP policy 0905.)

**Rationale**

Nearly all states permit some form of collaborative practice. ASHP not only supports collaborative practice but advocates its expansion. To help achieve the goal of recognizing and paying pharmacists for medication management services (a step toward universal recognition of pharmacists as healthcare providers), ASHP recognizes that public and private payers may require pharmacists to demonstrate competence to provide medication management services and that state licensure may not be the only state-imposed legal requirement to provide those services.

ASHP supports a professional initiative to develop national standards for determining pharmacist competence and the appropriate use of these standards by clinical privileging systems, governments, and public or third-party payers. ASHP continues to support the application of the clinical privileging process to medication management services as practiced within hospitals and health systems and notes the need for state boards of pharmacy to establish quality improvement processes with respect to patient safety and outcomes of medication management services.

**Background**

The Council considered ASHP policy 0905, Credentialing and Privileging by Regulators, Payers, and Providers for Collaborative Drug Therapy Management, as part of sunset review, and voted to recommend amending policy 0905 as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

To advocate expansion of collaborative practice agreements ~~collaborative drug therapy management (CDTM) practices~~ in which the prescriber and the licensed pharmacist agree upon the conditions under which the pharmacist initiates, monitors, and adjusts a patient's drug therapy; further,

To acknowledge that as a step toward the goal of universal recognition of and payment for pharmacist medication management services ~~CDTM services~~, public or private third-party payers may require licensed pharmacists to demonstrate their competence to provide medication management services ~~CDTM~~, before the payers authorize them to engage in or be paid for such clinical services; further,

To support (1) the development (as a professional initiative by pharmacist associations rather than as a government activity) of national standards for determining a pharmacist's competence to provide medication management services ~~CDTM~~ and (2) the appropriate use of these standards by clinical privileging systems, government authorities, and public or third-party payers; further,

To support the use of clinical privileging by hospitals and health systems to assess a licensed pharmacist's competence to engage in medication management services ~~CDTM~~ within the hospital or health system; further,

To advocate that state boards of pharmacy apply the principles of continuous quality improvement in assessing the quality, safety, and outcomes of medication management services ~~CDTM~~.

The Council revised the policy to reflect changing terminology regarding collaborative practice as well as the Joint Commission of Pharmacy Practitioners definition of medication management services.

## Board Actions

### Sunset Review of Professional Policies

As part of sunset review of existing [ASHP policies](#), the following were reviewed by the Council and Board and found to be still appropriate. (No action by the House of Delegates is needed to continue these policies.)

- Pharmacist Role in the Healthcare (Medical) Home (0908)
- Regulation of Interstate Pharmacy Practice (0909)
- Federal and State Regulation of Compounding (1406)
- State Prescription Drug Monitoring Programs (1408)
- Drug Nomenclature (9011)

## Other Council Activity

### Joint Meeting: Pharmacists Role in Suicide Awareness and Prevention

On Tuesday, September 25 members of all councils and the Commission on Affiliate Relations were asked to suggest through a card-storming exercise potential elements of ASHP policy on as well as ASHP programmatic activities relating to the pharmacist's role in suicide awareness and prevention. Those suggestions were collated for presentation on Thursday, September 27. On Thursday, members of all councils and the Commission on Affiliate Relations met to hear a presentation from Dr. Daina L. Wells, Pharm.D., BCPS, BCPP, National Program Manager, Academic Detailing Service, VACO Pharmacy Benefits Management. Dr. Wells provided an overview of suicide awareness and prevention, the role of pharmacists in suicide awareness and prevention, and lessons learned from the Veterans Administration's efforts on suicide prevention. Council and Commission members were then presented with the results of the card-storming exercise and engaged in a brief discussion. Council and Commission members then returned to committee deliberation to reflect on current scientific evidence, best practices, the presentation from the outside expert, background reading, the meeting discussion, and personal experience to consider the need for new or revised ASHP professional policy and related ASHP programmatic activities related to topics within its purview. Topics identified for consideration in advance of the Joint Meeting included state-mandated suicide awareness and prevention continuing education, FDA processes for assessing the suicidality risk of investigational drugs and informing the public of those risks, and the potential liability risk to pharmacists dispensing drugs that increase the risk of suicidal thoughts and behaviors. The Council developed draft policy language that was incorporated into the joint council policy recommendation on suicide awareness and prevention.

This issue was brought forth by a member of the Council who noted that federal law passed in June expands the right-to-try program that enables patients who are suffering from terminal illness to access investigational drugs that have not yet been approved by the FDA. In addition, in 2015, the Council on Public Policy developed a policy on compassionate use that recognizes that FDA is the proper authoritative body to grant access to drugs that are still in clinical trials.

## Right-to-Try Laws

The Council member brought this policy back for discussion to compare with the recently enacted right-to-try law and potentially update ASHP policy to reflect the change.

The right-to-try law expands access to drugs in phase I clinical trials. Patients who are terminally ill can work with their physician to be granted access to these drugs. One of the concerns expressed by the Council is the potential for the right-to-try law to create a loophole in the drug approval process by allowing use of a product that has not been approved. The concern is that a manufacturer could use this program to give access to a phase I drug, and then apply for orphan drug status to get around the full FDA approval processes. The Council believes that the right-to-try regime should not serve as a new business model. Council members were also concerned over the authority of hospital internal review boards and their ability to determine whether patients get access to nonapproved drugs.

Ultimately, the Council decided that more information is needed on how the program will be implemented and what impact it could have on patients and hospitals. As a result, the Council voted to table any new policy until the FDA releases regulations or guidance that implements the right-to-try law.

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# COUNCIL ON THERAPEUTICS POLICY RECOMMENDATION

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*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.*

Linda S. Tyler, *Board Liaison*

## **Council Members**

Kurt Mahan, *Chair* (New Mexico)  
Snehal Bhatt, *Vice Chair* (Massachusetts)  
Sarah Anderson (Colorado)  
Amie Blaszczyk (Texas)  
Michael Cooley, *Student* (Georgia)  
Megan Corrigan (Illinois)  
Rena Gosser (Washington)  
Cyrine Haider (Tennessee)  
Christi Jen (Arizona)  
Morgan King, *New Practitioner* (Ohio)  
Nathan Pinner (Alabama)  
Brian Potoski (Pennsylvania)  
Vicki Basalyga, *Secretary*

## **1. Therapeutic Use of Cannabidiol**

- 1 To support continued research on the therapeutic uses of cannabidiol (CBD); further,
- 2 To provide education on the therapeutic uses of CBD; further,
- 3 To oppose use of CBD-containing products not approved by the Food and Drug  
4 Administration; further,
- 5 To advocate for enhanced public education regarding safe use of CBD and unapproved  
6 CBD-containing products.

## **Rationale**

In June 2018, the FDA approved Epidiolex, an oral solution containing cannabidiol (CBD), for the treatment of seizures associated with Lennox-Gastaut syndrome and Dravet syndrome, in patients two years of age and older. Epidiolex is the first prescription formulation of highly purified component of the *Cannabis sativa* plant. Because it does not contain a significant amount of tetrahydrocannabinol, the substance in *Cannabis sativa* that causes intoxication, in September 2018 the Drug Enforcement Administration placed Epidiolex in schedule V of the Controlled Substances Act (CSA), the least restrictive schedule of the Act.



Given the patchwork of state legislation regarding recreational and medical cannabis, there is a robust but largely unregulated industry in cannabis derivatives, including products promoted as containing CBD. These formulations range from lotions for topical application to oils for enteral consumption, and their components and CBD concentrations vary, leading to questions about their safety. The FDA has issued over 40 warning letters to firms marketing products that allegedly contain CBD. As part of these actions, the FDA has tested the chemical content of cannabinoid compounds in some of the products, and many were found to not contain the levels of CBD they claimed to contain. The FDA has concluded that CBD products are excluded from the dietary supplement definition under section 201(ff)(3)(B)(ii) of the Federal Food, Drug and Cosmetic Act [21 U.S.C. § 321(ff)(3)(B)(ii)]. Under that provision, if a substance has been authorized for investigation as a new drug for which substantial clinical investigations have been instituted and for which the existence of such investigations has been made public, then products containing that substance are outside the definition of a dietary supplement. There is an exception if the substance was “marketed as” a dietary supplement or a conventional food before the new drug investigations were authorized; however, based on available evidence, FDA has concluded that this is not the case with CBD.

With its easy availability came erroneous claims regarding the efficacy of CBD in treating a number of maladies. The lack of a standardized product has inhibited legitimate research on most of these claims, and ASHP encourages research on the potential therapeutic uses of the FDA-approved product. ASHP is also committed to providing education to pharmacists and other healthcare providers on those uses, and advocates that pharmacists take a leadership role in educating patients and the public about the risks of unapproved CBD-containing products. Given the availability of an FDA-approved CBD product, ASHP opposes use of CBD-containing products not approved by the Food and Drug Administration in research and patient care. Further, due to concerns that patients may substitute unapproved cannabis derivative products for the FDA-approved drug or confuse the two, ASHP advocates for enhanced public education regarding safe use of CBD and unapproved cannabis derivatives.

### ***Background***

The Council discussed the growing number of mostly consumer-driven claims of conditions that can be treated with CBD, particularly what is marketed as “CBD oil.” Despite the FDA approval of Epidiolex CBD oral solution for two very specific seizure disorders, the Council expressed concern about the growing popularity of CBD oil, including the practice of patients bringing CBD oil into the hospital to continue use as a “patient’s own medication.” Council members discussed their hospital policies on CBD oil as a patient’s own medication. Many ban or restrict its use, especially in states where CBD oil is illegal. The Council recognized the ethical dilemma of discontinuing CBD oil for patients who have maintained themselves seizure-free on a CBD oil regimen. The Council also discussed the stigma associated with using a marijuana derivative such as CBD oil, which may make patients reluctant to disclose use as a part of a medication history, which can lead to significant drug-drug and drug-disease interactions.

## Board Actions

### Sunset Review of Professional Policies

As part of sunset review of existing [ASHP policies](#), the following were reviewed by the Council and Board and found to be still appropriate. (No action by the House of Delegates is needed to continue these policies.)

- Safe and Effective Use of Heparin in Neonatal Patients (0912)
- Automatic Stop Orders (1405)
- Therapeutic Interchange (8708)
- Access to Oral Contraceptives as an Intermediate Category of Drug Products (1410)

## Other Council Activity

### Joint Meeting: Pharmacists Role in Suicide Awareness and Prevention

On Tuesday, September 25, members of all councils and the Commission on Affiliate Relations were asked to suggest through a card-storming exercise potential elements of ASHP policy on suicide awareness and prevention as well as ASHP programmatic activities relating to the pharmacist's role in suicide awareness and prevention. Those suggestions were collated for presentation on Thursday, September 27. On Thursday, members of all councils and the Commission on Affiliate Relations met to hear a presentation from Dr. Daina L. Wells, Pharm.D., BCPS, BCPP, National Program Manager, Academic Detailing Service, VACO Pharmacy Benefits Management. Dr. Wells provided an overview of suicide awareness and prevention, the role of pharmacists in suicide awareness and prevention, and lessons learned from the Veterans Administration's efforts on suicide prevention. Council and Commission members were then presented with the results of the card-storming exercise and engaged in a brief discussion. Council and Commission members then returned to committee deliberation to reflect on current scientific evidence, best practices, the presentation from the outside expert, background reading, the meeting discussion, and personal experience to consider the need for new or revised ASHP professional policy and related ASHP programmatic activities related to topics within its purview. Topics identified for consideration in advance of the Joint Meeting included student and postgraduate education and training on suicide awareness and prevention; prevention of student and resident suicides; and specialty education, training, and credentialing on suicide prevention. The Council developed draft policy language that was incorporated into the joint council policy recommendation on suicide awareness and prevention.

### Intravenous to Enteral Antimicrobial Interchange

The Council discussed the current Infectious Diseases Society of America (IDSA) guidelines on antimicrobial stewardship, including the provision that advocates for conversion of intravenous

(IV) to enteral (PO) medications. Members discussed how this provision of the guidelines is implemented across the country, with current practices varying widely based on location and type of facility. Shared practices include automatic conversions for patients who meet certain criteria, pharmacist-led identification for conversion when a patient has met discharge requirements, and no active strategies or policies to convert patients to enteral formulations while in the hospital. There were several reasons identified for this wide variability, including physician attitudes towards the use of IV medications (e.g., patients in a hospital should receive IV antibiotics), certain patient populations that would not qualify for conversion (e.g., febrile neutropenic patients), lack of knowledge for appropriate conversion, pharmacist comfort in recommending changes, and justification for hospitalization (i.e., patient is receiving IV antibiotics solely to remain in the hospital). The Council identified ways in which ASHP could assist pharmacists with these barriers: a review of the “basics” of antimicrobial stewardship approaches, including ways to identify patients for IV-to-PO conversion, working with providers to prioritize enteral administration when clinically appropriate, and developing protocols regarding selection of agents. This initiative could take the form of PowerPoint templates to assist those unfamiliar with this section of the IDSA guidelines; identification of “Centers of Excellence” that would share their successes and strategies; the formation of an antimicrobial stewardship advisory group; a survey on the barriers that pharmacists are encountering; and providing resources with key references for pharmacists and potential partnership with infectious disease organizations reinforcing antimicrobial stewardship strategies. The Council also reviewed the [ASHP Statement on the Pharmacist’s Role in Antimicrobial Stewardship and Infection Prevention and Control](#) and noted the section about the IDSA guidelines that includes strategies for IV-to-PO conversion could be expanded to address this issue. The Council will convey these recommendations to the Council on Pharmacy Practice as they will be reviewing the statement as a part of their sunset review later this year.

## Safe and Effective Use of Ketamine

The Council reviewed the expanding used of ketamine across multiple areas of practice, including the emergency department, outpatient clinics, and units in the hospital outside anesthesia and the post-surgical care units. The Council reviewed the methods of administration utilized, including intranasal delivery as well as the different concentrations that are available for administration. This discussion also addressed safety issues, including the ability to rescue a patient in the field, as ketamine is being used to treat depressive episodes in psychiatry offices and is recommended as a treatment alternative to morphine for emergency medical services; the wide variety of dosing for these new indications; and the concern of diversion of this Schedule III medication. The effects of long-term use of ketamine are also unknown. Although there are some small-study data on the success of using ketamine to treat patients for post-traumatic stress disorder, there are no data to indicate that it would continue to be successful weighed against its adverse effects and potential for addiction. The Council recognized that there is increasing interest in using ketamine in new areas of practice but found many of the studies published were not strong enough to provide policy guidance or a therapeutics review publication in *AJHP*. However, the Council believed that publishing a scope in review on ketamine in *AJHP* would be an excellent way to highlight the new and emerging practices seen with this drug. Such a review would lay out what research questions need to be

answered, call for more research, share best practices, address the safety concerns of multiple concentrations of ketamine, highlight risks for overdose and diversion, considerations for boards of pharmacy and nursing, and dosing recommendations.

## **Use of Antihyperglycemic Therapies to Meet Cardiovascular Risk Reduction Goals**

The Council reviewed the new American Diabetes Association (ADA) Standards of Care recommendation that for patients with Type 2 Diabetes Mellitus (T2DM) and established arteriosclerotic cardiovascular disease that antihyperglycemic therapy should start with lifestyle modifications and metformin, followed by an agent proven to reduce cardiovascular disease (CVD), such as glucagon-like peptide-1 receptor agonists (GLP-1) and sodium-glucose cotransporter-2 inhibitors (SGLT2). The Council discussed the risks and benefits for this recommendation, including that some of the trials that the recommendations are based on are safety studies rather than studies that prove cardiovascular protection. Members also shared their experiences when patients started these classes of medications and had significant metabolic benefits (mostly significant weight loss) but had recurrent urinary tract infections, fungal infections, and an increased potential for falls. These sequelae prompt the concerns that while these medications are helping with one disease, are they causing harm in other ways. The cost and availability of these classes was also discussed. Of the members of the Council, only one member had these agents on formulary, and they were often discontinued when a patient was admitted to the hospital. The Council also expressed concern that the Standards of Care do not address evaluation of adherence to medications and shared anecdotes of patients who thought they were adherent but in reality were not taking their medications properly. The Council does not discount the recommendations from the ADA, but rather recommends that a careful evaluation of a patient's individual disease and medication regimen should be undertaken before starting one of these agents. The Council believed the best way to teach pharmacists to weigh the use of these medications as a way to meet cardiovascular risk reduction goals would be education from ASHP in the form of a presentation at the Midyear Clinical Meeting, a therapeutics debate webinar, or as a part of the programming offered through ASHP's Board of Pharmacy Specialties recertification programs.

## **Therapeutic Use of Essential Oils**

The Council discussed the increase in encounters with patients who use essential oils as a part of their wellness and treatment regimens. There was discussion regarding the risks and benefits of using essential oils as a part of complementary and alternative medicine, with concerns about safety and efficacy in patients who may be at high risk for adverse effects, particularly the pediatric, elderly, and pregnant patient populations. Many institutions do not permit the use of essential oils in patients on research protocols or in the patient rooms, and Council members shared anecdotes about the content of diffusers being dispersed in the air and on clothing, triggering allergic or asthmatic attacks for other patients and caregivers. The Council also discussed topical application as a part of therapeutic touch and palliative care, which members noted is considered exempt in some institutions. The Council discussed the lack of in-depth research on essential oils and the role of the pharmacists in ensuring that therapies are

safe and effective, something that is hard to do when there is widespread use in aerosolizers, lotions, and drops, and the products can be used in a variety of ways, including topical application and enteral consumption. There have been case reports with Poison Control Centers that have demonstrated the adverse effects of essential oils, but these compete with the myriad of official-looking resources that tout the benefits of using essential oils as well. The Council also discussed the reality that many patients will continue to use essential oils because they are seen as natural complement to wellness and that the need is therefore how to help pharmacists evaluate the risks and benefits associated with their use. The Council believes this would best be served by creating an *AJHP* publication that encompasses items such as evaluation of the evidence currently available; resources for pharmacists; medication-use policies; health-system and safety approaches; strategies for approaching patient conversations, especially for patients who have a strong belief in using essential oils; and the approach for palliative care patients. The Council believed that a separate policy that addresses the use of essential oils is not necessary but that the rationale that supports ASHP policy 1511, Complementary and Alternative Medicine (CAM) in Patient Care, should be updated to include essential oils in the list of types of CAM along with other minor updates to the rationale.

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# COUNCIL ON EDUCATION AND WORKFORCE DEVELOPMENT POLICY RECOMMENDATION

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*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.*

Stephen F. Eckel, *Board Liaison*

## **Council Members**

Whitney White, *Chair* (Alabama)  
Seena Haines, *Vice Chair* (Mississippi)  
David Gregory (Tennessee)  
Fischer Herald, *Student* (Iowa)  
Tadd Hellwig (South Dakota)  
Carol Heunisch (Illinois)  
Jesse Hogue (Michigan)  
Denise Kelley (Florida)  
Krystal Moorman (Utah)  
Garrett Schramm (Minnesota)  
Rebecca Taylor (Ohio)  
Molly Wascher, *New Practitioner*  
(Maryland)  
Erika Thomas, *Secretary*

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## **1. Pharmacy Expertise in Sterile Compounding**

- 1 To support colleges of pharmacy in providing sterile compounding and aseptic
- 2 technique instruction in didactic and experiential curricula that reflect the needs of
- 3 the workforce; further,
  
- 4 To promote the use of sterile compounding training programs to foster an increase
- 5 in the number of pharmacists and pharmacy technicians with sterile compounding
- 6 expertise; further,
  
- 7 To advocate that pharmacists and pharmacy technicians who work in sterile
- 8 compounding attain compounded sterile preparations advanced certifications.

(*Note: This policy would supersede ASHP policy 0915.*)

## **Rationale**

ASHP distinguishes between two needs related to pharmacy expertise in sterile compounding: a need for new pharmacy graduates to possess baseline training and knowledge of sterile



compounding, and the need for pharmacists with an advanced body of knowledge on sterile compounding, especially in pharmacy departments where complex compounded sterile preparations (CSPs) are compounded.

Although there is a clear need for students to have a basic understanding of sterile compounding upon graduation, education in colleges of pharmacy on sterile compounding varies. Sterile compounding and aseptic technique instruction are important areas of pharmacy practice to incorporate in the didactic curriculum and during experiential education.

The complexity of intravenous therapy, the risk of errors or patient harm, and new biologic therapies all demand a higher level of expertise in sterile compounding in the pharmacy, however. United States Pharmacopeia Chapter 797 and other efforts have increased the focus on the quality of CSP compounding and have prompted organizations to improve staff training, facilities, and procedures. In such an environment, there is a clear need for pharmacists whose education, training, and experience in sterile compounding provide expertise rather than baseline knowledge. To demonstrate competency, pharmacy technicians should attain PTCB's advanced Compounded Sterile Preparation Technician (CSPT) certification, and pharmacists, the Board of Pharmacy Specialties (BPS) Compounded Sterile Preparations Pharmacy (BCSCP) certification.

### **Background**

The Council reviewed ASHP policy 0915, Pharmacy Expertise in the Preparation and Handling of Injectable Medications, as part of sunset review and voted to recommend amending it as follows (underline indicates new text; ~~striketrough~~ indicates deletions):

To support ~~encourage~~ colleges of pharmacy in providing to include sterile compounding and aseptic technique instruction in ~~the didactic curriculum and during~~ and experiential ~~education~~ curricula that reflect the needs of the workforce; further,

To ~~support~~ promote the use of development of postgraduate, curriculum-based sterile compounding training programs to foster an increase in the number of pharmacists and pharmacy technicians with sterile compounding expertise; further,

To advocate that pharmacists and pharmacy technicians who work in sterile compounding attain compounded sterile preparations advanced certifications.

## Board Actions

### Sunset Review of Professional Policies

As part of sunset review of existing [ASHP policies](#), the following were reviewed by the Council and Board and found to be still appropriate. (No action by the House of Delegates is needed to continue these policies.)

- Pharmacy Residency Training (0917)
- Continuing Professional Development (0916)
- Credentialing, Privileging, and Competency Assessment (1415)
- Pharmacy Student Experiences in Medically Underserved Areas (0913)

## Other Council Activity

### Joint Meeting: Pharmacists Role in Suicide Awareness and Prevention

On Tuesday, September 25, members of all councils and the Commission on Affiliate Relations were asked to suggest through a card-storming exercise potential elements of ASHP policy on suicide awareness and prevention as well as ASHP programmatic activities relating to the pharmacist's role in suicide awareness and prevention. Those suggestions were collated for presentation on Thursday, September 27. On Thursday, members of all councils and the Commission on Affiliate Relations met to hear a presentation from Dr. Daina L. Wells, Pharm.D., BCPS, BCPP, National Program Manager, Academic Detailing Service, VACO Pharmacy Benefits Management. Dr. Wells provided an overview of suicide awareness and prevention, the role of pharmacists in suicide awareness and prevention, and lessons learned from the Veterans Administration's efforts on suicide prevention. Council and Commission members were then presented with the results of the card-storming exercise and engaged in a brief discussion. Council and Commission members then returned to committee deliberation to reflect on current scientific evidence, best practices, the presentation from the outside expert, background reading, the meeting discussion, and personal experience to consider the need for new or revised ASHP professional policy and related ASHP programmatic activities related to topics within its purview. Topics identified for consideration in advance of the Joint Meeting included student and postgraduate education and training on suicide awareness and prevention; prevention of student and resident suicides; and specialty education, training, and credentialing on suicide prevention. The Council developed draft policy language that was incorporated into the joint council policy recommendation on suicide awareness and prevention.

### Recent Pharmacy Workforce-related Survey Results

The Council participated in a discussion of several recent pharmacy workforce-related survey results, including the 2018 Graduating Student Survey, Independent Analysis of Bureau of Labor Statistics Projections Report, Pharmacy Demand Index (Second Quarter 2018), and selected





2018 ASHP National Survey results to determine whether there are implications for ASHP policy. Of note, Council members discussed possible reasons for the slightly lower quality rating for Introductory Pharmacy Practice Experiences (IPPEs) when compared to Advanced Pharmacy Practice Experiences (APPEs). Council members recognized that ASHP has a variety of useful tools for APPE preceptors available on the Preceptors Toolkit, but nothing specific to IPPE preceptors. The Council felt that, since many ASHP members serve as IPPE and APPE preceptors, additional tools directed to the IPPE preceptor would be useful, such as IPPE best practices case studies including examples of successful innovative and contemporary learning models, and suggestions for incorporating interprofessional education (IPE) exercises.

## Pharmacy Technician Workforce

Council members discussed PTCB's launch of a new Compounded Sterile Preparation Technician (CSPT) certification. PTCB's first advanced certification program, the CSPT Program certifies pharmacy technicians in compounded sterile preparation. Becoming certified as a CSPT is a way for PTCB-certified pharmacy technicians to further demonstrate their commitment to medication safety and could allow for advancement opportunities in a pharmacy technician career ladder. Council members learned that PTCB is considering a new advanced certification program in informatics as well.

Council members were pleased to learn of the increasing number of online accredited training programs and that more remote programs are under review for accreditation. The need for state board of pharmacy regulations to require that pharmacy technicians be certified was discussed, and action on this goal is currently in progress. Council members also discussed how to implement this requirement within their own health systems, including the need to set this as a system goal and meeting with hospital administrators to discuss implementation, citing important issues such as cost avoidance and pharmacy technician turnover rates. Finally, Council members suggested working with state affiliates on strategies to require PTCB certification of technicians.

## Long-Range Vision for the Pharmacy Workforce in Hospitals and Health Systems

The Council participated in a review of the draft ASHP Long-Range Vision for the Pharmacy Workforce in Hospitals and Health Systems to assess completeness and identify areas for improvement. Published last in 2007, the ASHP Long-Range Vision for the Pharmacy Workforce in Hospitals and Health Systems establishes an intention to engage, prepare, and leverage the pharmacy workforce in an evolving healthcare environment to ensure that medication use is optimal, safe, and effective for all people all of the time. ASHP seeks to identify an aspirational and achievable vision for the pharmacy workforce providing medication management services in hospitals and health systems. Considering anticipated changes to the healthcare landscape, the vision will enable a targeted investment and collective call to action to advance pharmacy practice by ensuring an engaged, prepared, and thriving pharmacy workforce. These are the areas in which ASHP will focus future resources, initiatives, and advocacy efforts.

To update ASHP Long-Range Vision for the Pharmacy Workforce in Hospitals and Health Systems, an extensive review process is being conducted, including Council member review and reaction. Numerous suggestions for inclusion in the document were presented, including the following: impact of mergers and acquisitions, greater emphasis on regulatory complexity and social determinants of health considerations, impact of the physician shortage, accountability for outcomes, broadening student experiences, vision for expanding pharmacy services, emerging role of biologics, pharmacy department research, supply chain optimization, clinician well-being and resilience, telehealth, and expanding the section on support staff, referred to as ancillary staff in the document. Recommendations from the Council will be addressed in the upcoming draft version.

## Professional Engagement as a Professional Obligation

The Council participated in a discussion of professional engagement as a professional obligation. The purpose of this discussion was to address a recommendation from the ASHP House of Delegates on “Professional Organization Involvement/Engagement as a Professional Obligation.” Engagement is defined as a positive, fulfilling, work-related state of mind that is characterized by vigor, dedication, and absorption in work. Engaged employees have a sense of energetic and effective connection with their work activities. In nursing, the literature demonstrates that nurse engagement in a professional nursing organization leads to professional growth and increased knowledge, and engagement ultimately leads to improved health outcomes of populations. Professional membership associations offer members value through collective interests and the acquisition of selective benefits. Research also suggests that young professionals join organizations and are motivated by a variety of factors, including career development, altruism, and social obligations. Peer support, also a benefit of engagement and membership in a professional association, has always been critical to helping pharmacists navigate professional challenges. Additionally, support by employers is important, and there are many employer benefits, including innovations, practice advancement, and engaged and contemporary employees. Further, professional engagement is important to student pharmacists. Student pharmacists should be exposed to the concept of professional socialization by professors, preceptors, and mentors. The professionally engaged students learn the benefits and satisfaction of being involved in the profession and are more likely to become professionally engaged pharmacists.

Council members agreed that professional engagement has many benefits for an individual and improves satisfaction with a job and the college of pharmacy experience. The Council discussed the fact that students are often overwhelmed with the number of professional organizations in colleges of pharmacy and that many choose not to join an association at all. Council members believed that a policy was not needed at this time but suggested that ASHP members and members of ASHP state affiliates should continue to promote awareness and the benefits of involvement with ASHP and ASHP state affiliates, especially in colleges of pharmacy. The Council also discussed the importance of promoting the value of ASHP membership to important and influential groups, including college of pharmacy faculty, residency preceptors, and technician educators.

## Social Determinants of Health

Council members participated in a discussion of social determinants of health. The purpose of the discussion was to address a recommendation from the ASHP House of Delegates to encourage the development of policy related to training pharmacists and student pharmacists to understand, identify, and address social determinants of health in collaboration with other healthcare team members. Healthy People 2020 defines social determinants of health as conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples of social determinants include access to health care services, transportation options, availability of resources to meet daily needs (e.g., safe housing and local food markets), socioeconomic conditions (e.g., concentrated poverty and the stressful conditions that accompany it), and language/literacy. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as “place.” In addition to the more material attributes of “place,” the patterns of social engagement and sense of security and well-being are also affected by where people live. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, availability of healthy foods, and local emergency/health services. Healthy People 2020 highlights the importance of addressing social determinants of health by including “create social and physical environments that promote good health for all” as one of the four overarching goals for the decade.

