American Pharmacists Association

For Every Pharmacist. For All of Pharmacy.

2024 House of Delegates

Report of the New Business Review Committee

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American Pharmacists Association
For Every Pharmacist. For All of Pharmacy.

American Pharmacists Association
House of Delegates – March 22-25, 2024

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

Item No.: I
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NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: **Briana Rider**
(Name)

2024 January 14 U.S. Public Health Service (USPHS) Commissioned Corps, Federal Caucus
(Date) **(Organization)**

Subject: Disaster Preparedness

Motion: To adopt the following policy statement as amended and part of the existing 2015 Disaster Preparedness policy

Disaster Preparedness, 2015

1. APhA encourages pharmacist involvement in surveillance, mitigation, preparedness, planning, response, and recovery related to natural, technological, or human-caused incidents ~~terrorism and infectious diseases~~.

Background:

In 2001, this policy, originally titled "Biological Terrorism, Infectious Diseases, and Pharmacy" was limited to bioterrorism preparedness planning. In 2015, the policy statement was revised, as written in the current APhA policy manual, and adopted as a New Business Item by the House; the 2001 policy was archived. The 2015 revision titled "Disaster Preparedness" included terrorism more broadly, expanded to include infectious diseases, and recognized pharmacists' role beyond planning, to include surveillance, mitigation, response, and recovery.

Pharmacists may be involved in all types of natural, technological, and human-caused incidents (e.g., wildfire, flood, hazardous materials spills, nuclear accidents, aircraft accidents, terrorist attacks, civil unrest,

earthquakes, hurricanes, tornadoes, tsunamis) throughout the entire lifecycle of the incident (e.g., surveillance, mitigation, preparedness, planning, response, recovery). However, existing APhA policies on pharmacists' roles in emergency and disaster management are more narrowly focused on terrorism, infectious diseases, emergencies (e.g., public health), and national defense. The proposed amendment seeks to be more inclusive of the types of incidents that pharmacists surveille and mitigate against, prepare and plan for, respond to, and recover from. Natural, technological, and human-caused incidents are inclusive of terrorism and infectious diseases. Thus, the proposed amendment would broaden the existing policy statement.

The Federal Emergency Management Agency (FEMA) defines the terms natural, technological, and human-caused hazards. Natural hazards are defined as environmental phenomena that are related to weather patterns and/or physical characteristics of an area. The National Risk Index includes eighteen natural hazards (e.g., earthquakes, tornado, hurricane, wildfire, winter weather). Technological hazards originate from technological or industrial accidents, infrastructure failures, or certain human activities (accidents). Human-caused hazards rise from deliberate, intentional human actions to threaten or harm the well-being of others (e.g., terrorism).

While terrorism is solely a human-caused incident, infectious diseases can result from natural (e.g., outbreak of natural origin), technological (e.g., accidental release from a laboratory), or human-caused (e.g., weaponized for biological warfare/terrorism) incidents.

FEMA defines disaster as "an occurrence of a natural catastrophe, technological accident, or human-caused event that has resulted in severe property damage, deaths, and/or multiple injuries". Thus, the proposed amendment is appropriate for the subject of the policy – Disaster Preparedness – and would create a more comprehensive policy.

References:

- https://hazards.fema.gov/nri/natural-hazards
- https://training.fema.gov/programs/emischool/el361toolkit/glossary.htm#E

Current APhA Policy & Bylaws:

Disaster Preparedness, 2015

1. APhA encourages pharmacist involvement in surveillance, mitigation, preparedness, planning, response, and recovery related to terrorism and infectious diseases.
   (JAPhA. N55(4):365; July/August 2015) (Reviewed 2021)

Uncompensated Care Mandates in Pharmacy, 2023

1. APhA calls for commensurate compensation for the provision of compulsory or mandated pharmacy services that include all products, supplies, labor, expertise, and administrative fees based on transparent economic analyses of existing and future services.
   (JAPhA. 63(4):1266; July/August 2023)

Pharmacy Personnel Immunization Rates, 2022, 2007

1. APhA supports efforts to increase immunization rates of health care professionals, for the purposes of protecting patients and urges all pharmacy personnel to receive all immunizations recommended by the Centers for Disease Control (CDC) for healthcare workers.
2. APhA encourages employers to provide necessary immunizations to all pharmacy personnel.
3. APhA encourages federal, state, and local officials and agencies to recognize pharmacists, student pharmacists, pharmacy technicians, and pharmacy support staff as among the highest priority groups to receive medications, vaccinations, and other protective measures as essential healthcare workers.
   (JAPhA. NS45(5):580; September/October 2007) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)
   (JAPhA. 62(4):942; July 2022)

Use of Social Media, 2022, 2014

1. APhA encourages the use of social media in ways that advance patient care and uphold pharmacists as trusted and accessible health care providers.

2. APhA supports the use of social media as a mechanism for the delivery of patient-specific care in a platform that allows for appropriate patient and provider protections and access to necessary health care information.
3. APhA supports the inclusion of social media education, including but not limited to appropriate use and professionalism, as a component of pharmacy education and continuing professional development.
4. APhA affirms that the patient's right to privacy and confidentiality shall not be compromised through the use of social media.
5. APhA urges pharmacists, pharmacy technicians and student pharmacists to self-monitor their social media presence for professionalism and that posted clinical information is accurate and appropriate.
6. APhA advocates for continued development and utilization of social media by pharmacists and other health care professionals during public health emergencies.

(JAPhA. 54(4):357; July/August 2014) (Reviewed 2019) (Amended 2022)

Continuity of Care and the Role of Pharmacists During Public Health and Other Emergencies, 2021

1. APhA asserts that pharmacists, student pharmacists, pharmacy technicians, and pharmacy support staff are essential members of the healthcare team and should be actively engaged and supported in surveillance, mitigation, preparedness, planning, response, recovery, and countermeasure activities related to public health and other emergencies.
2. APhA reaffirms the 2016 policy on the Role of the Pharmacist in National Defense, and calls for the active and coordinated engagement of all pharmacists in public health and other emergency planning and response activities.
3. APhA advocates for the timely removal of regulatory restrictions, practice limitations, and financial barriers during public health and other emergencies to meet immediate patient care needs.
4. APhA urges regulatory bodies and government agencies to recognize pharmacists' training and ability to evaluate patient needs, provide care, and appropriately refer patients during public health and other emergencies.

5. APhA advocates for pharmacists' authority to ensure patient access to care through the prescribing, dispensing, and administering of medications, as well as provision of other patient care services during times of public health and other emergencies.
6. APhA calls for processes to ensure that any willing and able pharmacy and pharmacy practitioner is not excluded from providing pharmacist patient care services during public health and other emergencies.
7. APhA calls on public and private payers to establish and implement payment policies that compensate pharmacists providing patient care services, including during public health and other emergencies, within their recognized authority.
8. APhA advocates for the inclusion of pharmacists as essential members in the planning, development, and implementation of alternate care sites or delivery models during public health and other emergencies.
9. APhA reaffirms the 2015 Interoperability of Communications Among Health Care Providers to Improve Quality of Care and encourages pharmacists, as members of the healthcare team, to communicate care decisions made during public health and other emergencies with other members of the healthcare team to ensure continuity of care.

   (JAPhA. 61(4):e15; July/August 2021)

Multi-State Practice of Pharmacy, 2021

1. APhA affirms that pharmacists are trained to provide patient care, and have the ability to address patient needs, regardless of geographic location.
2. APhA advocates for the continued development of uniform laws and regulations that facilitate pharmacists', student pharmacists', and pharmacy technicians' timely ability to practice in multiple states to meet practice and patient care needs.
3. APhA supports individual pharmacists' and student pharmacists' authority to provide patient care services across state lines whether in person or remotely.
4. APhA supports consistent and efficient centralized processes across all states for obtaining and maintaining pharmacist, pharmacy intern, and pharmacy technician licensure and/or registration.

5. APhA urges state boards of pharmacy to reduce administratively and financially burdensome requirements for licensure while continuing to uphold patient safety.
6. APhA encourages the evaluation of current law exam requirements for obtaining and maintaining initial state licensure, as well as licensure in additional states, to enhance uniformity and reduce duplicative requirements.
7. APhA urges state boards of pharmacy and the National Association of Boards of Pharmacy (NABP) to involve a member of the board of pharmacy and a practicing pharmacist in the review and updating of state jurisprudence licensing exam questions.
8. APhA calls for development of profession-wide consensus on licensing requirements for pharmacists and pharmacy personnel to support contemporary pharmacy practice.

(JAPhA. 61(4):e14–e15;July/August 2021)

Pharmaceutical Safety and Access During Emergencies, 2020

1. APhA urges government authorities to hold pharmaceutical manufacturers, wholesalers, pharmacies, and other pharmaceutical supply distributors and providers accountable to state and federal price gouging laws in selling those items to patients, pharmacies, hospitals, and other health care providers during times of local, state, or national emergency.
2. APhA urges government authorities to aggressively enforce laws and regulations against adulterated products and false and misleading claims by entities offering to sell pharmaceutical and medical products to health care providers and consumers.

(JAPhA. 60(5):e11; September/October 2020)

Protecting Pharmaceuticals as a Strategic Asset, 2020

1. APhA asserts that the quality and safety of pharmaceutical and other medical products and the global pharmaceutical and medical product supply chain are essential to the United States national security and public health.
2. APhA advocates for pharmacist engagement in the development and implementation of national and global strategies to ensure the availability, quality, and safety of pharmaceutical and other medical products.

3. APhA calls for the development, implementation, and oversight of enhanced and transparent processes, standards, and information that ensure quality and safety of all pharmaceutical ingredients and manufacturing processes.
4. APhA calls on the federal government to penalize entities who create barriers that threaten the availability, quality, and safety of United States pharmaceutical and other medical product supplies.
5. APhA calls for the development of redundancy and risk mitigation strategies in the manufacturing process to ensure reliable and consistent availability of safe and high-quality pharmaceutical and other medical products.
6. APhA advocates for regulatory and market incentives that bolster the availability, quality, and safety of pharmaceutical and other medical products.
7. APhA calls for greater transparency, accuracy, and timeliness of information and notification to health care professionals regarding drug shortages, product quality and manufacturing issues, supply disruption, and recalls.
8. APhA encourages pharmacy providers, health systems, and payers to develop coordinated response plans, including the use of therapeutic alternatives, to mitigate the impact of drug shortages and supply disruptions.
9. APhA supports federal legislation that engages pharmacists, other health professionals, and manufacturers in developing a United States-specific essential medicines list and provides funding mechanisms to ensure consistent availability of these products.
10. APhA recommends the use of pharmacists in the delivery of public messages, through media and other communication channels, regarding pharmaceutical supply and quality issues.

(JAPhA. 60(5):e9; September/October 2020)

Protecting Pharmacy Personnel During Public Health Crisis, 2020

1. APhA strongly urges all employers of pharmacists and pharmacy personnel, and the settings in which they practice, to implement protection and control measures and procedures, per consensus recommendations when available, and access to protective gear and cleaning supplies that ensure the safety of pharmacy personnel and that of their family members and the public.

2. APhA urges federal and state government officials, manufacturers, distributors, and health system administrators to recognize pharmacists and pharmacy personnel as "front-line providers" who should receive appropriate personal protective equipment and other resources to protect their personal safety and support their ability to continue to provide patient care.
   (JAPhA. 60(5):e11; September/October 2020)

Role of the Pharmacist in National Defense, 2016, 2011, 2002, 1963

APhA endorses the position that the pharmacist, as a member of the health care team, has the ethical responsibility to assume a role in disaster preparedness and emergency care operations. In view of these responsibilities, it shall be the policy of APhA,

1. Cooperate with all responsible agencies and departments of the federal government;
2. Provide leadership and guidance for the profession of pharmacy by properly assuming its role with other health profession organizations at the national level (e.g., American Medical Association, American Hospital Association, American Dental Association, American Nurses Association, and American Veterinary Medical Association);
3. Assist and cooperate with all national specialty pharmaceutical organizations to provide assistance and coordination in civil defense matters relevant to their area of concern;
4. Encourage and assist the state and local pharmacy associations in their efforts to cooperate with the state and local governments as well as the state and local health profession organizations in order that the pharmacist may assume their proper place in civil defense operations; and
5. Provide leadership and guidance so that individual pharmacists can contribute their services to civil defense and disaster planning, training, and operations in a manner consistent with their position as a member of the health team.
   (JAPhA. NS3:330; June 1963) (JAPhA. NS42(5)(suppl 1):S62; September/October 2002) (Reviewed 2006) (Reviewed 2010) (JAPhA. NS51(4):483; July/August 2011) (JAPhA. 56(4):379; July/August 2016) (Reviewed 2021)

Health Mobilization, 2011, 2002, 1996

APhA should continue to,

1. Emphasize its support for programs on disaster preparedness that involve the services of pharmacists (e.g., Medical Reserve Corps) and emergency responder registration networks [e.g., Emergency System for Advance Registration of Volunteer Health Professions (ESAR-VHP)];
2. Improve and expand established channels of communication between pharmacists; local, state, and national pharmacy associations; boards and colleges of pharmacy; and allied health professions;
3. Maintain its present liaison with the Office of the Assistant Secretary for Preparedness and Response (ASPR) of the Department of Health and Human Services and continue to seek Office of Emergency Management (OEM) assistance through professional service contracts to further develop pharmacy's activities in all phases of preparation before disasters; and
4. Encourage routine inspection of drug stockpiles and disaster kits by state boards of pharmacy.

