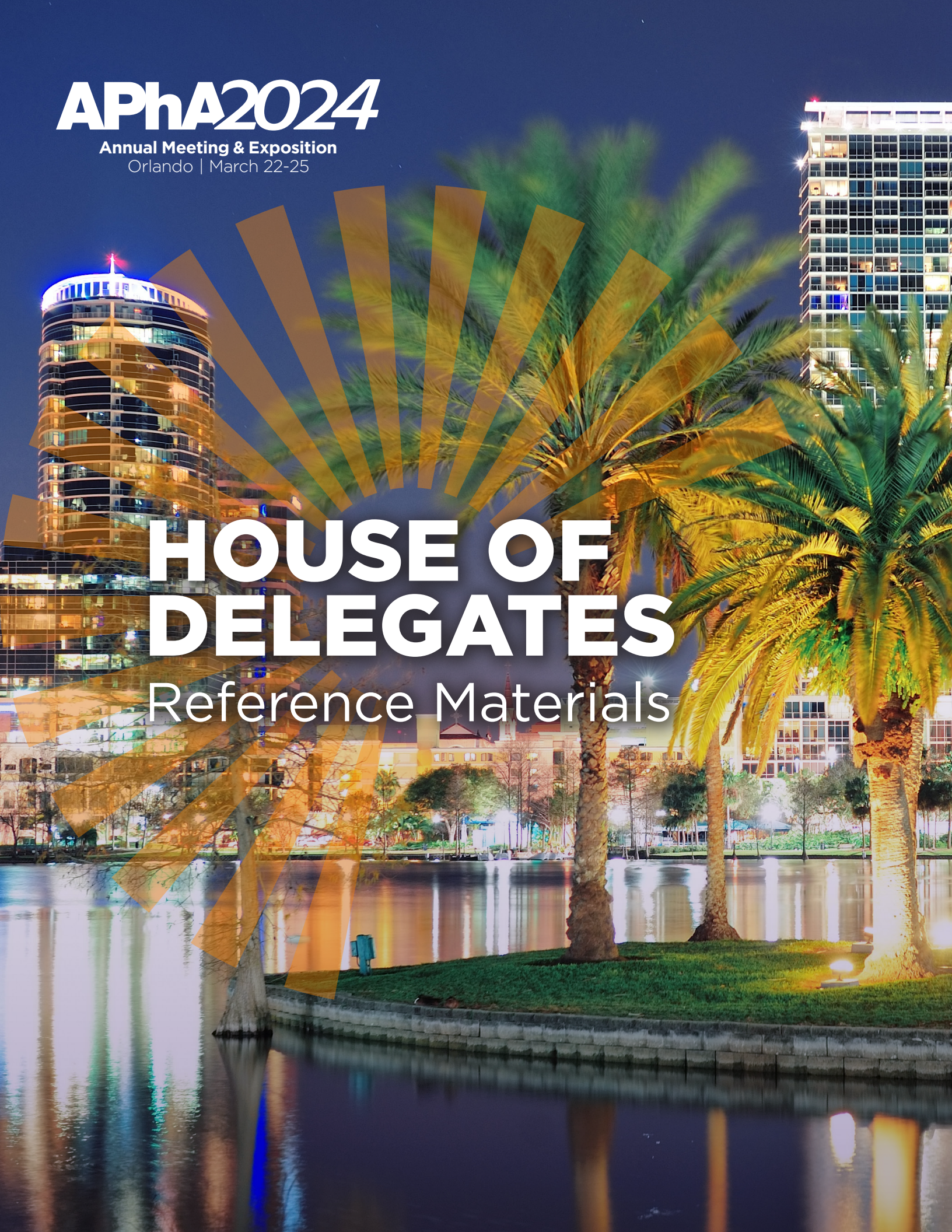
APhA2024
Annual Meeting & Exposition
Orlando | March 22-25



HOUSE OF DELEGATES

Reference Materials

APhA House of Delegates

MEMORANDUM

TO: Delegates and Alternate Delegates to the APhA House of Delegates
FROM: Brandi Hamilton, Speaker of the APhA House of Delegates
RE: Delegate Reference Materials and Important Information