The Council discussed two Accreditation Council for Pharmacy Education (ACPE) standards. Standard 3, Approach to Practice and Care, reads “The program imparts to the graduate the knowledge, skills, abilities, behaviors, and attitudes necessary to solve problems; educate, advocate, and collaborate, working with a broad range of people; recognize social determinants of health; and effectively communicate verbally and nonverbally.” Standard 3.5, Cultural Sensitivity, reads “The graduate is able to recognize social determinants of health to diminish disparities and inequities in access to quality care.” Council members felt that the topic is adequately addressed in college of pharmacy curricula but that there may be an educational gap with practitioners, although it was noted that pharmacists have already taken active roles in other public health initiatives, such as immunizations. The Council felt that a policy was not warranted but that social determinants of health would most appropriately be incorporated in the [ASHP Statement on the Role of Health-System Pharmacists in Public Health](#) that is currently under revision and practitioner education.

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# COUNCIL ON PHARMACY MANAGEMENT

## POLICY RECOMMENDATIONS

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*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.*

Jennifer M. Schultz, *Board Liaison*

### **Council Members**

Katherine Miller, *Chair* (Missouri)  
Victoria Serrano Adams, *Vice Chair* (California)  
Nitish Bangalore (Wisconsin)  
Patrice Dupart (New York)  
Monica Dziuba (Louisiana)  
Lynn Eschenbacher (Missouri)  
Staci Hermann (New Hampshire)  
Rondell Jagers (Georgia)  
Trinh Le (North Carolina)  
Bonnie Levin (Maryland)  
Stuart Pope, *Student* (Kentucky)  
Anthony Trovato, *New Practitioner* (Utah)  
Eric Maroyka, *Secretary*

### **1. Pharmaceutical Distribution Systems**

- 1 To support drug distribution business models that meet the requirements of hospitals
- 2 and health systems with respect to availability and timely delivery of products,
- 3 minimizing short-term outages and long-term product shortages, managing and
- 4 responding to product recalls, fostering product-handling and transaction efficiency,
- 5 preserving the integrity of products as they move through the supply chain, and
- 6 maintaining affordable service costs; further,
  
- 7 To oppose manufacturers, distributors, and wholesalers making availability of drug
- 8 products contingent on how those products are used; further,
  
- 9 To encourage selection of a wholesale distributor that (1) purchases products only from
- 10 a manufacturer before distribution to the purchasing end user; (2) is licensed in the state
- 11 where it is conducting business; (3) complies with the requirements of the Drug Supply
- 12 Chain Security Act; and (4) is accredited under the National Association of Boards of
- 13 Pharmacy Verified-Accredited Wholesale Distributors program.

(Note: This policy would supersede ASHP policy 1707.)

**Rationale**

Wholesalers and distributors have traditionally contracted with hospitals and health systems for basic drug product distribution and other services. Many wholesalers have made a large portion of their revenue through speculative buying and other business practices that are no longer desirable because of requirements for pedigrees, the risk of buying counterfeit or adulterated products, demands by manufacturers to limit product transactions, and the need to manage drug recalls. These changes, plus the vast diversification of many wholesaler distributors, have resulted in new business models that will affect how hospitals acquire and manage pharmaceuticals. These changing models for distribution may result in higher costs for hospitals and health systems, as current wholesaler distribution systems have become very efficient.

Additionally, some wholesalers have required that pharmacies ensure certain drugs are not used or sold for use for particular purposes, and there are concerns that this practice could grow. ASHP supports wholesaler and distribution business models that meet the requirements of hospitals and health systems, which includes the ability for pharmacies to obtain drug products for established patient care uses without restriction.

ASHP supports using strict vendor vetting policies to prevent sales from nonreputable or gray market vendors. Vendors should purchase products only from a manufacturer, not a secondary source; should be licensed in the state in which it operates; comply with the requirements of the Drug Supply Chain Security Act; and be accredited under the National Association of Boards of Pharmacy [Verified-Accredited Wholesale Distributors \(VAWD\) program](#). VAWD accreditation requires a rigorous criteria compliance review to ensure that a wholesale distribution facility operates legitimately, is licensed in good standing, and employs security and best practices for safe prescription drug distribution from manufacturers to pharmacies. As of 2018, 23 states had recognized VAWD accreditation.

**Background**

The Council reviewed ASHP policy 1707, Pharmaceutical Distribution Systems, and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

To support drug distribution business models that meet the requirements of hospitals and health systems with respect to availability and timely delivery of products, minimizing short-term outages and long-term product shortages, managing and responding to product recalls, fostering product-handling and transaction efficiency, preserving the integrity of products as they move through the supply chain, and maintaining affordable service costs; further,

To oppose manufacturers, distributors, and wholesalers making availability of drug products contingent on how those products are used; further,

To encourage selection of a wholesale distributor that (1) purchases products only from a manufacturer before distribution to the purchasing end user; (2) is licensed in the state where it is conducting business; (3) complies with the requirements of the Drug

Supply Chain Security Act; and (4) is accredited under the National Association of Boards of Pharmacy Verified-Accredited Wholesale Distributors program.

## 2. Safe Medication Preparation in All Sites of Care

- 1 To advocate that all sites of care be required to meet the same regulatory standards for medication preparation and compounding.
- 2

### **Rationale**

As pharmacy costs become increasingly relevant in managing the overall cost of healthcare, third-party payers have increased their attention to sites of care, increasing the pressure to manage this trend. Integrated pharmacy benefit models are working to funnel patients to lower-cost settings and deliver more comprehensive care by leveraging big data.

Consolidation in the pharmacy benefit management sector has resulted in just three major companies. To protect and further grow their margins and fend off disruptive entrants, the big three are reinventing themselves within vertically integrated conglomerates, allowing them to tap into other parts of the healthcare value chain. Patients are increasingly receiving care at nonhospital sites of care, where they can receive the care they need at a lower cost, rather than through traditional venues, such as hospital outpatient infusion centers. In addition to these alternative sites being less expensive for payers and purchasers, patients who seek care from alternative sites often have lower out-of-pocket costs and may perceive these sites as more convenient than traditional sites of care (e.g., emergency departments, hospital-based clinics). This trend has led to lower hospital outpatient revenues. Vertical integration of the healthcare value chain has given payers more control over healthcare costs and has better positioned them to link directly with providers and negotiate value-based contracts. Vertically integrated systems may allow payers to steer patients toward lower cost-of-care options (e.g., providers, pharmacies). In the [ASHP Foundation Pharmacy Forecast 2018](#), 44% of panelists predicted at least 25% of health systems will discontinue or abandon plans to begin drug dispensing services (e.g., distribution of specialty or infusion products) because of insufficient financial margins.

One of the challenges that confronts health systems is the level of infrastructure investment required to adequately address regulatory and accreditation requirements focused on quality and safety (e.g., United States Pharmacopeia Chapters 797 and 800, state boards of pharmacy regulations, and the standards of accreditors such as The Joint Commission and Det Norske Veritas Healthcare). Physician offices, dialysis centers, stand-alone cancer care centers, freestanding neighborhood hospitals, and other nonhospital sites of care are commonly devoid of this same level of regulatory and accreditation scrutiny.

### **Background**

The Council discussed the growing trend of payer-directed sites of care and the challenges and opportunities of vertical integration. The margin compression many hospitals are experiencing

because of rising drug costs is likely to continue due to site-of-care reimbursement changes and modifications to the 340B program. The Council stressed the need for ASHP to advocate for uniform application of medication-use standards where medications are prepared, dispensed, and administered, regardless of site. The Council also discussed whether ASHP should consider partnering with the American College of Healthcare Executives and representatives from managed care (e.g., pharmacy benefit managers, self-insured populations) to help pharmacy leaders better understand emerging business models and their influence on safe medication use, continuity of care, patient experience, and competitive positioning. Pharmacy leadership should seek to be part of business discussions regarding nontraditional partnerships to help with continuity of care, promote safe medication use, and bring awareness to health-system leadership regarding potential changes in revenue with nonhospital-based sites of care. Additionally, the Council discussed the idea of an innovation think tank and whether ASHP should explore the creation of a task force or guiding coalition to inform ASHP on how to assist members get ahead of or be part of forward-thinking and disruptive innovation. Such an effort could include networking sessions about innovating and strategic incubation at ASHP meetings.

### 3. Pharmacy Department Business Partnerships

- 1 To recognize that a key objective of pharmacy departments is to provide medication  
2 management services across the continuum of patient care, and that pharmacy leaders  
3 should proactively evaluate potential business partnerships against this objective;  
4 further,
- 5 To recognize that hospitals and health-system pharmacy leaders must ensure that  
6 business partners meet all applicable patient safety and accountability standards;  
7 further,
- 8 To provide education and tools for pharmacy leaders to aid in the evaluation of and  
9 development of business partnerships; further,
- 10 To educate health-system administrators on the importance of pharmacy leadership in  
11 evaluating and developing pharmacy-related business partnerships; further,
- 12 To encourage health-system pharmacy leaders to consider evolving healthcare financing  
13 systems when evaluating and developing business partnerships.

(Note: This policy would supersede ASHP policy 1416.)

#### **Rationale**

Hospitals and health-system pharmacy leaders have to increasingly assess and engage with external business partners in order to facilitate continuity of care for their patients and

optimize outcomes. Hospitals and health-system leaders must be positioned to provide the most comprehensive care for their patient populations. As these external entities expand their market share and become more engaged across the healthcare continuum, a significant number of hospitals and health systems are dealing with how to best evaluate potential business partnerships. In some cases hospital or health-system pharmacy leaders are seeking to create a network of pharmacy locations and services for their patients that the health system cannot build itself. In other cases hospital and health-system pharmacy leaders need to engage with external business partners to provide services they cannot provide or to improve the efficiency of services provided by the hospital or health system. Additionally, a number of business entities see changes in value-based purchasing and readmission payment as an opportunity to contract with health systems. Finally, there are also business partners (e.g., data management, automation, compounding, and consulting organizations) that pharmacy leaders need to engage with in order to manage their pharmacy enterprise. These changes have posed a political, logistical, and professional challenge for pharmacy leaders.

### **Background**

The Council discussed ASHP policy 1416, Pharmacy Department Business Partnerships, as part of sunset review. The Council determined the policy to still be appropriate but voted to recommend making a minor amendment to the policy as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

To recognize that a key objective of pharmacy departments is to provide ~~comprehensive~~ medication management services across the continuum of patient care, and that pharmacy leaders should proactively evaluate potential business partnerships against this objective; further,

To recognize that hospitals and health-system pharmacy leaders must ensure that business partners meet all applicable patient safety and accountability standards; further,

To provide education and tools for pharmacy leaders to aid in the evaluation of and development of business partnerships; further,

To educate health-system administrators on the importance of pharmacy leadership in evaluating and developing pharmacy-related business partnerships; further,

To encourage health-system pharmacy leaders to consider evolving healthcare financing systems when evaluating and developing business partnerships.

This policy was amended with the addition of “medication management services” to reflect the definition of [medication management services](#) approved by the Joint Commission of Pharmacy Practitioners Board of Governors in February 2018. The definition of medication management services encompasses a variety of services, including comprehensive medication management.



## Board Actions

### Sunset Review of Professional Policies

As part of sunset review of existing [ASHP policies](#), the following were reviewed by the Council and Board and found to be still appropriate. (No action by the House of Delegates is needed to continue these policies.)

- Pharmacist Leadership of the Pharmacy Department (1302)
- Integration of Pharmacy Services in Multifacility Health Systems (1417)
- Risk Assessment of Health Information Technology (1418)
- Documentation of Patient Care Services in the Permanent Health Record (1419)
- Workload Monitoring and Reporting (0901)
- Intimidating or Disruptive Behaviors (0919)
- Pharmacy Drug Theft (0303)
- Optimizing the Medication-Use Process (9903)

## Other Council Activity

### Joint Meeting: Pharmacist's Role in Suicide Awareness and Prevention

On Tuesday, September 25, members of all councils and the Commission on Affiliate Relations were asked to suggest through a card-storming exercise potential elements of ASHP policy as well as ASHP programmatic activities relating to the pharmacist's role in suicide awareness and prevention. Those suggestions were collated for presentation on Thursday, September 27. On Thursday, members of all councils and the Commission on Affiliate Relations met to hear a presentation from Dr. Daina L. Wells, Pharm.D., BCPS, BCPP, National Program Manager, Academic Detailing Service, VACO Pharmacy Benefits Management. Dr. Wells provided an overview of suicide awareness and prevention, the role of pharmacists in suicide awareness and prevention, and lessons learned from the Veterans Administration's efforts on suicide prevention. Council and Commission members were then presented with the results of the card-storming exercise and engaged in a brief discussion. Council and Commission members then returned to committee deliberation to reflect on current scientific evidence, best practices, the presentation from the outside expert, background reading, the meeting discussion, and personal experience to consider the need for new or revised ASHP professional policy and related ASHP programmatic activities related to topics within its purview. Topics identified for consideration in advance of the Joint Meeting included deployment of resources for suicide awareness and prevention, reimbursement for suicide awareness and prevention efforts, promotion of suicide awareness and prevention efforts at transitions of care, and the role of technology in suicide awareness and prevention efforts. The Council developed draft policy language that was incorporated into the joint council policy recommendation on suicide awareness and prevention.

## Predictive Analytics and Artificial Intelligence in Healthcare

The Council voted to develop an ASHP statement on predictive analytics and artificial intelligence in healthcare in cooperation with the Section of Pharmacy Informatics and Technology.

The Council discussed agenda topics related to artificial intelligence/machine learning (AI/ML), predictive analytics, and big data. The Council, in drafting a policy recommendation, decided to combine the topics into one proposed policy. The considerations given were that advanced analytics capabilities (e.g., predictive analytics, AI/ML) develop in stages, each one building on the other to handle more complex data and to provide more meaningful outputs. Advanced analytics refers to a broad range of analytics that are intended to give users greater insight into their data. Some of these techniques include AI/ML, data mining, predictive analytics, location analytics, big data analytics, and location intelligence.

Advanced healthcare analytics is an emerging area and pharmacists should take a leadership role in how it will support and enhance the pharmacist and pharmacy process (e.g., operations, clinical efficiencies, re-purposing of staff). The Council cited some areas of concern, including the lack of transparency of methods used by proprietary predictive modeling tools, absence of vendor standards, lack of structured data across systems, and information security through downstream control of data. The Council also discussed uncertainties in how to use big data effectively to impact patient care. Specifically, membership education is needed on its use to enforce practice standards, enhance clinical decision support, guide treatment decisions, use for information only, and to assist with population health management. The Council indicated a desire to ensure elements of meaningful use are incorporated with advanced analytics to ensure outputs are actionable. Advanced analytics technologies hold great promise leveraging pharmacy services in rural practice settings to augment risk-stratification and clinical decision making capabilities. Given the length and variety of topics in the proposed policy recommendation, the Council recommended that the Section of Pharmacy Informatics and Technology (SOPIT) develop a statement on the future role of the pharmacist in the advanced analytics in healthcare. Consideration should be given to how the pharmacist should be involved on the front end for analysis and implementation, ways to re-purpose pharmacy staff to perform other value-added activities, and opportunities for amplifying clinical pharmacy roles by leveraging these technologies. The Council also recommended SOPIT explore any additional policy, *AJHP* publication, and/or education needs regarding these technologies.

## Role of Autoverification in Pharmacy Practice

The Council discussed the role of autoverification of medication orders in pharmacy practice. Autoverification can be seen as a way to decrease pharmacist time dedicated to medication order review in order to redirect pharmacist focus on performing medication management services, improving patient access, and ensuring safe and effective medication use during care transitions.

Autoverification occurs when a medication order becomes active on the basis of previously approved criteria without review by a pharmacist. According to the [2016 ASHP National Survey of Pharmacy Practice in Hospital Settings](#), 51.6% of hospitals make use of autoverification within a computerized provider order entry (CPOE) system.

Over the past few decades, advancements in technology have improved many healthcare processes. Specifically, technology has enhanced pharmacy efficiency in verifying medication orders. With advanced technology, most medication orders are now processed electronically through a CPOE system. These medication orders are routed to the pharmacist for review before being administered to a patient. However, advancements in technology have also allowed some medication orders to skip pharmacist review and be automatically verified. With autoverification, there is uncertainty if a medication order can be safely dispensed and administered without pharmacist review.

Clinical decision support (CDS), within electronic ordering systems, may act as a pharmacist surrogate by checking each medication order for drug-allergy interactions, dose limits, duplication of therapy, drug-drug interactions, or drug-disease interactions, along with many other programmable checks. During a medication order review, a pharmacist is alerted by CDS if there are any interactions. With the use of CDS, many medication orders could be on autoverification, especially if these medication orders have little associated risk or harm. By using a risk stratification method with CDS technology, pharmacist verification queues could decrease. This stratification method could allow autoverification on less risky medication orders and mandate pharmacist verification for more risky, high-alert orders. Pharmacy leaders should determine whether CDS can automate verification of medication orders without pharmacist review and ensure safe outcomes. If so, a determination must be made, with organization and medical staff approval, about which medication orders are deemed “safe enough” to allow bypass of pharmacist verification.

Currently, there is a paucity of literature and standards related to autoverification. The Joint Commission (TJC) considers pharmacists as integral to the medication management process. TJC expects that when onsite pharmacy services are available, pharmacists must review “all prescription or medication orders unless a licensed independent practitioner controls the ordering, preparation, and administration of the medication; or in urgent situations when the resulting delay would harm the patient, including situations in which the patient experiences a sudden change in clinical status.” Pharmacy leaders should consider pursuing opportunities for additional research on safety and workflow efficiencies to validate the use of autoverification.

The Council discussed the willingness of technology vendors to build and support architecture for risk-stratified assisted verification. Beyond the quality assurance aspects of autoverification, a concern of the Council was the potential impact autoverification models may have on pharmacy resource allocation based on workload tied to the requirement for prospective order review by a pharmacist.

The Council recommended ASHP support research on the safety of order verification models (e.g., risk-stratified assisted verification, protocol-based algorithms, centralized order verification) for select eligible orders before widespread adoption is supported. The Council also selected optimal order verification models as a topic for further discussion with the Section of Pharmacy Informatics and Technology to explore any policy, guideline, and/or education needs in this area.

## **Standardized Clinical Drug Nomenclature**

The Council discussed ASHP policy 0920, Standardized Clinical Drug Nomenclature, as part of sunset review. The Council acknowledged an opportunity to possibly merge this policy with ASHP policy 9011, Drug Nomenclature. However, after conferring, the Council on Public Policy was not in favor of merging the policies as they felt the intent of each policy was different. The Council decided review of and further discussion related to ASHP policy 0920 should be tabled until the winter conference call.

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# PHARMACY TECHNICIAN FORUM

## POLICY RECOMMENDATION

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*The Pharmacy Technician Forum serves as the collective voice for pharmacy technicians by supporting their advancement, professionalism, and engagement within ASHP.*

Kathleen S. Pawlicki, Board Liaison

### **Executive Committee**

Barbara Hintzen, *Chair* (Minnesota)

Margarita Fedorova (California)

Glen Gard (Illinois)

Tiffany Kofroth (Texas)

Tara McNulty (Florida)

Tyffani Wingfield, *Secretary*

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### **1. Pharmacy Technician Student Drug Testing**

- 1 To advocate for the use of pre-enrollment, random, and for-cause drug testing as a
- 2 mandatory component throughout any accredited or unaccredited pharmacy technician
- 3 training program and practice experience, based on defined criteria with appropriate
- 4 testing validation procedures; further,
  
- 5 To encourage pharmacy technician training programs to develop policies and processes
- 6 to identify impaired individuals; further,
  
- 7 To encourage pharmacy technician training programs to facilitate access to and promote
- 8 programs for treatment and to support recovery; further,
  
- 9 To encourage pharmacy technician training programs to use validated testing panels
- 10 that have demonstrated effectiveness detecting commonly misused, abused, or illegally
- 11 used substances.

### ***Rationale***

Pharmacy technicians are essential members of the healthcare team and help ensure the health, safety, and welfare of patients. They have access to controlled substances and confidential information, and operate in settings that require the exercise of good judgment and ethical behavior. In addition, some state boards of pharmacy have reported that drug-abusing and -diverting persons are enrolling in pharmacy technician training programs to access drugs during experiential training and employment. Thus, an assessment of a pharmacy technician student's possible impairment, which could diminish his or her capacity to function in such a setting, is imperative to promote the highest level of integrity in healthcare services.

ASHP recognizes that drug testing pharmacy technician students, whose responsibilities may bring them into contact with controlled substances, is an essential element of diversion prevention programs. Pre-enrollment, random, and for-cause drug testing should be performed based on defined criteria, with appropriate testing validation procedures, and have demonstrated effectiveness detecting commonly abused or illegally used substances.

**Background**

The Executive Committee of the Pharmacy Technician Forum met at the ASHP Midyear Meeting in December 2018 and considered the topic of drug testing for students in pharmacy technician training programs. They reviewed existing ASHP policy on drug testing for employees (ASHP policy 1717, [Drug Testing](#)) and students (ASHP policy 1826, [Student Pharmacist Drug Testing](#)) and concluded that a separate policy on drug testing for students in pharmacy technician training programs is needed.

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## SECTION OF INPATIENT CARE PRACTITIONERS POLICY RECOMMENDATION

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*The Section of Inpatient Care Practitioners supports the personal and professional development and broad interests of members to achieve optimal patient outcomes by promoting best practices, opportunities for networking, collaboration, and creating tools and resources for members across diverse inpatient practice settings.*

Paul C. Walker, Board Liaison

### **Executive Committee**

Todd Lemke, *Chair* (Minnesota)

Paul Milligan (Missouri)

Linda Spooner (Washington)

Susan Skledar (Pennsylvania)

Erika Thomas, *Director*

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### **1. ASHP Statement on the Role of the Medication Safety Leader**

- <sup>1</sup> To approve the ASHP Statement on the Role of the Medication Safety Leader (Appendix).



# House of Delegates

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## ASHP Statement on the Role of the Medication Safety Leader

### Position

The American Society of Health-System Pharmacists (ASHP) believes that medication safety is a fundamental responsibility of all members of the profession of pharmacy. For a medication safety program to succeed, however, it is essential that there be an innovative leader to set a vision and direction, identify opportunities to improve the medication-use system, and lead implementation of error-prevention strategies. The medication safety leader's role includes responsibility for leadership, medication safety expertise, influencing practice change, research, and education. ASHP believes that because of their training, knowledge of the medication-use process, skills, and abilities, pharmacists are uniquely qualified to fill the roles and meet the responsibilities of the medication safety leader in hospitals and health systems.

### Background

Hospital and health-system pharmacists have improved pharmacy systems over the past 60 years to reduce the risk that medications could harm patients. Medication safety was at the heart of such historic innovations in pharmacy services as unit-dose systems, decentralized clinical pharmacy services, and intravenous admixture services. The crucial leadership role of pharmacists in medication safety has been summarized as follows:

Pharmacy leadership is the core of a successful medication safety program. Pharmacy leaders can play an enormously important role in performance improvement. They can be part of the senior leadership team's DNA because their impact and view go far beyond the walls of the pharmacy . . . . Pharmacists can play an important role as leaders to reduce patient safety risks, optimize the safe function of medication



management systems, and align pharmacy services with national initiatives that measure and reward quality performance.<sup>1</sup>

The landmark Institute of Medicine (IOM) report *To Err Is Human: Building a Safer Health System*<sup>2</sup> generated major patient safety initiatives by government agencies, regulatory and accrediting bodies, professional and organizational associations, and health care organizations. The Joint Commission National Patient Safety Goals (NPSGs)<sup>3</sup> are an example of a response to the original IOM report. The Practice Advancement Initiative (PAI)<sup>4</sup> and the National Quality Forum (NQF) Safe Practice 18: Pharmacist Leadership Structures and Systems<sup>5</sup> incorporate medication safety principles to ensure optimal patient safety and outcomes.

The medication safety leader (also referred to as a medication safety officer, medication safety manager, or medication safety coordinator, among other titles) is a clinical practitioner designated by an organization to serve as the authoritative expert in safe medication use. Traditionally, the medication safety leader has been a clinical pharmacist or manager within the department of pharmacy, although the position is sometimes filled by a nurse or physician. The medication safety leader may report to the organization's risk-management department, its office of quality, or a senior administrator (e.g., hospital vice president, chief medical officer, chief executive officer). Reporting outside the pharmacy department may foster interdisciplinary approaches to medication safety. Medication safety leadership may encompass a single hospital or a group of organizations (e.g., spanning a health system or at a corporate level of a larger organization). Regardless of organization size, it is critical that the fundamentals of medication safety are the central component of the medication safety leader's job function. Although medication safety leaders may have other responsibilities in smaller institutions, medication safety should remain their core responsibility, and they must be strategically positioned and empowered to lead efforts to reduce the risks of medication use.

The characteristics of a medication safety leader include

1. A strong understanding of the facility's internal systems and processes developed through firsthand experience, observations, medication-use evaluations, interviews, and data analysis for the spectrum of patient populations treated in their organization

- (e.g., pediatric, geriatric, cardiac, oncology).
2. Clinical expertise and a broad understanding of health care systems and processes to facilitate accurate interpretation of clinical events.
  3. Knowledge of and experience with all aspects of the medication-use system, including procurement, prescribing, transcribing, preparation, distribution, administration, documentation, and monitoring.
  4. Strong analytical skills and an understanding of statistics, population data, and the concepts of risk and prioritization.
  5. Knowledge of performance-improvement methodology and tools, including root cause analysis (RCA), failure mode and effects analysis (FMEA), cause-and-effect diagramming, process-flow mapping, and methods for monitoring projects and measuring the progress of performance-improvement initiatives.
  6. Post-graduate specialized training (e.g., medication safety residency or fellowship) or three or more years of health-system practice experience.
  7. Demonstrated leadership skills.
  8. Excellent small- and large-group presentation skills.
  9. Excellent oral communication skills, especially the ability to communicate to all types of health care providers as individuals as well as in small and large groups.
  10. Excellent writing and editing skills.
  11. Strong personal belief that resolving the problem of medication errors is a systems issue and not an individual health care provider issue.
  12. Ability to function proactively rather than reactively.
  13. Strong personal belief in the concept of a “just culture”<sup>6</sup> that enhances transparency, opens participation to all health care professionals, and fosters a “lessons learned” environment in an organization’s medication error reporting system.
  14. Understanding of concepts and application of safety principles, continuous quality improvement, and human factors engineering.
  15. Appropriate assertiveness.
  16. A passion for medication safety and improving patient outcomes.

17. Proven success in working with interdisciplinary teams and engaging diverse groups.
18. Strong personal belief in engaging patients as part of the health care team.
19. Eagerness to learn from events outside one's own facility (e.g., through external sources of information) to apply learning about what went wrong in order to identify and remedy possible system weaknesses to prevent patient harm.

The scope of a medication safety leader's responsibilities reaches into every corner of the health care system and encompasses many roles, such as educator, preceptor, mentor, detective, compliance officer, risk manager, engineer, accountant, statistician, computer analyst, and counselor. A typical day may include attending safety rounds, precepting pharmacy students and residents, writing policies, reviewing adverse drug events and medication error reports,<sup>7</sup> developing error-prevention strategies, leading process-improvement teams, implementing action items, reviewing smart pump libraries, ensuring safe use of automated medication dispensing systems, assessing the safety of replacement drug products during drug shortages, orienting new professional staff, designing and optimizing the medication reconciliation process, conducting tracers to ensure compliance with accreditation standards (e.g., Joint Commission medication management standards and NPSGs), working with practitioners to resolve acute events, attending medical staff meetings, and educating staff and leaders across the system on the culture of safety. Most medication safety leaders quickly find themselves involved in many projects and committees as well as serving as the contact person when nursing, pharmacy, or medical staff have questions or problems. The medication safety leader needs a solid understanding of patient safety principles and must have the ability to prioritize work activities to have a positive impact on the safety of patient care. The medication safety leader should strive to acquire additional skills crucial to success, such as presentation and communication skills, as well as expertise in process-improvement methodologies such as Six Sigma and Lean. Formalized training in medication safety can be achieved through residency, fellowship, and certificate programs and other methods of continuing education. ASHP supports the expansion of pharmacy education and postgraduate residency training to include an emphasis on medication safety.<sup>8</sup>

## **Responsibilities of Medication Safety Leaders**

Medication safety leaders must collaborate with all types of health care professionals, support staff, and management and consider all components of the medication-use process in all settings of healthcare (e.g., inpatient, clinic, community pharmacies, drug distribution centers) in order to improve medication safety. The medication safety leader's role includes responsibility for leadership, medication safety expertise, influencing practice change, research, and education.

**Leadership.** To provide leadership, the medication safety leader will

1. Develop a vision of an ideal safe medication-use system for the organization.
2. Oversee the planning, creation, review, and refinement of a medication safety plan.
3. Proactively develop and lead implementation of error-prevention strategies based on practice standards, best practice guidelines (or recommendations), literature review, external error reports, medication safety tools, and analysis of the organization's medication safety data.
4. Participate in the planning, design, and implementation of the organization's medication-use technology and automation systems.
5. Build a culture of safety through "lesson learned" education and communication across the entire organization.
6. Oversee processes to collect information on the organization's medication errors and system failures to ensure that they are captured and barriers to reporting are addressed.
7. Ensure compliance with state and federal regulatory and legal requirements relating to medication safety and assist in the accreditation process by ensuring that the organization's medication-use processes meet applicable medication management standards and NPSGs.