(JAPhA. NS6:328; June 1996) (JAPhA. NS42(5)(suppl 1):S62; September/October 2002) (Reviewed 2006) (JAPhA NS51(4):483; July/August 2011) (Reviewed 2016) (Reviewed 2022)

Model Disaster Plan for Pharmacists, 2006, 2002, 1971

1. The committee recommends that APhA develop a disaster plan for the guidance of pharmacy organizations in responding to the needs of pharmacists who experience losses from disasters and that this model plan be disseminated to state associations for their reference.
2. The committee recommends that APhA cooperate with associations representing pharmaceutical manufacturers, wholesale distributors, and others in the pharmaceutical supply system in developing a mechanism to facilitate the communication of information about the losses incurred by pharmacists as a result of disasters. Those firms that make it a practice to replace uninsured losses of inventories of their products could do so promptly and efficiently so that normal pharmaceutical services to the affected community are resumed as soon as possible.

(JAPhA. NS11:256; May 1971) (JAPhA. NS42(5)(suppl 1):S62; September/October 2002) (JAPhA. NS46(5):562; September/October 2006) (Reviewed 2011) (Reviewed 2016)

****Phone numbers will only be used by the New Business Review Committee in case there are questions for the delegate who submitted the New Business Item content.**

New Business Items are due to the Speaker of the House by **January 22, 2024** (60 days prior to the start of the first House session). Consideration of urgent items can be presented with a suspension of the House Rules at the session where New Business will be acted upon. Please submit New Business Items to the Speaker of the House via email at hod@aphanet.org.

American Pharmacists Association
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American Pharmacists Association
House of Delegates – March 22-25, 2024

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

Item No.: **2**
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Time received: **6:54pm ET**

NEW BUSINESS
(To be submitted and introduced by Delegates only)

Introduced by: Matthew Lacroix, PharmD, MS, BCPS, FAPhA
(Name)

January 22
(Date)

Rhode Island Delegation
(Organization)

Subject: **Community Pharmacy Methadone Dispensing for Opioid Use Disorder**

Motion: Adopt the following policy statements as written

1. APhA supports changes in laws, regulations, and policies to permit DEA-registered and trained opioid treatment program clinicians and other providers the ability to prescribe methadone for opioid use disorder and offer referrals to addiction specialist physicians according to patient need.

2. APhA supports changes in laws, regulations, and policies to permit community pharmacy dispensing of methadone for opioid use disorder and appropriate reimbursement for these services.

3. APhA supports partnerships and collaborations to increase patient access to opioid treatment programs (OTPs) and clinicians.

4. APhA advocates for interprofessional education on laws, regulations, and policies regarding office-based prescribing and community pharmacy dispensing of methadone in curricula, postgraduate training, and continuing professional development programs of all health professions.

Background:

More than 75% of more than 106,000 drug overdose deaths between August 2022 and August 2023 involved opioids.[1] The majority of these opioids were illegally produced high potency synthetic opioids, primarily fentanyl and fentanyl analogs. There are six million people in the US living with opioid use disorder (OUD) and would benefit from medication treatment; only one in five people receive treatment for their disease.[2,3] When accessible, methadone is an highly effective medication treatment for (OUD) which decreases all-cause

mortality in OUD patients by more than 50%; It is listed as an "essential medication" by the World Health Organization.[4,5] However, for half a century, federal regulations have made methadone for OUD treatment only available within opioid treatment programs (OTPs) also known as methadone maintenance or treatment programs.[6] Unlike the medical system, only OTP-based providers can prescribe methadone, patients are required to go every day for a dose, often restricted to early mornings only, and must stay in treatment for years before gaining approval for "take-home" regimens.[6] State and federal guidelines place additional onerous restrictions on patients, requiring counseling visits and observed urine samples.

Although there are ~1,700 OTPs in the US, 80% of counties and the entire state of Wyoming lack even one.[7] Although the number of OTPs in the U.S. increased by ~40% over the past decade, fatal and nonfatal overdoses have increased nearly annually in most of the US. The median drive time one-way to an OTP in rural areas is disproportionately longer as compared to urban areas, and significantly longer than traveling to community pharmacies located in the same urban and rural areas. [8–10]

While board-certified addiction medicine specialists are the ideal prescribers for methadone, there are fewer than 5,000 addiction medicine and psychiatry specialists in active practice. These are relatively small numbers to the nearly 1,000,000 physicians, 385,000 nurse practitioners, and 168,000 physician assistants and 60,000 community pharmacies available nationwide.[11–14] With adequate pre- and post-graduate training, these providers can safely prescribe methadone for OUD, greatly expanding access to this life-saving therapy.

Community pharmacists stocked and dispensed methadone for pain management *and* OUD prior to the regulations, but currently can only dispense methadone for treatment of pain.[15–17] During the COVID-19 pandemic, take-home doses of methadone for up to 28 days were permitted for any stable patient temporarily from OTPs after federal and some state laws were relaxed.[18] Reported overdose deaths with methadone identified declined from 4.5% in January 2019 to 3.2% in August 2021, which was the time frame during which take-home doses were allowed.[19,20] This demonstrates how better access to methadone for OUD is safe, and Substance Abuse and Mental Health Services Administration (SAMHSA) has proposed guidance that would permanently permit 28 day take-homes for anyone 31+ days in treatment.[21] The Board of Directors of the American Society for Addiction Medicine (ASAM) approved the following statement "SAMHSA and Drug Enforcement Administration (DEA) regulations should allow pharmacy dispensing and/or administration of methadone that has been prescribed for patients who meet certain criteria by a legally authorized prescriber of controlled medications who is affiliated with an OTP, is an addiction specialist physician, or is a physician who has met specific qualifications." In 2023, the federal Modernizing Opioid Treatment Access Act (MOTAA) was introduced to permit addiction physicians specialists to prescribe methadone which can be dispensed from community pharmacies.[22] In a study where community pharmacy dispensing of methadone for OUD was permitted, participants reported strong satisfaction, and attendance rate to pharmacies was perfect.[23,24] The National Institute for Drug Abuse (NIDA) Clinical Trials Network (CTN) has funded a trial of physician prescribed and community pharmacy dispensed methadone (CTN-131).[25]

Increasing collaboration between providers would improve access to OUD treatment and give patients a better chance for sustaining recovery, whether they want to and are able to go to an OTP or whether they seek care at a community pharmacy. There is approximately one OTP for every thirty two pharmacies in the country, with many areas having no local OTPs.[26] OTPs typically have dispensing hours from 5am to 12pm, varying between facilities, which may limit adherence to treatment. Fortunately, community pharmacies are open for broader ranges of time, allowing easier access for attendance for dosing administration. Ultimately, patients should maintain the choice of treatment setting when pharmacies can dispense methadone for OUD.

In Canada, Australia, the United Kingdom (UK), and in western Europe, community pharmacies have provided methadone access for decades.[27] In Australia, pharmacists are considered clinicians who may supervise dosing administration once they have received orientation, training, and support to provide their services.[28] The majority of prescriptions for methadone are written by general practitioners, and over 70% of prescriptions are dispensed by community pharmacists.[29] In Canada, pharmacists are able to dispense methadone with a valid written order or prescription so long as they complete their training of the Narcotic Control Regulations. Once healthcare providers in Canada complete all trainings required in their province, they may prescribe methadone that can be dispensed in retail or community pharmacies.[30]

Pharmacists feel that lack of training is a barrier to their ability in dispensing methadone for OUD including inadequate baseline knowledge from post-graduate education and limited available training courses.[31] If training were to be more readily accessible, pharmacists would be more likely to participate and feel more adequately prepared for methadone dispensing for OUD. Student pharmacists were less likely to perceive stigma associated with OUD than pharmacists who are currently practicing, and they did desire more participation in patient care managing OUD. Student pharmacists would like to receive exposure to therapeutic knowledge and lived experience of OUD and methadone treatment, more so than what is currently implemented into their curriculum.[32] Providing continuing education to providers is an efficient and frequently used method for providers to stay current with treatments for patients. Modules for clinician education and training for methadone have been developed and will increase confidence for providing medication treatment for OUD with methadone. Implementation and provider engagement to these services is key to improving OUD treatment in order to decrease opioid overdose mortality.

We are grateful for the assistance of Cassie Capezza, University of Rhode Island PharmD '24 for initial drafts of the statements, background writing, and research.

References

1. Ahmad F, Cisewski J, Rossen L, Sutton P. Ahmad FB, Cisewski JA, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2023.
2. Substance Abuse and Mental Health Services Administration. (2023). Key substance use and mental health indicators in the United States: Results from the 2022 National Survey on Drug Use and Health (HHS Publication No. PEP23-07-01-006, NSDUH Series H-58). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2022-nsduh-annual-national-report. Published online 2022.
3. Jones CM, Han B, Baldwin GT, Einstein EB, Compton WM. Use of Medication for Opioid Use Disorder Among Adults With Past-Year Opioid Use Disorder in the US, 2021. *JAMA Network Open*. 2023;6(8):e2327488. doi:10.1001/jamanetworkopen.2023.27488
4. Herget G. Methadone and buprenorphine added to the WHO list of essential medicines. *HIV AIDS Policy Law Rev*. 2005;10(3):23-24.
5. Sordo L, Barrio G, Bravo MJ, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *BMJ*. 2017;357:j1550.
6. Treatment I of M (US) C on FR of M, Rettig RA, Yarmolinsky A. Federal Regulation of Methadone Treatment. In: *Federal Regulation of Methadone Treatment*. National Academies Press (US); 1995. Accessed January 21, 2024. https://www.ncbi.nlm.nih.gov/books/NBK232105/
7. Opioid Treatment Programs: A Key Treatment System Component. Published July 16, 2021. Accessed January 21, 2024. https://pew.org/3AVbDPo
8. Joudrey PJ, Chadi N, Roy P, et al. Pharmacy-based methadone dispensing and drive time to methadone

treatment in five states within the United States: A cross-sectional study. *Drug and Alcohol Dependence*. 2020;211:107968. doi:10.1016/j.drugalcdep.2020.107968
9. Joudrey PJ, Edelman EJ, Wang EA. Drive Times to Opioid Treatment Programs in Urban and Rural Counties in 5 US States. *JAMA*. 2019;322(13):1310-1312. doi:10.1001/jama.2019.12562
10. Joudrey PJ, Edelman EJ, Wang EA. Methadone for Opioid Use Disorder-Decades of Effectiveness but Still Miles Away in the US. *JAMA Psychiatry*. Published online July 15, 2020. doi:10.1001/jamapsychiatry.2020.1511
11. What is a PA? AAPA. Accessed January 21, 2024. https://www.aapa.org/about/what-is-a-pa/
12. Berenbrok LA, Tang S, Gabriel N, et al. Access to Community Pharmacies: A Nation-Wide Geographic Information Systems Cross-sectional Analysis. *Journal of the American Pharmacists Association*. Published online 2022. doi:10.1016/j.japh.2022.07.003
13. NP Fact Sheet. American Association of Nurse Practitioners. Accessed January 21, 2024. https://www.aanp.org/about/all-about-nps/np-fact-sheet
14. Number of People per Active Physician by Specialty, 2021. AAMC. Accessed January 21, 2024. https://www.aamc.org/data-reports/workforce/data/number-people-active-physician-specialty-2021
15. Bensel JJ. Community pharmacist's role. Methadone maintenance of narcotic addicts. *J Am Pharm Assoc*. 1971;11(7):372-373 passim.
16. Bowden CL, Vordenbaumen TL, Rubin M. Methadone maintenance in community pharmacies. *J Am Pharm Assoc*. 1973;13(12):684-686 passim.
17. Bowden CL, Maddux JF, Esquivel M. Methadone dispensing by community pharmacies. *Am J Drug Alcohol Abuse*. 1976;3(2):243-254.
18. Amram O, Amiri S, Panwala V, Lutz R, Joudrey PJ, Socias E. The impact of relaxation of methadone take-home protocols on treatment outcomes in the COVID-19 era. *The American Journal of Drug and Alcohol Abuse*. 2021;47(6):722-729. doi:10.1080/00952990.2021.1979991
19. Jones CM, Compton WM, Han B, Baldwin G, Volkow ND. Methadone-Involved Overdose Deaths in the US Before and After Federal Policy Changes Expanding Take-Home Methadone Doses From Opioid Treatment Programs. *JAMA Psychiatry*. Published online 2022. doi:10.1001/jamapsychiatry.2022.1776
20. Kleinman RA, Sanches M. Methadone-involved overdose deaths in the United States before and during the COVID-19 pandemic. *Drug and Alcohol Dependence*. Published online 2022:109703. doi:10.1016/j.drugalcdep.2022.109703
21. Methadone Take-Home Flexibilities Extension Guidance. Published November 17, 2021. Accessed January 22, 2024. https://www.samhsa.gov/medications-substance-use-disorders/statutes-regulations-guidelines/methadone-guidance
22. Methadone Tx for OUD Policymaker Resources. Default. Accessed January 21, 2024. https://www.asam.org/advocacy/national-advocacy/methadonetxoud
23. Brooner RK, Stoller KB, Patel P, Wu LT, Yan H, Kidorf M. Opioid treatment program prescribing of methadone with community pharmacy dispensing: Pilot study of feasibility and acceptability. *Drug Alcohol Depend Rep*. 2022;3:100067. doi:10.1016/j.dadr.2022.100067
24. Wu L, John WS, Morse ED, et al. Opioid treatment program and community pharmacy collaboration for methadone maintenance treatment: results from a feasibility clinical trial. *Addiction*. Published online August 16, 2021:add.15641. doi:10.1111/add.15641
25. CTN-0131: Office-Based Methadone versus Buprenorphine to Address Retention in Medication for Opioid Use Disorder (MOUD)– A Pragmatic Hybrid Effectiveness/Implementation Trial. CTN Dissemination Library. Accessed January 21, 2024. https://ctnlibrary.org/protocol/ctn0131-2/
26. Re: ASAM's Input on the Reauthorization and Strengthening of the SUPPORT Act of 2018. Accessed January 22, 2024. https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/advocacy/letters-and-comments/11.21.23-asam-support-act-reauthorization-letter---senate-help.pdf?sfvrsn=a594d62_1
27. Calcaterra SL, Bach P, Chadi A, et al. Methadone Matters: What the United States Can Learn from the Global Effort to Treat Opioid Addiction. *J Gen Intern Med*. 2019;34(6):1039-1042. doi:10.1007/s11606-