Congratulations on your appointment as a Delegate or Alternate Delegate to the APhA House! I appreciate your willingness to serve the profession and your interest in the policy development process. Within this booklet, you will find schedules, background information, and reports to help you prepare for your important role in the House. Extra copies of this booklet will not be available, so **please remember to bring this information with you.**

Included within your Delegate Reference Materials, you will find:

- APhA House of Delegates Schedule At A Glance;
- Policy Reference Committee and New Business Review Committee Poll Results;
- 2023-2024 APhA House Rules Review Committee Report;
- 2023-2024 APhA Policy Review Committee Report;
- 2023-2024 APhA Policy Reference Committee Report;
- 2023-2024 APhA Policy Committee Background Papers:
- 2023-2024 APhA New Business Items received; and
- 2023-2024 APhA New Business Review Committee Report.

***Amendment Forms** - New Process for 2024*

Amendment forms will no longer be placed at delegate seats. You may pick up an amendment form at the registration table outside the ballroom or from a staff person seated within your delegation. As this is an effort to reduce overall waste.

Policy-Related Webinars Available

If you were unavailable to participate in any of the committee-related webinars, I encourage you to visit https://pharmacist.com/About/Leadership/HOD/Learn to view an archived version of the webinars conducted to date. These webinars will present you with additional background information related to the subjects and provide insight into the questions raised by your fellow Delegates.

If you are new to the House of Delegates, or if you just desire a refresher course on the rules and procedures of the APhA House, I encourage you to view the ***Delegate Orientation Webinar* recording.**

Onsite Delegate Registration – Valencia Foyer

Registration for the First Session will open from **12:00pm-2:45pm on Friday**, **March 22, 2024.** Delegate registration will be located at the **Orange County Convention Center** (9800 International Drive, Orlando, FL).

Registration for the Final session is in the same location, from **11:00am-1:30pm on Monday, March 25, 2024**. There is no need to check-in with the House of Delegates prior to these registration times.

Delegates **ONLY** are required to complete the following steps below prior to each House session:

Step 1 – Report to the Delegate registration area in the **Valencia Foyer**. Please remember to bring your delegate reference materials and your APhA2024 meeting badge with you to registration. Please allocate sufficient time to check in prior to the start time of the House.

Step 2 – Scan your name badge, pick up your Delegate ribbon (if needed), and pick up your electronic voter keypad from APhA staff. Note: you must return the keypad to staff at the conclusion of each House session.

Delegates who have not pre-registered will be required to sign a waiver agreeing to pay a replacement fee if the voter keypad is not returned to APhA staff. **Also, Alternate Delegates are not required to register or check-in unless asked to substitute for a Delegate. When registering in place of a Delegate, Alternate Delegates will follow the same check-in procedures as a Delegate**.

House of Delegates Office Hours

If you have specific questions regarding the policy development process or general House procedures, I encourage you to schedule an appointment to speak with me or the House Parliamentarian during the Annual Meeting. See your Schedule At-A-Glance for House of Delegates Office Hours or contact APhA staff at hod@aphanet.org for further information.

Planning for the 2025 House

As we look forward to the future, we want to hear your voice on the issues that matter to you and the pharmacy profession. That's why we are launching the policy development process for 2025 in mid-April. This is your opportunity to propose policy topics that you think the House of Delegates should address. To submit your policy topic idea, please visit https://apha.secure-platform.com/a/solicitations/1584/home by early **April 8, 2024**. Thank you for your participation and input!

On a related note, there are a number of opportunities for you to serve APhA on one of the House of Delegates committees. If you are interested in serving during the 2024-2025 policy development process, I encourage you to complete the committee volunteer interest form **by April 8, 2024** at https://apha.secure-platform.com/a/solicitations/1587/home.

Thank you again for your interest and service to the 2024 House of Delegates! I look forward to seeing you in Orlando, FL! If you have any questions about House activities, please visit https://pharmacist.com/hod or contact APhA staff at hod@aphanet.org.