**Medication Safety Expertise.** In the role of medication safety expert, the medication safety leader will

1. Serve as an authoritative resource on medication safety for the organization.
2. Contribute the medication safety perspective for technology initiatives.
3. Contribute the medication safety perspective to internal and external emergency-preparedness planning.
4. Serve as an internal consultant to investigate medication safety events or issues and develop recommendations for action.
5. Serve as the chair of the medication safety committee, whose duties may include setting the agenda, reviewing general and specific error reports, and examining the progress of projects and initiatives assigned to the medication safety team.
6. Be knowledgeable in the application and use of a variety of quality-improvement methodologies and tools (e.g., FOCUS-PDCA or Lean methodologies, RCA, FMEA).
7. Collect, review, and analyze the organization's medication-use process, medication errors, adverse drug reactions, and continuous quality-improvement data (e.g., markers of adverse drug events, smart pump event data, triggers and surveillance information, automated dispensing system and bedside bar-code scanning reports) and use appropriate data analysis techniques to identify needed improvements and develop high-leverage error-reduction strategies.
8. Predict and prepare to manage medication safety issues caused by potential or actual drug product shortages and the use of replacement drug products.
9. Maintain knowledge of trends and developments in the patient safety field through continuous professional development: reading articles, journals, and related material; attending appropriate seminars, conferences, or educational programs; and using information from the Institute of Safe Medication Practices (ISMP) National Medication Error Reporting Program, the Food and Drug Administration (FDA) MedWatch program, and similar programs.
10. Participate at local and national levels in patient safety and medication safety organizations and initiatives. Medication safety leaders are also encouraged to seek and share best practices with other regional safety leaders and practice sites.

***Influencing Practice Change.*** To influence practice change, the medication safety leader will

1. Collaborate with other departments (e.g., pharmacy, risk management, patient safety), hospital or health-system senior leadership, frontline staff, and nursing and medical staff leadership to identify and prioritize safety issues and develop risk-reduction strategies using the methods listed above to identify opportunities to improve medication safety.
2. Manage changes in the medication-use system to enhance medication safety, ensure that appropriate measures are taken to address and resolve medication safety issues, and see that hospital staff and faculty are supported in providing safe care for patients.
3. Work closely with others (e.g., the patient safety officer) to integrate medication safety into the overall strategic plan for patient safety and coordinate medication safety initiatives with organizational patient safety initiatives.
4. Participate in or lead multidisciplinary hospital and health-system committees concerned with medication errors, adverse drug events and reactions, near misses, policy review, safe medication use, new product review, and patient safety to identify risk points and prioritize system improvements to reduce the potential for medication error and patient harm.
5. Consult with and advise specific clinical teams and the hospital and health system generally on opportunities and strategies to improve patient care.
6. Encourage organization wide medication error reporting through an established and accepted error reporting system that utilizes appropriate error detection methods (e.g., trigger tools) and through other appropriate avenues such as the pharmacy and therapeutics committee, medication safety committee, and patient safety committee.
7. Develop effective methods for spreading best medication-use practices throughout the organization.
8. Use continuous quality-improvement principles to assess and report on the status of efforts to improve medication safety.
9. Periodically review and update clinical decision-support tools to alert staff to high-risk situations and educate staff as needed.

**Research and Education.** To further research and education regarding medication safety, the medication safety leader will

1. Design and assist in the implementation of education and orientation programs in safe medication use, including
2. Development of competency assessment for
  - staff tasks related to medication safety (e.g., use of smart pumps and automated medication dispensing systems);
  - Education of health care providers, other pertinent staff, and (as possible) patients to ensure they are competent in safe medication-use practices; and
  - Provision of effective ongoing programs and presentations related to safe medication use to diverse audiences (e.g., nursing, pharmacy, respiratory care, and medical staff).
3. Share information about actual or potential medication errors or harm with safety organizations such as ISMP, FDA, drug or product manufacturers, and state error reporting programs.
4. Conduct medication-use safety research through well-designed, externally validated studies and implement evidence-based practices for medication safety.
5. Contribute to the literature on medication safety.
6. Provide medication safety education to pharmacy colleagues, students, and residents, as well as other health care professionals.
7. Integrate medication safety into orientation and training for all health care providers who participate in the medication-use process.

## Conclusion

ASHP believes that pharmacists, as experts on medication use, are uniquely qualified to serve as medication safety leaders. Medication safety leaders articulate the vision and direction for improving the safety of the medication-use system to prevent patient harm. The medication safety leader's role includes responsibility for leadership through direction and prioritization,

medication safety expertise, influencing practice change, research, and education. Through analysis of the organization's medication safety data and literature review, the medication safety leader will lead development and implementation of proactive error-prevention strategies and build a culture of safety across the organization.

## References

1. Burgess LH, Cohen MR, Denham CR. A new leadership role for pharmacists: a prescription for change. *J Patient Saf.* 2010; 6:31–7.
2. Kohn LT, Corrigan JM, Donaldson MS, eds. *To err is human: building a safer health system.* Washington, DC: National Academy Press; 1999.
3. The Joint Commission. Facts about the National Patient Safety goals. [https://www.jointcommission.org/facts\\_about\\_the\\_national\\_patient\\_safety\\_goals/](https://www.jointcommission.org/facts_about_the_national_patient_safety_goals/) (accessed 2019 March 7).
4. The consensus of the Pharmacy Practice Model Summit. *Am J Health-Syst Pharm.* 2011; 68:1148–52.
5. National Quality Forum. Safe practices for better healthcare 2009 update: a consensus report. [https://www.qualityforum.org/Publications/2009/03/Safe\\_Practices\\_for\\_Better\\_Healthcare%20%932009\\_Update.aspx](https://www.qualityforum.org/Publications/2009/03/Safe_Practices_for_Better_Healthcare%20%932009_Update.aspx) (accessed 2019 March 7).
6. Marx D. *Patient safety and the “just culture”: a primer for health care executives.* New York: Columbia University Press; 2001.
7. National Coordinating Council for Medication Error Reporting and Prevention. Contemporary view of medication-related harm: a new paradigm. 2015. [http://www.nccmerp.org/sites/default/files/nccmerp\\_fact\\_sheet\\_2015-02-v91.pdf](http://www.nccmerp.org/sites/default/files/nccmerp_fact_sheet_2015-02-v91.pdf) (accessed 2019 March 7).
8. American Society of Health-System Pharmacists. Required educational outcomes, goals, and objectives for postgraduate year two (PGY2) pharmacy residencies in medication-use safety. <https://www.ashp.org/-/media/assets/professional-development/residencies/docs/pgy2-medication-use->



[safety.ashx?la=en&hash=642AFA9DCC931BE72EF8877DCD1AC5095D286B60](https://www.ashp.org/safety.ashx?la=en&hash=642AFA9DCC931BE72EF8877DCD1AC5095D286B60)

(accessed 2019 March 7).

### Suggested Readings

1. Larson CM, Saine D. Medication safety officer's handbook. Bethesda, MD: American Society of Health-System Pharmacists. 2013.
2. Cohen MR, ed. Medication errors. Washington, DC: American Pharmacists Association; 2007.
3. Manasse HR, Thompson KK, eds. Medication safety: a guide for health care facilities. Bethesda, MD: American Society of Health-System Pharmacists; 2005.
4. Hepler CD, Segal R. Preventing medication errors and improving drug therapy outcomes: a management systems approach. Boca Raton, FL: CRC Press; 2003.
5. Joint Commission Resources. Medication use: a systems approach to reducing errors, 2nd ed. Oakbrook Terrace, IL: Joint Commission Resources; 2008.
6. Committee on Quality of Health Care in America, Institute of Medicine. Crossing the quality chasm: a new health system for the 21st century. Washington, DC: National Academy Press; 2001.
7. Committee on Data Standards for Patient Safety, Institute of Medicine. Patient safety: achieving a new standard for care. Washington, DC: National Academy Press; 2004.
8. Committee on the Work Environment for Nurses and Patient Safety, Board on Health Care Services, Institute of Medicine. Page A, ed. Keeping patients safe: transforming the work environment of nurses. Washington, DC: National Academy Press; 2004.
9. Committee on Identifying and Preventing Medication Errors, Board on Health Care Services, Institute of Medicine. Aspden P, Wolcott JA, Bootman JL, et al., eds. Preventing medication errors. Washington, DC: National Academy Press; 2007.
10. National Patient Safety Foundation. Free from harm: accelerating patient safety improvement fifteen years after to err is human. 2015.  
<http://www.npsf.org/?page=freefromharm> (accessed 2019 March 7).
11. Vaida AJ, Lamis RL, Kenward K, Cohen MR. Assessing the state of safe medication practices

using the ISMP medication safety self-assessment for hospitals: 2000 and 2011. *Jt Comm J Qual Patient Saf.* 2014 Feb;40(2):51-67.

<https://www.ncbi.nlm.nih.gov/pubmed/?term=24716328> (accessed 2019 March 7).

12. Chassin MR, Loeb JM. High-reliability health care: getting there from here. The Joint Commission. 2013.

[https://www.jointcommission.org/assets/1/6/Chassin\\_and\\_Loeb\\_0913\\_final.pdf](https://www.jointcommission.org/assets/1/6/Chassin_and_Loeb_0913_final.pdf)

13. Hertig J, Hultgren K, Weber R. Using contemporary leadership skills in medication safety programs. *Hospital Pharmacy* [serial online]. April 2016;51(4):338-344.

<https://www.ncbi.nlm.nih.gov/pubmed/27303083> (accessed 2019 March 7).

14. American Hospital Association, Health Research & Education Trust, and the Institute for Safe Medication Practices. Pathways for Medication Safety: Leading a Strategic Planning Effort. 2002. <http://www.ismp.org/tools/PathwaySection1.pdf> (accessed 2019 March 7).

15. American Hospital Association, Health Research & Education Trust, and the Institute for Safe Medication Practices. Pathways for medication safety: looking collectively at risk. 2002.

<http://www.ismp.org/tools/PathwaySection2.pdf> (accessed 2019 March 7).

### Web Resources

[www.ashp.org](http://www.ashp.org)

[www.ismp.org](http://www.ismp.org)

[www.safemedication.com](http://www.safemedication.com)

[www.medsafetyofficer.org](http://www.medsafetyofficer.org)

[www.asmsso.org](http://www.asmsso.org)

[www.ahrq.gov](http://www.ahrq.gov)

[www.fda.gov/cder/drugSafety.htm](http://www.fda.gov/cder/drugSafety.htm)

[www.ihl.org](http://www.ihl.org)

[www.jointcommission.org/standards\\_information/npsgs.aspx](http://www.jointcommission.org/standards_information/npsgs.aspx)

[www.leapfroggroup.org](http://www.leapfroggroup.org)

[www.qualityforum.org](http://www.qualityforum.org)

[www.nccmerp.org](http://www.nccmerp.org)

[www.usp.org](http://www.usp.org)

[www.patientsafety.gov](http://www.patientsafety.gov)

[www.npsf.org](http://www.npsf.org)

Approved by the ASHP Board of Directors on February 13, 2019. Developed through the ASHP Section of Inpatient Care Practitioners Section Advisory Group on Medication Safety.

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# House of Delegates

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## Supplemental Board of Directors Report: Policy Recommendations for the June 2019 House of Delegates

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# COUNCIL ON PHARMACY PRACTICE

## POLICY RECOMMENDATION

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*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.*

Paul C. Walker, *Board Liaison*

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Andrew Stivers (Georgia)  
Anna L. Dopp, *Secretary*

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## **2. Compounded Sterile Preparation Verification**

- 1 To advocate that health systems adopt automation and information technology to
- 2 facilitate in-process and final verification of compounded sterile preparations (CSPs) to
- 3 ensure CSP quality; further,
  
- 4 To advocate that, until such time as automation or technology can be implemented,
- 5 independent in-process and final verification of CSPs be performed; further,
  
- 6 To oppose the use of the syringe pull-back method or other proxy methods of CSP
- 7 verification.

(Note: This policy would supersede ASHP policy 1617.)

### **Rationale**

Adoption of automation and information technology for preparing and dispensing compounded sterile preparations (CSPs) is increasing but not evenly distributed among healthcare organizations. A 2017 ASHP survey showed that 64% of hospitals did not use any technology for sterile product preparation activities. Only 26.9% of health systems surveyed employed barcode verification in their IV medication preparation and verification process. The survey

found that 12.8% of all health systems surveyed used drug workflow software to manage IV drug preparation, verification, and dispensing. There are many reasons for these disparate rates of adoption. Each institution has a different break-even point of investment versus return, and challenges of implementation can be daunting. Some organizations have implemented automated compounding technology only to withdraw it later. These technologies may slow the preparation and verification process; however, the enhanced safety outweighs losses in operational efficiency.

Information technology and automation, including robotics, can be used to improve the safety of CSP compounding. Although IV workflow technologies continue to be developed and improved, the majority of pharmacy departments continue to compound manually without the assistance of barcode or other technologies. Health systems have been slow to adopt IV workflow technology, with only 27% of respondents to the 2017 survey indicating their departments use barcode scanning to verify the ingredients in CSPs. If automated procedures are not employed, there are only two methods of in-process or final verification: real-time, direct, and independent visualization, or retroactive, proxy verification (e.g., the syringe pull-back method). The dangers of the syringe pull-back method have been well demonstrated, and the 2016 Institute for Safe Medication Practices (ISMP) [Guidelines for Safe Preparation of Compounded Sterile Preparations](#) discourage its use.

### **Background**

The Council reviewed ASHP policy 1617, Automated Preparation and Dispensing Technology for Sterile Preparations, in light of USP Chapter 800 and the recently approved ASHP Guidelines on Handling Hazardous Drugs. After reviewing and accepting suggested edits from the Board of Directors, the Council voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

To advocate that health systems adopt automation and information technology to facilitate in-process and final verification of compounded sterile preparations (CSPs) to ensure CSP quality for preparing and dispensing compounded sterile preparations when such adoption is (1) planned, implemented, and managed with pharmacists' involvement; (2) implemented with adequate resources to promote successful development and maintenance; and (3) supported by policies and procedures that ensure the safety, effectiveness, and efficiency of the medication use process; further,

To advocate that, until such time as automation or technology can be implemented, independent in-process and final verification of CSPs be performed; further,

To oppose the use of the syringe pull-back method or other proxy methods of CSP verification.

~~To educate patient safety advocacy groups and regulatory agencies on the capabilities and benefits of automation and technology for preparing and dispensing compounded sterile preparations, and to encourage them to establish expectation of adoption by health systems; further,~~

~~To foster further research, development, and publication of best practices regarding automation and information technology for preparing and dispensing sterile preparations.~~

The Council noted that the text deleted from the first clause was redundant with ASHP policy 1020, Role of Pharmacists in Safe Technology Implementation, which states that pharmacists have an essential role "in the evaluation, implementation, and ongoing assessment of all technology intended to ensure safety, effectiveness, and efficiency of the medication-use process." The Council further noted that patient safety advocacy groups, such as ISMP, have been made aware of the benefits of automation and technology for preparing and dispensing CSPs, and that research, development, and publication of best practices regarding automation and information technology in preparing and dispensing CSPs is ongoing. The Council recognized the barriers to adoption of such technology and recommended that ASHP take a stand in opposition to the syringe pull-back method of CSP verification and in favor of real-time, direct, and independent visualization.

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## COUNCIL ON PUBLIC POLICY

### POLICY RECOMMENDATIONS

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*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.*

Todd A. Karpinski, *Board Liaison*

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#### **5. 340B Drug Pricing Program Sustainability**

- 1 To affirm the intent of the federal drug pricing program (the "340B program") to stretch  
2 scarce federal resources as far as possible, reaching more eligible patients and providing  
3 more comprehensive services; further,
- 4 To advocate legislation or regulation to ensure continued access to the 340B program in  
5 accordance with the intent of the program; further,
- 6 To advocate that reimbursement and contracting policies promote 340B program  
7 stability and to oppose reimbursement and savings reductions to covered entities;  
8 further,
- 9 To advocate for clarification and simplification of the 340B program and any future  
10 federal discount drug pricing programs with respect to program definitions, eligibility,  
11 and compliance measures to ensure the integrity of the program; further,
- 12 To encourage 340B participants to provide appropriate stewardship of the 340B  
13 program; further,



- 14 To educate pharmacy leaders and health-system administrators about the internal  
15 partnerships and accountabilities and the patient-care benefits of program participation;  
16 further,
- 17 To educate health-system administrators, risk managers, and pharmacists about the  
18 resources required to support 340B program compliance and documentation; further,
- 19 To encourage communication and education concerning the value of the 340B program;  
20 further,
- 21 To advocate that the Health Resources & Services Administration Office of Pharmacy  
22 Affairs have sufficient regulatory authority to enforce compliance with the 340B  
23 program.

(Note: This policy would supersede ASHP policy 1817.)

### **Rationale**

Statutory and other policy changes to the federal drug pricing (“340B”) program over the years have spurred an increase in the number of hospitals and other eligible entities that participate. Since the program’s inception, the number of 340B-eligible and participating hospitals has continued to grow. In response, policymakers and other stakeholders have raised questions over how the discounts are used by covered entities and what value the program brings to their respective communities. Congress has held hearings, and bills have been introduced to reform the program. Among the items Congress is considering are transparency, increasing authority of the Health Resources & Services Administration (HRSA) to oversee the program, reimbursement cuts imposed under Medicare Part B on 340B drugs, and examining policy that passes the discount along to the patient.

Expansion of Medicaid eligibility in 2014 (through provisions in the Affordable Care Act) allowed additional hospitals to participate in the program, further driving scrutiny and questions from policymakers and stakeholders. In response to policymaker and stakeholder concerns, ASHP recognizes the important intent and role of the 340B program and stresses the need for its continued sustainability. These developments demonstrate the need for pharmacy leaders to engage in a strategic response to this compliance environment.

The original intent of the 340B program was to “to enable these entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.” (H.R. Rept. 102-384, pt. 2, at 12 [1992]). ASHP emphasizes the need for clarification and simplification (to the extent possible) of the program in order to enable compliance and maintain program integrity. Further, there is a need for communication and collaboration with public and private payers to ensure optimization of benefits from the 340B program and related contract and reimbursement policies.

**Background**

At its September 2018 meeting, the Council recommended amending ASHP policy 1817, 340B Drug Pricing Program Sustainability, and the Board approved the recommendation. At its February 2019 meeting, the Council recommended further amending the policy recommendation to address recent actions by payers to impose different terms and conditions on 340B pharmacies than on other pharmacies, in effect clawing back to the payer savings provided by the 340B program to covered entities. The amendments to policy 1817 recommended by the Council at its September and February meetings are as follows (underline indicates new text; ~~strike through~~ indicates deleted text):

To affirm the intent of the federal drug pricing program (the “340B program”) to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services; further,

To advocate legislation or regulation that would ~~optimize~~ ensure continued access to the 340B program in accordance with the intent of the program; further,

To advocate ~~with state Medicaid programs to ensure~~ that reimbursement and contracting policies promote 340B program stability and to oppose reimbursement and savings reductions to contracted entities; further,

To advocate for clarification and simplification of the 340B program and any future federal discount drug pricing programs with respect to program definitions, eligibility, and compliance measures to ensure the integrity of the program; further,

To encourage 340B participants ~~pharmacy and health-system leaders~~ to provide appropriate stewardship of the 340B program ~~by documenting the expanded services and access created by the program~~; further,

To educate pharmacy leaders and health-system administrators about the internal partnerships and accountabilities and the patient-care benefits of program participation; further,

To educate health-system administrators, risk managers, and pharmacists about the resources required to support 340B program compliance and documentation; further,

To encourage communication and education concerning the value of the 340B program ~~expanded services and access provided by 340B participants to patients in fulfillment of its mission~~; further,

To advocate that the Health Resources & Services Administration Office of Pharmacy Affairs have sufficient regulatory authority to enforce compliance with the 340B program.

The purpose of this policy is to clarify ASHP's stance on the 340B program in light of reform efforts by Congress and federal agencies. The Council was charged with examining existing ASHP policy on the 340B program and determining whether new policy is needed. The Council reviewed ASHP policy 1817, 340B Drug Pricing Program Sustainability, and recommended several changes to the policy. First, the Council removed any wording that could be interpreted to suggest ASHP is pursuing program expansion. ASHP previously supported expanding the 340B discount to cover inpatient care, but noting how the program and the increase in number of covered entities have been depicted by critics, the Council suggested backing away from advocating program expansion, as increased scrutiny has made expansion highly unlikely. Second, the Council discussed issues such as program transparency and the recent release of [340B stewardship resources](#) by the American Hospital Association. The Council observed that current policy calls for stewardship of the 340B program and encourages communication about the value of the program to the public. The Council noted that the policy language very broadly supports concepts such as program transparency and concluded that no additional language was needed. The Council further concluded that program transparency should also include communicating the value of the program to the public at large, emphasizing that the program actually saves the government and taxpayers money, as it is not publicly funded.

The Council made two additions to the policy. The first is the recognition that HRSA's Office of Pharmacy Affairs is the proper regulatory body to oversee the program. The statutory authority rests with HRSA. However, HRSA has been limited in its ability to issue regulations enforcing the program's requirements. A recent letter from Senator Orrin Hatch (R-Utah) to the Secretary of Health and Human Services suggested that CMS could assume authority to regulate the 340B program. The Council believes that HRSA is the appropriate body to regulate the program. Second, the Council included specific language that opposing cuts under Medicare Part B and state Medicaid programs that reduce reimbursement for drugs purchased under the program that could deter participation in the 340B program. Finally, the Council added language advocating that savings under the program be retained by the covered entity and not clawed back by payers, in accordance with the program's intent to stretch scarce federal resources as far as possible in caring for patients rather than as a source of revenue for payers.

## 6. Pharmacist Authority to Provide Medication-Assisted Treatment

- 1 To advocate for the role of the pharmacist in medication-assisted treatment (MAT) for
- 2 opioid use disorder, including patient assessment, education, and prescribing of
- 3 pharmacologic therapies; further,
- 4 To pursue the development of federal and state laws and regulations that recognize
- 5 pharmacists as providers of MAT for opioid use disorder.

### **Rationale**

An estimated 2.5 million Americans suffer from opioid use disorder. In 2017, the President's Commission on Combating Drug Addiction and the Opioid Crisis recommended that the U.S.

increase screenings and treatment for opioid use disorder. Many pharmacists have the skills to provide direct care to patients with opioid addiction or assist other healthcare providers in caring for these patients. Although some states allow pharmacists to prescribe controlled substances under collaborative practice agreements, pharmacists are not eligible to obtain a waiver under the Drug Addiction Treatment Act of 2000 to prescribe buprenorphine or other drugs for opioid use disorder. Having such prescribing authority would allow pharmacists to fully exercise their expertise and expand the pool of MAT providers.

**Background**

The Council considered this topic in response to concerns expressed by members and state affiliates that pharmacists are not eligible to obtain a waiver under the Drug Addiction Treatment Act of 2000 to prescribe buprenorphine and other drugs for opioid-use disorder, which limits their role in providing MAT for opioid use disorder.

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# COUNCIL ON EDUCATION AND WORKFORCE DEVELOPMENT POLICY RECOMMENDATION

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*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.*

Stephen F. Eckel, *Board Liaison*

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Krystal Moorman (Utah)  
Garrett Schramm (Minnesota)  
Rebecca Taylor (Ohio)  
Molly Wascher, *New Practitioner* (Maryland)  
Erika Thomas, *Secretary*

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## **2. Pharmacy Technician Training and Certification**

- 1 To advocate that the completion of a pharmacy technician education and training
- 2 program accredited by ASHP and the Accreditation Council for Pharmacy Education
- 3 (ACPE) be required for all new pharmacy technicians by the year 2022; further,
  
- 4 To advocate that all pharmacy technicians be required to obtain and maintain
- 5 Pharmacy Technician Certification Board certification; further,
  
- 6 To foster expansion of ASHP/ACPE-accredited pharmacy technician education and
- 7 training programs.

(Note: This policy would supersede ASHP policy 1609.)

### **Rationale**

In January 2017, the Pharmacy Technician Certification Board (PTCB) suspended the condition that by 2020 the completion of an accredited technician education and training program is required to be eligible for the PTCB certification exam. There is no indication that PTCB will reinstate that requirement; however, ASHP supports completion of an education and training



program accredited by ASHP and the Accreditation Council for Pharmacy Education (ACPE) as well as PTCB certification for all pharmacy technicians. Although education requirements have been added by PTCB to take the certification exam starting in 2020, completion of an accredited education and training program is only one pathway for eligibility for the exam; PTCB also recognizes equivalent work experience. If an applicant has completed an unaccredited program, there is a required attestation for the content of that program.

In 2018, ASHP and ACPE developed revised national standards that serve as a guide for the development of ASHP/ACPE-accredited pharmacy technician education and training programs. These standards serve as the criteria for the evaluation of new and established pharmacy technician training programs and will help ensure that pharmacy technicians possess the knowledge, skills, and abilities necessary for their critical role on the healthcare team. A number of environmental factors, including changes in state laws allowing for expanded roles, responsibilities, and authority for pharmacy technicians, prompted the reassessment of the standards, which were last revised in 2015. ASHP supports more uniform state statutes and regulations regarding pharmacy technicians. The anticipated increase in demand for enrollment in ASHP/ACPE-accredited training programs will require an expansion of the number and distribution of such programs, including innovative education and training formats.

The target date of 2022 was included to provide a goal for requiring that all new pharmacy technicians in hospitals and health systems complete a pharmacy technician education and training program accredited by ASHP and the Accreditation Council for Pharmacy Education (ACPE). The date is in line with the initiatives and timeline of the Stakeholder Advisory Committee (the Committee). This Committee continues to advance the recommendations of the Pharmacy Technician Stakeholder Consensus Conference ([\*Toward uniform standards for pharmacy technicians: Summary of the 2017 Pharmacy Technician Stakeholder Consensus Conference\*](#)), the national consensus conference that engaged all sectors of pharmacy to define basic knowledge, skills, and abilities of pharmacy technicians, to promote and define advanced competencies, and to promote national definitions and regulation of pharmacy technicians. The Committee uses the recommendations and consensus statements to guide their work. Two of these statements are as follows:

- 2.1 The profession of pharmacy should move urgently towards the development and adoption of national standards for pharmacy technician education.
- 2.2 The profession of pharmacy should set a target for implementation of the national standard for pharmacy technician education at 3 to 5 years after adoption of the standard.

The accreditation standard for the education and training of pharmacy technicians was revised and approved by both the ASHP and ACPE Boards in June of 2018. Consistent with recommendation 2.2, 2022 is a reasonable target to require accredited training for new pharmacy technicians as it is four years from the time new standard was developed.

The Committee is currently working with the National Association of Boards of Pharmacy (NABP) to modify the *Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy*. NABP will consider commissioning a task force to evaluate the needs for a national licensure exam as well as educational and experiential prerequisites. Additionally, work is being done at the state level with individual boards of

pharmacy to evaluate requirements for accredited education and training for new pharmacy technicians. This activity follows the consensus statement below:

5.2 The level of urgency for achieving state-to-state consistency in regulation of pharmacy technicians' scope of practice, education, certification, and licensure or regulation is high.

### **Background**

In September 2018, the Council reviewed ASHP policy 1609, Pharmacy Technician Training and Certification, as part of sunset review and voted to recommend amending it. In November 2018, PTCB made changes to the eligibility requirements for its certification exam. After considering the Council's policy recommendation in January 2019, the Board referred the recommendation to the Council for reconsideration to address PTCB's changes. The Council met in February 2019 and recommended amending ASHP policy 1609 as follows (underscore indicates new text; ~~strike through~~ indicates deletions):

To ~~support the position that by the year 2020,~~ advocate that the completion of a pharmacy technician education and training program accredited by ASHP and the Accreditation Council for Pharmacy Education (ACPE) be required ~~to obtain PTCB certification~~ for all new pharmacy technicians by the year 2022; further, [clause moved]

~~To advocate that Pharmacy Technician Certification Board (PTCB) certification be required for all pharmacy technicians; further,~~

To advocate that all pharmacy technicians be required to obtain and maintain Pharmacy Technician Certification Board ~~PTCB~~ certification; further,

To foster expansion of ASHP/ACPE-accredited pharmacy technician education and training programs.

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# COUNCIL ON PHARMACY MANAGEMENT

## POLICY RECOMMENDATION

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*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.*

Jennifer M. Schultz, *Board Liaison*

### **Council Members**

Katherine Miller, *Chair* (Missouri)  
Victoria Serrano Adams, *Vice Chair* (California)  
Nitish Bangalore (Wisconsin)  
Patrice Dupart (New York)  
Monica Dziuba (Louisiana)  
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Staci Hermann (New Hampshire)  
Rondell Jagers (Georgia)  
Trinh Le (North Carolina)  
Bonnie Levin (Maryland)  
Stuart Pope, *Student* (Kentucky)  
Anthony Trovato, *New Practitioner* (Utah)  
Eric Maroyka, *Secretary*

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### **4. Intimidating or Disruptive Behavior**

- 1 To affirm the professional responsibility of the pharmacist to ensure patient and
- 2 workplace safety by communicating with other healthcare personnel to clarify and
- 3 improve medication management; further,
  
- 4 To advocate that hospitals and health systems adopt zero-tolerance policies for
- 5 intimidating or disruptive behaviors in their institutions; further,
  
- 6 To encourage hospitals and health systems to develop and implement education and
- 7 training programs for all healthcare personnel to encourage effective communication,
- 8 set expectations for standards of conduct, promote use of de-escalation techniques, and
- 9 discourage intimidating or disruptive behaviors; further,
  
- 10 To encourage colleges of pharmacy and residency training programs to incorporate
- 11 training in communications and managing intimidating or disruptive behaviors; further,
  
- 12 To collaborate with other organizations to advocate codes of conduct that minimize
- 13 intimidating or disruptive behavior in hospitals and health systems; further,



- 14 To encourage hospitals and health systems to adopt processes for identification and  
15 reporting of intimidating or disruptive behaviors to evaluate and mitigate unacceptable  
16 behaviors in a timely and effective manner.