018-4801-3
28. National guidelines for medication-assisted treatment of opioid dependence.
29. In Australia, Primary Care and Pharmacies Deliver Methadone. Published May 17, 2023. Accessed January 22, 2024. https://pew.org/3BwTVU4
30. In Canada, Lifesaving Methadone Is Available in a Variety of Treatment Settings. Published May 17, 2023. Accessed January 22, 2024. https://pew.org/3IfU9CA
31. Fonseca J, Chang A, Chang F. Perceived Barriers and Facilitators to Providing Methadone Maintenance Treatment Among Rural Community Pharmacists in Southwestern Ontario. *J Rural Health*. 2018;34(1):23-30. doi:10.1111/jrh.12264
32. Hohmeier KC, Cernasev A, Sensmeier M, et al. U.S. student pharmacist perceptions of the pharmacist's role in methadone for opioid use disorder: A qualitative study. *SAGE Open Medicine*. 2021;9:20503121211022994. doi:10.1177/20503121211022994

Current APhA Policy & Bylaws:

2003, 1972 Methadone Used as Analgesic and Antitussive

APhA encourages developers of methadone programs to place pharmacists in charge of their drug distribution and control systems.
(JAPhA. NS12:308; June 1972) (JAPhA. NS43(5)(suppl 1):S58; September/October 2003) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016)

2019, 2016 Substance Use Disorder

1. **APhA supports legislative, regulatory, and private sector efforts that include pharmacists' input and that will balance patient/consumers' need for access to medications for legitimate medical purposes with the need to prevent the diversion, misuse, and abuse of medications.**
2. **APhA supports consumer sales limits of nonprescription drug products, such as methamphetamine precursors, that may be illegally converted into drugs for illicit use.**
3. **APhA encourages education of all personnel involved in the distribution chain of nonprescription products so they understand the potential for certain products, such as methamphetamine precursors, to be illegally converted into drugs for illicit use. APhA supports comprehensive substance use disorder education, prevention, treatment, and recovery programs.**
4. **APhA supports public and private initiatives to fund treatment and prevention of substance use disorders.**
5. **APhA supports stringent enforcement of criminal laws against individuals who engage in drug trafficking.**

(JAPhA. 56(4):369; July/August 2016) (JAPhA. 59(4):e28; July/August 2019) (Reviewed 2022)

2023 2016 Medication for Substance Use Disorders Medication-Assisted Treatment

APhA supports expanding access to medications indicated for opioid use disorders (MOUDs) and other substance use disorders, including but not limited to pharmacist-administered injection services for treatment and maintenance of substance use disorders that are based on a valid prescription.
(JAPhA, Volume 63, Issue 4, 1265 – 1281)

2020 Increasing Access to and Advocacy for Medications for Opioid Use Disorder- (MOUD)

1. APhA supports the use of evidence-based medicine as first-line treatment for opioid use disorder for patients, including healthcare professionals in and out of the workplace, for as long as needed to treat their disease.
2. APhA encourages pharmacies to maintain an inventory of medications used in treatment of opioid use disorder (MOUD), to ensure access for patients.
3. APhA encourages pharmacists and payers to ensure patients have equitable access to, and coverage for, at least one medication from each class of medications used in the treatment of opioid use disorder.
(JAPhA. 62(4):942; July 2022)

2023 Pharmacy Shortage Areas

1. APhA recognizes geographic proximity and transportation to pharmacies as key determinants in equitable access to medications, vaccines, and patient care services.
2. APhA calls for laws, regulations, and policies that reduce pharmacy shortage areas and ensure equitable access to essential services.
3. APhA supports the development of financial incentives to establish physical pharmacy locations in pharmacy shortage areas and to prevent the closure of pharmacies in underserved areas.
(JAPhA, Volume 63, Issue 4, 1265 – 1281)

2023 Access to Essential Medicines

APhA advocates regulation, policies and legislation that recognize access to quality and affordable essential medicines as a fundamental human right.
(JAPhA, Volume 63, Issue 4, 1265 – 1281)

2004, 1975 Other Health Care Professional Organizations

APhA supports continuing joint action with other health care and professional organizations.

2023 Uncompensated Care Mandates in Pharmacy

1. APhA calls for commensurate compensation for the provision of compulsory or mandated pharmacy services that include all products, supplies, labor, expertise, and administrative fees based on transparent economic analyses of existing and future services.
(JAPhA, Volume 63, Issue 4, 1265 – 1281)

2023 Workplace Conditions

1. APhA calls for employers to provide fair, realistic, and equitable workplace conditions for pharmacy personnel that promote a safe, healthy, and sustainable working environment.
2. APhA urges all entities that impact pharmacy personnel workplace conditions to adopt the Pharmacists Fundamental Responsibilities and Rights.
3. APhA urges employers to develop and empower pharmacy personnel to use flexible practice management models based on available staffing, expertise, and resources that balance workloads to minimize distractions.
4. APhA advocates for employers to provide workplace onboarding and training for pharmacy personnel to optimize employee performance and satisfaction.
5. APhA encourages pharmacy personnel, starting with leaders, to model and facilitate individualized healthy working behaviors that improve well-being and to encourage and empower colleagues to do the same.
6. APhA opposes the sole use of productivity and fiscal measures for employee performance evaluations.
7. APhA calls for employers and employees to collaborate in the development and use of behavioral performance competencies in performance evaluations.
(JAPhA, Volume 63, Issue 4, 1265 – 1281)

2023 Enforcing Anti Discrimination in the Dispensing of Medicines

APhA affirms that discrimination and stigma should not impact a patient's ability to obtain medications.
(JAPhA, Volume 63, Issue 4, 1265 – 1281)

2019 Referral System for the Pharmacy Profession

1. APhA supports referrals of patients to pharmacists, among pharmacists, or between pharmacists and other health care providers to promote optimal patient outcomes.
2. APhA supports referrals to and by pharmacists that ensure timely patient access to quality services and promote patient freedom of choice.
3. APhA advocates for pharmacists' engagement in referral systems that are aligned with those of other health care providers and facilitate collaboration and information sharing to ensure continuity of care.
4. APhA supports attribution and equitable payment to pharmacists providing patient care services as a result of a referral.
5. APhA promotes the pharmacist's professional responsibility to uphold ethical and legal standards of care in referral practices.
6. APhA reaffirms its support of development, adoption, and use of policies and procedures by pharmacists to manage potential conflicts of interest in practice, including in referral systems.

(JAPhA. 59(4):e16; July/August 2019) (Reviewed 2022)

2018 Pharmacists Electronic Referral Tracking

1. APhA supports the development of electronic systems that enhance and simplify the ability of pharmacists in all practice settings to receive, send, and track referrals among all members of the health care team, including other pharmacists, irrespective of the health care system, model, or network in which the patient participates.
2. APhA supports the interoperability and integration of referral tracking systems with electronic health records so patients can receive the benefit of optimally coordinated care from all members of the health care team.

(JAPhA. 58(4):356; July/August 2018) (Reviewed 2020)

2012 Controlled Substances Regulation and Patient Care

1. APhA encourages the Drug Enforcement Administration (DEA) and other regulatory agencies to recognize pharmacists as partners that are committed to ensuring that patients in legitimate need of controlled substances are able to receive the medications.
2. APhA supports efforts to modernize and harmonize state and federal controlled substance laws.
3. APhA urges DEA and other regulatory agencies to balance patient care and regulatory issues when developing, interpreting, and enforcing laws and regulations.
4. APhA encourages DEA and other regulatory agencies to recognize the changes occurring in health care delivery and to establish a transparent and inclusive process for the timely updating of laws and regulations.
5. APhA encourages the U.S. Department of Justice to collaborate with professional organizations to identify and reduce (a) the burdens on health care providers, (b) the cost of health care delivery, and (c) the barriers to patient care in the establishment and enforcement of controlled substance laws.

(JAPhA. NS52(4):457; July/August 2012) (Reviewed 2015)

2019 Patient-Centered Care of People Who Inject Non-Medically Sanctioned Psychotropic or Psychoactive Substances

1. APhA encourages state legislatures and boards of pharmacy to revise laws and regulations to support the patient-centered care of people who inject non-medically sanctioned psychotropic or psychoactive substances.
2. To reduce the consequences of stigma associated with injection drug use, APhA supports the expansion of interprofessional harm reduction education in the curriculum of schools and colleges of pharmacy, postgraduate training, and continuing professional development programs.
3. APhA encourages pharmacists to initiate, sustain, and integrate evidence-based harm reduction principles and programs into their practice to optimize the health of people who inject non-medically sanctioned psychotropic or psychoactive substances.

4. APhA supports pharmacists' roles to provide and promote consistent, unrestricted, and immediate access to evidence-based, mortality- and morbidity-reducing interventions to enhance the health of people who inject nonmedically sanctioned psychotropic or psychoactive substances and their communities, including sterile syringes, needles, and other safe injection equipment, syringe disposal, fentanyl test strips, immunizations, condoms, wound care supplies, pre- and post-exposure prophylaxis medications for human immunodeficiency virus (HIV), point-of-care testing for HIV and hepatitis C virus (HCV), opioid overdose reversal medications, and medications for opioid use disorder.
5. APhA urges pharmacists to refer people who inject non-medically sanctioned psychotropic or psychoactive substances to specialists in mental health, infectious diseases, and addiction treatment; to housing, vocational, harm reduction, and recovery support services; and to overdose prevention sites and syringe service programs.
(JAPhA. 59(4):e17; July/August 2019) (Reviewed 2021) (Reviewed 2022)

2020 Community-Based Pharmacists as Providers of Care

1. APhA advocates for the identification of medical conditions that may be safely and effectively treated by community-based pharmacists.
2. APhA encourages the training and education of pharmacists and student pharmacists regarding identification, treatment, monitoring, documentation, follow-up, and referral for medical conditions treated by community-based pharmacists
3. APhA advocates for laws and regulations that allow pharmacists to identify and manage medical conditions treated by community-based pharmacists.
4. APhA advocates for appropriate remuneration for the assessment and treatment of medical conditions treated by community-based pharmacists from government and private payers to ensure sustainability and access for patients.
5. APhA supports research to examine the outcomes of services that focus on medical conditions treated by community-based pharmacists.
(JAPhA. 60(5):e10; September/October 2020)

2013 Ensuring Access to Pharmacists' Services

1. Pharmacists are health care providers who must be recognized and compensated by payers for their professional services.
2. APhA actively supports the adoption of standardized processes for the provision, documentation, and claims submission of pharmacists' services.
3. APhA supports pharmacists' ability to bill payers and be compensated for their services consistent with the processes of other health care providers.
4. APhA supports recognition by payers that compensable pharmacist services range from generalized to focused activities intended to improve health outcomes based on individual patient needs.
5. APhA advocates for the development and implementation of a standardized process for verification of pharmacists' credentials as a means to foster compensation for pharmacist services and reduce administrative redundancy.
6. APhA advocates for pharmacists' access and contribution to clinical and claims data to support treatment, payment, and health care operations.
7. APhA actively supports the integration of pharmacists' service level and outcome data with other health care provider and claims data.
(JAPhA. 53(4):365; July/August 2013) (Reviewed 2018) (Reviewed 2019) (Reviewed 2021)

2005, 1977 Government-Financed Reimbursement

1. APhA supports only those government-operated or -financed, third-party prescription programs which ensures that participating pharmacists receive individualized, equitable compensation for professional services and reimbursement for products provided under the program.
2. APhA regards equitable compensation under any government-operated or -financed, third party prescription programs as requiring payments equivalent to a participating pharmacist's prevailing charges to the self-paying

public for comparable services and products, plus additional, documented, direct and indirect costs which are generated by participation in the program.