Sincerely,

Brandi Hamilton, PharmD, MS, BCPS
Speaker of the House of Delegates

Michael Hogue, Executive Vice President & Chief Executive Officer

cc:

Brian Wall, Senior Director, APhA Executive Office, Governance & Foundation Programs (bwall@aphanet.org)
Brittany Botescu, Senior Manager, Governance and Policy (bbotescu@aphanet.org)
Wendy Gaitwood, Project Manager, Executive Office & Governance (wgaitwood@aphanet.org)

Online: https://pharmacist.com/hod *Email:* *hod@aphanet.org*

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HOUSE OF DELEGATES Schedule at a Glance

FRIDAY, MARCH 22		
12:00 pm – 2:45 pm	Valencia Foyer	Delegate Registration (outside of ballroom)
1:00 pm – 2:00 pm	W308CD	APhA-APPM Delegate Caucus
1:00 pm – 2:00 pm	W308AB	APhA-APRS Delegate Caucus
1:00 pm – 2:00 pm	W309	HOD Caucus Group - Midwest
1:00 pm – 2:00 pm	W307C	HOD Caucus Group - Northeast
1:00 pm – 2:00 pm	W307B	HOD Caucus Group - South
1:00 pm – 2:00 pm	W307A	HOD Caucus Group - West
2:30 pm – 5:00 pm	Valencia Ballroom ABC	House of Delegates – First Session (Be seated by 2:15 pm)

SATURDAY, MARCH 23		
1:00 pm – 2:30 pm	W414B	New Business Review Committee Open Hearing

SUNDAY, MARCH 24		
1:00 pm – 3:00 pm	W414B	Policy Reference Committee Open Hearing

MONDAY, MARCH 25		
9:00 am - 11:30 am	W308CD	APhA-APPM Delegate Caucus
9:00 am – 11:30 am	W308AB	APhA-APRS Delegate Caucus
9:45 am – 10:45 am	W309	HOD Caucus Group - Midwest
9:45 am – 10:45 am	W307C	HOD Caucus Group - Northeast
9:45 am – 10:45 am	W307B	HOD Caucus Group - South
9:45 am – 10:45 am	W307A	HOD Caucus Group - West
11:00 am – 1:30 pm	Valencia Foyer	Delegate Registration (outside of ballroom)
1:30 pm – 4:30 pm	Valencia Ballroom ABC	House of Delegates – Final Session (Be seated by 1:15 pm)

HOUSE OF DELEGATES OFFICE HOURS - ROOM	
Thursday, March 21	3:00 pm – 6:00 pm
Friday, March 22	7:30 am – 3:00 pm
Saturday, March 23	8:00 am – 3:00 pm
Sunday, March 24	8:00 am – 3:00 pm
Monday, March 25	7:30 am – 1:00 pm

FRIDAY, MARCH 22 • House of Delegates – First Session

Agenda

1. Call to Order
2. Review of Voting Procedures
3. Credentials Report*
4. Adoption of Agenda and Rules*
5. Introduction of Head Table
6. Report of the Speaker, APhA House of Delegates
7. APhA House Rules Review Committee Report*
8. New Business Procedure
9. Report of the Committee on Nominations*
10. Speaker-elect Candidate Introductions
11. Unfinished/Referred Business Items
12. APhA Policy Review Committee Report*
13. APhA Policy Reference Committee and New Business Review Committee Reports – Consent Agenda*
14. APhA Policy Reference Committee Report – Items not Added to Consent Agenda or that were Pulled Out for Separate Consideration*
15. APhA New Business Review Committee Report – Items not Added to Consent Agenda or that were Pulled Out for Separate Consideration*
16. Recognition of APhA and Academy Officers
17. Meet the Candidates for the 2024 APhA Board of Trustees Election
18. Housekeeping Announcements
19. Adjournment of the First House Session