(Note: This policy would supersede ASHP policy 0919.)

### **Rationale**

Intimidating or disruptive behaviors can lead to medical errors, contribute to poor patient satisfaction, increase costs, and cause staff turnover. Such behaviors range from passive behaviors such as providers refusing to answer questions or return pages to use of condescending language to overt actions such as verbal outbursts or physical threats. The Institute for Safe Medication Practices conducted a national survey regarding intimidation in the workplace in 2003 and conducted a follow-up survey in 2013 for comparison. There has been no reduction between 2003 and 2013 in the percentage of respondents who were aware of a medication error during the year in which disrespectful behavior played a role.

In addition, healthcare workers face an increased risk of work-related assaults resulting primarily from intimidating or disruptive behavior of patients and their caregivers or family members. Disruptive behavior, including interference with treatment plans, vulgar language, and threatening statements, can impede a healthcare worker's ability to provide safe and effective care. While such behavior is often overlooked, underreported, or considered to be part of the job, it can also lead to more serious confrontations. Unfortunately, there is no clear way to identify patients or family members who will be disruptive to healthcare personnel, so every patient and family member must be treated with the same level of caution.

According to the Bureau of Labor Statistics and National Crime Victimization Survey, more assaults occur in the healthcare and social services industries than in any other industry. For healthcare workers, assaults comprise 10-11% of workplace injuries involving days away from work, compared with 3% of injuries of all private sector employees. Further, it has been identified that workplace violence can harm a person's intrinsic sense of self-worth and confidence, which can result in physical symptoms including headaches, anxiety, and depression. The American Nurses Association and the American Medical Association have taken positions concerning violence against healthcare workers and are actively promoting solutions to address the issue.

ASHP believes organizations should develop training programs to discourage disruptive behaviors and to train employees in handling disruptive situations, including de-escalation techniques, and colleges of pharmacy and residency training programs should also provide such training. These organizational efforts will help with compliance with The Joint Commission leadership standard on disruptive behavior (LD.03.01.01), which suggests that healthcare organizations should "educate all team members – both physicians and non-physician staff – on appropriate professional behavior defined by the organization's code of conduct. The code and education should emphasize respect. Include training in basic business etiquette (particularly phone skills) and people skills."

**Background**

The Council discussed ASHP policies 0810, Education, Prevention, and Enforcement Concerning Workplace Violence, and 0919, Intimidating and Disruptive Behaviors, to determine whether ASHP policy adequately addresses threatening or abusive behavior of patients and family members toward pharmacy staff. The Council voted to recommend amending policy 0919 to read as follows (underscore indicates new text; ~~striketrough~~ indicates deletions):

To affirm the professional responsibility of the pharmacist to ensure patient and workplace safety by communicating with other healthcare personnel to clarify and improve medication management; further,

To advocate that hospitals and health systems adopt zero-tolerance policies for intimidating or disruptive behaviors in their institutions; further,

To encourage hospitals and health systems to develop and implement education and training programs for all healthcare personnel to encourage effective communication, set expectations for standards of conduct, promote use of de-escalation techniques, and discourage intimidating or disruptive behaviors; further,

To encourage colleges of pharmacy and residency training programs to incorporate training in communications and managing intimidating or disruptive behaviors; further,

To collaborate with other organizations to advocate codes of conduct that minimize intimidating or disruptive behavior in hospitals and health systems; further,

To encourage hospitals and health systems to adopt processes for identification and reporting of intimidating or disruptive behaviors to evaluate and mitigate unacceptable behaviors in a timely and effective manner.

This policy was amended to expand its scope, including mention of disruptive or intimidating behavior by patients and family members and support for reporting mechanisms to maintain acceptable standards of conduct.

## 2019 report of the ASHP treasurer

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2019; 76:1437-1439

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**Keywords:** assets, finance

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Each year, the treasurer has the responsibility to report to the membership on ASHP's financial condition. ASHP's fiscal year is from June 1 through May 31, coinciding with our policy development process and timetable. This report describes ASHP's actual financial performance for fiscal year 2018, projected financial performance for fiscal year 2019, and the fiscal year 2020 budget.

### Fiscal Year 2018 (Ending May 31, 2018)—Actual

ASHP's fiscal year 2018 financial audit ending May 31, 2018, was performed by the independent audit firm of Tate & Tryon. The audit resulted in ASHP receiving the best opinion available, an unmodified opinion.

ASHP's core operations<sup>1</sup> had another successful year. Core gross revenue grew to \$50.3 million, or by 3% over fiscal year 2017 (Figure 1), primarily due to strong membership growth, the success of the Midyear Clinical Meeting, and growth in residency accreditation services. Membership grew to nearly 45,000 as of December 31, 2017, which represents a 2.2% increase from the prior year. The core net income was a surplus of \$1.48 million. The program development and capital budget<sup>2</sup> had a surplus of \$767,000, primarily due to better-than-budgeted

We are proud to have nearly 50,000 members and to be at the forefront of improving medication use and enhancing patient safety.



investment income. Spending from reserves/net assets<sup>3</sup> was \$839,000, and there was a favorable pension adjustment of \$425,000. The building sale reserve funds<sup>4</sup> had a surplus of \$570,000, primarily due to strong investment returns. The building fund<sup>5</sup> had an accrual accounting deficit of \$521,000, primarily due to depreciation expense. This was anticipated in the financial model, and the building fund is on track to continue supporting ASHP's building/office space expenses and reach its long-term financial target.

ASHP's reserves/net assets on May 31, 2018, represented 83%<sup>6</sup> of the total fiscal year 2018 expense. Our long-term financial policy is to maintain reserves/net assets within the Board of Directors-approved guidelines of 50% minimum, 70% target, and 90% maximum.

ASHP's total net assets grew by \$1.9 million during fiscal year 2018 (Figure 2), and our year-end balance sheet remains strong, with an asset-to-liability ratio of 5.17:1.

### Fiscal Year 2019 (Ending May 31, 2019)—Projected

Fiscal year 2019 is shaping up to be another solid year. As of February 28, 2019, we anticipate that core operations will end the fiscal year slightly better than budget (Figure 1). The financial performance of the program development and capital budget, building sale reserve funds, and building fund will ultimately depend on our fiscal year

investment returns, which are trending in a favorable direction.

A significant accomplishment during fiscal year 2019 is growing ASHP's total membership to nearly 49,500 members as of December 31, 2018, which is a 10% increase from the prior year. With your continued involvement and support, we can collectively advance the roles and impact of pharmacy services across the continuum of care.

### Fiscal Year 2020 (Ending May 31, 2020)—Budget

ASHP's core operations budget for fiscal year 2020 is balanced (Figure 1). The core gross revenue is projected to increase to \$54.2 million. The program development and capital budget and building sale reserve funds have budgeted surpluses of \$175,000 and \$185,000, respectively. Reserves/net assets spending is budgeted at \$200,000 for the depreciation of previously purchased assets. Although the building fund has a budgeted accrual accounting loss of \$416,000, primarily related to depreciation, it is budgeted to have positive cash flow for fiscal year 2020 and continues to be on track to achieve its long-term financial target.

### 7272 Wisconsin Building Corporation

ASHP's subsidiary, the 7272 Wisconsin Building Corporation, owned ASHP's previous headquarters building in Bethesda, Maryland, and derived income from leased commercial and

Figure 1. ASHP condensed statement of activities.

	Actual Fiscal Year Ended May 31, 2017	Actual Fiscal Year Ended May 31, 2018	Projection Fiscal Year Ended May 31, 2019	Budget Fiscal Year Ended May 31, 2020
<b>CORE OPERATIONS</b>				
Gross revenue	48,843,159	50,310,485	53,521,735	54,181,085
Total Expense	(48,624,344)	(48,831,214)	(53,450,606)	(54,179,073)
<b>CORE OPERATIONS NET INCOME</b>	218,815	1,479,271	71,129	2,012
<b>PROGRAM DEVELOPMENT AND CAPITAL BUDGET</b>	2,425,113	766,706	(370,484)	175,011
<b>BUILDING SALE RESERVE FUNDS</b>	75,058	569,526	285,720	185,000
<b>PROGRAMS FUNDED FROM RESERVES/NET ASSETS</b>	(311,973)	(839,356)	(444,775)	(200,453)
Pension Plan Adjustment	43,389	425,004	0	0
<b>NET CHANGES IN RESERVES/NET ASSETS</b>	2,450,402	2,401,151	(458,410)	161,570
<b>BUILDING FUND</b>	2,674,719	(520,799)	(2,184,757)	(416,325)

Figure 2. ASHP statement of financial position (in thousands).

	Actual as of May 31, 2017	Actual as of May 31, 2018
<b>ASSETS</b>		
Current assets	5,596	5,743
Fixed assets	11,113	9,606
Long-term investments (at market)	38,085	39,831
Long-term investments (at market) Building Sale Reserve Funds	16,100	16,869
Long-term investments (at market) Building Fund	86,282	89,282
Other Assets	169	204
Investment in 7272 Wisconsin Building Corp	199	267
<b>Total Assets</b>	157,544	161,802
<b>LIABILITIES</b>		
Current liabilities	18,954	20,356
Long-term liabilities	9,945	10,921
<b>Total Liabilities</b>	28,899	31,276
<b>RESERVES/NET ASSETS</b>		
Net assets	128,645	130,526
<b>Total Net Assets</b>	128,645	130,526
<b>Total Liabilities and Net Assets</b>	157,544	161,802

office space that was used to support ASHP's expansive membership mission. We anticipate that this subsidiary will be closed by the middle of calendar year 2019.

**Investments and Growth in ASHP**

Due to our strong financial position, we are pleased to have had the resources to invest in new initiatives to better serve our members and the profession. ASHP has developed the Pharmacy Technician Forum and the Section of Specialty Pharmacy Practitioners to better support member needs in those

areas. ASHP has also further developed specialty pharmacy accreditation, enhanced our pharmacy residency and technician accreditation management systems, joined the National Academy of Medicine Collaborative on Clinician Well-Being and Resilience, and developed additional certification and certificate products. In addition, ASHP has supported Board of Pharmacy Specialties petitions for sterile compounding, solid organ transplant, and emergency medicine specialties. There have also been investments to enhance the ASHP website and upgrade ASHP's financial accounting

and reporting systems. The staff and Board of Directors of ASHP continue to look actively to the future and invest in programs and services that support our members in advancing the profession of pharmacy.

**Conclusion**

The ASHP Board of Directors, CEO, and staff remain committed to supporting you—our members—and advancing the profession of pharmacy. We are proud to have nearly 50,000 members and to be at the forefront of improving medication use and enhancing patient safety. ASHP's financial strength and diversity of revenue sources allow for continued investment and development of a wide variety of member services, including educational resources, advocacy resources, and advancement of membership sections and forums. ASHP is positioned for the long term to continue to advance the profession and positively impact pharmacy services to fulfill our Mission and Vision.

It is hard to believe that my 3-year term as ASHP treasurer comes to an end in August 2019. It has been a pleasure and an honor to serve as your treasurer. I continue to be truly amazed at the outstanding work by ASHP members in so many diverse practice areas. Also, thank you to everyone who continues to move our profession forward

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to make a difference in the lives and health of our patients.

**Disclosures**

The author has declared no potential conflicts of interest.

<sup>1</sup>Represents the revenue and expense associated with the operations of ongoing ASHP products, programs and services, and infrastructure support.

<sup>2</sup>Is intended for expenditures that are (1) associated with new, enhanced, and

expanded programs; (2) associated with time-limited programs; (3) capital asset purchases; or (4) supplemental operating expenses. The program development and capital budget is funded primarily with investment income from reserves/net assets.

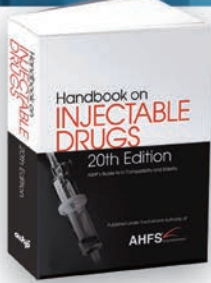
<sup>3</sup>Additional reserves/net assets spending is only occasionally used to fund programs. Funding requests from reserves/net assets are reviewed on a case-by-case basis and approved by the Board of Directors.

<sup>4</sup>Created with a portion of the cash proceeds from the sale of ASHP's previous headquarters building. The investment

earnings are intended to be used for new programs, products, and services, as well as to sustain ASHP through an economic downturn. Funding requests are approved by the Board of Directors on a case-by-case basis.

<sup>5</sup>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.

<sup>6</sup>The building fund is excluded from the reserves/net assets calculation due to its designated use.



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## 2019 REPORT OF THE PRESIDENT AND CHAIR OF THE BOARD

## ASHP is all in for its members and all in for pharmacy

**Am J Health-Syst Pharm.**

2019; 76:1429-1432

**Kelly M. Smith, Pharm.D., FASHP, FCCP**, University of Georgia College of Pharmacy, Athens, GA.Address correspondence to Dr. Smith ([kelly.smith@uga.edu](mailto:kelly.smith@uga.edu)).**Keywords:** certificates, connectivity, drug pricing, opioid, well-being© American Society of Health-System Pharmacists 2019. All rights reserved. For permissions, please e-mail: [journals.permissions@oup.com](mailto:journals.permissions@oup.com).

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Supporting. Connecting. Including. These concepts underlie why each of us should be all in for pharmacy. They reflect the best of ASHP and underscore why ASHP is such an important aspect of our professional lives. Through ASHP programming and connections we make with our fellow members, we have the support we need to be all in for our careers, our colleagues, and, most importantly, our patients.



Good afternoon! It's great to see you here in Boston at the 2019 Summer Meetings! I can't believe that it was only a year ago that I stood before you as your new president. It's been a privilege to serve ASHP, our nearly 50,000 members, and the profession.

I want to extend a heartfelt thanks to all of my colleagues and friends who reached out to me, encouraged me, connected with me, and inspired me throughout my tenure as ASHP president and made this such a memorable year.

I want to thank you, the members of the House of Delegates, for all that you do for the pharmacy profession, for patients, and ASHP. The work of the House of Delegates, along with that of ASHP's councils, sections, forums, and state affiliates, is the backbone of our organization and the force behind our efforts to optimize medication use, improve patient care, and advance the roles of pharmacy professionals.

I would also like to recognize the dedication of the ASHP Board of Directors. Thank you for your commitment, your leadership, and your passion for this organization and its mission.

Finally, on behalf of the Board of Directors, a sincere thank you to our

CEO, Paul Abramowitz. His guidance and encouragement have made this another remarkable year for ASHP and our members. Thank you, Paul!

### All in

"All in." That has been my mantra this year as your ASHP president. It was the theme of my inaugural address, and it is a concept that guides me in my professional life. As we congregate here in Boston this week, it means "all in" as we work towards a common outcome to advance our profession. And "all in" as we fully commit to a purpose that unifies us. There is possibly no better city than Boston in which to talk about the concept of being "all in." The colonists were all in for creating a better future, just as we are all in for creating a better future for our patients and our profession!

My year as ASHP president has reinforced for me that we truly are all in this together—pharmacists, student pharmacists, pharmacy technicians, residents, our healthcare colleagues, and, most certainly, our patients. Is ASHP all in to support you and your commitment to elevating the quality and safety of care that all patients deserve? The answer is a resounding "yes," and I'd

like to highlight a few examples of how ASHP is all in for you.

ASHP continues to go all in to support members as you care for individuals and patient populations. Since its inception in 2010, our Practice Advancement Initiative (PAI) has resulted in a great partnership with ASHP state affiliates to help drive practice change at a local level. The PAI has successfully engaged practitioners, leaders, students, and technicians in assessing and advancing practice.

To continue this forward movement, ASHP has created PAI 2030, a member-driven effort to update the already successful initiative. PAI 2030 will include tools, resources, and research collaboration aimed at advancing pharmacy practice. This work began this spring with a meeting of the PAI 2030 Advisory Panel, which has been charged with generating a set of reframed and initial recommendations that will be reviewed and vetted by ASHP members, other stakeholders, and the ASHP Board of Directors. Our goal is to create a set of revised recommendations that highlight and enhance the evolving roles of pharmacy professionals in the workforce and embrace emerging technologies to reflect the future of

patient care. These final PAI 2030 recommendations will be unveiled at the 2019 Midyear Clinical Meeting in Las Vegas.

ASHP goes all in for you by continuing to provide exceptional resources for career development and continued education. Our extensive line of professional certificates continues to grow and now encompasses 13 products. In the last year alone, we added the Pharmacy Technician Certification Board-recognized Sterile Product Preparation Certificate, the Compounded Sterile Product Preparation Certificate for Pharmacists, the Pharmacogenomics Certificate, the Clinical Skills Certificate for International Pharmacy, the Emergency Medicine Certificate, and the Nutrition Support Certificate. We are pleased to offer this growing library of certificates to expand and enhance your knowledge in key practice areas.

Our prestigious journal, *AJHP*, remains the unparalleled peer-reviewed journal in our profession. Last year we established an important partnership with Oxford University Press, a global leader in scientific publishing. This partnership is creating tremendous opportunity to enhance the reach and impact of *AJHP's* content, leveraging Oxford's state-of-the-art technology, enhanced sales and marketing capabilities, and significant presence in the international marketplace. As part of the partnership, changes were also made to *AJHP's* editorial structure, creating new ways for members to contribute their practice and research expertise and providing expanded development resources for authors and reviewers.

Enhancing its position as the leader in pharmacy publishing, ASHP continues offering new book titles that support our members in critical areas of practice and professional growth. In the past 12 months, ASHP introduced several key titles, including *Demystifying Opioid Use Calculations*, *Letters from Women in Pharmacy*, and the 20th edition of the *Handbook on Injectable Drugs*.

### ASHP advocacy

ASHP is also all in when it comes to advocating on behalf of its members and leading efforts to find solutions to some of the most pressing challenges in pharmacy practice.

ASHP continues to spearhead efforts in providing guidance on the impact of rising drug prices. ASHP continues to spearhead efforts in providing guidance on the impact of rising drug prices. As an active member of the Campaign for Sustainable Drug Pricing, ASHP has participated in numerous collaborative efforts with our partners to combat skyrocketing drug prices and ensure that medications are affordable and accessible to those who need them. ASHP has submitted numerous statements for the record to committees on Capitol Hill in support of key measures to address rising drug prices, including measures to increase pricing transparency and reduce barriers to competition. ASHP has also authored and submitted a number of statements in support of the Creating and Restoring Equal Access to Equivalent Samples (CREATES) Act.

There may be no issue more critical to our membership than the escalating opioid crisis that afflicts millions of patients. ASHP is at the forefront of addressing this epidemic, working diligently across a number of fronts to identify enduring solutions.

Earlier this year, the ASHP Board of Directors voted to approve the formation of an ASHP Opioid Task Force in an effort to further ASHP's longstanding engagement in combating the opioid crisis. The task force will allow ASHP to concentrate various efforts on the important roles pharmacists play in opioid stewardship, pain management, and in helping to solve this devastating epidemic harming our patients and overwhelming our communities. The task force will begin its important work on behalf of ASHP during its members' first face-to-face meeting this fall.

More recently, in April, the ASHP Board of Directors voted to approve joining the National Academy of

Medicine (NAM) Action Collaborative on Countering the U.S. Opioid Epidemic as a sponsoring organization. ASHP serves as its members' collective voice on all issues related to public health, and we are most eager to engage with the National Academy of Medicine and designated network organizations on this important effort to end the opioid epidemic.

Increasing opportunities for pharmacists to distinguish themselves as medication experts through continuing education, leading the charge on critical issues like the opioid crisis and drug pricing, and shaping the future of pharmacy with efforts like PAI 2030 are just a handful of ways ASHP goes all in for you.

### Connections

Connectivity is an essential benefit and opportunity that ASHP provides to all of its members. Whether you are a student just beginning your professional journey, a technician learning new skills to advance in your profession, a resident gaining vital practice knowledge in your chosen specialty, or a seasoned practitioner and leader, ASHP has developed communities and networking opportunities to provide the support and resources you need.

In my inaugural address, I told you that my ASHP involvement began with the Midyear Clinical Meeting, which I attended in order to find a residency program. We've come a long way since I first attended. Today, the Midyear Clinical Meeting is the can't-miss networking event in pharmacy. Nearly 24,000 attendees from almost 40 countries joined us for the 53rd Midyear Clinical Meeting in Anaheim this past December, with growing numbers in our Residency Showcase, Personnel Placement Service, and poster submissions program.

As the largest annual gathering of pharmacists in the world, the Midyear Clinical Meeting offers the very best in educational programming and networking opportunities for pharmacy professionals. Networking opportunities are

not just reserved for the Midyear meeting. Our Summer Meetings, the National Pharmacy Preceptors Conference, and the ASHP Conference for Pharmacy Leaders also offer unique opportunities to network with peers, mentors, and leaders. Over the past year, we hosted 37 networking sessions collectively at our meetings, engaging more than 5,000 members.

Connectivity also means supporting the growth and development of our rising professionals. ASHP is all in for this and hosts hundreds of students and residents each year at its headquarters in Bethesda to provide special development and networking experiences. This past year alone, ASHP hosted nearly 150 student visitors in Bethesda to provide information about the organization and engagement and volunteer opportunities. We hosted 11 students and 7 postgraduate year 1 and postgraduate year 2 residents on elective association management rotations, as well as a summer intern for a 10-week internship in association management.

This past January, we also hosted 7 military pharmacy residents and 1 military Institute for Safe Medication Practices fellow, collectively representing the U.S. Air Force, Army, and Navy. During their visits, they learned about ASHP's advocacy, research, leadership, residency accreditation, and practice advancement initiatives. Moreover, we were visited by 121 pharmacy residents and residency preceptors during the ASHP Resident Visit event last fall. The session was recorded and has been offered virtually to members of the New Practitioners Forum as a member benefit.

For ASHP, "all in" means understanding who our members are and how they want to engage with us. We host a number of thriving platforms on which members can engage with one another and ASHP content to enhance the overall experience of being part of this amazing practitioner community. We are active across multiple social media channels, growing our presence this past year on Facebook and Twitter. The number of visitors to our *AJHP* Twitter account, @AJHPOfficial,

grew more than 50% last year, making it ASHP's fastest-growing social media account. We also launched our Instagram account at the Midyear last fall and currently boast more than 1,000 followers. If you aren't following ASHP on social media, you are missing out! It's a great way to stay on top of timely and relevant news and information.

Over the past year, ASHP has re-committed to ensuring that our online information and communications channels are meeting the needs of all members. We recently unveiled some welcome updates to our award-winning website. The new navigation bar and upgraded search capabilities have provided an enhanced user experience for members, making important ASHP content easier to find.

This year we also launched 2 additional NewsLink email products—our biweekly Government Affairs NewsLink and a monthly Drug Shortages Update NewsLink. Both provide timely news and information on topics that you, our members, have identified as relevant and important to your practice. Our increasingly robust and effective presence across all of these digital channels and platforms is yet another way ASHP is committed to being all in for you. We want you to have the content you need, when you need it and where you need it! Look for more improvements in our digital engagement efforts and some exciting new communications products in the year to come!

### Clinician well-being and resilience

Connectivity is also an important element of provider well-being, and ASHP continues to enhance its commitment to our members in this area, leading efforts on multiple fronts. ASHP launched the Web-based Workforce Well-Being and Resilience Resource Center, enriched with over 30 unique peer-reviewed articles, webinars, conversations, and resources designed to help you and your team members "tame the flames of burnout," "heal our healers," and "cultivate joy in pharmacy practice."

ASHP has also continued our work with NAM through the Clinician Well-Being and Resilience Action Collaborative, of which ASHP is an original sponsoring organization. ASHP contributed to several discussion papers that reached NAM's list of most-read published articles for 2018. ASHP also participated in a number of NAM national public meetings centered on establishing clinician well-being as a national priority and the NAM consensus study entitled "Systems Approaches to Improve Patient Care by Supporting Clinician Well-Being."

In Anaheim, the Midyear meeting included 13 hours of programming dedicated to the critical topic of health-care workforce well-being and hosted the inaugural Clinician Well-Being and Resilience networking session. Attendees had the opportunity to view *Expressions of Clinician Well-Being*, a traveling art exhibit curated by NAM to promote greater awareness and understanding of barriers to clinician well-being and solutions that promise a brighter future.

ASHP recognizes that a healthy and thriving clinician workforce is essential to ensuring optimal patient health outcomes and safety. Our ongoing work with NAM and the development of these dynamic tools and resources reinforces ASHP's and our profession's commitment to fostering and sustaining the well-being, resilience, and professional engagement of pharmacists, pharmacy residents, student pharmacists, and pharmacy technicians.

### Conclusion

Supporting. Connecting. Including. These concepts underlie why each of us should be all in for pharmacy. They reflect the best of ASHP and underscore why ASHP is such an important aspect of our professional lives. Through ASHP programming and connections we make with our fellow members, we have the support we need to be all in for our careers, our colleagues, and, most importantly, our patients.



Last year during my inaugural address, I asked attendees to stand, turn on the flashlights on their phones, and raise them high to show their support for the profession. I urge you to take every opportunity to proudly raise your light to show that you are all in for

our patients, for our profession, and for ASHP.

Thank you so much for your support this past year and for being all in for me. Now go all in for the remainder of the Summer Meetings! Thank you, and enjoy your time here in Boston!

**Disclosure**

The author has declared no potential conflicts of interest.

**Additional information**

Presented at the ASHP Summer Meetings, Boston, MA, June 11, 2019.

# EMERGENCY MEDICINE CERTIFICATE

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This self-guided, online program is designed for pharmacists to increase the foundational knowledge and skills necessary to provide optimal patient care in emergency medicine.

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**Earn an ASHP Professional Certificate by passing a comprehensive final exam. Successful completion of the exam is required to earn a professional certificate and is separate from the education component.**



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## 2019 REPORT OF THE CHIEF EXECUTIVE OFFICER

## ASHP: An era of growth and transformational change

Am J Health-Syst Pharm.  
2019; 76:1433-1436

**Paul W. Abramowitz, Pharm.D., Sc.D. (Hon), FASHP**, ASHP, Bethesda, MD.

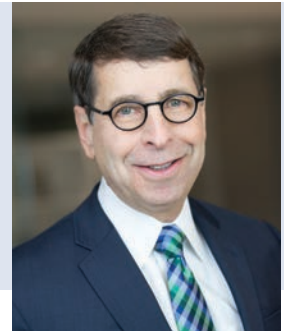
Address correspondence to Dr. Abramowitz ([ceo@ashp.org](mailto:ceo@ashp.org)).

**Keywords:** innovation, leadership, partnership, pharmacy, strategic initiatives

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Our growth gives us the means to be heard in the halls of Congress and in statehouses, giving voice to our members on critical issues like drug shortages, drug pricing, and identifying solutions to the opioid crisis.



Good afternoon. I am pleased to be here with you today and report on another remarkable year of growth and impact for ASHP. As I reflect on ASHP's 77-year history, I am filled with a great sense of pride for all that ASHP's members and staff have accomplished in support of our profession and our patients.

We have built a portfolio of world-class educational meetings and products, awarding more than 250,000 continuing education credits each year. We have established ASHP as the go-to thought leader on critical policy, regulatory, and legislative issues that impact our patients. We have continued to grow ASHP-accredited residency programs at an impressive rate, and *AJHP* remains the preeminent peer-reviewed pharmacy journal. But most significantly, we have a growing, thriving membership representing the best and brightest in pharmacy!

Today I am happy to share details with you about some of the exceptional accomplishments from this past year, as well as a number of exciting initiatives that will be part of our future. I am honored to serve as the CEO of this forward-facing organization whose vision is that medication use will be optimal, safe, and effective for all people all of the time.

Before I proceed, I would like to take a moment to recognize and thank a number of important people who are here today. First, our exceptional ASHP staff, who work incredibly hard to support our members throughout their professional journeys and with whom I am privileged to serve alongside.

Next, I would like to recognize ASHP President Kelly Smith, a tireless and passionate advocate for the development of pharmacy professionals and the advancement of practice and patient care. Kelly, you have inspired all of us to be "all in" for pharmacy! Thank you for your leadership these past years.

I would also like to recognize the work of the ASHP Board of Directors. Each of these individuals commits an extraordinary amount of their time to ASHP. We are fortunate to have this group of talented professionals, each of them a leader in their own organization, at the forefront of our efforts to advance our mission.

Lastly I would like to recognize our past presidents, who have contributed so much to our organization and continue to influence all of us. The breadth and depth of your legacies will be felt for many years to come.