3. APhA supports those government-operated or -financed, third-party prescription programs which base compensation for professional services on professional fees and reimbursement for products provided on actual cost, with the provision of a specific exception to this policy in those instances when equity in professional compensation cannot otherwise be attained.

(JAPhA. NS17:452; July 1977) (JAPhA. NS45(5):558; September/October 2005) (Reviewed 2009) (Reviewed 2011) (Reviewed 2012) (Reviewed 2017) (Reviewed 2021) (Reviewed 2022)

1987 Compensation for Cognitive Services

1. APhA recognizes that pharmacists provide to patients cognitive services (i.e., services requiring professional judgment) that may or may not be related to the dispensing or sale of a product.

2. APhA supports compensation of pharmacists for providing cognitive services (i.e., services requiring professional judgment) that may or may not be related to the dispensing or sale of a product.

(Am Pharm. NS27(6):422; June 1987) (Reviewed 2005) (Reviewed 2009) (Reviewed 2011) (Reviewed 2013) (Reviewed 2018)

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

Item No.: 3
Date received: 1/22/24
Time received: 9:26pm ET

American Pharmacists Association
House of Delegates – March 22-25, 2024

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Stephanie Gernant
(Name)

January 22, 2024
(Date)

APhA-APRS & APhA-APPM Delegations
(Organization)

Subject: Collective Bargaining

Motion: To adopt the following policy statement as written and part of the existing 2012, 2009 Collective Bargaining policy

2012, 1999 Collective Bargaining/Unionization

1. APhA affirms the United Nations' Universal Declaration of Human Rights that collective bargaining is a fundamental human right.

Background:

In October of 2023, pharmacists' (and other health care professionals) right to collectively bargain received public attention following multiple major walkouts which cited steady decreases in pharmacists' working environments as a threat to the profession.[1] Poor working environments contribute to the decrease of pharmacy school applicants and the increase of licensed pharmacists leaving the profession on a national and international level.[2-5] Poor working environments threaten professional unity as professional organizations like APhA must navigate competing interests between members (i.e., working pharmacists) and businesses (i.e., pharmacist-employers). Poor working conditions may also put patients at risk.[6-10] In addition to causing unquestionable pain, morbidity, and mortality from medication errors, media reports and individual observations of poor and unsafe working conditions mire the public's trust and perception of pharmacy.

APhA has existing policy related to collective bargaining to provide APhA leadership, staff, and members a uniform voice on the subject. This includes the 1999, 1971 Unionization of Pharmacists policy, and 2012, 1999 Collective Bargaining/Unionization policy. These existing policies distinguish

roles that, while APhA the organization does not serve as a collective bargaining unit, APhA supports the right of pharmacists to participate in related organization and negotiate working conditions.

The 1991, 1971 Unionization of Pharmacists policy was initially developed in response to the American Nursing Association's creation of a national nurses' union, and is in line with the policies of other professional health care organizations.[11-13] This policy may be insufficient to define APhA's stance on collective bargaining due to wording which refers to pharmacists' rights to negotiate as individuals rather than pharmacists' rights to negotiate as collective bargaining units or trade unions. Further, this policy is insufficient to define APhA's stance on collective bargaining because it fails to reference other professions aside from pharmacists.

The National Labor Relations Act passed in the United States in 1935 recognizes employees' right to association.[13] The proposed amendment to existing APhA policy references the United Nations Universal Declaration of Human Rights (UDHR).[14] Proclaimed by the United Nations General Assembly in 1948, the UDHR sets out fundamental human rights to be universally protected as a common standard for all peoples and all nations. Select quotations of the Declaration include[14]:

- Article 23(4)- "*Everyone has the right to form and to join trade unions for the protection of his interests*."
- Declaration on Social Progress and Development. Part II, Article 10(a)- "*Social progress and development shall aim …the following main goals: The assurance at all levels of the right to work and the right of everyone to form trade unions and workers' associations and to bargain collectively;…*"

This proposed policy addresses topics of a) Worker's Rights & Working Environment, b) Stress, Burnout, and Well-being, c) Patient Safety, and d) Collective Bargaining/Unionization/ Unionization of Pharmacists. This policy would target audiences such as pharmacy personnel, health care professionals, employers, government regulators, the media, patients, international sectors and public health organizations.

The final adopted policy, if approved as presented, would read as follows:

2012, 1999 Collective Bargaining/Unionization

1. APhA affirms the United Nations' Universal Declaration of Human Rights that collective bargaining is a fundamental human right.
2. APhA supports pharmacists' participation in organizations that promote the discretion or professional prerogatives exercised by pharmacists in their practice, including the provision of patient care.
3. APhA supports the rights of pharmacists to negotiate with their respective employers for working conditions that will foster compliance with the standards of patient care as established by the profession.

(JAPhA. 39(4) 447; July/August 1999) (Reviewed 2001) (Reviewed 2007) (JAPhA. NS52(4):458; July/August 2012) (Reviewed 2017) (Reviewed 2019) (Reviewed 2020)

Literature to support the need for the proposed policy topic.

1. Le Coz E. 'Pharmageddon' hits US with walkouts at multiple pharmacies, including CVS and Walgreens. https://www.usatoday.com/story/news/investigations/2023/10/30/phamageddon-walkout-hits-us-pharmacies/71386906007/ October 30, 2023
2. Antrim A. Despite Rapid Growth of Institutions, Pharmacy School Applications Decline. Pharmacy Times. April, 2023; 17(1). Retrieved Oct 2023 from: [https://www.pharmacytimes.com/view/despite-rapid-growth-of-institutions-pharmacy-school-applications-decline]
3. Bonner L. Pharmacists' well-being: Solutions for the short term, plans for the long term. Pharmacy Today. May, 2023; 29 (5):26-30. Retrieved Oct 2023 from: https://www.pharmacist.com/CEO-Blog/pharmacists-well-being-solutions-for-the-short-term-plans-for-the-long-term]

4. Clabaugh M, Newlon JL, Illingworth Plake KS. Perceptions of working conditions and safety concerns in community pharmacy. J Am Pharm Assoc (2003). 2021 Nov-Dec;61(6):761-771. doi: 10.1016/j.japh.2021.06.011. Epub 2021 Jun 12. PMID: 34176759.
5. Dilliard R, Hagemeier NE, Ratliff B, Maloney R. An analysis of pharmacists' workplace patient safety perceptions across practice setting and role characteristics. Explor Res Clin Soc Pharm. 2021;2:100042. Published 2021 Jun 29. doi:10.1016/j.rcsop.2021.100042
6. Gabler E. How Chaos at Chain Pharmacies Is Putting Patients at Risk. New York Times. Jan, 2020. Retrieved Oct, 2023 from: [https://www.nytimes.com/2020/01/31/health/pharmacists-medication-errors.html]
7. Associated Press. Pharmacist Shortages and Heavy Workloads Challenge Drugstores Heading Into Their Busy Season. https://www.usnews.com/news/business/articles/2023-10-07/pharmacist-shortages-and-heavy-workloads-challenge-drugstores-heading-into-their-busy-season October 7, 2023
8. Kaplan A, Nguyen V, and Godie M. Overworked, understaffed: Pharmacists say industry in crisis puts patient safety at risk. NBC News. March, 2021. Retrieved Oct 2023 from:[https://www.nbcnews.com/health/health-care/overworked-understaffed-pharmacists-say-industry-crisis-puts-patient-safety-risk-n1261151]
9. Kaufman M. Pharmacists are burning out. Patients are feeling the effects. https://www.washingtonpost.com/wellness/2023/03/30/pharmacy-shortages-staffing/ March 30, 2023
10. Robinson J. Nearly three-quarters of pharmacy staff considered leaving profession in the past year, finds RPS survey. The Pharmaceutical Journal. January 2023; 310(796). Retrieved Oct 2023 from:[https://pharmaceutical-journal.com/article/news/nearly-three-quarters-of-pharmacists-considered-leaving-profession-in-the-past-year-finds-rps-survey]
11. American Medical Association. ARC Issue brief: Collective bargaining for physicians and physicians-in-training. https://www.ama-assn.org/system/files/advocacy-issue-brief-physician-unions.pdf 2023
12. August J. Healthcare Insights: Collective Bargaining and Value for Patients. https://www.ilr.cornell.edu/scheinman-institute/blog/john-august-healthcare/healthcare-insights-collective-bargaining-and-value-patients May 2023
13. Hostetter M, Klein S. In Focus: How Unions Act as a Force for Change in Health Care Delivery and Payment https://www.commonwealthfund.org/publications/2019/mar/focus-how-unions-act-force-change-health-care-delivery-and-payment March 2019
14. National Labor Relations Board. National Labor Relations Act. https://www.nlrb.gov/guidance/key-reference-materials/national-labor-relations-act
15. United Nations General Assembly. General Assembly resolution 217 A. Universal Declaration of Human Rights (UDHR). Paris, France. December, 1948. Available from: [https://www.un.org/en/about-us/universal-declaration-of-human-rights#:~:text=Drafted%20by%20representatives%20with%20different,all%20peoples%20and%20all%20nations]

Current APhA Policy & Bylaws:

2012, 1999 Collective Bargaining/Unionization

1. APhA supports pharmacists' participation in organizations that promote the discretion or professional prerogatives exercised by pharmacists in their practice, including the provision of patient care.
2. APhA supports the rights of pharmacists to negotiate with their respective employers for working conditions that will foster compliance with the standards of patient care as established by the profession.

(JAPhA. 39(4) 447; July/August 1999) (Reviewed 2001) (Reviewed 2007) (JAPhA. NS52(4):458; July/August 2012) (Reviewed 2017) (Reviewed 2019) (Reviewed 2020)

1999, 1970 Unionization of Pharmacists: State Participation in Employer/Employee Relations

The committee endorses the recommendations in the Provisional Policy Statement on Employment Standards submitted by the Board of Trustees at the special meeting of the House of Delegates in November 1969. The committee recommends that any change in this statement to provide that APhA function as a collective bargaining unit be rejected.

(JAPhA. NS10:353; June 1970) (JAPhA. 39(4):447; July/August 1999) (Reviewed 2001) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

1999, 1971 Unionization of Pharmacists

1. The committee recommends that no change be made in the present policy of APhA with regard to becoming a collective bargaining unit.
2. The committee recommends that APhA continue its educational efforts concerning the mutual responsibilities of the employer and employee pharmacist inherent in the employment relationship.
3. The committee recommends that APhA continue to urge state associations to develop employee/employer relations committees to

   (a) Study all aspects of both the professional and employment relationships that exist between the employer and the employee;

   (b) Develop and recommend guidelines to provide direction and guidance to both the employed pharmacist and the employer in developing a mutually acceptable relationship;

   (c) Conduct necessary surveys designed to provide information on salaries, benefits, and specific problems with attention given to possible regional variations in the data obtained; and

   (d) Consider the establishment of an employment standards committee where feasible in each appropriate area of the state to act in an advisory and/or arbitrating capacity on matters pertaining to employment standards and employment grievances.
4. The committee recommends that colleges of pharmacy include the subject of employer/ employee relations within an appropriate course of the curriculum.

(JAPhA. NS11:273 May 1971) (JAPhA. 39(4):447; July/August 1999) (Reviewed 2001) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

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American Pharmacists Association
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American Pharmacists Association
House of Delegates – March 22-25, 2024

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

Item No.: 4
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NEW BUSINESS
(To be submitted and introduced by Delegates only)

Introduced by: Mahwish Yousaf
(Name)

January 5, 2024 **(Date)**

APhA-APPM, on behalf of the Care of Underserved Patients SIG **(Organization)**

Subject: Pharmacist's roles in sexually transmitted infections prevention and treatment in underserved patients

Motion: To adopt the following policy statements as written

1. APhA recognizes that pharmacists play a vital role in improving outcomes in patients with or at risk of sexually transmitted infections, particularly in underserved patient populations.
2. APhA supports the pharmacist's role in the development of education and resources, particularly for individuals with Sexually Transmitted Infections (STIs), Expedited Partner Therapy (EPT), Pre-Exposure Prophylaxis (PrEP), and Post-Exposure Prophylaxis (PEP) in order to increase awareness and access, particularly in underserved patient populations.
3. APhA advocates for revision of state practice acts to permit pharmacists to provide timely pharmacotherapy for individuals with Sexually Transmitted Infections (STIs), Expedited Partner Therapy (EPT), Pre-Exposure Prophylaxis (PrEP), and Post-Exposure Prophylaxis (PEP) therapy, particularly in under-served communities.

Background:

Expedited partner therapy (EPT) for chlamydia or gonorrhea treatment, HIV pre-exposure prophylaxis (PrEP), and post-exposure prophylaxis (PEP) services play a critical role in public health. Expanding access to these services through pharmacists could have a profound impact on reducing the spread of sexually transmitted infections (STIs), preventing HIV infections, and improving overall community health.

The CDC states more than 2.5 million cases of chlamydia, gonorrhea, and syphilis were reported in 2021. This statistic likely underestimates the prevalence of STIs due to reallocation of healthcare personnel and resources to addressing SARS-CoV-2 immunization and treatment.[1] Sexually transmitted infection and HIV disproportionately impact underserved and vulnerable communities, including men who have sex with men (MSM), men who have sex with partners of unknown sex (MSU), racial and ethnic minorities, and youth age 15-24 years old.[1] The prevalence of HIV infections among economically disadvantaged patients living in urban areas is more than 5% compared to less than 1% in the general U.S. population. [2] While PrEP is underutilized nationally, prescribing disparities exist based on patient gender, race, and ethnicity.[3] Underserved patient populations, by definition, receive fewer health care services because of barriers to services, lack of familiarity with the healthcare system, or a shortage of healthcare providers.

An expansion of PrEP and PEP education and services through pharmacist providers aligns with the National HIV/AIDS Strategy (NHAS) 2022-2025 to increase the capacity of the healthcare workforce to expand preventative interventions aimed at reducing the spread of HIV.[4] Pharmacists are trained to provide evidence-based care, ensuring that patients receive the most effective treatments. Models of services coordinated by or including pharmacists in the care team, have been shown to improve uptake, adherence, and outcomes among patients at higher risk for acquiring HIV.[3,5,6] One such study evaluated initial PrEP prescriptions, dispensations, and attrition of care among patients experiencing homelessness. Statistically significant improvements in patient assistance programs and primary medication adherence were noted with the addition of a clinical pharmacist who manages a PrEP service—including prescribing-- under a collaborative practice agreement to the care team.[7]

Pharmacists play a critical role in addressing misinformation and serving as a public health resource for patients. Therefore, pharmacists should play an active role in the development of education and resources, particularly on EPT, PrEP, and PEP to increase awareness and access in underserved patient populations. A survey of youth participants aged 14-24 years old showed that most participants (86%) were unaware of EPT as a treatment option for STI. Notably, the 7% of respondents who opposed EPT believed it was the their sexual partner's health was not the respondent's responsibility and the partner's responsibility alone, illustrating the global importance of STI prevention and screening education.[8] In a study assessing persistence among patient receiving PrEP at a pharmacist-led clinic, a majority of patients who successfully started PrEP cited the pharmacist's knowledge, caring attitude, and assistance in obtaining the necessary prescription as key factors in taking PrEP. Cost was a limiting factor for primary non-adherence. Patients self-reported that misconceptions and misinformation about PrEP negatively impacted persistence.[5] There remains a need for pharmacists in the development of education and resources regarding PrEP, PEP and EPT to bridge this gap.

Pharmacists are arguably the most accessible healthcare providers, seeing their patients 1.5-10 times more often than a primary care physician.[9] The role of the pharmacist has grown beyond dispensing medications to include the provision of services that focus on the use of cost effective medications, medication adherence, immunization administration, and—in some cases—managing care from testing to treatment.[10] Pharmacists are well positioned to provide EPT, PrEP, and PEP services. In regular practice, pharmacists dispense medication, work with patients to ensure adherence, address adverse effects that may arise, and educate patients

about non-pharmacologic interventions. Pharmacists are trained to address many of the barriers that prevent the initiation of and persistence with PrEP. Pharmacists can currently recommend PrEP, PEP, or that partners seek treatment, but legislative barriers exist that prevent pharmacists providing immediate assistance. Legal nuances surrounding prescription requirements impeded the success of EPT as a public health strategy. While EPT is intended to promote partner treatment, traditional prescription requirements include patient information (e.g. name, address), the need for medical evaluation prior to prescribing, and direct prescription for an individual patient. Laws related to EPT vary significantly from state to state. In a regional survey of New England pharmacists, only half of pharmacists were familiar with laws governing EPT and aware of the resources available to them through their respective state boards of pharmacy. While a majority of pharmacists agree that pharmacists play a critical role, concern regarding liability and legality of EPT hinder patient access to care.[11] These issues are not a geographically limited issue. Revision of laws to permit pharmacists to provide immediate access to EPT, PrEP, and PEP therapy is critical in addressing these public health issues.

Current APhA Policy & Bylaws:

2022 Data to Advance Health Equity

1. APhA urges pharmacists to use patient-specific data and social determinants of health to address health inequities and drive decision-making in practice and advocacy. *(JAPhA. 62(4): 941; July 2022)*

2017 Patient Access to Pharmacist-Prescribed Medications

1. APhA asserts that pharmacists' patient care services and related prescribing by pharmacists help improve patient access to care, patient outcomes, and community health, and they align with coordinated, team-based care.
2. APhA supports increased patient access to care through pharmacist prescriptive authority models.
3. APhA opposes requirements and restrictions that impede patient access to pharmacist-prescribed medications and related services.
4. APhA urges prescribing pharmacists to coordinate care with patients' other health care providers through appropriate documentation, communication, and referral.
5. APhA advocates that medications and services associated with prescribing by pharmacists must be covered and compensated in the same manner as for other prescribers.
6. APhA supports the right of patients to receive pharmacist-prescribed medications at the pharmacy of their choice.

(JAPhA. 57(4):442; July/August 2017) (Reviewed 2019) (Reviewed 2020) (Reviewed 2021)

2017, 2012 Contemporary Pharmacy Practice

1. APhA asserts that pharmacists should have the authority and support to practice to the full extent of their education, training, and experience in delivering patient care in all practice settings and activities.
2. APhA supports continuing efforts toward establishing a consistent and accurate perception of the contemporary role and practice of pharmacists by the general public, patients, and all persons and institutions engaged in health care policy, administration, payment, and delivery.
3. APhA supports continued collaboration with stakeholders to facilitate adoption of standardized practice acts, appropriate related laws, and regulations that reflect contemporary pharmacy practice.
4. APhA supports the establishment of multistate pharmacist licensure agreements to address the evolving needs of the pharmacy profession and pharmacist-provided patient care.
5. APhA urges the continued development of consensus documents, in collaboration with medical associations and other stakeholders, that recognize and support pharmacists' roles in patient care as health care providers.
6. APhA urges universal recognition of pharmacists as health care providers and compensation based on the level of patient care provided using standardized and future health care payment models.
   (JAPhA. NS52(4):457; July/August 2012) (Reviewed 2016) (JAPhA. 57(4):441; July/August 2017) (Reviewed 2019) (Reviewed 2021) (Reviewed 2022)

2009 Disparities in Health Care

1. APhA supports elimination of disparities in health care delivery.
   (JAPhA. NS49(4):493; July/August 2009) (Reviewed 2013) (Reviewed 2018) (Reviewed 2020) (Reviewed 2022)

1995 Continuum of Patient Care

1. APhA advocates and will facilitate pharmacists' participation in the continuum of patient care. The continuum of patient care is characterized by the interdisciplinary care provided a patient through a series of organized, connected events or activities independent of time and practice site, in order to optimize desired therapeutic outcomes.
2. APhA will facilitate pharmacists' participation in the continuum of patient care by (a) achieving recognition for the pharmacist as a primary care provider; (b) securing access for pharmacists to patient information systems, including creation of the necessary software for the purpose of record maintenance of cognitive services provided by pharmacists; and (c) developing means and methods to establish and enable pharmacists' direct participation in the continuum of patient care.

(Am Pharm. NS35(6):36 June; 1995) (Reviewed 2004) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016) (Reviewed 2019)

2013, 1980 Medication Selection by Pharmacists

1. APhA supports the concept of a team approach to health care in which health care professionals perform those functions for which they are educated. APhA recognizes that the pharmacist is the expert on drugs and drug therapy on the health care team and supports a medication selection role for the pharmacist, based on the specific diagnosis of a qualified health care practitioner.

   (Am Pharm. NS20(7):62; July 1980) (Reviewed 2003) (Reviewed 2007) (Reviewed 2008) (Reviewed 2009)(Reviewed 2011) (Reviewed 2012) (JAPhA. 53(4):366; July/August 2013) (Reviewed 2018)

2003, 1992 The Pharmacist's Role in Therapeutic Outcomes

1. APhA affirms that achieving optimal therapeutic outcomes for each patient is a shared responsibility of the health care team.

2. APhA recognizes that a primary responsibility of the pharmacist in achieving optimal therapeutic outcomes is to take an active role in the development and implementation of a therapeutic plan and in the appropriate monitoring of each patient.

   (Am Pharm. NS32(6):515; June 1992) (JAPhA. NS43(5)(suppl 1):S57; September/October 2003) (Reviewed 2007) (Reviewed 2009) (Reviewed 2010) (Reviewed 2011)(Reviewed 2016) (Reviewed 2016)

2012, 2005, 1992 The Role of Pharmacists in Public Health Awareness

1. APhA recognizes the unique role and accessibility of pharmacists in public health.
2. APhA encourages pharmacists to provide services, education, and information on public health issues.
3. APhA encourages the development of public health programs for use by pharmacists and student pharmacists.
4. APhA should provide necessary information and materials for student pharmacists and pharmacists to carry out their role in disseminating public health information.
5. APhA encourages organizations to include pharmacists and student pharmacists in the development of public health programs.

   (Am Pharm. NS32(6):515; June 1992) (JAPhA. 45(5):556; September/October 2005) (Reviewed 2009) (Reviewed 2010) (JAPhA. NS52(4):460; July/August 2012) (Reviewed 2017) (Reviewed 2020)

2023 Pharmacy Shortage Areas

1. APhA recognizes geographic proximity and transportation to pharmacies as key determinants in equitable access to medications, vaccines, and patient care services.
2. APhA calls for laws, regulations, and policies that reduce pharmacy shortage areas and ensure equitable access to essential services.
3. APhA supports the development of financial incentives to establish physical pharmacy locations in pharmacy shortage areas and to prevent the closure of pharmacies in underserved areas.
   (JAPhA. 63(4):1266; July/August 2023)

2020 Providing Affordable and Comprehensive Pharmacy Services to the Underserved

1. APhA supports the expansion and increased sources of funding for pharmacies and pharmacist-provided care services that serve the needs of underserved populations to provide better health outcomes and lower healthcare costs.
2. APhA supports charitable pharmacies and pharmacy services that ensure the quality, safety, drug storage, and integrity of the drug product and supply chain, in accordance with applicable law.

(JAPhA. 60(5):e11; September/October 2020) (Reviewed 2022)

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American Pharmacists Association
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American Pharmacists Association
House of Delegates – March 22-25, 2024

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

Item No.: 5
Date received: 1/22/24
Time received: 9:57PM ET

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Jessica Comstock
(Name)

January 22
(Date)

APhA-APPM Delegation on behalf of the Nuclear Pharmacy SIG
(Organization)

Subject: Access to Radiopharmaceuticals

Motion: To adopt the following policy statement as written

1. APhA advocates for policy and legislation that increase patient access to radiopharmaceuticals.

Background:
Radiopharmaceuticals have been in use for decades. The first FDA approved radioactive product was Iodine-131 in 1951. Since then, the utilization of nuclear medicine has increased, with over 20 million diagnostic studies performed in the United States each year. These radioactive drug products allow patients to undergo a non-invasive diagnostic procedure using small amounts of radioactivity to image internal organs and structures. While other imaging studies show physical structure, nuclear medicine can provide information about physiological processes to show how the body is functioning, detail on organ function, and cancer diagnosis and staging. Because imaging with nuclear medicine allows abnormalities to be identified at an early stage, healthcare teams can create treatment plans and start well before other diagnostic tests could have identified the problem.