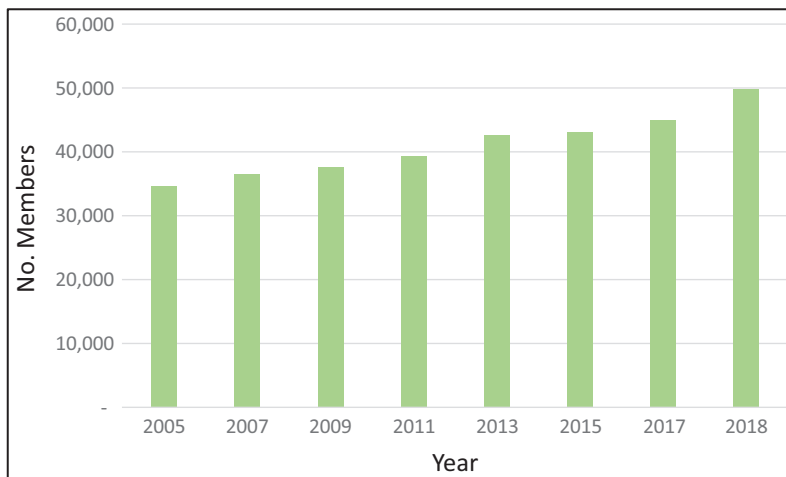
### ASHP growth

Please let me share some exciting details about several areas of significant

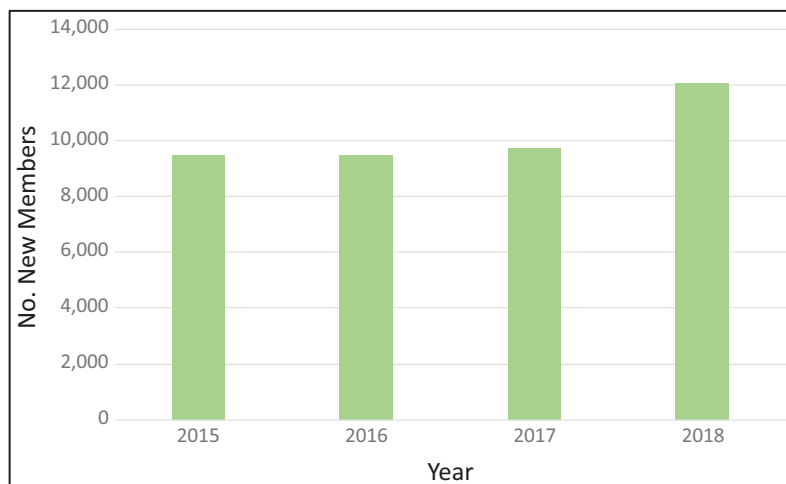
growth for ASHP. Total membership this year reached another major milestone (Figure 1), as we are now 50,000 members strong and growing! To give you some perspective, we have grown membership by 13.5% this past year alone. There are many catalysts for this tremendous growth. One area of which we are most proud is our growth in new ASHP members, which reached over 12,000 this year and represents an astounding 24% increase from last year. This is the highest new member total in ASHP history. Growth in new members is an essential driver of the dynamic and diverse makeup of our membership (Figure 2).

Many of you may recall that at our Summer Meetings in Denver last year, we announced the creation of our new Section of Specialty Pharmacy Practitioners. This section was formally launched in the fall of 2018 and has experienced tremendous uptake in the engagement of current and new members who practice in diverse specialty pharmacy areas. In the first 6 months after the launch, we had 1,000 primary members and 4,000 secondary members join the section. Also growing is our Pharmacy Technician Forum, which was launched in April 2018 and has taken off. In just 12 months, ASHP's pharmacy technician membership total went from 800 to 5,000 technicians. The

**Figure 1.** Growth in ASHP membership from 2005 through 2018.



**Figure 2.** Growth in new ASHP members from 2015 through 2018.



creation of these new membership sections and forums, as well as our continued alignment with our 52 affiliates and 130 student societies, showcases how ASHP is providing leadership to shape the evolving healthcare landscape and advance patient care.

Another important area of growth for our members is in residency accreditation. In just the past 5 years, pharmacy residency programs have grown by 32%. Moreover, the total number of annual residency positions has increased from 3,600 positions in 2014 to 5,100 positions in 2019, representing a 42% increase. Ambulatory care continues to be the fastest-growing

postgraduate year 2 residency category, followed by infectious diseases and oncology (Figure 3).

Also this year, ASHP successfully operationalized our partnership with the American College of Clinical Pharmacy on many of our board certification resources, including resources in the areas of ambulatory care, geriatrics, oncology, infectious diseases, cardiology, and—soon to be available—transplantation.

Further, ASHP’s professional certificate programs, which we introduced in 2015, have grown to encompass 13 unique certificates. The creation of these professional certificate programs was driven largely by articulated

member needs and recognized marketplace gaps in areas such as sterile preparation, pharmacogenomics, pain management, informatics, emergency medicine, and nutrition support.

I’d also like to take a moment to share some additional context about ASHP’s growth as an organization. Since 2011, ASHP’s overall annual revenue has grown from just over \$41 million to nearly \$54 million. That’s a 32% increase in 8 years, with consistent year-over-year growth (Figure 4).

This revenue growth allows us to invest in the advancement of our profession. Our growth gives us the means to be heard in the halls of Congress and in statehouses, giving voice to our members on critical issues like drug shortages, drug pricing, and identifying solutions to the opioid crisis. It gives us the means to sit at the table with key influencers from industry and government and other public and private entities to represent the interests of pharmacy as we collectively map the future of healthcare in America. And it gives us the ability to be the leader that we are in supporting the wellness and resiliency of our pharmacy workforce. Finally, it allows us to offer new programs and services to ensure that you have the tools and resources to grow professionally, adapt to the ever-changing healthcare landscape, and provide the absolute best in patient care.

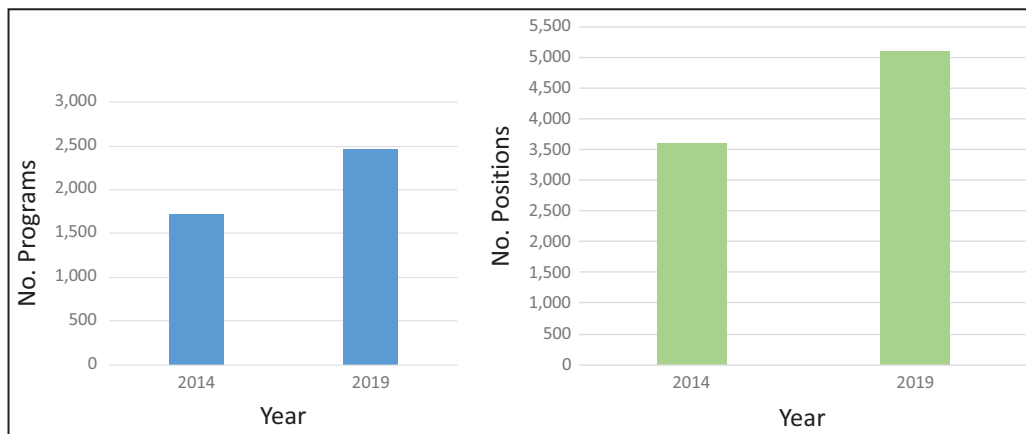
**Organizational strategic direction**

Now I would like to spend a few minutes talking with you about some important strategic initiatives that ASHP has advanced over the past year.

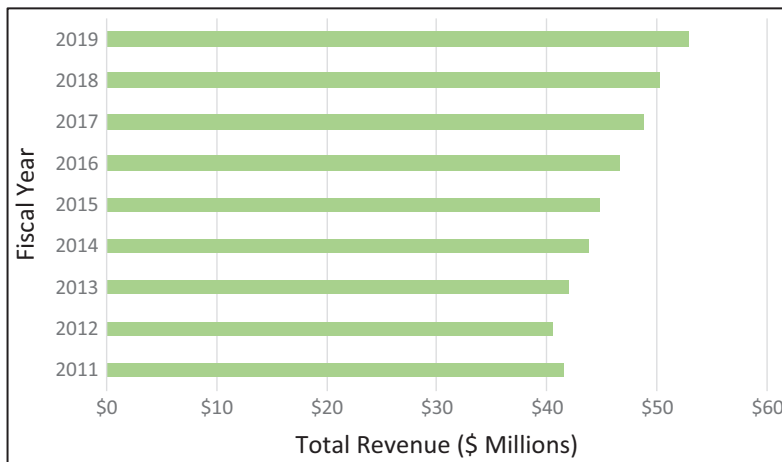
One of our greatest imperatives as an organization is to advocate for our members, our profession, and the patients we serve. We recently announced our plans to significantly elevate these efforts in Congress, federal agencies, and the White House and at the state level. To lead this effort, ASHP welcomed a new member to our senior leadership team in April. Tom Kraus has joined us as ASHP’s Vice President of Government Relations. Tom, an

Downloaded from https://academic.oup.com/ajhp/article-abstract/76/18/1433/5544542 by guest on 19 September 2019

**Figure 3.** Growth in number of ASHP-accredited residency programs and positions from 2014 through 2019.



**Figure 4.** Growth in ASHP’s total revenue from fiscal year 2011 through fiscal year 2019.



attorney, is a former Food and Drug Administration (FDA) chief of staff and FDA associate commissioner. He served on the U.S. Senate HELP Committee as staff director, working under Senators Kennedy and Harkin. Tom has also served as a health policy, management, and life sciences senior executive at major Washington consulting firms. Tom’s leadership experience, contacts, and engagement with the legislative and regulatory issues that impact ASHP’s members and their patients will be an asset to our already strong government relations team.

Also looking to elevate its strategic direction is the ASHP Foundation, which this year celebrated its 50th

anniversary. In 1968 Joseph Oddis—along with Milton Skolaut and Joseph Beckerman—had the foresight to create a research-focused organization that would be supported through donations and would encourage, provide for, and engage in scientific research and the advancement of hospital pharmacy. For 50 years, the Foundation has helped support ASHP members and the profession through countless funded programs and practice research grants.

Over the past year, ASHP and the ASHP Foundation have been working hard to more closely align the work of the Foundation with ASHP’s key strategic initiatives. As ASHP’s

philanthropic arm, the Foundation will be working with ASHP to identify the most important issues facing our members and the patients they serve and then raising the funds that help ASHP build the programs, tools, and resources to help support our practice advancement goals. The Foundation has developed a revised strategic direction that will fully align with the work and priorities of ASHP, maximize its impact, and help ensure the Foundation’s long-term growth and viability. Last year I introduced the Foundation’s new CEO, Steve Rubloff, who along with the Foundation’s Board has stimulated these key strategic initiatives.

**Partnerships and initiatives**

Critical to any organization’s success is the identification of strategic partnerships that can help accelerate impact, and I’d like to briefly mention a few.

ASHP is committed to working with partners in government, nonprofits, and industry to mitigate the continuous problem of drug shortages, which disrupt patient care and negatively impact our members. In September 2018, ASHP coconvened the “Drug Shortages as a Matter of National Security” summit. The summit was convened by ASHP and the American Society of Anesthesiologists in coordination with the American Hospital Association, the Institute for Safe Medication Practices, and the American Society of Clinical

Oncology. It brought together representatives from clinician groups, industry, supply chain entities, and government officials. Participants discussed weaknesses in the production and supply chain infrastructure and risks of dependency on foreign-sourced pharmaceutical ingredients.

ASHP has shared the recommendations from the summit at FDA meetings and continues to work with stakeholders to advocate for enhanced communication with the entire drug supply chain, develop incentives for drug manufacturers to have contingency plans, and further examine the supply chain for new issues exacerbating drug shortages.

Artificial intelligence (AI) is another area in which ASHP seeks to play a leadership role, helping shape the use of AI in the improvement of medication use and the advancement of pharmacy practice. In March, ASHP convened an interprofessional commission at headquarters to examine the impact of AI. This year's Commission on Goals included key leaders from Microsoft, IBM Watson, the American Heart Association, American Nurses Association, American Medical Association, American Medical Informatics Association, American College of Cardiology, and other prominent organizations.

The Commission examined how AI is penetrating healthcare to provide real-time insights and predictions to

improve patient outcomes. Participants discussed potential innovations AI will bring to clinical practice, federal and state policies needed to apply AI in the medication-use system, and best practices to embrace new technology. ASHP looks forward to sharing the full proceedings of this meeting with you in an upcoming issue of *AJHP*.

President Smith mentioned our Opioid Task Force and new partnership with the National Academy of Medicine. All of these partnerships and initiatives are just a few examples of how ASHP has grown its influence and collaboration among federal agencies and interprofessional colleagues. We will continue to advocate for pharmacy and for our patients in the halls of Congress and work with other organizations inside and outside of healthcare to achieve our mission.

Lastly, I would like to share some news about a very exciting initiative that we are announcing for the first time here in Boston.

I am pleased to announce the creation of the new ASHP Innovation Center, which the ASHP Board of Directors approved in April. This important new Center will elevate and expand ASHP's internationally recognized reputation as an innovator, leader, and pioneer of numerous advances in pharmacy practice and healthcare that have made health-system pharmacists the medication therapy specialists.

The ASHP Innovation Center will look to the future at the many opportunities for ASHP to further elevate the vital roles that health-system pharmacy practitioners play in new and emerging sciences such as AI, pharmacogenomics and personalized medicine, next-generation robotics, digital therapeutics, and the overall digital transformation of healthcare.

The ASHP Innovation Center will serve as a conduit, with traditional and nontraditional stakeholders both inside and outside of healthcare, to build out a portfolio of strategic partnerships, research, and member tools and resources. We will look forward to sharing more details with you in the coming months.

## Conclusion

I conclude my remarks today by thanking you—our members, who are driven by a passion and a determination to create a brighter future for our profession and, most importantly, for our patients. Thank you so much for everything that you do for ASHP and the patients you serve.

## Disclosures

The author has declared no potential conflicts of interest.

## Additional information

Presented at the ASHP Summer Meetings, Boston, MA, June 11, 2019.

# House of Delegates

## **2019 NEW BUSINESS SUBMISSION FORM**

PLEASE RETURN BY 4PM ON MONDAY, JUNE 10, TO THE EXECUTIVE OFFICE IN ROOM 202, LEVEL 2, HYNES CONVENTION CENTER

**ASHP  
HOUSE OF DELEGATES  
JUNE 10, 2019  
BOSTON, MASSACHUSETTS**

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

*Date Submitted:* June 10, 2019

*Time Submitted:* 11:25 a.m.

**INTRODUCED BY (NAME):**

Mollie Ashe Scott, Laura Traynor, Julie Groppi, Melanie Dodd, and Heather Qurth

**SUBJECT:**

Pharmacists Can Mitigate the Primary Care Physician Shortage

**MOTION:**

We recommend that ASHP create a new statement on the physician shortage and the important role that pharmacists play on interprofessional teams. Specific recommendations for elements for such a statement include:

1. To recognize the shortage of primary care physicians; further,
2. To advocate that pharmacists are direct care providers who increase access to care and unburden the interprofessional team through comprehensive medication management, population health, and prevention and wellness services; further,
3. To partner with interprofessional stakeholders at the state and national level to develop solutions to the primary care provider shortage that include the incorporation of pharmacists into primary care models of care.

**BACKGROUND:**

The Association of American Medical Colleges recently published an updated report in April 2019 entitled “Complexities of Physician Supply and Demand: Projections from 2016-2030” that projected a shortage of up to 122,000 physicians by the year 2032, including a shortfall of up to 55,200 primary care physicians. Population growth and aging are the most important contributing factors for increased demand in healthcare services. The shift from fee-for-service to value-based care as part of the U.S. healthcare system transformation places an increased emphasis on population health initiatives that achieve the quadruple aim of healthcare including lowering costs, improving quality, and improving the patient and provider

experience. Increases in chronic disease, mental health concerns, and the opioid epidemic have impacted on the number of patients needing care, and improving access to care is a goal of the Affordable Care Act. Rural and underserved communities are particularly impacted by the primary care provider shortage, leading to health disparities and poorer outcomes.

Pharmacists are considered our nation’s medication experts, and multiple organizations including the National Governors’ Association, the Patient Centered Primary Care Collaborative (PCPCC), and Get the Medications Right Institute advocate for recognizing pharmacists as providers, embedding pharmacists into primary care practices and creating financial sustainability for the provision of comprehensive medication management by pharmacists, ASHP has long championed the role of the pharmacist on interprofessional teams, the development of collaborative practice agreements, and served as a leader in developing best practices in ambulatory care. Pharmacists across the country provide a wide variety of services in interprofessional teams including but not limited to, annual wellness visits, disease management, transitions of care, comprehensive medication management, immunizations, medication assistance, medication adherence programs, and many others. In order to increase uptake of these models, ASHP developed the Ambulatory Care Self-Assessment as part of the Practice Advancement Initiative, and partnered with the A3 Collaborative to support pharmacists and health systems with the development of innovative care models that increase access to care and improve patient care outcomes. Despite all that the profession of pharmacy does to improve patient care outcomes through the provision of direct patient care services, the AAMC report focuses primarily on the role that physician assistants and nurse practitioners play to mitigate the primary care physician shortage. As the national grapples with the how to care for an aging population and provide comprehensive, accessible, patient-centered care for a growing population, it is paramount that pharmacists are seen as a profession who can mitigate the primary care provider shortage. Collaboration with medical, physician assistant, and nurse practitioner professional organizations as well as groups such as Get the Medications Right Institute, the A3 Collaborative, PCPCC, CMS, and others, is warranted so that the profession of pharmacy is at the table when solutions to the primary care shortage are developed.

**SUGGESTED OUTCOMES:**

1. Pharmacists are nationally recognized as a viable and integral solution for addressing the primary care shortage.
2. Creation of an ASHP Statement on “How Pharmacists Can Mitigate the Primary Care Shortage” that is endorsed by interprofessional external stakeholders.

# House of Delegates

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## Recommendations from the 2019 House of Delegates

The delegate[s] who introduced each Recommendation is [are] noted. Each Recommendation is forwarded to the appropriate body within ASHP for assessment and action as may be indicated.

### 1. High-Cost Drug Management Impacting Patients and Pharmacies

Jerome Wohleb (NE), Nebraska delegation

**Recommendation:** Position/guidance statement for high-cost medication being developed impacting viability of health systems and pharmacies.

**Background:** Specialty drugs are critical to the integrated health systems and hospitals for patient access, optimum care, and vertical integration of healthcare driving excellent patient care outcomes. However, new gene therapy and rare orphan drugs may exceed reimbursement models projected by CMS and commercial payers. These multi-million dollar drugs could compromise health-system viability.

### 2. Home Infusion Pharmacy Standing Working Group

Carol Rollins (AZ)

**Recommendation:** Recommend that ASHP appoint a standing working group on home infusion pharmacy to keep the small but active home infusion pharmacy group involved in the multiple issues that impact home infusion pharmacy, especially with the home infusion SAG having been dissolved.

**Background:** None.

### 3. Certificate Program in Pediatric Nutrition Support

Carol Rollins (AZ)

**Recommendation:** Recommend development of a pharmacy-oriented certificate program in pediatric nutrition support pharmacy that includes the entire range of pediatric patients and a second subset of the certificate for pharmacists that only work with neonatal patients; further, the primary emphasis of the certificate program should be parenteral nutrition (PN).

**Background:** Pediatric patients requiring nutrition support, especially parenteral nutrition, are high-risk patients, and PN is a high-risk product. Few colleges/schools of pharmacy teach pediatric nutrition support and no pharmacy residency, including PGY2 pediatric residencies require training in pediatric nutrition support.

### 4. ASHP Response to State Laws Approving Importation of Drugs from Canada



Jennifer Davis (CO) Colorado delegation

**Recommendation:** To minimize confusion and clarify ambiguity in the current ASHP policy statement, ASHP should issue a renewed statement opposing state and federal movements approving importation of drugs from Canada solely based on cost due to its lack of feasibility.

**Background:** Several states have passed legislation allowing importation of drugs from Canada if approved by Secretary Azar (CO, VT, FL). See Colorado Senate Bill 5. These bills are not actionable and are creating confusion. ASHP should educate officials and the community about the futility of this approach.

## 5. Development and Implementation of a Pharmacy Resident Research Database

Tyler Vest, New Practitioners Forum

**Recommendation:** The New Practitioners Forum recommends that ASHP consider development and implementation of a comprehensive resident research database.

**Background:** Most pharmacy residents complete a research or quality improvement project as a required component of their ASHP-accredited pharmacy residency. Currently, there is no centralized system for recording and retrieving these projects. Our goal is to seek development of a comprehensive database to house resident research projects for the purposes of connecting residents, preceptors, programs, and health systems over similar research projects and areas of interests all while maintaining relevance rather than duplication. Simultaneously, the quality and content of these research projects would continue to rise and advance the boundaries of pharmacy practice in allowing for larger, potentially more impactful projects.

## 6. Unifying Name for Pharmacists Providing Direct Patient Care

Jannet Carmichael, Past President

**Recommendation:** ASHP should study, select, and market a name for pharmacists who perform direct patient care services that would be recognizable to the public.

**Background:** Many names have been promulgated over the years for pharmacists with an advanced scope of practice. Pharmacy education has been elevated; residency training is more common; formal specialties credentials and certificates are available, and years of experience have led to many trained professional pharmacists providing direct patient care. The public may be confused about who these pharmacists are. ASHP should define and name (e.g., pharmacist practitioner) these pharmacists and market this name to the public.

## 7. International Pricing Index (IPI) Model

Patti Hawkins, Josh Fleming, Anastasia Jenkins, Kristie Gholson, Wes Pitts, (MS)

**Recommendation:** ASHP should develop official policy to oppose the implementation of the IPI model.

**Background:** The American Hospital Association published a letter on December 27, 2018, summarizing concerns with the IPI model proposal. It appears the IPI model would have third parties or vendors “dispensing” and shipping in certain drugs that are to be used in hospitals, clinics, etc. This ‘forced white bagging’ does not address the root problem which is high drug costs from manufacturers. In addition to the negative direct financial impact, the administrative burden and patient safety issues are paramount.

**8. Substance Abuse in the Elderly: The Unique Issues and Concerns that Pharmacists Can Address**

Karen L. Kier (OH) Ohio delegation

**Recommendation:** Data suggest that the elderly have a higher rate of substance abuse than other demographics and this results in unique opportunities for pharmacists to be involved in their care.

**Background:** Recent data suggest higher rates of substance abuse in the elderly and the impact this can have on medication issues, hospitalizations, and falls. HHS publication #SMA-11-4618 indicates that treatment of elderly substance abuse will double by 2020. Benscholf and Harrawood discuss in their article the unique issues this presents for the healthcare profession and health systems.

**9. Pharmacist’s Role in Educating the Public on the Dangers of Vaping**

Karen L. Kier (OH) Ohio delegation

**Recommendation:** To encourage pharmacists to engage in community outreach to educate the public on the dangers of vaping and to oppose consumer advertising of vaping products.

**Background:** ASHP policy 1625 discusses position on E-cigarettes and tobacco products but does not address pharmacists’ role in educating the public on the dangers of vaping. Considering the September 12, 2018, FDA Commissioner’s statement on youth vaping as an epidemic, pharmacists should lead the way in educating and community outreach. (See similar outreach as stated in ASHP policy 1305.) Also to directly oppose DTC on TV and print on vaping.

**10. Transparency of Pharmacy Payer Networks**

Section of Specialty Pharmacy Practitioners (SSPP)

**Recommendation:** The SSPP recommends development of a policy on transparency of pharmacy provider networks.

**Background:** Pharmacy payer networks may be structured to allow access of health system pharmacies or to restrict access of health system pharmacies. The trend to restrict access is increasing. The new policy should support full transparency of all requirements for access for all pharmacies and demonstrate equal treatment of health system pharmacies.

**11. Minimization of ASHP Expenditures in States that Pass Laws and Regulations That Limit or Deny Access to Healthcare**

Brian I. Kawahara

**Recommendation:** That the ASHP Board of Directors adopt policies that avoids minimize ASHP expenditures in state where laws have been passed legislation and/or regulations designed to force values upon their citizens leading to the denial, removal, or prohibition of their constitutional rights and freedoms, that denies and individual of legal age and sound mind, their ability to access healthcare or interferes with patient physician confidentiality.

**Background:** Recently several states have passed laws which infringe upon the access of healthcare and/or a decision between physician and patient for a healthcare procedure. Since pharmacists are patient advocates, ASHP should protect basic rights to healthcare. This recommendation is written broadly to cover not only current laws and regulations but future infringements on these basic rights.

**12. ADA Accessibility at ASHP Functions**

Mindy Burnworth (AZ)

**Recommendation:** To support further incorporation of American Disabilities Act (ADA) accessibility needs for individuals at ASHP functions.

**Background:** ASHP has been proactive in sending basic registration emails for RDC and HOD events. Consider adding a question to determine if ADA accessibility needs are required in advance. For example, for those individuals who are mobile via wheelchair, seating should be located at a convenient location free of obstructions and accessible to microphones and prepared in advance to prevent an awkward or embarrassing situation in that moment. In addition, instead of the “front and back” microphones; have a “small” and “TALL” microphone in speaker rooms and the House floor, or a “mobile and immobile” microphone.

**13. CBD Guidance Document**

Craig Kirkwood (VA)

**Recommendation:** For ASHP to develop a guidance document to assist healthcare pharmacists for managing the diversity and variation in state and federal laws and regulations pertaining to CBD.

**Background:** None.

**14. High Significance of Joint Council Recommendations**

Mindy Burnworth (AZ)

**Recommendation:** To support further activities (such as policy development) associated with joint collaboration among the councils to emphasize significance of importance.

**Background:** Many policies cross various councils and with group collaboration a more robust policy may be created. For example, 2019 Suicide Awareness and Prevention was created and passed.

**15. Exploration of Flexible Pharmacy Staffing Models to Support the Working Professional**  
Justin Konkol (WI)

**Recommendation:** ASHP should study, publish, and promote staffing models that provide flexibility for practitioners that recognizes the changing priorities of the workforce while maintaining consistent, safe, high quality patient care.

**Background:** Members are being challenged to evolve/modify staffing models to meet their staff members changing priorities for additional flexibility in the workplace being identified through staff engagement surveys and published literature on the workforce. Leaders are being challenged to maintain high-quality and consistent patient care services from their customers and have to work through individual HR departmental rules. Promoting models that balance patient care with staff priorities would help the profession.

**16. Work-Life Integration Through Family Participation at Pharmacy Continuing Education Events**

Mindy Burnworth (AZ)

**Recommendation:** To further support ASHP's emphasis on work-life integration by offering family friendly participation and attendance at live CE events.

**Background:** Building on the availability of childcare at the MCM, ASHP has taken strides to emphasize the importance of work-life integration. CE requirements may be more easily obtained for working mothers and fathers if children are allowed to participate in the events. For example, considering offering an inaugural CE program whereby children are taught about "look alike" medications (human or animal) to candy and safe medication use. For the pharmacist parents, share tips on how to prevent overdose of medications by children or pets.

**17. Pharmacists Can Mitigate the Primary Care Physician Shortage**

Lucas Schulz (WI)

**Recommendation:** Recommend that the Pharmacists Can Mitigate the Primary Care Physician Shortage clause 2 delete "comprehensive medication management" and replace with "medication management services" to be consistent with the Joint Commission on Pharmacy Practice.

**Background:** <https://jccp.net/wup-content/uploads/2018/05/Medication-Management-Services-Definition-and-Key-Points-Version-1.pdf>. Also see Anna Dopp.

**18. Policy on Pharmacist Participation in the Emerging Healthcare Gig Economy**

David Hager (WI)

**Recommendation:** That ASHP create policy on the professional obligations of pharmacists participating in the emerging healthcare contingent work facilitated by digital platforms, more commonly referred to as the “gig economy”.

**Background:** Aspen RxHealth intends to create the first gig economy for pharmacists in 2019. These pharmacists will be connected to patients and paid by health plans to optimize therapy. Resulting recommendations may be regarding patients cared for by health system pharmacists, by pharmacists outside of their system. This could lead to competing recommendations to providers. We should recognize the value in providing this work opportunity for those seeking additional income given student debt, so careful policy will need to be crafted.

#### 19. Pharmacists Role in the Care of a Solid Organ Transplant

Justin Konkol (WI)

**Recommendation:** ASHP to continue to educate to CMS that a pharmacist should be the primary discipline qualified to provide pharmacy services on the SOT content care team.

**Background:** CMS interpretive guidelines updated on 3/29/2019 expanded the language to include other disciplines qualified to provide pharmacology services.

#### 20. Methods for Continuation of Training in Nutrition Support Pharmacy

Carol Rollins (AZ) and delegates from MA, TX, PA

**Recommendation:** ASHP to appoint a group of pharmacists trained in or who have experience as a program director for a nutrition support pharmacy residency and/or fellowship to determine effective methods to assure continued training of pharmacists in the specialized knowledge associated with nutrition support pharmacy and the benefits to patient safety from such training, especially for complex patients requiring parenteral and enteral nutrition for both acute and ongoing care.

**Background:** With sunseting of accreditation by ASHP for PGY2 nutrition support pharmacy residencies, there is a lack of formally recognized training programs in nutrition support. While nutrition support is included in a couple of PGY2 residency programs, the majority of those programs depend on nutrition support trained pharmacists to provide that training. ASPEN provides nutrition support training; however, pharmacy-specific topics, especially more in-depth topics, are rarely accepted for presentation because of perceived lack of participation from the ASPEN membership, which is overwhelmingly dietitians. Shortages of parenteral nutrition products over the past decade have highlighted the importance of pharmacy-specific knowledge related to nutrition support as errors have occurred when products which are therapeutic equivalents (e.g., amino acids) are treated as generic equivalents when there are significant differences in products that affect patient safety and product efficacy (e.g., increased risk of precipitation, instability, component inactivation). As a registered dietitian myself and one who has taught dietetic interns parenteral nutrition for over three decades, I can state with assurance that dietitians are NOT prepared to

handle nutrition support without more in-depth post-registration/licensure training, nor is any healthcare professional.

**21. Proportionate Delegate Allocation for Pharmacy Technicians, Pharmacy Student, and New Practitioner Forums**

Mindy Burnworth (AZ), Tara McNulty (FL), Jen Towle (NH), Florida delegation

**Recommendation:** To support further incorporation of the Pharmacy Technician and Pharmacy Student and New Practitioner Forums by re-evaluating the number of allocated delegates serving on the AHSP HOD from these forums to parallel the continued growth of the forum membership.

**Background:** As the involvement of the newly created Pharmacy Technician Forum continues to expand, re-consideration of the number of delegates allocated to represent pharmacy technicians may need to be revised. Consideration for determining parallel needs for the Pharmacy Student Forum may be necessary as well.

**22. Electronic Processing for HAK Whitney Award Seating**

Brandon Ordway, Matt Ditmore, Paul Krogh, Kevin Dillion (MN); Jamie Sinclair, Lisa Mascardo, David Weetman (IA); Past President Chris Jolowsky

**Recommendation:** Develop an electronic HAK Whitney Award ticket exchange for seating.

**Background:** The current ticket exchange, while nostalgic, has run its course. Attendees arrive different days and times for the meeting. The current process is inefficient as attendees balance their travel, work responsibilities and session attendance with need to queue up for a good seat at the table. This also disadvantages those who arrive late. We recommend being able to request seats and tables electronically (after confirming that someone has a valid ticket).

**23. Medicare Administrative Contractor Actions That Interfere with Safe Pharmacy Practice**

Jennifer Davis (CO)

**Recommendation:** We recommend that ASHP work with CMS and its Medicare administrative contractors (MACs) to oppose reimbursement practices that restrict compounding flexibility and compromise safety.

**Background:** Some MACs have started to deny reimbursement for waste of drug products if the smallest vial size/NDC is not used. In some cases, use of the smallest vial size or specific NDCs increases the cost of CSTDs and increases the complexity of compounding.

**24. Raise ASHP-PAC Visibility**

Jeff Little (KS)

**Recommendation:** In an effort to raise awareness for the ASHP-PAC, ASHP should evaluate further opportunities to publicize the publicly reported PAC data including financial statements and recipients of PAC funding.

**Background:** In attempting to fundraise for the ASHP-PAC over the years, the PAC Advisory Committee has found there is a lack of awareness about the ASHP-PAC in the general membership. Many members do not know where the PAC money goes, how much money the ASHP-PAC spends, or even in some cases that ASHP has a PAC. ASHP should evaluate potential opportunities when there is a captive audience of ASHP members to raise awareness of the PAC.

## 25. Dose Rounding of High-Cost Medications to Reduce Waste and Reduce Cost

Kevin Marvin (VT, NH, MA, RI, ME, CT)

**Recommendation:** We recommend that ASHP initiate an effort to develop specific standards for the rounding of BSA and weight-based dosing for all such ordered medications to reduce waste and medication costs; furthermore, such effort shall include specific recommendations for EHR and label communication of this rounding from ordering to medication administration in collaboration with the Hematology and Oncology Pharmacists Association (HOPA).

**Background:** Many facilities when implementing dose rounding are doing it inconsistently. Through rounding workflows pharmacists are converting the weight-based doses to non-weight-based doses and therefore compromising safe therapy monitoring, dose checking and administration workflows. HOPA has developed recommendations for what information needs to be carried on a rounded order/label. Best practice standards are needed to support these rounding workflows.

## 26. ASHP Standardize 4 Safety Expansion

Kevin Marvin (VT, NH, MA, RI, ME, CT)

**Recommendation:** We recommend that ASHP continue with expansion of the ASHP Standardization for Safety Initiative with the goal to develop standards that support a goal of sharable order sets, therapy protocols and IV pump libraries across health systems and to increase the availability of pre-packaged products to include: standardized dosing units of measure, standardized common recommended doses, and standardized unit of use package sizes or injectable and oral liquid medications for all adult, pediatric, and neonatal use.

**Background:** The standardization of medication ordering, preparation, and administration has tremendous potential to increase safety, efficiency, and availability of medications and the medication use process. Such efforts should be considered as a continuous quality improvement effort as opposed to a project with a defined beginning and end. ASHP is well positioned to lead this initiative to develop and support the appropriate decision making structures for this continuing pharmacist driven effort.

**27. Collaborate with CDC, FDA to Provide More Guidance on Blood Borne Pathogen Testing for Diversion from HCWs Involving Tampering**

Tricia Meyer, Tammy Cohen, Jeff Wagoner, Steve Knight, Katie Morneau, Sid Phillips, Lea Eiland, Roger Woolf (TX delegation)

**Recommendation:** ASHP to work with CDC, FDA to develop recommendations when healthcare worker diversion involves tampering, used/shared needles/syringes that may expose patients to harm that support and justify testing of implicated HCW for blood borne pathogens.

**Background:** Numerous outbreaks have been described by CDC due to HCW diversion. CDC, FDA mention/comment on further testing for HCW.

**28. Nutrition Support Education of Pharmacists**

Texas delegation, Tammy Cohen, Steven Knight, Katie Morneau, Tricia Meyer, Sidney Phillips, Jeffrey Wagoner on behalf of Todd Canada; Arizona delegates Carol Rollins, Mindy Burnworth

**Recommendation:** Incorporate nutrition support training, especially related to parenteral nutrition into existing PGY1 competency areas, goals, and objectives.

**Background:** Pharmacy nutrition support education and training has reached a nadir with sun setting of the Nutrition Support PGY2 competency areas, goals, and objectives this past year. The lack of ASHP (outside of a proprietary certificate program) and health-system pharmacy leadership/administrative support for safe nutrition care practices has led to the incorporation of these specific duties into a general pharmacy role including the compounding or outsourcing of parenteral nutrition. Currently only PGY2 Pharmacotherapy and Critical Care competency areas, goals, and objectives have nutrition support as a required patient experience or direct patient care (pediatrics and oncology do not) and only enteral nutrition is required for PGY2 Geriatrics. Health-system pharmacy leadership is expecting all pharmacist to be competent in the use of parenteral and enteral nutrition when it is not a fundamental component of any PGY1 training program. It should be advocated for pharmacists in direct patient care to have nutrition support training by 2020 especially in the era of drug shortages and with electronic health records bypassing connectivity to automated compounders.

**29. Creation of a Section Advisory Group for Investigational Drug Services (IDS)**

Elyse MacDonald, Kavish Choudhury, Erin Fox, UT delegation, IN delegation

**Recommendation:** IDS pharmacy practice is becoming more complex from the operational and clinical perspectives, so much so, in pharmacy practice in this area is become more recognized as a specialty.

**Background:** There are not many “homes” in pharmacy organizations for IDA practitioners. Also, IDS practice touches many specialties, (e.g., oncology, informatics) which brings pharmacy staff from these areas to collaborate to conduct studies accurately. Practice in IDS needs the opportunity to expand services outside of the



central pharmacy. Joining pharmacy practitioners together to discuss IDS-related issues will help move this pharmacy specialty forward as research continues to grow.

### 30. Parity of Reimbursement for Pharmacist Services

Davena Norris, Melanie Dodd (NM)

**Recommendation:** Recommend a policy be developed regarding parity of reimbursement for services provided by pharmacists acting within their scope of practice when these same services are reimbursed if provided by a physician or other healthcare provider.

**Background:** It remains difficult for pharmacists to get reimbursed for patient care services despite state provider status. Several states are working to pass payment parity legislation, such as Texas HB 3441 and NM HB 578. HB 578 would prevent insurers from discriminating with respect to reimbursement against any pharmacist who is acting within the scope of his/her license and require insurers to reimburse pharmacists at the same rate that the plan reimburses a physician or physician assistant for that service.

### 31. ASHP Organizational Task Force

M. Woods, S. Sheaffer, D. Ginsburg, J. Boone (Past Presidents)

**Recommendation:** Given the recent development of the Technician Forum and Specialty Pharmacy Section we recommend ASHP consider the formation of an Organizational Task Force to review, assess, and optimize the effectiveness of the current policy development process and membership engagement.

**Background:** None.

### 32. Pharmacy of Distinction

Leigh Briscoe-Dwyer (NY)

**Recommendation:** That ASHP explore the development of an accreditation program for health-system pharmacy, similar to that of the Magnet Recognition Program that recognizes pharmacies of distinction that have met standards for quality, service, cost, and human resources.

**Background:** None.

### 33. Use of Certificate Program Materials for Student, Resident, and Multiple Pharmacist Training

Carol Rollins, Delegates from MA, TX, PA, AZ

**Recommendation:** Recommend that ASHP develop a plan for use of certificate program materials in training program involving multiple students, residents, and/or pharmacists that includes a group rate with or without actual certification exam completion; further, that ASHP identify a select group of topic experts who could be contracted to serve as facilitators for the training process.

**Background:** ASHP has invested considerable time and finances, as well as volunteer time, into developing the various certificate programs because a need for such information has been identified. Developing a plan to allow training of groups (students, residents, pharmacists) using the already developed materials would leverage ASHP investment and likely would reach a broader audience if group pricing were developed (e.g., it might be possible for affiliates, colleges/schools of pharmacy, and/or residency programs to offer the program as many now do for APhA certificate programs). Having a non-certificate option (i.e., materials are reviewed by the certificate exam is not completed) at a reduced price could potentially increase the pharmacists/trainees who receive the information associated with certificate programs and still provide improved patient safety. Many colleges/schools of pharmacy lack faculty with expertise in the areas covered by the ASHP certificate programs and having an option of the high quality ASHP certificate program information available at an affordable price would allow pharmacy trainees the benefit of learning from the experts, especially if an option were available for an expert identified by ASHP to be brought in to facilitate the training process.

**34. Revision of Article 7.1 in the ASHP Bylaws to Increase the Number of Fraternal Delegates allotted to the Department of Veterans Affairs**

Heather Ourth, Veterans Affairs

**Recommendation:** On behalf of the nearly 9,000 VHA pharmacists, we recommend amending article 7.1 in the ASHP Bylaws to increase the number of fraternal delegates allotted to the Department of Veterans Affairs.

**Background:** The Department of Veterans Affairs has nearly 9,000 pharmacists of which over 4,500 have a scope of practice that includes prescriptive authority and over 600 residents are trained through ASHP accredited residency programs each year. VA would request amending the bylaws and increase the number of fraternal delegates allotted to the system. APhA allots to fraternal delegates to VA.

**35. Recertification Materials to State Affiliates**

Ursula Iha, Carla Darling, Michelle Eby (AK, DC, AZ)

**Recommendation:** Recommend that ASHP develop a plan to provide board certified pharmacotherapy pharmacists recertification materials to state affiliates for continuing education.

**Background:** We believe that the ability to provide intensive programs will improve the quality and attendance for our state's continuing education programs and conventions. It will help to increase membership and elevate the profession at the grassroots level.

**36. Therapeutic Uses of Cannabinoid Derivatives**

Daniel Dong (CA)

**Recommendation:** I recommend that ASHP develop a broad professional policy on the research, education, therapeutic uses, and adverse effects of cannabinoid derivatives.

**Background:** I recommend that ASHP develop a broad professional policy on cannabinoid derivatives to potentially avoid having separate professional policies covering each individual derivative such as CBD oil. This will allow ASHP to have a professional policy when these new entities become commonly used.

**37. Pharmacist\* Practice Across State Lines**

**\*(not pharmacy dispensing)**

Steven Gray (self)

**Recommendation:** ASHP, as the national organization for pharmacists, should actively pursue the ability to practice CMM across state borders.

**Background:** Too many states require a pharmacist in a “Center of Excellence” in another state to be licensed also in the state in which the patient resides. This prevents patients from getting the best care from the practitioners of their choice.

**38. Licensed Pharmacist Assistant**

Elizabeth Wade, Staci Hermann (NH)

**Recommendation:** To recommend that ASHP evaluate the role of a licensed pharmacist assistant.

**Background:** Other countries have pharmacists, pharmacy technicians, and a licensed pharmacist assistant role. As our pharmacy technician workforce meets more challenging demands for training and certification, the pay scale for technicians has not risen to meet the same level of skill. New Hampshire has introduced legislation for the role of a new licensed pharmacist assistant. It would be helpful for ASHP to assist with research of this role in other countries and the potential risks and benefits of having such a role in the United States.

**39. Task Force for ASHP’s Relationship with Schools of Pharmacy**

Christene Jolowsky, Diane Ginsburg, Steve Sheaffer (Past Presidents)

**Recommendation:** Recommend that ASHP convene a task force to address relationships with schools of pharmacy.

**Background:** APhA and AACP have a well-established working relationship. Both have prominent visibility at each others’ meetings, along with a high level of support of APhA through schools’ faculty. Students often see ASHP meetings as a requirement for residencies, not as a sustained organizational choice. Health-system pharmacy is vital to the profession. There is value in strengthening the exposure to ASHP on campuses, and strengthening our relationships with students and faculty.

**40. Mental Health First Aid**

Julie Kalabalik, Lu Brunetti, Paul Goebel (NJ)

**Recommendation:** ASHP should develop a policy on advocating mental health first aid training for pharmacists, pharmacy technicians, and support staff.

**Background:** APhA 2019 House of Delegates adopted a policy encouraging healthcare personnel to receive mental health training. Pharmacists practice in settings that place them in ideal situations to identify mental health issues; however, appropriate mental health training will provide the tools needed to identify mental health issues.

**Citation:** Giannetti V, Caley CF, Kamal KL et al. Community pharmacists and mental health: a survey of service provision, stigma, attitudes, and beliefs. *Int J Clin Pharm* 2018;40(5):1096-1105.

**41. Inclusion of Pharmacists as Part of Optimal Team-Based Care in AHA Training Videos**

Jodi Taylor (NY, LA, IN, MO, MS, AL, OH, OR, NM, NC, MN, DC, AK, KY, WI, WA, VA, TX, MI, ME, WV, MA)

**Recommendation:** ASHP should petition the American Heart Association (AHA) to ensure that pharmacists are appropriately represented as part of optimal team-based care in Acute Cardiovascular Life Support (ACLS) training videos.

**Background:** The AHA ACLS course materials emphasize the importance of effective team dynamics and role selection for team members to maximize team effectiveness during cardiac arrest codes; however, the course video showcases multiple team members delivering care without the assistance of a pharmacist. Literature and ASHP policy 1527 support the inclusion of the pharmacist in emergency response teams. New AHA training materials will be developed after release of the 2020 guideline update.

\*\* Of note, the Tennessee Pharmacists Association House of Delegates, at the recommendation of the Tennessee Society of Health-System Pharmacists, adopted a resolution to work with ASHP to petition the AHA on behalf of pharmacists in 2018.

**42. Pharmacist's Role in the Selection of Health-System's Pharmacy Benefit Manager (PBM)**

Samm Anderegg (TX, SOPIT)

**Recommendation:** Pharmacy leadership should be directly involved in the selection of their health system's pharmacy benefit manager servicing their employee's health plan.

**Background:** The PBM market is an oligopoly. Many health systems are self-insured entities and have control over which PBM provides pharmacy benefits. PBMs inflate costs, over charging health systems. Currently very few pharmacy leaders are involved in the process.

**43. Pharmacists Can Mitigate the Primary Care Physician Shortage**

Mollie Ashe Scott, Laura Traynor, Julie Groppi, Melanie Dodd, and Heather Ourth

**New Business Item:** We recommend that ASHP create a new statement on the physician shortage and the important role that pharmacists play on interprofessional teams. Specific recommendations for elements for such a statement include:

1. To recognize the shortage of primary care physicians; further,
2. To advocate that pharmacists are direct care providers who increase access to care and unburden the interprofessional team through comprehensive medication management, population health, and prevention and wellness services; further,
3. To partner with interprofessional stakeholders at the state and national level to develop solutions to the primary care provider shortage that include the incorporation of pharmacists into primary care models of care.

**Background:**

The Association of American Medical Colleges recently published an updated report in April 2019 entitled “Complexities of Physician Supply and Demand: Projections from 2016-2030” that projected a shortage of up to 122,000 physicians by the year 2032, including a shortfall of up to 55,200 primary care physicians. Population growth and aging are the most important contributing factors for increased demand in healthcare services. The shift from fee-for-service to value-based care as part of the U.S. healthcare system transformation places an increased emphasis on population health initiatives that achieve the quadruple aim of healthcare including lowering costs, improving quality, and improving the patient and provider experience. Increases in chronic disease, mental health concerns, and the opioid epidemic have impacted on the number of patients needing care, and improving access to care is a goal of the Affordable Care Act. Rural and underserved communities are particularly impacted by the primary care provider shortage, leading to health disparities and poorer outcomes.

Pharmacists are considered our nation’s medication experts, and multiple organizations including the National Governors’ Association, the Patient Centered Primary Care Collaborative (PCPCC), and Get the Medications Right Institute advocate for recognizing pharmacists as providers, embedding pharmacists into primary care practices and creating financial sustainability for the provision of comprehensive medication management by pharmacists, ASHP has long championed the role of the pharmacist on interprofessional teams, the development of collaborative practice agreements, and served as a leader in developing best practices in ambulatory care. Pharmacists across the country provide a wide variety of services in interprofessional teams including but not limited to, annual wellness visits, disease management, transitions of care, comprehensive medication management, immunizations, medication assistance, medication adherence programs, and many others. In order to increase uptake of these models, ASHP developed the Ambulatory Care Self-Assessment as part of the Practice Advancement Initiative, and partnered with the A3 Collaborative to support pharmacists and health systems with the development of innovative care models that increase access to care and improve patient care outcomes. Despite all that the

profession of pharmacy does to improve patient care outcomes through the provision of direct patient care services, the AAMC report focuses primarily on the role that physician assistants and nurse practitioners play to mitigate the primary care physician shortage. As the national grapples with the how to care for an aging population and provide comprehensive, accessible, patient-centered care for a growing population, it is paramount that pharmacists are seen as a profession who can mitigate the primary care provider shortage. Collaboration with medical, physician assistant, and nurse practitioner professional organizations as well as groups such as Get the Medications Right Institute, the A3 Collaborative, PCPCC, CMS, and others, is warranted so that the profession of pharmacy is at the table when solutions to the primary care shortage are developed.

**Suggested Outcomes:**

1. Pharmacists are nationally recognized as a viable and integral solution for addressing the primary care shortage.
2. Creation of an ASHP Statement on “How Pharmacists Can Mitigate the Primary Care Shortage” that is endorsed by interprofessional external stakeholders.

# ASHP Board of Directors, 2019–2020

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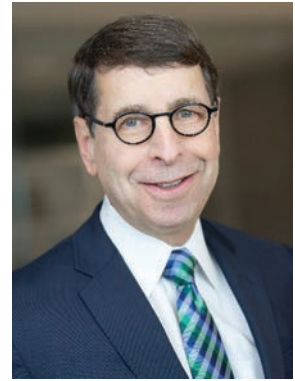
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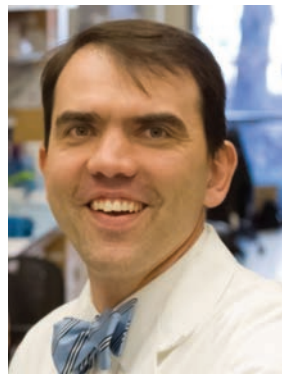
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## INAUGURAL ADDRESS OF THE INCOMING PRESIDENT

## Never settle

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ASHP has a proven track record of  
advancing the profession and remains a  
leader in pharmacy practice by  
listening, evolving, adapting, changing,  
and never settling.



Thank you for that wonderful welcome! Hey—did everybody hear that song? You know who did that song, don't you? That's right—it's by the band Boston. But I didn't pick it just because we're in Boston. You know that line "More than a feeling"? I have more than a feeling that by the end of my speech today, you're going to have a better appreciation of how we're going to work together in the next year.

I am energized to be your president and honored to serve you, ASHP, and our profession. Before we are done this morning, you will know a little more about me: who I am, where I've been, and what I'd like to accomplish as your president in the coming year. However, before I do that, I want to tell you why I'm here.

### Never settle

I'm here because of Ashley Chernaowski, who refused to settle for the high costs of medications for her patients—and whose constant search for alternative solutions ultimately reduced her patient's out-of-pocket costs by 90%.

I'm here because of Erin Fox, who refused to settle for drug shortages for her patients and who has taken her advocacy all the way to the halls of the Federal Trade Commission and the U.S.

Congress to ensure that essential therapies are available to patients.

And I'm here because of Mike Cohen, who won't settle for problems with packaging and labeling that increase the likelihood of medication errors. Mike's commitment to reduce or eliminate drug delivery mistakes is legendary.

I'm also here because of my dad and my family. My dad, who believed in community and family, instilled in me at an early age the importance of always doing the right thing. He was the first of many people who have inspired me over the years and modeled a characteristic that resonates with me today.

Never settle. Never stop striving to make something, including you, better. Think about that for a second. When you settle for something, you accept things the way they are. You stop. You don't keep working to grow professionally or as an individual. If we as pharmacists had settled years ago and accepted that pharmacy was only responsible for product preparation and dispensing, we wouldn't have grown our clinical experience. We wouldn't be seen as the experts in medication management, and we wouldn't be making the impact on patient care that pharmacists and technicians do today. This all happened

because we didn't settle. And that's what I want to talk to you about: the importance of pressing forward, always asking, always collaborating, always seeking the answers—and never, ever settling for the status quo just because it might be easy to do so or because change may seem difficult to imagine.

Please allow me to take a moment to thank my family and colleagues. First, my husband Frank, who is here with me today, for his unending support for whatever idea I might have or get involved in. He is always willing to travel with me or stay at home and take care of our family. Thank you! And thank you to my children, Kate, Tom, and Sydnee, who have grown into amazing individuals. And I can't forget my new grandson, Ford.

I'd also like to recognize my phenomenal pharmacy team at Beaumont Health and their commitment to doing the right thing. Through their dedication to patient care, we have expanded services and are seen as the medication experts in our health system.

And finally, thank you to all of my colleagues who have impacted my growth as a professional and as a person. Your friendship and inspirational careers have shaped who I am today.



## My story

The concept of never settling begins as a feeling of restlessness, an awareness of something better. To me, “never settle” implies that there is an action to take, a feeling of eagerness and hope, a drive to achieve more.

Here’s my own personal example. Several years ago, I was reviewing proposed legislation in Michigan related to sterile compounding. It occurred to me that it could not be operationalized in an acute care pharmacy. As a director of pharmacy at a 1,100-bed hospital, I knew the legislation, as proposed, would create significant workload in our busy sterile compounding areas, where we prepare over 300,000 doses of i.v. medications every year.

The legislation would have required us to keep records for every dose, which tech and which pharmacist was involved, and every lot number and manufacturer for every ingredient. We would need to maintain these records for years! Are you kidding me? I knew I had to speak up.

I was not on the government affairs team at Beaumont, but they connected me with the Michigan Hospital Association staff. Believe it or not, they had also been searching for guidance on this legislation. I was able to talk to the bill’s sponsor, and ultimately we were able to exempt hospital pharmacy from this burdensome recordkeeping.

Furthermore, the hospital association quickly recognized it could benefit its member hospitals by creating a statewide group of pharmacy directors. This group could provide feedback on upcoming state-level activities related to medication and pharmacy practice. And so, as a result, we have been able to influence state legislation concerning opioids, biosimilars, and various other medication-related actions.

Do you recognize yourself in our stories? I’ll bet you do because, as pharmacists, we have so many opportunities to make a difference—because we don’t settle. It’s our responsibility to speak up, take action, or do something!

Remember I told you about Ashley? She was contacted by a care coordinator about a patient who couldn’t afford her medications. The patient had multiple comorbidities, including diabetes, irritable bowel syndrome, and COPD. The patient’s \$500 monthly prescription costs ate into her fixed income of \$1,700 per month. She had to choose between food, medications, and other living expenses.

Ashley—an internal medicine pharmacist at Beaumont—was relentless in her search to find a way to obtain her patient’s medications at a more manageable cost. Ashley reduced the patient’s out-of-pocket prescription costs from \$500 per month to \$50 per month. How did she do it? She leveraged patient assistance programs, Medicare part B, \$4 prescription programs, and medication alternatives.

Like so many of us, Ashley went to pharmacy school so that she could help people. She realized early on that this patient did not have anyone on her side to advocate for her. So Ashley didn’t settle for the status quo and made an enormous difference in that patient’s life. Today, Ashley is continuing to help patients manage costs and teaching her students how to do so as well.

In 2001, Erin Fox volunteered to assist her institution in a partnership with ASHP to address drug shortages. She saw an opportunity to prevent patient harm when drugs weren’t available. Erin will never settle until drug shortages are a thing of the past.

Today, Erin, who is one of the country’s leading experts on drug shortages, tracks them for ASHP’s Drug Shortages Resource Center through her role at the University of Utah Drug Information Service. She also is a media resource and an advocate for change to resolve ongoing drug shortages. When I asked Erin what inspired her to take on this issue, she said, “It makes me frustrated and angry that we do not have the essential drugs we need for patients.”

In pharmacy circles, the name Mike Cohen resonates with medication safety. Early in his career at Temple

University, medication error reports were sent to him for review and action. One day, Mike was inspired to write an article about medication errors. That first article ran in *Hospital Pharmacy* journal in March 1975, and his work on this issue continues today.

Mike has a passion for patient safety and reducing preventable drug and drug-delivery mistakes. His commitment has resulted in hundreds of thousands of drug manufacturer product labeling changes and critical patient safety practices in our health systems. I asked Mike, “Why is this important to you?” He replied, “Isn’t that what the pharmacist’s responsibility is—to keep our patients from harm?” Mike Cohen exemplifies an individual who wouldn’t settle then and still won’t settle now!

## ASHP never settles

Now I would like to talk about us—everyone here in this room—and how we, as ASHP, have never settled. We began 77 years ago as an organization focused on hospital pharmacy and pharmacists. Today we encompass all areas of practice, including acute care, ambulatory care, and specialty pharmacy. Comprehensive patient care would not be possible without the contributions of our pharmacy technicians and the future of our profession—students!

ASHP has a proven track record of advancing the profession and remains a leader in pharmacy practice by listening, evolving, adapting, changing, and never settling. Since 2010, the Practice Advancement Initiative (PAI) has successfully engaged practitioners, leaders, students, and technicians in assessing and advancing practice. The PAI 2030 initiative was launched this year to provide a clear and visionary road map to the future of practice and build on the success of the current PAI recommendations.

PAI 2030 builds on PAI 2010 as a member-driven revision to this important work. Stay tuned! We’ll hear more about this at the Midyear Clinical Meeting in Las Vegas later this year. The future of our profession is tied to the

strength and abilities of our pharmacists and technicians. That's why ASHP provides continual professional development to enhance our ability to be *the* medication experts.

Think about it. We have been accrediting residencies for 56 years, and it's been 40 years since ASHP's Resident Matching Program began. There are now more than 5,000 residency positions available. That number continues to grow to meet the demand for highly trained pharmacists.

We offer numerous professional certificates, including 2 new certificates in emergency medicine and nutritional support. Just recently we added a Pharmacy Technician Certification Board-recognized Sterile Product Preparation Certificate for technicians and a Compounded Sterile Preparations Certificate for pharmacists. We also added a Pharmacogenomics Certificate and a Clinical Skills Certificate for international pharmacists.

ASHP is at the forefront of advancing the pharmacy technician role. New technician accreditation training standards were introduced earlier this year. These new standards recognize the need for introductory as well as advanced training. It is in the best interest of our patients and the practice of pharmacy to champion state legislative changes requiring technician education and training through an accredited training program. To do this, we are partnering with the Accreditation Council for Pharmacy Education and attending critical meetings across the country. The goal is to establish minimum education and training standards for crucial members of our pharmacy team.

Finally, we have expanded our sections and forums to develop professional communities for technicians and our members who practice in specialty pharmacy. As our profession and the healthcare landscape continue to evolve, I am confident that ASHP will never settle in its drive to ensure that our members are equipped to advance our practice and improve patient outcomes.

Ashley Cherniawski can't settle. Erin Fox wouldn't settle. Mike Cohen didn't settle. And we will never settle until we are fully recognized as healthcare providers, until every patient has a pharmacist, and until pharmacy leaders are recognized members of the C-suite. Your colleagues and peers didn't settle, and neither should you. As a profession, we can never settle. We make a difference to millions of patients.

ASHP is 50,000 strong, and our collective desire to never settle extends to each and every one of us in every corner of the nation, affecting every student, resident, pharmacist, and technician. We must be eager, restless, and ready to take action to improve the environments in which we practice, to improve the resources we have to care for our patients, and to influence public policy.

For example, we cannot be bystanders to the opioid crisis. We must be part of the solution. After all, it's not just a behavioral health issue, it's not just a prescriber issue, and it's not just an individual misuse issue. It's a societal issue that will take every single healthcare provider to be part of the solution. We should never allow ourselves to settle by saying it's not our problem.

And when it comes to drug shortages and drug pricing, we all need to tell our stories. How do excessive drug costs impact your organization and your patients? What happens when you can't get the right drug for your patient? Never stop telling those stories until the problems are fixed.

And we must never settle for stress and burnout as somehow being an accepted aspect of our profession. We each have to find meaning in the work we do, find balance in our lives, and engage in workplace discussions about how to address stress. So please, learn about resiliency and how to thrive during adversity. Take advantage of your hospital's programs. Check out ASHP's Well-Being and Resilience Resource Center, where you can find webinars, conversation starters, a toolkit for state affiliates, and more.

## Conclusion

In conclusion, I encourage all of you to find your voice. Advocate for sound public policy that allows us to fully and effectively care for patients. Most of all, keep telling your stories. You never know when something you say or do will change a patient's life. You just never know . . . so never settle!

Thank you! Enjoy the Summer Meetings and the rest of your day!

## Disclosure

The author has declared no potential conflicts of interest.