Sample of Disease States Nuclear Medicine Can Diagnose or Treat

Alzheimer's Disease	Heart Disease	Neuroendocrine Tumors
Brain Disorders	Kidney Disorders	Parkinson's Disease
Breast Cancer	Lung Disorders	Prostate Cancer
Epilepsy	Lymphoma	Thyroid Disorder
GI Disorders	Melanoma	

Currently Centers for Medicare and Medicaid services classify diagnostic radiopharmaceuticals as a "supply" as part of a packaged payment system for the nuclear medicine procedure even though the radiopharmaceuticals are regulated by the FDA and undergo the same stringent standards as other approved drug products. With the new precision medicine products that have come to market over the last 10 years, this pricing model is restricting access to these life altering products. CMS averages the pricing of all the diagnostics products which has resulted in overpaying for low-cost radiopharmaceuticals and has reduced reimbursement for the higher cost products. These reduced reimbursement rates have resulted in many providers choosing not to offer these services. This model decreases patient access and potentially impacts quality of care.

While this limitation impacts all patients, the decrease in availability disproportionately affects people of color and those of lower socioeconomic classes. Breast and prostate cancer, neuroendocrine cancer, and Alzheimer's disease affect all population groups, but examples of their impact on these groups are outlined below:

- Breast Cancer
    - Black women face a higher likelihood of developing breast cancer before age 45 compared to white women and are more likely to die from breast cancer at every age.[1]
- Alzheimer's Disease
    - 18.6% of Blacks and 14% of Hispanic Americans aged 65 and older have Alzheimer's dementia compared with 10% of whites.[2]
    - Black patients with dementia also have approximately twice the risk of underdiagnosis compared with white patients.[3]

- Prostate Cancer
    - Black men are 1.8 times more likely to be diagnosed with and 2.2 times more likely to die from prostate cancer than white men. Black men are also slightly more likely than white men to be diagnosed with advanced disease.[4]
- Neuroendocrine Tumors
    - Black patients are more likely to be diagnosed with later stages of neuroendocrine tumors and have worse overall survival rates compared to non-Black patients.[5]

Increasing access to patient care has been a priority of APhA through education, training, and advocacy. However, APhA has not been able to advocate for current or past legislation to increase access to radiopharmaceuticals. Currently the Facilitating Innovative Nuclear Diagnostics (FIND) Act centering on changing the payment structure for diagnostic radiopharmaceuticals is under Congressional review. The number of new diagnostic radiopharmaceuticals is expected to match the growing radiopharmaceutical therapy market with several new oncologic treatments anticipated in the next 3-5 years. The need for adequate reimbursement will continue to be a high priority to ensure continuity of patient care.

Adoption of this policy will allow APhA to advocate and act of the behalf of patients now and into the future as nuclear medicine continues to grow.

[1]Yedjou, C.G., Sims, J.N., Miele, L., Noubissi, F., Lowe, L., Fonseca, D.D., Alo, R.A., Payton, M., & Tchounwou, P.B. (2019). Health and racial disparity in breast cancer. Andances in experimental medicine and biology. Retrieved January 14, 2022, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6941147/

[2]Rajan KB, Weuve J, Barnes LL, McAninch EA, Wilson RS, Evans DA. Population estimate of people with clinical AD and mild cognitive impairment in the United States (2020-2060). Alzheimers Dement 2021;17.

[3]Gianattasio, K.Z., Prather, C., Glymour, M.M., Ciarleglio, A. and Power, M.C. (2019), Racial disparities and temporal trends in dementia misdiagnosis risk in the United States. Alzeimer's Dementia: Translational Research and Clinical Interventions, 5: 891-898.

[4]African Americans and Prostate Cancer. (2021, June 23). ZERO – The End of Prostate Cancer. https://zerocancer.org/learn/about-prostate-cancer/risks/african-americans-prostate-cancer/

[5]Zhou, H., Zhang, Y., Wei, X., Yang, K., Tan, W., Qiu, Z., Li, S., Chen, Q., Song, Y., &Gao, S. (2017, November). Racial disparities in pancreatic neuroendocrine tumors survival: A seer study. Cancer medicine.

Current APhA Policy & Bylaws:

2023 – Access to Essential Medications

APhA Advocates regulation, policies and legislation that recognize access to quality and affordable essential medications as a fundamental human right.

(JAPhA. 63(4):1266; July/August 2023)

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American Pharmacists Association
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To be completed by the Office of the Secretary of the House of Delegates

Item No.: 6
Date received: 1/22/24
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American Pharmacists Association
House of Delegates – March 22-25, 2024

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Molly Nichols (APhA-APPM PPCA SIG)
(Name)

January 22
(Date)

APhA-APPM, on behalf of the Pain, Palliative Care and Addiction SIG
(Organization)

Subject: Removal of Stigmatizing Language

Motion: To adopt the following policy statement as amended and part of the existing 2020, 2015 Integrated Nationwide Prescription Drug Monitoring Program policy

2020, 2015 Integrated Nationwide Prescription Drug Monitoring Program

6. APhA supports the use of interprofessional advisory boards, that include pharmacists, to coordinate collaborative efforts for (a) compiling, analyzing, and using prescription drug monitoring program (PDMP) data trends related to controlled substance use in a manner other than prescribed ~~misuse, abuse,~~ and/or fraud; (b) providing focused provider education and patient referral to treatment programs; and (c) supporting research activities on the impact of PDMPs.

Background:
The language in these policies was reviewed and updated based on the APhA Pharmacists' Role in Reducing Stigma Surrounding Opioid Use Disorder (OUD) fact sheet (link here). The goal of this NBI is to update potentially stigmatizing language in existing APhA policies to reflect currently recommend language in OUD and, more broadly, substance use disorders (SUDs). The SIG hopes that by revising this policy language we will reduce indirect exposures to, and influences of, stigma in the profession.

Impacts of Stigma (pulled from https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction)

- Feeling stigmatized can reduce the willingness of individuals with substance use disorders (SUDs) to seek treatment.
- Stigmatizing views of people with SUD are common; this stereotyping can lead others to feel pity, fear, anger, and a desire for social distance from people with an SUD.
- Stigmatizing language can negatively influence health care provider perceptions of people with SUD, which can impact the care they provide.

Importance of Eliminating Stigma (pulled from https://www.shatterproof.org/sites/default/files/2023-02/Shatterproof%20Addiction%20Stigma%20Index%202021%20Report%20NEW.pdf)

- Eliminating the stigma and discrimination faced by those with SUDs has never been more important. Despite decades of action from nonprofits, healthcare providers, those with lived experience, and government agencies, stigma remains one of the largest and most persistent drivers of negative outcomes for those struggling with addiction.
- During 2020 alone, more than 93,000 people died from overdoses – the highest number in history. At the same time, more than 20 million American adults continued to suffer from the disease of addiction.
- The COVID-19 pandemic has exacerbated this crisis by increasing economic instability, imposing social isolation, and reducing access to harm reduction, treatment, and recovery services. Structural racism and health inequities have worsened the impacts of the pandemic for marginalized communities, leading to increased rates of substance use and overdose. These effects will be felt for years to come, highlighting the urgent need to act.
- Addiction stigma and discrimination experienced by those with a substance use disorder independently leads to tens of thousands of preventable deaths every single year:
    - It prevents many with a SUD from ever seeking treatment;
    - It makes the public less willing to have someone with a SUD as a close personal friend, a co- worker, a neighbor, and as a family member;
    - It limits the ability of institutions and providers to offer help when someone does seek assistance by limiting resources and perpetuating harmful policies;
    - And it fuels an ongoing feeling of shame that serves as an obstacle to long-term health for those with a SUD, regardless of whether they have received treatment – entrenching addiction as a relentless and devastating public health crisis.

Current APhA Policy & Bylaws:

2020, 2015 Integrated Nationwide Prescription Drug Monitoring Program (Original Language)
1. APhA advocates for nationwide integration and uniformity of prescription drug monitoring programs (PDMP) that incorporate federal, state, and territory databases for the purpose of providing health care professionals with accurate and real-time information to assist in clinical decision making when providing patient care services related to controlled substances.
2. APhA supports pharmacist involvement in the development of uniform standards for an integrated nationwide prescription drug monitoring program (PDMP) that includes the definition of authorized registered users, documentation, reporting requirements, system response time, security of information, minimum reporting data sets, and standard transaction format.

3. APhA supports mandatory prescription drug monitoring program (PDMP) enrollment by all health care providers, mandatory reporting by all those who dispense controlled substances, and appropriate system query by registrants during the patient care process related to controlled substances.
4. APhA advocates for the development of seamless workflow integration systems that would enable consistent use of a nationwide prescription drug monitoring program (PDMP) by registrants to facilitate prospective drug review as part of the patient care process related to controlled substances.
5. APhA advocates for continuous, sustainable federal funding sources for practitioners and system operators to utilize and maintain a standardized integrated and real-time nationwide prescription drug monitoring program (PDMP).
6. APhA supports the use of interprofessional advisory boards, that include pharmacists, to coordinate collaborative efforts for (a) compiling, analyzing, and using prescription drug monitoring program (PDMP) data trends related to controlled substance and/or fraud; (b) providing focused provider education and patient referral to treatment programs; and (c) supporting research activities on the impact of PDMPs.
7. APhA supports education and training for registrants about a nationwide prescription drug monitoring program (PDMP) to ensure proper data integrity, use, and confidentiality.
(JAPhA. N55(4):364; July/August 2015) (JAPhA. 2020; 60(5): e10)

Efforts to Reduce the Stigma Associated with Mental Health Disorders or Diseases
2018
1. APhA encourages all stakeholders to develop and adopt evidence-based approaches to educate the public and all health care professionals to reduce the stigma associated with mental health diagnoses.
2. APhA supports the increased utilization of pharmacists and student pharmacists with appropriate training to actively participate in the care of patients with mental health diagnoses as members of interprofessional health care teams in all practice settings.
3. APhA supports the expansion of mental health education and training in the curriculum of all schools and colleges of pharmacy, post-graduate training, and within continuing professional development programs.
4. APhA supports the development of education and resources to address health care professional resiliency and burnout.
(JAPhA. 58(4):356; July/August 2018)

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

Item No.: 7
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American Pharmacists Association
House of Delegates – March 22-25, 2024

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Molly Nichols (APhA-APPM PPCA SIG)
(Name)

January 22
(Date)

APhA-APPM, on behalf of the Pain, Palliative Care and Addiction SIG
(Organization)

Subject: Removal of Stigmatizing Language

Motion: To adopt the following policy statement as amended and part of the existing 2019, 2016 Substance Use Disorder policy

2019, 2016 Substance Use Disorder

1. APhA supports legislative, regulatory, and private sector efforts that include pharmacists' input and that will balance patient/consumers' need for access to medications for legitimate medical purposes with the need to prevent the diversion and use of medications in a manner other than prescribed~~, misuse, and abuse of medications~~.

Background:
The language in these policies was reviewed and updated based on the APhA Pharmacists' Role in Reducing Stigma Surrounding Opioid Use Disorder (OUD) fact sheet (link here). The goal of this NBI is to update potentially stigmatizing language in existing APhA policies to reflect currently recommend language in OUD and, more broadly, substance use disorders (SUDs). The SIG hopes that by revising this policy language we will reduce indirect exposures to, and influences of, stigma in the profession.

Impacts of Stigma (pulled from https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction)

- Feeling stigmatized can reduce the willingness of individuals with substance use disorders (SUDs) to seek treatment.
- Stigmatizing views of people with SUD are common; this stereotyping can lead others to feel pity, fear, anger, and a desire for social distance from people with an SUD.
- Stigmatizing language can negatively influence health care provider perceptions of people with SUD, which can impact the care they provide.

Importance of Eliminating Stigma (pulled from https://www.shatterproof.org/sites/default/files/2023-02/Shatterproof%20Addiction%20Stigma%20Index%202021%20Report%20NEW.pdf)

- Eliminating the stigma and discrimination faced by those with SUDs has never been more important. Despite decades of action from nonprofits, healthcare providers, those with lived experience, and government agencies, stigma remains one of the largest and most persistent drivers of negative outcomes for those struggling with addiction.
- During 2020 alone, more than 93,000 people died from overdoses – the highest number in history. At the same time, more than 20 million American adults continued to suffer from the disease of addiction.
- The COVID-19 pandemic has exacerbated this crisis by increasing economic instability, imposing social isolation, and reducing access to harm reduction, treatment, and recovery services. Structural racism and health inequities have worsened the impacts of the pandemic for marginalized communities, leading to increased rates of substance use and overdose. These effects will be felt for years to come, highlighting the urgent need to act.
- Addiction stigma and discrimination experienced by those with a substance use disorder independently leads to tens of thousands of preventable deaths every single year:
    - It prevents many with a SUD from ever seeking treatment;
    - It makes the public less willing to have someone with a SUD as a close personal friend, a co- worker, a neighbor, and as a family member;
    - It limits the ability of institutions and providers to offer help when someone does seek assistance by limiting resources and perpetuating harmful policies;
    - And it fuels an ongoing feeling of shame that serves as an obstacle to long-term health for those with a SUD, regardless of whether they have received treatment – entrenching addiction as a relentless and devastating public health crisis.