## Additional information

Presented at the ASHP Summer Meetings, Boston, MA, June 11, 2019.

# House of Delegates

## REPORT ON IMPLEMENTATION OF 2018

### ASHP HOUSE OF DELEGATES ACTIONS AND RECOMMENDATIONS

#### Council on Pharmacy Management 1801: Unit Dose Packaging Availability

To advocate that pharmaceutical manufacturers provide all medications used in health systems in unit dose packages or, when applicable, in packaging that reduces medication waste; further,

To urge the Food and Drug Administration to support this goal in the interest of public health and healthcare worker and patient safety.

*This policy supersedes ASHP policy 0309.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

#### Council on Pharmacy Management 1802: Gene Therapy

To assert that health-system decisions on the selection, use, and management of gene therapy agents should be managed as part of the medication formulary system in that (1) decisions are based on clinical, ethical, legal, social, philosophical, quality-of-life, safety, comparative effectiveness, and pharmaco-economic factors that result in optimal patient care; and (2) such decisions must include the active and direct involvement of physicians, pharmacists, and other appropriate healthcare professionals; further,

To advocate that gene therapy be documented in the permanent patient health record; further,

To advocate that documentation of gene therapy in the permanent patient health record accommodate documentation by all healthcare team members, including pharmacists.

*This policy supersedes ASHP policy 0103.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. The ASHP policy is reflected in the following activities:

[Biomarkers 101 - Webinar](#)

[Gene Replacement and Gene Modifying Therapies: Therapeutics and Safety for Pharmacists](#)

[Pharmacogenomics Certificate Program](#)

[Live Webinar: Ask the Experts: Key Considerations in Using Viral Vector Gene Therapies](#)

[Advancing pharmacy practice by reducing gaps in pharmacogenetic education](#) (AJHP)

**Council on Public Policy 1803: Confidence in the U.S. Drug Approval and Regulatory Process**

To support and foster legislative and regulatory initiatives designed to improve public and professional confidence in the drug approval and regulatory process in which all relevant data are subject to public scrutiny.

*This policy supersedes ASHP policy 9010.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. ASHP staff serve in a leadership role with FDA and industry on REMS standardization and codification to electronically optimize prescription processing of REMS drugs. For example, operating under an MOU between FDA and ASHP, staff provided expert advice on possible waivers for Abbreviated New Drug Application (ANDA) holders for requirement to develop a single shared REMS with the reference listed drug holder (innovator). ASHP has been active in advocating with FDA regarding 503A and 503B compounding. ASHP submitted comments on FDA Draft Guidance: Current Good Manufacturing Practice—Guidance for Human Drug Compounding Facilities under Section 503B of the FD&C Act.

**Council on Therapeutics 1804: Drug Dosing in Conditions that Modify Pharmacokinetics or Pharmacodynamics**

To encourage research on the pharmacokinetics and pharmacodynamics of drugs in acute and chronic conditions; further,

To advocate healthcare provider education and training that facilitate optimal patient-specific dosing in populations of patients with altered pharmacokinetics and pharmacodynamics; further,

To support development and use of standardized models, laboratory assessment, genomic testing, utilization biomarkers, and electronic health record documentation of pharmacokinetic and pharmacodynamic changes in acute and chronic conditions; further,

To collaborate with stakeholders in enhancing aggregation and publication of and access to data on the effects of such pharmacokinetic and pharmacodynamic changes on drug dosing within these patient populations.

*This policy supersedes ASHP policy 1720.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

**Council on Pharmacy Management 1805: Medication Formulary System 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.

*This policy supersedes ASHP policy 0102.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. The ASHP policy is reflected in the following activities:

[Formulary Submission Toolkit Tips for Use](#)

[Use of economic predictions to make formulary decisions](#) (*AJHP*)

**Council on Pharmacy Management 1806: Manufacturer-sponsored Patient Assistance Programs**

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 has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. The ASHP policy is reflected in the following activities:

[Patient Assistance Programs: Technicians Impacting Access to Care \(Free Trial\)](#)

[Topic related coverage - Insurers restrict copay coupons \(AJHP\)](#)

**Council on Pharmacy Management 1807: Reimbursement and Pharmacist Compensation for Drug Product Dispensing**

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

To educate pharmacists and stakeholders about those methods.

*This policy supersedes ASHP policy 1304.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

**Council on Pharmacy Management 1808: Patient Access to Pharmacist Care Within Provider Networks**

To advocate for laws and regulations that require healthcare payer provider networks to include pharmacists and pharmacies providing patient care services within their scope of practice when such services are covered benefits; further,

To advocate for laws and regulations that allow pharmacists and pharmacies to participate as a provider within a healthcare payer's network if the pharmacist or pharmacy meets the payer's criteria for providing those healthcare services; further,

To acknowledge that healthcare payers may develop and use criteria to determine provider access to its networks to ensure the quality and viability of healthcare services provided; further,

To advocate that healthcare payers be required to disclose to pharmacists and pharmacies applying to participate in a provider network the criteria used to include, retain, or exclude pharmacists or pharmacies.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. The ASHP policy is reflected in the following activities:

[A3 Collective](#)

[A3 Collective - Welcome video](#)

[Home health service gets assist from pharmacists](#) (AJHP)

### **Council on Pharmacy Management 1809: Health Insurance Policy Design**

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 has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. The ASHP policy is reflected in the following activities:

[Insurers restrict copayment coupons but leave coverage explanations to pharmacy staff](#) (AJHP)

### **Council on Pharmacy Management 1810: Pharmacy Accreditations, Certifications, and Licenses**

To advocate that healthcare accreditation, certification, and licensing organizations include providers and patients in their accreditation and standards development processes; further,

To advocate that healthcare accreditation, certification, and licensing organizations adopt consistent standards for the medication-use process, based on established evidence-based principles of patient safety and quality of care; further,

To encourage hospitals and health systems to include pharmacy practice leaders in decisions about seeking recognition by specific accreditation, certification, and licensing organizations; further,

To advocate that health-system administrators, including compliance officers and risk managers, allocate the resources required to support medication-use compliance and regulatory demands.

*This policy supersedes ASHP policy 1303.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

**Council on Pharmacy Practice 1811: Use of International System of Units for Patient- and Medication-related Measurements**

To advocate that the U.S. healthcare system adopt and only use the International System of Units (SI units) for all patient- and medication-related measurements and calculations; further,

To advocate that healthcare organizations use clinical decision support systems, equipment, and devices that allow input and display of patient- and medication-related measurements and calculations in SI format only; further,

To advocate that health information technology manufacturers utilize only SI units in their product designs for patient- and medication-related measurements; further,

To promote education in the use of SI units and the importance of using SI units to prevent medical errors.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

**Council on Pharmacy Practice 1812: Availability and Use of Appropriate Vial Sizes**

To advocate that pharmaceutical manufacturers provide drug products in vial sizes that reduce pharmaceutical waste and enhance safety; further,

To collaborate with regulators, manufacturers, and other healthcare providers to develop best practices on the safe and appropriate use of single-dose, single-use, and multiple-dose vials.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

**Council on Pharmacy Practice 1813: Use of Closed-System Transfer Devices to Reduce Drug Waste**

To recognize that a growing body of evidence supports the ability of specific closed-system transfer devices (CSTDs) to maintain sterility beyond the in-use time currently recommended by United States Pharmacopeia Chapter 797, when those CSTDs are used with aseptic technique and following current sterile compounding standards; further,

To foster additional research on and develop standards and best practices for use of CSTDs for drug vial optimization; further,

To educate healthcare professionals, especially pharmacists and pharmacy technicians, about standards and best practices for use of CSTDs in drug vial optimization.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

**Council on Public Policy 1814: Direct and Indirect Remuneration Fees**

To advocate that payers and pharmacy benefit managers be prohibited from recovering direct and indirect remuneration fees from pharmacies on adjudicated dispensing claims; further,

To oppose the application of plan-level quality measures on specific providers, such as participating pharmacies.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. In addition to [other advocacy](#) on the topic, in July 2018, ASHP and over 100 pharmacy groups and individual pharmacies signed onto a letter to DHHS urging the

department to eliminate altogether or prohibit retroactive direct and indirect remuneration (DIR) fees collected by PBMs under Medicare Part D.

#### **Council on Public Policy 1815: Impact of Drug Litigation Ads on Patient Care**

To oppose drug litigation advertisements that do not provide a clear and conspicuous warning that patients should not modify or discontinue drug therapy without seeking the advice of their healthcare provider.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Public Policy 1816: Biosimilar Medications**

To encourage the development of safe and effective biosimilar medications in order to make such medications more affordable and accessible; further,

To encourage research on the safety, effectiveness, and interchangeability of biosimilar medications; further,

To support legislation and regulation to allow Food and Drug Administration (FDA) approval of biosimilar medications that are also determined by the FDA to be interchangeable and therefore supports substitution for the reference product without the intervention of the prescriber; further,

To oppose the implementation of any state laws regarding biosimilar interchangeability prior to finalization of FDA guidance; further,

To oppose any state legislation that would require a pharmacist to notify a prescriber when a biosimilar deemed to be interchangeable by the FDA is dispensed; further,

To support the development of FDA guidance documents on biosimilar use, with input from healthcare practitioners; further,

To require postmarketing surveillance for all biosimilar medications to ensure their continued safety, effectiveness, purity, quality, identity, and strength; further,

To advocate for adequate reimbursement for biosimilar medications that are approved by the FDA; further,

To promote and develop education of pharmacists about biosimilar medications and their appropriate use within hospitals and health systems; further,

To advocate and encourage pharmacist evaluation and the application of the formulary system before biosimilar medications are used in hospitals and health systems.

*This policy supersedes ASHP policy 1509.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. In addition to ASHP's [drug pricing advocacy](#), ASHP served as a member of the [Biosimilars Forum](#) Stakeholder Workshop on Education and published [Biologics and Biosimilars](#) (Lucio).



**Council on Public Policy 1817: 340B Drug Pricing Program Sustainability**

To affirm the intent of the federal drug pricing program (the “340B program”) to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services; further,

To advocate legislation or regulation that would optimize access to the 340B program in accordance with the intent of the program; further,

To advocate with state Medicaid programs to ensure that reimbursement policies promote 340B program stability; further,

To advocate for clarification and simplification of the 340B program and any future federal discount drug pricing programs with respect to program definitions, eligibility, and compliance measures to ensure the integrity of the program; further,

To encourage pharmacy and health-system leaders to provide appropriate stewardship of the 340B program by documenting the expanded services and access created by the program; further,

To educate pharmacy leaders and health-system administrators about the internal partnerships and accountabilities and the patient-care benefits of program participation; further,

To educate health-system administrators, risk managers, and pharmacists about the resources required to support 340B program compliance and documentation; further,

To encourage communication and education concerning expanded services and access provided by 340B participants to patients in fulfillment of its mission.

*This policy supersedes ASHP policy 1407.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP [advocacy](#), education, and communication efforts.

**Council on Public Policy 1818: Federal Quality Rating Program for Pharmaceutical Manufacturers**

To advocate that the Food and Drug Administration (FDA) assign quality ratings to pharmaceutical manufacturers based on the quality of their manufacturing processes, sourcing of active pharmaceutical ingredients and excipients, selection of contract manufacturers, and business continuity plans; further,

To advocate that the FDA consider offering incentives for manufacturers to participate in the program.

*This policy supersedes ASHP policy 0814.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

**Council on Public Policy 1819: Intravenous Fluid Manufacturing Facilities as Critical Public Health Infrastructure**

To advocate that federal and state governments recognize intravenous fluid and associated supply manufacturing facilities as critical public health infrastructure.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. ASHP, along with the American Society of

Anesthesiologists, American Hospital Association, American Society of Clinical Oncology, and Institute for Safe Medication Practices, released a set of recommendations that came as a result of the interprofessional summit of healthcare leaders, [Drug Shortages as a Matter of National Security: Improving the Resilience of the Nation's Health Care Critical Infrastructure](#), held in September 2018.

#### **Council on Public Policy 1820: Medical Devices**

To advocate that the Food and Drug Administration (FDA) and manufacturers of drug preparation, drug distribution, and drug administration devices and associated new technologies ensure transparency, clarity, and evidence be provided on the intended use of devices and technologies in all phases of the medication-use process; further,

To advocate that the FDA and device manufacturers ensure compatibility between the intended use of any device and the drugs to be used with that device.

*This policy supersedes ASHP policy 9106.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Therapeutics 1821: Ensuring Effectiveness, Safety, and Access to Orphan Drug Products**

To encourage continued awareness of, research on, and development of orphan drug products; further,

To advocate for the use of innovative strategies and incentives to expand the breadth of rare diseases addressed by this program; further,

To encourage postmarketing research to support the safe and effective use of orphan drug products for approved and off-label indications; further,

To advocate that health policymakers, payers, and pharmaceutical manufacturers ensure continuity of care and patient access to orphan drug products; further,

To advocate federal review to evaluate whether orphan drug designation is being used inappropriately to receive FDA approval, extend patents, decrease competition, or limit discounts, thereby reducing patient access.

*This policy supersedes ASHP policy 1413.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Therapeutics 1822: Rational Use of Medications**

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 has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

**Council on Therapeutics 1823: Responsible Medication-related Clinical Testing and Monitoring**

To recognize that overuse of clinical testing leads to unnecessary costs, waste, and patient harm; further,

To encourage pharmacist accountability and engagement in interprofessional efforts to promote the judicious use of clinical testing and monitoring; further,

To promote research that evaluates pharmacists' contributions and identifies opportunities for the appropriate ordering of medication-related procedures and tests; further,

To promote the use of interoperable health information technology services and health information exchanges to decrease unnecessary testing.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

**Council on Therapeutics 1824: Use of Biomarkers in Clinical Practice**

To promote appropriate, evidence-based use of biomarkers in clinical practice; further,

To encourage research that evaluates the clinical and safety implications of biomarkers in the care of patients and to guide clinical practice; further,

To promote Food and Drug Administration qualified biomarkers in drug development, regulation, and use in clinical practice; further,

To foster the development of timely and readily available resources about biomarkers and their evidence-based application in clinical practice.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

**Council on Education and Workforce Development 1825: Clinician Well-being and Resilience**

To affirm that burnout adversely affects an individual's well-being and healthcare outcomes; further,

To acknowledge that the healthcare workforce encounters unique stressors throughout their education, training, and careers that contribute to burnout; further,

To declare that healthcare workforce well-being and resilience requires shared responsibility among healthcare team members and between individuals and organizations; further,

To encourage individuals to embrace well-being and resilience as a personal responsibility that should be supported by organizational culture; further,

To encourage the development of programs aimed at prevention, recognition, and treatment of burnout, and to support participation in these programs; further,

To encourage education and research on stress, burnout, and well-being; further,

To collaborate with other professions and stakeholders to identify effective preventive and treatment strategies at an individual, organizational, and system level.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. ASHP has an active Clinician Well-being and Resilience initiative, including a dedicated [ASHP Connect Community](#), an [online resource center](#), and a [State Affiliate Toolkit Well-Being and Resilience](#). ASHP provided a meditation/quiet room at the Midyear meeting as well as a travelling art exhibit on the topic.

#### **Council on Education and Workforce Development 1826: Student Pharmacist Drug Testing**

To advocate for the use of pre-enrollment, random, and for-cause drug testing throughout pharmacy education and pharmacy practice experiences, based on defined criteria with appropriate testing validation procedures; further,

To encourage colleges of pharmacy to develop policies and processes to identify impaired individuals; further,

To encourage colleges of pharmacy to facilitate access to and promote programs for treatment and to support recovery; further,

To encourage colleges of pharmacy to use validated testing panels that have demonstrated effectiveness detecting commonly misused, abused, or illegally used substances.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Education and Workforce Development 1827: Collaboration on Experiential Education**

To encourage practitioner contributions to pharmacy education; further,

To encourage pharmacists and pharmacy leaders to recognize their professional responsibility to contribute to the development of new pharmacy practitioners; further,

To promote collaboration of experiential teaching sites with the colleges of pharmacy (nationally or regionally), for the purpose of fostering preceptor development, standardization of experiential rotation schedule dates and evaluation tools, and other related matters; further,

To encourage colleges of pharmacy and health systems to define and develop collaborative organizational relationships that support patient care and advance the missions of both institutions in a mutually beneficial manner.

*This policy supersedes ASHP policies 0315 and 0804.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. In addition, ASHP has an active Section of Inpatient Care Practitioners Advisory Group on Pharmacy Practice Experiences that is continually building resource for APPE and IPPE preceptors.

#### **Council on Education and Workforce Development 1828: Promoting the Image of Pharmacists and Pharmacy Technicians**

To promote the professional image of pharmacists and pharmacy technicians who work in all settings of health systems to the general public, public policymakers, payers, other healthcare professionals, and healthcare organization decision-makers.

*This policy supersedes ASHP policy 0703.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Education and Workforce Development 1829: Pharmacy Training Models**

To promote pharmacy training models that: (1) provide experiential and residency training in interprofessional patient care; (2) use the knowledge, skills, and abilities of student pharmacists and residents in providing direct patient care; and (3) promote use of innovative and contemporary learning models; further,

To support the assessment of the impact of these pharmacy training models on the quality of learner experiences and patient care outcomes.

*This policy supersedes ASHP policy 1316.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. Interprofessional care is incorporated into [ASHP residency standards](#).

#### **Council on Public Policy 1830: ASHP Statement on Advocacy as a Professional Obligation**

To approve the ASHP Statement on Advocacy as a Professional Obligation.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Therapeutics 1831: Safe and Effective Use of IV Promethazine**

To advocate that intravenous promethazine be used only when medically necessary.

*This policy supersedes ASHP policy 1105.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Pharmacist-specific Issues in Parenteral Nutrition (Recommendation): Carol Rollins (AZ, MA)**

Recommend that ASHP offer continuing education activities (e.g., boot-camp, plenary sessions, certificate program) that include patient care and pharmacist-specific issues (e.g., stability compatibility, calculations, storage) related to both adult and pediatric parenteral nutrition management.

ASHP is committed to continue to provide education and resources for nutrition to its members. The Section of Clinical Specialists and Scientists reviews member needs when selecting network facilitators and nutrition support will continue as a facilitated session at the 2018 Midyear Clinical Meeting as well as providing contributions to ASHP Connect that members would find interesting or essential. Additionally, the Section Executive Committee is working with the Nutrition Support Network Facilitator to create a resource center for ASHP members that is dedicated to nutrition support, both parenteral and enteral in nature.

ASHP has also begun work on adding a [certificate program](#) in nutrition that will focus on both parenteral and enteral nutrition for nonspecialists. The goal of this certificate program is to help pharmacists who are not nutrition specialists develop a level of competency such that they can offer assistance to their interprofessional colleagues in the assessment and management of patients with uncomplicated nutritional needs. ASHP plans to have this certificate available in 2019.

#### **Diversity and Inclusion (Recommendation): Christopher M. Scott (IN); Tate N. Trujillo (IN); IA, CT, PA, NH**

Given the diversity of patients whom we serve, we recommend ASHP intentionally and strategically expand and support initiatives that promote diversity and inclusion in programming, policy, leadership, recognition, and membership. (This should incorporate all realms of diversity and inclusion, e.g., ethnic, cultural, gender, LGBTQ, etc.)

ASHP as a large national and international membership organization represents those from many facets including age, ethnicity, culture, gender, sexual orientation, religion, and more. ASHP supports and celebrates the diversity of our membership and seeks to promote inclusion.

**Concern of Gray Market Distributors/Wholesalers (Recommendation): Lonnye Finneman (MT)**

That the Council of Pharmacy Management revise existing ASHP drug distribution policy(s) to address the concern of gray market distributors/wholesalers contributing to increased drug prices and drug shortage issues.

This recommendation was referred to the Council on Pharmacy Management, which revised ASHP policy position 1707, Pharmaceutical Distribution Systems, to address this issue. In addition to the [ASHP Guidelines on Managing Drug Product Shortages](#), ASHP policies that touch on this issue include:

0814 – FEDERAL REVIEW OF ANTICOMPETITIVE PRACTICES BY DRUG PRODUCT MANUFACTURERS

1622 – INCLUSION OF DRUG PRODUCT SHORTAGES IN STATE PRICE-GOUGING LAWS

1716 – GREATER COMPETITION AMONG GENERIC AND BIOSIMILAR MANUFACTURERS

**Multi-state Law Certification (Recommendation): Matthew Christie (ME)**

ASHP work with states to develop regional licenses for pharmacists such as New England as done by other professions and VA.

ASHP Government Relations staff are investigating opportunities to advocate on this issue.

**The Alignment of Beyond Use Dating for Single Dose and Multi-Dose Vials (Recommendation): Caryn Belisle (MA)**

In order to reduce drug waste and mitigate safety risks in the event of drug shortages, all enforceable regulatory standards that address the beyond-use-date of a single or multi-dose drug vial must be in alignment with each other, and also recognize published literature that supports beyond-use-dating.

The Council on Pharmacy Practice agrees that this is an important topic and would be an additional policy in lieu of this past year's policy, Availability and Use of Appropriate Vial Sizes. The council may choose to deliberately wait for the new USP 797 standards to be released before choosing to write policy on this topic, but the topic will be discussed during the current council year.

**Student Learner Consistency within Policies and Position Statements (Recommendation): SACP**

The Section of Ambulatory Care Practitioners recommends that ASHP create an advisory group to review existing policies and position statements for alignment and the consistency of inclusion of student learners.

ASHP policy positions are periodically sunset reviewed, and the inclusion of student pharmacists will be added to that process moving forward.

**USP 797: Literature-based Beyond Use Dating (Recommendation): Jeff Little (KS, MO)**

ASHP should work with USP to develop evidence to support and potentially update USP 797 standard beyond use dating.

ASHP has submitted comments on recent proposed revisions to USP Chapters <795> and <797> asking for science-based information on beyond-use date assignments. ASHP will continue to work with USP to request more transparency in the science behind beyond-use date assignments so that compounded sterile preparations may be used safely while also minimizing waste. The ASHP House of Delegates and Board of Directors recently passed ASHP policy position 1813: Use of Closed-System Transfer Devices to Reduce Drug Waste. The policy position recognizes that some evidence supports using a closed-system transfer device to extend the duration that a vial may be used without microbial contamination. ASHP supports further studies and the development of standards to address this practice.

**Creation of a New PGY-1 Residency Program in Pharmacy Operations (Recommendation): Justin Konkol (WI and the Vizient Pharmacy Executive Committee)**

We ask ASHP to create a task force to develop competency areas, goals, and objectives (CAGO) for the creation of a new PGY-1 health-system pharmacy operations residency program.

The ASHP Commission on Credentialing (COC) reviewed the recommendation at the August 2018 meeting and concluded that the recommendation is inconsistent with the ASHP vision for residencies (see below). Further, the request focuses solely on training staff members – not supervisors, managers, or leaders. This is also inconsistent with ASHP's longstanding philosophy of residency training. Additionally, given the scope of responsibility of the medication-use system and technology (MST) pharmacist provided by the requestors, it was determined that the bulk of those are technical in nature and therefore may be areas of growth of increased scope of responsibilities for pharmacy technicians.

#### **Technician Representation on ASHP Councils (Recommendation): Lindsay Massey (KS, MO, IL)**

To recommend that ASHP evaluate the role of a technician representative on the ASHP Councils.

ASHP appreciates the desire to include pharmacy technicians in the policy-making process through ASHP Councils. A representative from the Pharmacy Technician Forum Executive Committee has been invited to participate in Policy Week and can attend all of the ASHP Council meetings, which is consistent with the other membership Sections of ASHP. In addition, a member of the Pharmacy Technician Forum Executive Committee will serve on the 2019-2020 Council on Pharmacy Practice.

#### **Meeting Attendance Incentives for ASHP-related Positions (Recommendation): SCS**

Encourage ASHP to evaluate meeting-related incentives to ASHP-related positions (e.g., program presenters, council chairs/vice chairs, section network facilitators, as appropriate) when meeting related activities are integral to the designated role.

ASHP offers a wide variety of volunteer leadership opportunities such as serving on Councils or as network facilitators. These volunteer roles are just a few of the many ways that our exceptional members provide their expertise and time to support ASHP's patient care and public health mission.

ASHP recognizes the need to always review and be sensitive to the time volunteers are asked to engage in various committee and other activities. The support ASHP currently provides is generally consistent with the underlying purpose and philosophy of volunteer service to ASHP and other mission-driven not-for-profit organizations. However, one area ASHP will review now is what is implied or encouraged of ASHP Council Chairs and/or Vice Chairs with regards to the House of Delegates and attending the ASHP Summer Meetings, which should be viewed as optional.

#### **Delegate Financial Support for ASHP Annual Summer Meetings (Recommendation): Michelle Eby; Carla Darling; (Washington Metro Area)**

We recommend that ASHP provide reduced or waived registration fees for each delegate to attend the ASHP Annual Summer Meetings.

During its September 2015 meeting, the ASHP Commission on Affiliate Relations discussed a variety of ways that ASHP could support House of Delegate activities, including adjusting the delegate stipend process. Their discussion considered Summer Meeting registration fees. The Commission concluded that increasing the delegate stipend would be the most efficient method to provide additional support for each state's delegates. Therefore, starting in 2017, ASHP increased the stipend amount provided to support each delegation, and that stipend will be evaluated on an ongoing basis. The Commission requested that ASHP continue to collect best practices around delegate issues by surveys of members and state organizations and to share this information on a regular basis.

#### **Social Determinants of Health (Recommendation): Davena Norris (NM)**

To encourage the development of policy related to training pharmacists and student pharmacists to understand, identify, and address social determinants of health in collaboration with other team members.

The Council on Education and Workforce Development considered this recommendation at its September meeting. See its report for more information about ASHP activities on this topic.

**Collaborative Practice Consistency (Recommendation): SACP**

The Section of Ambulatory Care Practitioners recommends that ASHP convene a task force to review existing policies and position statements for consistency in use of the term collaborative practice.

ASHP policy position 0905, Credentialing and Privileging by Regulators, Payers, and Providers for Collaborative Drug Therapy Management, is the only ASHP policy position still containing the term “collaborative drug therapy management.” The Council on Public Policy revised the policy position, using the term “collaborative practice” instead.

**New Antimicrobial Therapy Advocacy (Recommendation): Lucas Schulz (WI)**

To advocate for identification of innovative strategies to incentivize pharmaceutical manufacturers to continue developing and studying optimal use scenarios for novel antimicrobial agents and immune modulation therapies.

ASHP believes there may be an opportunity to work with FDA on expediting off label indications for some of these products. If the NDA only lists one indication for the product, FDA will only approve or not approve based upon the indication in the application. Obviously it takes considerable time to resubmit another NDA, but perhaps the off label approach would speed things along. ASHP also recognizes that CMS is looking to ensure that newly developed antimicrobials do meet any coverage or reimbursement barriers as well. There may be an opportunity to communicate with manufacturers about their NDA processes and the potential for FDA to expedite off-label use if there is evidence to support that the product is effective for uses not specified in the NDA. There are incentives for companies to develop and fast track use of antimicrobials in limited populations. However, these products have not gone through the full approval process by FDA and are allowed only as a last resort. ASHP communicates with FDA frequently on issues relating to public health. This issue could be something ASHP includes for FDA as a way to continue to develop new antimicrobial therapies.

The Council on Pharmacy Practice believes there is enough being done at a federal level that policy related to this topic is not needed. ASHP works closely with the CDC, TJC, Pew Trusts, and others about antimicrobial stewardship. ASHP has discussed this model with our CDC and TJC colleagues. Given the level of interest, this topic would make a good subject for an *AJHP* editorial.

**USP 800: Ensuring Safe and Consistent Implementation (Recommendation): Jeff Little (KS and MO)**

ASHP should work with USP to develop evidence based/expert opinion national standards for safe and consistent implementation of the USP 800 standard to prevent each institution from evaluating and developing their own standards.

Consistent application of USP Chapter <800>, specifically related to the hazardous drug list and assessment of risk, is also something ASHP is actively working toward. In April 2018, ASHP submitted comments to [www.regulations.gov](http://www.regulations.gov) on the NIOSH proposed revisions to the List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings, 2018 and on the NIOSH Policy and Procedures for Developing the NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings. ASHP requested that the hazardous drug groups be sorted by type of risk rather than AHFS pharmaceutical class. Clearer categorization of the hazardous drug list should allow more consistent practice in applying USP Chapter <800> to non-antineoplastic drugs. ASHP will continue working with NIOSH and USP to look for opportunities to provide more guidance and drug information on the hazardous drug list so that stakeholders can make informed and consistent decisions about the application of USP Chapter <800>.

**Recruitment of Pharmacy Technicians to Pharmacy Workforce (Recommendation): Lonnye Finneman (MT)**

Recommend that the new Pharmacy Technician Forum develop and disseminate information related to career opportunities to enhance recruitment and retention of qualified pharmacy technicians.

ASHP intends to address the development and dissemination of information related to career opportunities to enhance recruitment and retention of qualified pharmacy technicians with the creation of one of the



Pharmacy Technician Forum's new advisory groups: the Professional and Career Ladder Development Advisory Group (operational Fall 2018). The goal of this advisory group is to provide education and training materials for practicing pharmacy technicians and student pharmacy technicians. Specifically, the advisory group is charged with:

- Developing submissions for AJHP to support facets of pharmacy technician professional and career ladder development;
- Reviewing and developing Forum professional career ladder development resources of pharmacy technicians; and
- Planning educational and/or networking opportunities at ASHP's MCM18 and SM19.

#### **Outside Access to Health System Electronic Health Records for Transitions of Care (Recommendation): Dave Hager (WI)**

That ASHP create a policy encouraging pharmacists in post-discharge care locations such as ALFs, SNFs, LTACs, and community pharmacies be granted health system electronic health record access to improve the safety of the transitions of care process with explicit oversight on who may obtain access by the health system's pharmacy department.

Two existing ASHP policies, Transitions of Care (1208) and Electronic Information Systems (0507), cover the intent of the recommendation. Access to electronic health information is broad and all-encompassing and will be served appropriately by policies that include all areas of care. Access for community pharmacies to individual health system EHRs may be helpful but can create legal issues with cybersecurity, credentialing, and privileging for all of those organizations and individuals. Informaticists agree that it is much broader than having access to just one system. All pertinent health data should be available to pharmacists and other involved healthcare providers. Some areas of the country have achieved this with regional Health Information Exchanges.

The new SOPIT Strategic Plan, finalized at the ASHP Summer Meetings, recognizes this issue and appears in our Mission Statement as follows:

**Vision:** Health information technology is utilized to ensure that medication use processes are optimal, safe, and effective for all people all the time.

**Mission:** Support the mission of ASHP by being the professional home for all members who are dedicated to advancing medication use and health outcomes through the use of health information technology.

Through collaboration, provide a collective voice on best practices and issues related to the use of health information technology for medication use processes across the continuum of care, and the advancement of pharmacy informatics as a specialty practice.

There are other organizations working on this issue as well, the biggest of which is likely the Pharmacy Health Information Technology Collaborative. ASHP is a Founding Member of this organization, and SOPIT has multiple representatives on each of their five workgroups. Composed of multiple national professional organizations, their mission is to create successful pharmacy interoperability so as to create an environment in healthcare as described in the recommendation.

By having a broad approach in our policies and other statements and collaboration with other pharmacy organizations, ASHP supports the interoperability of all areas of practice across the continuum of care, and SOPIT is working diligently as a Section and ASHP as a whole to achieve these goals.

#### **Emergency Supply of Medications during Catastrophic Events (Recommendation): Charzetta James (FL)**

To advocate for increased limits in day's supply of prescription medication dispensed by non-community pharmacy permit holders during catastrophic events.

The Council on Public Policy considered this recommendation at its September meeting and developed a policy recommendation, Emergency Refills.

### **Recognition of Perpetual Inventory of Controlled Substances in Automated Dispensing Technologies (Recommendation): Kate McKinney (OH)**

To encourage ASHP to partner with the DEA to recognize perpetual inventory of controlled substances (CII-V) for biennial inventory (title 21 CFR Part 1304.1) inventory requirements.

The ASHP Government Relation staff is exploring opportunities to advocate this topic with the Drug Enforcement Administration.

### **Pharmacist Authority to Prescribe Controlled Substances (Recommendation): Heather Ourth (VA Affairs)**

ASHP to develop policy and advocacy efforts to support state practice act expansion for prescribing of controlled substances by pharmacists, including federal authorization which allows pharmacists to obtain X waivers to prescribe medication assisted treatment.

ASHP does support state scope of practice expansion to include pharmacists prescribing and weigh in on the state level when one of our affiliates requests us to do so. In other cases, ASHP provides any useful resources to our affiliates who are working the issue on the ground.

As for federal efforts, ASHP has been partnering with APhA on this issue and has had numerous meetings on Capitol Hill. The most recent action ASHP has taken is a letter to Senate leadership on the opioid issue requesting that pharmacists be eligible for the DATA waiver to prescribe controlled drugs. ASHP professional policy sufficiently covers this, as ASHP has state scope of practice policy as well as policy on provider status.

### **ASHP Policy to Manage PBMs (or guidelines) (Recommendation): Nish Kasbekar (PA)**

That ASHP develop strategies to assist health systems with managing PBM relationship or assisting health systems (providing guidance) to create their own.

The role and impact of PBMs continue to plague and impact health-systems and the pharmacy enterprise. ASHP has been working through its advisory groups and government relations to develop strategies to assist health-systems with managing PBM relationships and assisting health-systems to create their own. As is well known, the group of members that typically have the influence over or are impacted by PBM-related decisions from a health-system perspective are the Chief Pharmacy Officers. This issue will continue to be a priority item for ASHP and the Section of Pharmacy Practice Managers and can be anticipated in being an issue addressed by the new Section of Specialty Pharmacy Practitioners with the goal of developing education and resources for members.

Some recent ASHP activities related to this issue include:

1. Development of two policies that were approved by the House of Delegates in 2018:
  - 1808 – Patient Access to Pharmacist Care Within Provider Networks
  - 1809 – Health Insurance Policy Design

2. Education session and workshop at the 2018 ASHP Leaders Conference:
  - a. Pharmacy Benefit Managers: Opportunities and Challenges for Executives  
<https://leaders.ashp.org/Education-and-Posters/Tuesday>
  - b. Specialty Pharmacy Workshop (by invite only)

3. ASHP advocacy regarding retroactive DIR fees:

ASHP Issue Brief: Direct and Indirect Remuneration Fees

ASHP Comments on Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs

4. PBM Connect Community

<https://connect.ashp.org/communities/community-home?CommunityKey=7fe59dde-9418-45b1-a0ca-b8b78f5530d2>

**Sections and Forums Integration (Recommendation): Kevin Marvin (VT, MA, NE)**

We recommend that ASHP develop a structure that manages issues identified by sections and forums that require integration of resources between the sections and forums to address specific topics and create specific deliverables. Furthermore, this structure should be supported by ASHP staff and have additional staff as specialized task forces are created

The recommendation to develop a structure to address topics of common interest between and among the membership Sections and Forums is one of great merit. ASHP intends to move forward with piloting a system to meet the intent of the recommendation.

**House of Delegates State Affiliate Membership Requirement (Recommendation): Amada Hansen (OH)**

Consider requiring state affiliate membership as a requirement of serving as a state representative for ASHP HOD.

ASHP understands the intent of this recommendation; however, requiring state affiliate membership as a prerequisite for participation as a delegate in the ASHP House of Delegates is not consistent with the ASHP Governing Documents. All ASHP practitioner members must have the opportunity to serve and vote in ASHP delegate elections, regardless of state affiliate membership status.

State affiliate organizations may determine the nomination criteria for delegate elections conducted in the state, which could include state affiliate engagement as part of the delegate nominations process. The ASHP Commission on Affiliate Relations discussed best practices in ASHP House of Delegates activities in September 2018, and ASHP shared the results of the discussion with affiliates.

**Amazon Entry into Pharmacy (Recommendation): SACP**

The Section of Ambulatory Care Practitioners recommends that ASHP partner with other national pharmacy organizations to approach companies that are considering entry into the healthcare marketplace (e.g., Amazon) about being at the table for discussions that would affect the profession of pharmacy.

ASHP strongly advocates for the pharmacy profession, collaborating with other pharmacy and healthcare organizations when advantageous. ASHP is closely monitoring the entry of new players in the healthcare marketplace and will advocate for the profession when antitrust considerations allow and when ASHP members have a strong interest in outcomes.

**Addressing Barriers to Biosimilar Reimbursement (Recommendation): Karen McConnell (CO); Amy Sipe (MO); Snehal Bhatt (MA)**

For ASHP to evaluate the impact of reference product rebates on the third party reimbursement of biosimilar products.

Because of ASHP's market power, ASHP volunteers and staff need to be aware of the possible antitrust exposure that may arise when representatives of competing entities discuss issues and recommend activities such as influencing pricing (e.g., opposing rebate programs). This may be interpreted as actions by competitors. ASHP has policies related to access, biosimilars, and fair reimbursement (see below):

- 0814 - FEDERAL REVIEW OF ANTICOMPETITIVE PRACTICES BY DRUG PRODUCT MANUFACTURERS
- 1001 - HEALTH INSURANCE COVERAGE FOR U.S. RESIDENTS
- 1716 - GREATER COMPETITION AMONG GENERIC AND BIOSIMILAR MANUFACTURERS
- 1807 - REIMBURSEMENT AND PHARMACIST COMPENSATION FOR DRUG PRODUCT DISPENSING
- 1809 - HEALTH INSURANCE POLICY DESIGN
- 1816 - BIOSIMILAR MEDICATIONS

ASHP will continue its pursuit to advocate on addressing barriers to patient access and on the ideal site of care to ensure continuity of care and patient safety are not compromised.

**Disclosure of Price Increases by Drug Product Manufacturers (Recommendation): Jesse Hogue (MI)**

ASHP should develop a policy to advocate that drug product manufacturers be required to provide public notification in advance of significant price increases.

The Council on Public Policy considered this recommendation at its September meeting and made the policy recommendation, Notification of Drug Product Price Increases.

**Professional Organization Involvement/Engagement as a Professional Obligation (Recommendation): Katie Morneau (TX, NH)**

Professional organization involvement is a professional responsibility and no current ASHP policies exist that speak to this topic.

The [ASHP Statement on Leadership as a Professional Obligation](#) states that “Pharmacists also have an obligation to exert leadership and participate in shaping the future of the profession. Participation in professional societies such as ASHP provides opportunities to shape the future of the profession and affords excellent opportunities for the development of leadership skills.” The Council on Pharmacy Practice reviewed and discussed this recommendation during its February 2019 meeting. The Council believes this recommendation to be a sound idea and may require an expansion of existing ASHP policy, but the Council will defer to the Council on Education and Workforce Development to move forward during the next year given the scope of the needed language and associated actions

**Availability of Electrical Outlets at HOD (Recommendation): Carla Darling and Laura Zendel (Washington Metro)**

Consider providing necessary resources for HOD meeting such as electrical outlets.

The issue of providing electrical outlets at the House of Delegates has been considered but is not easily implemented. From a meeting management perspective, the setup required for the House of Delegates makes distribution of power sources logistically challenging. Unfortunately, convention centers do not have the type of furniture that include electrical outlets and power sources to adequately meet our needs in a safe, efficient, and cost-effective manner. However, ASHP does provide charging stations in multiple stations that may be used by our attendees immediately prior or after the House of Delegates.

**Cannabinoids (Recommendation): Scott Anderson (VA)**

Recommend ASHP to review and update policy 1101 to include cannabinoids and related research.

ASHP policy 1101 originated with the Council on Therapeutics. There has been much discussion between CPHP, CPuP, and COT about the medical use of marijuana/cannabinoids over the past three years. At this point ASHP has decided not to revise this policy given that, with the exception of a newly approved product, the grouping is still categorized as Schedule I at the federal level. ASHP knows that states are actively creating laws and policies, but again at the federal level none of these products are considered legal, so changing the terminology to be more inclusive may be warranted, but it may still be premature until more can be done with this policy. ASHP is monitoring this topic and will act when the timing is appropriate. Please also see the Council on Therapeutic policy recommendation, Therapeutic Use of Cannabidiol, before the House at this meeting.

**House of Delegates Term Limits (Recommendation): Scott Knoer (OH)**

Consider imposing term limits on ASHP state delegates to give more members the opportunity to be involved and engaged.

Serving as an ASHP delegate is indeed an excellent membership engagement opportunity. Election of state delegates should be in accordance with the bylaws of ASHP’s affiliated state societies and in accordance with the state’s delegate election procedures. However, eligibility of the delegates should be in accordance with the ASHP Bylaws. All ASHP practitioner members must have the opportunity to serve and vote in ASHP delegate elections.

State affiliates may determine the nomination criteria for state delegate elections which could consider term limits. The ASHP Commission on Affiliate Relations will be discussing best practices in ASHP House of Delegates activities in September 2018 and ASHP will be sharing the results of the discussion with our affiliates. This could include information and recommendations about term limits of state delegates.

**Pharmacist Involvement in Post-Acute Care Settings (Recommendation): Tammy Cohen (TX)**

That ASHP recognize that post-acute care pharmacy services are integral components.

This recommendation has been shared with the appropriate ASHP sections and is being investigated for advocacy, research, and education.

**Student Programming: Resilience (Recommendation): Nancy Korman (CA)**

ASHP to develop programming specific for the student forum that addresses student specific scenarios which lead to burnout and stress.

The focus on clinician burnout as a growing public health problem is gaining significant momentum. ASHP is an original sponsor of the National Academy of Medicine (NAM) Action Collaborative on Clinician Well-Being and Resilience and is honored to lead the pharmacy profession on this issue. ASHP recognizes that a healthy and thriving clinician workforce is essential to ensuring optimal patient health outcomes and safety. Therefore, ASHP is committed to fostering and sustaining the well-being, resilience, and professional engagement of pharmacists, pharmacy residents, student pharmacists, and pharmacy technicians.

The Pharmacy Student Forum Executive Committee met at the ASHP Summer Meetings and will be incorporating well-being and resilience into Forum programs and activities for this year. For example, ASHP is planning educational programming related to workforce well-being and resilience for the upcoming Midyear Clinical Meeting and it will be added to our student programming. ASHP encourages members to join the conversation around well-being and resilience by joining the ASHP Connect Community on Clinician Well-Being and Resilience.

**Utilization of Electronic Resources to Streamline Amendments, Recommendations, and New Business Items during the ASHP House of Delegates (Recommendation):**

To recommend that ASHP investigate alternative electronic methods to collate recommendations, amendments, new business items, and other HOD relevant materials to streamline efforts and facilitate timely dissemination of revised information.

In response to this recommendation, ASHP staff discussed several suggestions with the Chair of the House of Delegates about using ASHP Connect and other technologies to collect proposed amendments, recommendations, and new business. Delegate use of ASHP Connect has grown tremendously in the past few years, and it has already been used to improve the amendment process before the House meets. Making more use of ASHP Connect at the Summer Meetings and even during the House of Delegates is a wise suggestion that is worthy of implementation.

**Awareness and Education for Rare (Orphan) Diseases (Recommendation): Mindy Burnworth, Carol Rollins, Renee Tyree (AZ)**

To recommend that ASHP develop a statement on the pharmacist's role in the management of patients with rare (orphan) diseases and orphan drug products; further,

To develop a resource center on rare diseases that includes information on orphan drug products (e.g., unusual procurement procedures, special handling, dosing and administration) and related disease information; further,

To collaborate with rare disease, medical, and other pharmacy organizations to promote healthcare provider and public awareness, education, and resources for patients with rare disorders.

This recommendation is under consideration by the Council on Pharmacy Practice.

**Sterile and Non-Sterile Compounding Continuing Education (Recommendation): SACP, Home Infusion SAG, MA, AZ**

Recommend that ASHP include a track with multiple activities related to sterile and non-sterile compounding for the Summer 2019 Meeting, and then continue to provide compounding-related CE activities especially sterile compounding, in small units (e.g., 1-4 hours) through various formats (e.g., Midyear meeting, electronic formats) to meet the growing need for education in compounding.

ASHP will offer two workshops on sterile compounding at the [Summer Meetings](#).

#### **Use of International Classification of Disease Terminology in Publications (Recommendation): Paul Driver (ID)**

AJHP and ASHP should use International Classification of Disease (ICD) diagnosis code terminology in publications.

This recommendation has been shared with ASHP publishing staff and will be implemented as possible in coming publications.

#### **Reconsideration of Policy Title “Use of International System of Units for Patient- and Medication-related Measurements” (Recommendation): Elizabeth Wade (NH)**

I recommend amending the title of the policy to include medication-related measurements.

The council recently reviewed and discussed this request and has no issues with changing the name. This will be done in the near future.

#### **ASHP Guidelines for Pharmacist Relations with Industry (Recommendation): Jim Lile (MI)**

That ASHP complete the update to ASHP Guidelines for Pharmacists’ Relations with Industry

The guidelines are still in development, due to competing priorities and volunteer turnover.

#### **Pharmacy Technician Forum Request (Recommendation): Steven Gray (CA)**

Ask the Pharmacy Technician Forum to consider the ASHP policy that was just adopted regarding Student Pharmacist Drug Testing to apply to student and employed pharmacy technicians for adoption next year.

This recommendation was referred to the Pharmacy Technician Forum, which proposed a policy recommendation on the topic.

#### **Recruitment Process: ASHP Residency Showcase (Recommendation): Joan Kramer (KS, MO)**

To recommend that ASHP convene a task force to assess the ASHP Residency Showcase and resident recruitment process, including but not limited to match rates and residency program return on investment for participation; further, to recommend the task force findings and action plan to close any identified gaps be presented to the ASHP Board of Directors within the next 12 months.

ASHP appreciates the interest in improving the recruitment process for residents and shares the desire to enhance the process. ASHP has looked at ways to improve the process and has recently invested in some technology advances to assist with the ASHP Residency Showcase and recruitment process.

Beginning in 2018, ASHP has partnered with two of the leading vendors in their respected industries to improve both the application/booth assignment process and program listing portal of the Residency Showcase. Moving forward, ASHP will have a new portal for programs to use to request booth space at the Midyear Clinical Meeting. The new portal is a streamlined, user-friendly system that has allowed ASHP to update its policies and create a significantly more customer-centric experience. In addition, ASHP has invested in technology to host the program listing sheets and will greatly enhance the experience of both programs and candidates. Programs will have access to sign in and post/edit their own listings, while adding specific description and category elements. Candidates will have a dynamic, mobile friendly, searchable and sortable list of residency opportunities available at the Residency Showcase. They will be able to browse through descriptions and sort by numerous categories with a focus of arriving at Midyear with a clear plan to attack the Residency Showcase.

These are the first round of improvements that will be made to the Residency Showcase process. ASHP will continue to look at any procedural and systematic enhancements while focusing on opportunities that

will allow programs new chances for promotion of their opportunities and make the candidate experience more user-friendly.

**Incorporation of Sterile and Non-sterile Compounding Educational Sessions at the 2019 ASHP Summer Meetings (Recommendation): Karl Gumpper (MA)**

ASHP should provide educational sessions at the 2019 ASHP Summer Meetings that provide both sterile and non-sterile compounding to meet MA pharmacist annual CE requirements.

ASHP will offer two workshops on sterile compounding at the [Summer Meetings](#).

# Professional Policies Approved by the 2019 ASHP House of Delegates

Boston, MA

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The new professional policies approved by the ASHP House of Delegates are listed below. Policies proposed by councils or other ASHP bodies are first considered by the Board of Directors and then acted on by the House of Delegates.

The background information on these policies appears on the ASHP website ([www.ashp.org](http://www.ashp.org)); click on “House of Delegates,” and then on “Session Information for Delegates,” and then on “Consolidated Documents for the June House” (<https://www.ashp.org/House-of-Delegates/Session-Information-for-Delegates>). The complete proceedings of the House of Delegates will be provided to delegates and will be posted on the ASHP website (<https://www.ashp.org/House-of-Delegates/Annual-Proceedings>).

## 1901

### Suicide Awareness and Prevention

Source: Council on Education and Workforce Development, Council on Pharmacy Management, Council on Pharmacy Practice, Council on Public Policy, and Council on Therapeutics

To support the goal of zero suicides; further,

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

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

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

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

To provide education that assists the pharmacy workforce in their continuing professional development efforts related to suicide awareness and prevention; further,

To support the inclusion of suicide awareness and prevention principles throughout pharmacy curricula and postgraduate educational and training programs; further,

To encourage efforts that support universal education and training of healthcare providers in suicide awareness and prevention; further,

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

To enhance awareness of local, state, and national suicide awareness and prevention resources, including the National Suicide Prevention Lifeline funded by the Substance Abuse and Mental Health Services Administration; further,

To foster education and research on suicide awareness and prevention.

## 1902

### Safe Administration of Hazardous Drugs

Source: Council on Pharmacy Practice

To advocate that all healthcare settings proactively conduct an inter-professional assessment of risk for exposure to hazardous drugs (HDs) during administration, including when closed-system transfer devices (CSTDs) cannot be used; further,

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

To encourage device and pharmaceutical manufacturers and the Food and Drug Administration to foster development of CSTD-compatible, ready-to-administer HD products.

## 1903

### Compounded Sterile Preparation Verification

Source: Council on Pharmacy Practice

To advocate that health systems adopt automation and information technology to facilitate in-process and final verification of compounded sterile preparations (CSPs) to ensure CSP quality; further,

To advocate that, until such time as automation or technology can be implemented, independent in-process and final verification of CSPs be performed; further,

To oppose the use of the syringe pull-back method or other proxy methods of CSP verification.

This policy supersedes ASHP policy 1617.

## 1904

### Notification of Drug Product Price Increases

Source: Council on Public Policy

To advocate for manufacturers to provide notice and justification to the public and healthcare providers in advance of drug price increases; further,

To advocate for transparency in drug product pricing decisions.

## 1905

### Mitigating Drug Product Shortages

Source: Council on Public Policy



To advocate for ongoing federal evaluation of how drug product shortages present risks to national security and public health; further,

To advocate that drug product manufacturers be required to disclose manufacturing sites and sources of active pharmaceutical ingredients (APIs) to facilitate such a risk assessment; further,

To recommend that the Food and Drug Administration (FDA) require drug product manufacturers to have contingency plans for maintaining drug supplies; further,

To advocate that drug product manufacturers be required to provide a specific reason for a shortage and an estimated timeline for resolution in their Food and Drug Administration Safety and Innovation Act notifications to FDA; further,

To advocate that FDA be required to publicly provide quality ratings for 503B outsourcing facilities preparing copies of drug products under the exemption for products on FDA's shortage list; further,

To advocate that the Federal Trade Commission be required to evaluate the potential for drug product supply chain interruptions when considering manufacturer consolidations.

## 1906

### Emergency Supplies of Drug Products

*Source: Council on Public Policy*

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

## 1907

### Credentialing and Privileging by Regulators, Payers, and Providers for Collaborative Practice

*Source: Council on Public Policy*

To advocate expansion of collaborative practice agreements in which the prescriber and pharmacist agree upon

the conditions under which the pharmacist initiates, monitors, and adjusts a patient's drug and non-drug therapy; further,

To support (1) the development (as a professional initiative by pharmacist associations rather than as a government activity) of national standards for determining a pharmacist's competence to provide medication management services and (2) the appropriate use of these standards by clinical privileging systems, government authorities, and public or third-party payers; further,

To advocate pharmacists be included as providers in medical staff bylaws; further,

To support the use of credentialing and/or clinical privileging by hospitals, health systems, and payers in a manner that is consistent with other healthcare professionals to assess a pharmacist's competence to engage in medication management services within the hospital or health system.

*This policy supersedes ASHP policy 0905.*

## 1908

### 340B Drug Pricing Program Sustainability

*Source: Council on Public Policy*

To affirm the intent of the federal drug pricing program (the "340B program") to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services; further,

To advocate for continued access to the 340B program in accordance with the intent of the program; further,

To advocate that reimbursement and contracting policies promote 340B program stability and to oppose reimbursement and savings reductions to covered entities; further,

To advocate for clarification and simplification of the 340B program and any future federal discount drug pricing programs with respect to program definitions, eligibility, and compliance measures to ensure the integrity of the program; further,

To encourage 340B participants to provide appropriate stewardship of the 340B program; further,

To educate pharmacy leaders and health-system administrators about the internal partnerships and accountabilities and the patient-care benefits of program participation; further,

To educate health-system administrators, risk managers, and pharmacists about the resources required to support 340B program compliance and documentation; further,

To encourage communication and education concerning the value of the 340B program; further,

To advocate that the Health Resources & Services Administration Office of Pharmacy Affairs have sufficient regulatory authority to enforce compliance for all stakeholders with the 340B program.

*This policy supersedes ASHP policy 1817.*

## 1909

### Pharmacist Authority to Provide Medication-Assisted Treatment

*Source: Council on Public Policy*

To advocate for the role of the pharmacist in medication-assisted treatment (MAT) for opioid use disorder, including patient assessment, education, prescribing, and monitoring of pharmacologic therapies; further,

To pursue the development of federal and state laws and regulations that recognize pharmacists as providers of MAT for opioid use disorder; further,

To foster additional research on clinical outcomes of pharmacist-driven MAT; further,

To advocate for the removal of barriers for all providers to be able to provide MAT to patients.

## 1910

### Therapeutic Use of Cannabidiol

*Source: Council on Therapeutics*

To support continued research and to provide education on the therapeutic uses, adverse effects, and drug interactions of cannabidiol (CBD); further,

To oppose use of CBD-containing products not regulated by the Food and Drug Administration; further,

To advocate for enhanced public education regarding safe use of CBD-containing products.

## 1911

### Pharmacy Expertise in Sterile Compounding

*Source: Council on Education and Workforce Development*

To support colleges of pharmacy in providing sterile compounding and aseptic technique instruction in didactic and experiential curricula that reflect the needs of the workforce; further,

To promote the use of sterile compounding training programs to foster an increase in the number of pharmacists and pharmacy technicians with sterile compounding expertise; further,

To advocate that pharmacists and pharmacy technicians who work in sterile compounding attain compounded sterile preparations advanced certifications.

*This policy supersedes ASHP policy 0915.*

## 1912

### Pharmacy Technician Training and Certification

*Source: Council on Education and Workforce Development*

To advocate for adoption of a national standard for accreditation of pharmacy technician education and training programs; further,

To advocate that a pharmacy technician education and training program accredited by ASHP and the Accreditation Council for Pharmacy Education (ACPE) be required for all

new pharmacy technicians by the year 2022; further,

To advocate that all pharmacy technicians be required to obtain and maintain Pharmacy Technician Certification Board certification; further,

To foster expansion of ASHP/ACPE-accredited pharmacy technician education and training programs.

*This policy supersedes ASHP policy 1609.*

## 1913

### Pharmaceutical Distribution Systems

*Source: Council on Pharmacy Management*

To support drug distribution business models that meet the requirements of hospitals and health systems with respect to availability and timely delivery of products, minimizing short-term outages and long-term product shortages, managing and responding to product recalls, fostering product-handling and transaction efficiency, preserving the integrity of products as they move through the supply chain, and maintaining affordable service costs; further,

To oppose manufacturers, distributors, and wholesalers restricting or making availability of drug products contingent on how those products are used; further,

To encourage selection of a wholesale distributor that (1) purchases products only from a manufacturer before distribution to the purchasing end user; (2) is licensed in the state where it is conducting business; (3) complies with the requirements of the Drug Supply Chain Security Act; (4) is accredited under the National Association of Boards of Pharmacy Verified-Accredited Wholesale Distributors program; and (5) uses information systems that are interoperable with common types of pharmacy systems.

*This policy supersedes ASHP policy 1707.*

## 1914

### Safe Medication Preparation, Compounding, and Administration in All Sites of Care

*Source: Council on Pharmacy Management*

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

## 1915

### Pharmacy Department Business Partnerships

*Source: Council on Pharmacy Management*

To recognize that a key objective of pharmacy departments is to provide medication management services across the continuum of patient care and that pharmacy leaders should proactively evaluate potential business partnerships against this objective; further,

To recognize that hospitals and health-system pharmacy leaders must ensure that business partners meet all applicable patient safety and accountability standards; further,

To provide education and tools for pharmacy leaders to aid in the evaluation of and development of business partnerships; further,

To educate health-system administrators on the importance of pharmacy leadership in evaluating and developing pharmacy-related business partnerships; further,

To encourage health-system pharmacy leaders to consider evolving health-care financing systems when evaluating and developing business partnerships.

*This policy supersedes ASHP policy 1416.*

## 1916

### Intimidating or Disruptive Behavior

*Source: Council on Pharmacy Management*

To affirm the professional responsibility of the pharmacist to ensure patient and workplace safety by communicating with other healthcare personnel to clarify and improve medication management; further,

To advocate that hospitals and health systems adopt zero-tolerance policies for intimidating or disruptive behaviors in their institutions; further,

To encourage hospitals and health systems to develop and implement education and training programs for all healthcare personnel to encourage effective communication, set expectations for standards of conduct, promote use of de-escalation techniques, and discourage intimidating or disruptive behaviors; further,

To encourage colleges of pharmacy and residency training programs to incorporate training in communications and managing intimidating or disruptive behaviors; further,

To collaborate with other organizations to advocate codes of conduct that do not allow intimidating or disruptive behavior in hospitals and health systems; further,

To encourage hospitals and health systems to adopt processes for identification and reporting of intimidating or disruptive behaviors to evaluate and

mitigate unacceptable behaviors in a timely and effective manner.

*This policy supersedes ASHP policy 0919.*

## 1917

### Pharmacy Technician Student Drug Testing

*Source: Pharmacy Technician Forum*

To advocate for the use of pre-enrollment, random, and for-cause drug testing as a mandatory component throughout any accredited or unaccredited pharmacy technician training program and practice experience, based on defined criteria with appropriate testing validation procedures; further,

To encourage pharmacy technician training programs to develop policies and processes to identify impaired individuals; further,

To encourage pharmacy technician training programs to facilitate access to and promote programs for treatment and to support recovery; further,

To encourage pharmacy technician training programs to use validated testing panels that have demonstrated effectiveness detecting commonly misused, abused, or illegally used substances.

## 1918

### Minimum Educational Qualification Standards for Pharmacists

*Source: House of Delegates Resolution*

To support minimum educational qualification standards for pharmacists to practice pharmacy that are consistent with the licensing standards of state boards of pharmacy; further,

To oppose the basic education requirement within the Office of Personnel Management Classification & Qualifications—General Schedule Qualification Standards—Pharmacy Series, 0660, requiring a Doctor of Pharmacy or Doctor of Philosophy degree as the minimum qualification to practice pharmacy.

## 1919

### ASHP Statement on the Role of the Medication Safety Leader

*Source: Section of Inpatient Care Practitioners*

To approve the ASHP Statement on the Role of the Medication Safety Leader.

*This statement supersedes a previous version dated April 13, 2012.*