Current APhA Policy & Bylaws:

2019, 2016 Substance Use Disorder

1. APhA supports legislative, regulatory, and private sector efforts that include pharmacists' input and that will balance patient/consumers' need for access to medications for legitimate medical purposes with the need to prevent the diversion.
2. APhA supports consumer sales limits of nonprescription drug products, such as methamphetamine precursors, that may be illegally converted into drugs for illicit use.

3. APhA encourages education of all personnel involved in the distribution chain of nonprescription products so they understand the potential for certain products, such as methamphetamine precursors, to be illegally converted into drugs for illicit use. APhA supports comprehensive substance use disorder education, prevention, treatment, and recovery programs.
4. APhA supports public and private initiatives to fund treatment and prevention of substance use disorders.
5. APhA supports stringent enforcement of criminal laws against individuals who engage in drug trafficking.
(JAPhA. 56(4):369; July/August 2016) (JAPhA. 59(4): e28; July/August 2019)

Efforts to Reduce the Stigma Associated with Mental Health Disorders or Diseases
2018

1. APhA encourages all stakeholders to develop and adopt evidence-based approaches to educate the public and all health care professionals to reduce the stigma associated with mental health diagnoses.
2. APhA supports the increased utilization of pharmacists and student pharmacists with appropriate training to actively participate in the care of patients with mental health diagnoses as members of interprofessional health care teams in all practice settings.
3. APhA supports the expansion of mental health education and training in the curriculum of all schools and colleges of pharmacy, post-graduate training, and within continuing professional development programs.
4. APhA supports the development of education and resources to address health care professional resiliency and burnout.
(JAPhA. 58(4):356; July/August 2018)

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

Item No.: 8
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American Pharmacists Association
House of Delegates – March 22-25, 2024

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Molly Nichols (APhA-APPM PPCA SIG)
(Name)

January 22
(Date)

APhA-APPM, on behalf of the Pain, Palliative Care and Addiction SIG
(Organization)

Subject: Removal of Stigmatizing Language

Motion: To adopt the following policy statements as amended and part of the existing 2014 Controlled Substances and Other Medications with the Potential for Abuse and Use of Opioid Reversal Agents policy

2014 Controlled Substances and Other Medications with the Potential for Use in a Manner other than Prescribed ~~Abuse~~ and Use of Opioid Reversal Agents

1. APhA supports education for pharmacists and student pharmacists to address issues of pain management, palliative care, appropriate use of opioid reversal agents in opioid-associated emergencies ~~overdose~~, drug diversion, and substance use ~~-related and addictive~~ disorders.
2. APhA supports recognition of pharmacists as the health care providers who must exercise professional judgment in the assessment of a patient's conditions to fulfill corresponding responsibility for the use of controlled substances and other medications with the potential for ~~misuse, abuse,~~ use in a manner other than prescribed and/or diversion.
3. APhA supports pharmacists' access to and use of prescription monitoring programs to identify and prevent drug ~~misuse, abuse,~~ use in a manner other than prescribed and/or diversion.
4. APhA supports the development and implementation of state and federal laws and regulations that permit pharmacists to furnish opioid reversal agents to prevent deaths due to opioid-~~related~~ associated emergencies ~~deaths due to overdose~~.
5. APhA supports the pharmacist's role in selecting appropriate therapy and dosing and initiating and providing education about the proper use of opioid reversal agents to prevent deaths due to opioid-~~related deaths due to overdose~~ associated emergencies.

(JAPhA. 54(4):358; July/August 2014) (Reviewed 2015)(Reviewed 2018) (Reviewed 2021)

Background:
The language in these policies was reviewed and updated based on the APhA Pharmacists' Role in Reducing Stigma Surrounding Opioid Use Disorder (OUD) fact sheet (link here). The goal of this NBI is to update potentially stigmatizing language in existing APhA policies to reflect currently recommend language in OUD and, more broadly, substance use disorders (SUDs). The SIG hopes that by revising this policy language we will reduce indirect exposures to, and influences of, stigma in the profession.

Impacts of Stigma (pulled from https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction)

- Feeling stigmatized can reduce the willingness of individuals with substance use disorders (SUDs) to seek treatment.
- Stigmatizing views of people with SUD are common; this stereotyping can lead others to feel pity, fear, anger, and a desire for social distance from people with an SUD.
- Stigmatizing language can negatively influence health care provider perceptions of people with SUD, which can impact the care they provide.

Importance of Eliminating Stigma (pulled from https://www.shatterproof.org/sites/default/files/2023-02/Shatterproof%20Addiction%20Stigma%20Index%202021%20Report%20NEW.pdf)

- Eliminating the stigma and discrimination faced by those with SUDs has never been more important. Despite decades of action from nonprofits, healthcare providers, those with lived experience, and government agencies, stigma remains one of the largest and most persistent drivers of negative outcomes for those struggling with addiction.
- During 2020 alone, more than 93,000 people died from overdoses – the highest number in history. At the same time, more than 20 million American adults continued to suffer from the disease of addiction.
- The COVID-19 pandemic has exacerbated this crisis by increasing economic instability, imposing social isolation, and reducing access to harm reduction, treatment, and recovery services. Structural racism and health inequities have worsened the impacts of the pandemic for marginalized communities, leading to increased rates of substance use and overdose. These effects will be felt for years to come, highlighting the urgent need to act.
- Addiction stigma and discrimination experienced by those with a substance use disorder independently leads to tens of thousands of preventable deaths every single year:
    - It prevents many with a SUD from ever seeking treatment;
    - It makes the public less willing to have someone with a SUD as a close personal friend, a co- worker, a neighbor, and as a family member;
    - It limits the ability of institutions and providers to offer help when someone does seek assistance by limiting resources and perpetuating harmful policies;
    - And it fuels an ongoing feeling of shame that serves as an obstacle to long-term health for those with a SUD, regardless of whether they have received treatment – entrenching addiction as a relentless and devastating public health crisis.

Current APhA Policy & Bylaws:

2014 Controlled Substances and Other Medications with the Potential for and Use of Opioid Reversal Agents

1. APhA supports education for pharmacists and student pharmacists to address issues of pain management, palliative care, appropriate use of opioid reversal agents in drug diversion, and substance disorders.
2. APhA supports recognition of pharmacists as the health care providers who must exercise professional judgment in the assessment of a patient's conditions to fulfill corresponding responsibility for the use of controlled substances and other medications with the potential for misuse, abuse, and/or diversion.
3. APhA supports pharmacists' access to and use of prescription monitoring programs to identify and prevent drug misuse, abuse, and/or diversion.
4. APhA supports the development and implementation of state and federal laws and regulations that permit pharmacists to furnish opioid reversal agents to prevent opioid-related deaths due to overdose.
5. APhA supports the pharmacist's role in selecting appropriate therapy and dosing and initiating and providing education about the proper use of opioid reversal agents to prevent opioid-related deaths due to overdose.

(JAPhA. 54(4):358; July/August 2014) (Reviewed 2015)(Reviewed 2018) (Reviewed 2021)

Efforts to Reduce the Stigma Associated with Mental Health Disorders or Diseases
2018

1. APhA encourages all stakeholders to develop and adopt evidence-based approaches to educate the public and all health care professionals to reduce the stigma associated with mental health diagnoses.
2. APhA supports the increased utilization of pharmacists and student pharmacists with appropriate training to actively participate in the care of patients with mental health diagnoses as members of interprofessional health care teams in all practice settings.
3. APhA supports the expansion of mental health education and training in the curriculum of all schools and colleges of pharmacy, post-graduate training, and within continuing professional development programs.
4. APhA supports the development of education and resources to address health care professional resiliency and burnout.

(JAPhA. 58(4):356; July/August 2018)

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

Item No:. 9
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American Pharmacists Association
House of Delegates – March 22-25, 2024

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Molly Nichols (APhA-APPM PPCA SIG)
(Name)

January 22
(Date)

APhA-APPM, on behalf of the Pain, Palliative Care and Addiction SIG
(Organization)

Subject: Removal of Stigmatizing Language

Motion: Adopt the following policy statement as amended and part of the existing 2003, 1971 Security: Pharmacists' Responsibility policy

2003, 1971 Security: Pharmacists' Responsibility

APhA encourages pharmacists to voluntarily remove all proprietary drug products with potential for ~~misuse, abuse,~~ use in a manner other than prescribed or adverse drug interactions from general sales areas and to make their dispensing the personal responsibility of the pharmacist.

Background:
The language in these policies was reviewed and updated based on the APhA Pharmacists' Role in Reducing Stigma Surrounding Opioid Use Disorder (OUD) fact sheet (link here). The goal of this NBI is to update potentially stigmatizing language in existing APhA policies to reflect currently recommend language in OUD and, more broadly, substance use disorders (SUDs). The SIG hopes that by revising this policy language we will reduce indirect exposures to, and influences of, stigma in the profession.

Impacts of Stigma (pulled from https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction)

- Feeling stigmatized can reduce the willingness of individuals with substance use disorders (SUDs) to seek treatment.
- Stigmatizing views of people with SUD are common; this stereotyping can lead others to feel pity, fear, anger, and a desire for social distance from people with an SUD.
- Stigmatizing language can negatively influence health care provider perceptions of people with SUD, which can impact the care they provide.

Importance of Eliminating Stigma (pulled from https://www.shatterproof.org/sites/default/files/2023-02/Shatterproof%20Addiction%20Stigma%20Index%202021%20Report%20NEW.pdf)

- Eliminating the stigma and discrimination faced by those with SUDs has never been more important. Despite decades of action from nonprofits, healthcare providers, those with lived experience, and government agencies, stigma remains one of the largest and most persistent drivers of negative outcomes for those struggling with addiction.
- During 2020 alone, more than 93,000 people died from overdoses – the highest number in history. At the same time, more than 20 million American adults continued to suffer from the disease of addiction.
- The COVID-19 pandemic has exacerbated this crisis by increasing economic instability, imposing social isolation, and reducing access to harm reduction, treatment, and recovery services. Structural racism and health inequities have worsened the impacts of the pandemic for marginalized communities, leading to increased rates of substance use and overdose. These effects will be felt for years to come, highlighting the urgent need to act.
- Addiction stigma and discrimination experienced by those with a substance use disorder independently leads to tens of thousands of preventable deaths every single year:
    - It prevents many with a SUD from ever seeking treatment;
    - It makes the public less willing to have someone with a SUD as a close personal friend, a co- worker, a neighbor, and as a family member;
    - It limits the ability of institutions and providers to offer help when someone does seek assistance by limiting resources and perpetuating harmful policies;
    - And it fuels an ongoing feeling of shame that serves as an obstacle to long-term health for those with a SUD, regardless of whether they have received treatment – entrenching addiction as a relentless and devastating public health crisis.

Current APhA Policy & Bylaws:

2003, 1971 Security: Pharmacists' Responsibility

APhA encourages pharmacists to voluntarily remove all proprietary drug products with potential for misuse, abuse, or adverse drug interactions from general sales areas and to make their dispensing the personal responsibility of the pharmacist.
(JAPhA. NS11:267; May 1971) (JAPhA NS43(5)(suppl 1):S58; September/October 2003) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016)

Efforts to Reduce the Stigma Associated with Mental Health Disorders or Diseases
2018

1. APhA encourages all stakeholders to develop and adopt evidence-based approaches to educate the public and all health care professionals to reduce the stigma associated with mental health diagnoses.
2. APhA supports the increased utilization of pharmacists and student pharmacists with appropriate training to actively participate in the care of patients with mental health diagnoses as members of interprofessional health care teams in all practice settings.
3. APhA supports the expansion of mental health education and training in the curriculum of all schools and colleges of pharmacy, post-graduate training, and within continuing professional development programs.
4. APhA supports the development of education and resources to address health care professional resiliency and burnout.

(JAPhA. 58(4):356; July/August 2018)

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American Pharmacists Association
For Every Pharmacist. For All of Pharmacy.

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

Item No.: 10
Date received: 1/22/24
Time received: 10:31pm ET

American Pharmacists Association
House of Delegates – March 22-25, 2024

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Molly Nichols (APhA-APPM PPCA SIG)
(Name)

January 22
(Date)

APhA-APPM, on behalf of the Pain, Palliative Care and Addiction SIG
(Organization)

Subject: Removal of Stigmatizing Language

Motion: To adopt the following policy statements as amended and part of the existing 2019 Patient-Centered Care of People Who Inject Non-Medically Sanctioned Psychotropic or Psychoactive Substances policy

2019 Patient-Centered Care of People Who Use ~~Inject~~ Non-Medically Sanctioned Psychotropic or Psychoactive Substances

1. APhA encourages state legislatures and boards of pharmacy to revise laws and regulations to support the patient-centered care of people who use ~~inject~~ non-medically sanctioned psychotropic or psychoactive substances.
2. To reduce the consequences of stigma associated with ~~injection~~ drug use, APhA supports the expansion of interprofessional harm reduction education in the curriculum of schools and colleges of pharmacy, postgraduate training, and continuing professional development programs.
3. APhA encourages pharmacists to initiate, sustain, and integrate evidence-based harm reduction principles and programs into their practice to optimize the health of people who use ~~inject~~ non-medically sanctioned psychotropic or psychoactive substances.
4. APhA supports pharmacists' roles to provide and promote consistent, unrestricted, and immediate access to evidence-based, mortality- and morbidity-reducing interventions to enhance the health of people who use ~~inject~~ nonmedically sanctioned psychotropic or psychoactive substances and their communities, including sterile syringes, needles, and other safe injection equipment, syringe disposal, fentanyl test strips, immunizations, condoms, wound care supplies, pre- and post-exposure prophylaxis medications for human immunodeficiency virus (HIV),

point-of-care testing for HIV and hepatitis C virus (HCV), opioid ~~overdose~~ reversal medications, and medications for opioid use disorder.
5. APhA urges pharmacists to refer people who use ~~inject~~ non-medically sanctioned psychotropic or psychoactive substances to specialists in mental health, infectious diseases, and substance use disorder ~~addiction~~ treatment; to housing, vocational, harm reduction, and recovery support services; and to safe consumption facilities ~~overdose prevention sites~~ and syringe service programs.
(JAPhA. 59(4); e17July/August 2019) (Reviewed 2021)

Background:
The language in these policies was reviewed and updated based on the APhA Pharmacists' Role in Reducing Stigma Surrounding Opioid Use Disorder (OUD) fact sheet (link here). The goal of this NBI is to update potentially stigmatizing language in existing APhA policies to reflect currently recommend language in OUD and, more broadly, substance use disorders (SUDs). The SIG hopes that by revising this policy language we will reduce indirect exposures to, and influences of, stigma in the profession.

Impacts of Stigma (pulled from https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction)

- Feeling stigmatized can reduce the willingness of individuals with substance use disorders (SUDs) to seek treatment.
- Stigmatizing views of people with SUD are common; this stereotyping can lead others to feel pity, fear, anger, and a desire for social distance from people with an SUD.
- Stigmatizing language can negatively influence health care provider perceptions of people with SUD, which can impact the care they provide.

Importance of Eliminating Stigma (pulled from https://www.shatterproof.org/sites/default/files/2023-02/Shatterproof%20Addiction%20Stigma%20Index%202021%20Report%20NEW.pdf)

- Eliminating the stigma and discrimination faced by those with SUDs has never been more important. Despite decades of action from nonprofits, healthcare providers, those with lived experience, and government agencies, stigma remains one of the largest and most persistent drivers of negative outcomes for those struggling with addiction.
- During 2020 alone, more than 93,000 people died from overdoses – the highest number in history. At the same time, more than 20 million American adults continued to suffer from the disease of addiction.
- The COVID-19 pandemic has exacerbated this crisis by increasing economic instability, imposing social isolation, and reducing access to harm reduction, treatment, and recovery services. Structural racism and health inequities have worsened the impacts of the pandemic for marginalized communities, leading to increased rates of substance use and overdose. These effects will be felt for years to come, highlighting the urgent need to act.

- Addiction stigma and discrimination experienced by those with a substance use disorder independently leads to tens of thousands of preventable deaths every single year:
    - It prevents many with a SUD from ever seeking treatment;
    - It makes the public less willing to have someone with a SUD as a close personal friend, a co- worker, a neighbor, and as a family member;
    - It limits the ability of institutions and providers to offer help when someone does seek assistance by limiting resources and perpetuating harmful policies;
    - And it fuels an ongoing feeling of shame that serves as an obstacle to long-term health for those with a SUD, regardless of whether they have received treatment – entrenching addiction as a relentless and devastating public health crisis.

Current APhA Policy & Bylaws:

2019 Patient-Centered Care of People Who Inject Non-Medically Sanctioned Psychotropic or Psychoactive Substances

1. APhA encourages state legislatures and boards of pharmacy to revise laws and regulations to support the patient-centered care of people who inject non-medically sanctioned psychotropic or psychoactive substances.
2. To reduce the consequences of stigma associated with injection-drug use, APhA supports the expansion of interprofessional harm reduction education in the curriculum of schools and colleges of pharmacy, postgraduate training, and continuing professional development programs.
3. APhA encourages pharmacists to initiate, sustain, and integrate evidence-based harm reduction principles and programs into their practice to optimize the health of people who inject non-medically sanctioned psychotropic or psychoactive substances.
4. APhA supports pharmacists' roles to provide and promote consistent, unrestricted, and immediate access to evidence-based, mortality- and morbidity-reducing interventions to enhance the health of people who inject nonmedically sanctioned psychotropic or psychoactive substances and their communities, including sterile syringes, needles, and other safe injection equipment, syringe disposal, fentanyl test strips, immunizations, condoms, wound care supplies, pre- and post-exposure prophylaxis medications for human immunodeficiency virus (HIV), point-of-care testing for HIV and hepatitis C virus (HCV), opioid overdose reversal medications, and medications for opioid use disorder.
5. APhA urges pharmacists to refer people who inject non-medically sanctioned psychotropic or psychoactive substances to specialists in mental health, infectious diseases, and addiction treatment; to housing, vocational, harm reduction, and recovery support services; and to overdose prevention sites and syringe service programs.
(JAPhA. 59(4); e17July/August 2019) (Reviewed 2021)

Efforts to Reduce the Stigma Associated with Mental Health Disorders or Diseases
2018

1. APhA encourages all stakeholders to develop and adopt evidence-based approaches to educate the public and all health care professionals to reduce the stigma associated with mental health diagnoses.
2. APhA supports the increased utilization of pharmacists and student pharmacists with appropriate training to actively participate in the care of patients with mental health diagnoses as members of interprofessional health care teams in all practice settings.
3. APhA supports the expansion of mental health education and training in the curriculum of all schools and colleges of pharmacy, post-graduate training, and within continuing professional development programs.
4. APhA supports the development of education and resources to address health care professional resiliency and burnout.

(JAPhA. 58(4):356; July/August 2018)

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American Pharmacists Association
For Every Pharmacist. For All of Pharmacy.

American Pharmacists Association
House of Delegates – March 22-25, 2024

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

Item No.: 11
Date received: 1/22/24
Time received: 10:39pm ET

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Wendy Mobley-Bukstein
(Name)

01/17/2024 — **(Date)**

APhA-APPM Delegation — **(Organization)**

Subject: Contemporary Pharmacy Practice

Motion: To adopt the following policy statements as amended and part of the existing 2017, 2012 Contemporary Pharmacy Practice policy

2017, 2012 Contemporary Pharmacy Practice

1. APhA ~~asserts that pharmacists should have the authority and support to practice to~~ supports practice authorities based on the full extent of ~~their~~ pharmacists' education, training, and experience ~~in~~to deliver~~ing~~ patient care in all practice settings and activities.
2. APhA opposes burdensome legal and regulatory requirements beyond continuing professional development for the provision of patient care services.

(JAPhA. NS52(4):457; July/August 2012) (Reviewed 2016) (JAPhA. 57(4):441; July/August 2017) (Reviewed 2019) (Reviewed 2021) (Reviewed 2022) (Reviewed 2023

Background:

In matters related to pharmacy practice and patient care, the Government Affairs (GA) staff at APhA is often consulted regarding the education, training, knowledge and credentials that a pharmacist must possess to provide adequate patient care services. When combing through APhA policy, it is cited many times that a pharmacist must possess education, training and knowledge in order to provide patient care services but it is

not called out specifically that an individual who has graduated from an accredited pharmacy program and who maintains a professional license in a recognized US state or territory and keeps this license current through continuing professional development or continuing education is sufficiently trained to provide patient care services. Amending the Contemporary Pharmacy Practice policy as proposed above is intended to create stronger wording to assist the GA staff in their daily business. All six statements of the existing 2017, 2012 Contemporary Pharmacy Practice policy are provided below for reference.

Current APhA Policy & Bylaws:

2017, 2012

Contemporary Pharmacy Practice

1. APhA asserts that pharmacists should have the authority and support to practice to the full extent of their education, training, and experience in delivering patient care in all practice settings and activities.
2. APhA supports continuing efforts toward establishing a consistent and accurate perception of the contemporary role and practice of pharmacists by the general public, patients, and all persons and institutions engaged in health care policy, administration, payment, and delivery.
3. APhA supports continued collaboration with stakeholders to facilitate adoption of standardized practice acts, appropriate related laws, and regulations that reflect contemporary pharmacy practice.
4. APhA supports the establishment of multistate pharmacist licensure agreements to address the evolving needs of the pharmacy profession and pharmacist-provided patient care.
5. APhA urges the continued development of consensus documents, in collaboration with medical associations and other stakeholders, that recognize and support pharmacists' roles in patient care as health care providers.
6. APhA urges universal recognition of pharmacists as health care providers and compensation based on the level of patient care provided using standardized and future health care payment models.

(JAPhA. NS52(4):457; July/August 2012) (Reviewed 2016) (JAPhA. 57(4):441; July/August 2017) (Reviewed 2019) (Reviewed 2021) (Reviewed 2022)

Continuing Professional Development, 2005

1. APhA supports continuing professional development, a self-directed, individualized, systematic approach to life-long learning, to support pharmacist's efforts to maintain professional competence in their practice.

2. APhA should work with appropriate organizations to provide self-assessment and plan development tools. APhA shall help identify and facilitate access to quality educational programs.

3. Employers should foster and support pharmacist participation in continuing professional development.

4. Continuing professional development is a learning process that requires full participation to achieve desired individual outcomes. To facilitate that participation, each pharmacist controls disclosure of their individual assessments and outcomes.

(JAPhA. NS45(5):554; September/October 2005) (Reviewed 2006) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

Continued Competence Assessment Examination, 2003, 1997

1. APhA should develop, in cooperation with other state and national associations, a voluntary process for self-assessing pharmaceutical care competence.

2. APhA opposes regulatory bodies utilizing continuing competence examinations as a requirement for renewal of a pharmacist's license.

3. APhA supports programs that measure and evaluate pharmacist competence based on established valid standards.

(JAPhA. NS37(4):460; July/August 1997) (JAPhA. NS43(5)(suppl 1):S58; September/October 2003) (Reviewed 2005) (Reviewed 2006) (Reviewed 2008) (Reviewed 2011) (Reviewed 2016)

Standards of Care Regulatory Model for State Pharmacy Practice Acts, 2022

1. APhA requests that state boards of pharmacy and legislative bodies regulate pharmacy practice using a standard of care regulatory model similar to other health professions' regulatory models, thereby allowing pharmacists to practice at the level consistent with their individual education, training, experience, and practice setting.

2. To support implementation of a standard of care regulatory model, APhA reaffirms 2002 policy that encourages states to provide pharmacy boards with the following: (a) adequate resources; (b) independent authority, including autonomy from other agencies; and (c) assistance in meeting their mission to protect the public health and safety of consumers.

3. APhA encourages NABP as well as state and national pharmacy associations to support and collaborate with state boards of pharmacy in adopting and implementing a standard of care regulatory model.

4. APhA and other pharmacy stakeholders should provide educational programs, information, and resources regarding the standard of care regulatory model and its impact on pharmacy practice.

(JAPhA. 62(4):941; July 2022)

Multi-State Practice of Pharmacy, 2021

1. APhA affirms that pharmacists are trained to provide patient care, and have the ability to address patient needs, regardless of geographic location.

2. APhA advocates for the continued development of uniform laws and regulations that facilitate pharmacists', student pharmacists', and pharmacy technicians' timely ability to practice in multiple states to meet practice and patient care needs.

3. APhA supports individual pharmacists' and student pharmacists' authority to provide patient care services across state lines whether in person or remotely.

4. APhA supports consistent and efficient centralized processes across all states for obtaining and maintaining pharmacist, pharmacy intern, and pharmacy technician licensure and/or registration.

5. APhA urges state boards of pharmacy to reduce administratively and financially burdensome requirements for licensure while continuing to uphold patient safety.

6. APhA encourages the evaluation of current law exam requirements for obtaining and maintaining initial state licensure, as well as licensure in additional states, to enhance uniformity and reduce duplicative requirements.

7. APhA urges state boards of pharmacy and the National Association of Boards of Pharmacy (NABP) to involve a member of the board of pharmacy and a practicing pharmacist in the review and updating of state jurisprudence licensing exam questions.

8. APhA calls for development of profession-wide consensus on licensing requirements for pharmacists and pharmacy personnel to support contemporary pharmacy practice.

(JAPhA. 61(4):e14-e15;July/August 2021) (Reviewed 2023)

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New Business Items are due to the Speaker of the House by **January 22, 2024** (60 days prior to the start of the first House session). Consideration of urgent items can be presented with a suspension of the House Rules at the session where New Business will be acted upon. Please submit New Business Items to the Speaker of the House via email at hod@aphanet.org.