MONDAY, MARCH 25 • House of Delegates – Final Session

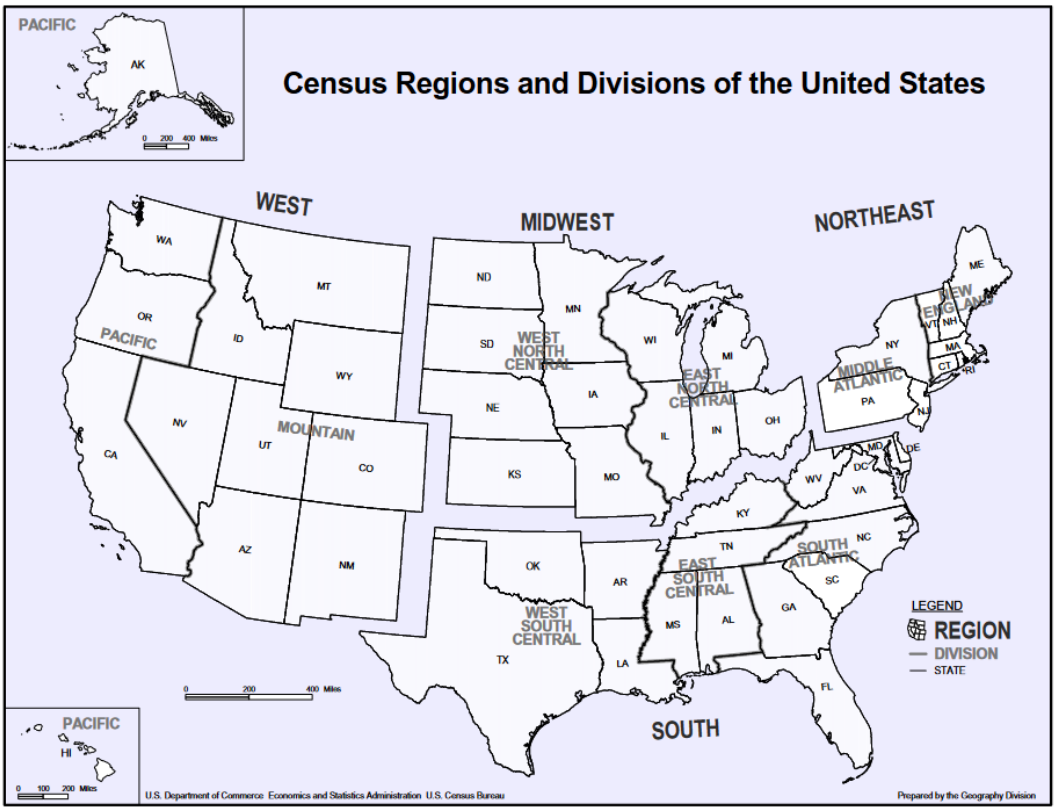
Agenda

1. Call to Order
2. Review of Voting Procedures
3. Credentials Report*
4. Adoption of Agenda*
5. Consideration of Unfinished Business
   a. APhA Policy Reference Committee Report*
6. Speaker-elect Candidate Speeches
7. Speaker-elect Election*
8. Consideration of Unfinished Business
   a. APhA New Business Review Committee Report*
9. Announcement of Election Results
10. Installation of the 2024-2025 Speaker-elect
11. Installation of the APhA Board of Trustees
12. Installation of the 2024-2025 APhA President
13. Recommendations from APhA Members
14. Closing Announcements
15. Adjournment of the 2024 APhA House of Delegates

Please note: (*) asterisk indicates potential opportunities to cast votes.

Regional Caucus Opportunities

Friday, March 22 from 1:00 – 2:00 pm ET ● Monday, March 25 from 9:45 – 10:45 am ET



Northeast – W307C	Midwest – W309	South – W307B	West – W307A
Connecticut	Illinois	Alabama	Alaska
Maine	Indiana	Arkansas	Arizona
Massachusetts	Iowa	Delaware	California
New Hampshire	Kansas	Florida	Colorado
New Jersey	Michigan	Georgia	Hawaii
New York	Minnesota	Kentucky	Idaho
Pennsylvania	Missouri	Louisiana	Montana
Rhode Island	Nebraska	Maryland	Nevada
Vermont	North Dakota	Mississippi	New Mexico
	Ohio	North Carolina	Oregon
	South Dakota	Oklahoma	Utah
	Wisconsin	Puerto Rico	Washington
		South Carolina	Wyoming
		Tennessee	
		Texas	
		Virginia	
		Washington DC	
		West Virginia	

As of Date: 3/15/2024

AACP (*Delegates-2 Out of 2*)
Craig Cox
Lee Vermeulen

AAPP (*Delegates-1 Out of 2*)
Megan Ehret

AAPS (*Delegates-0 Out of 2*)

ACA (*Delegates-2 Out of 2*)
Brian Hose
DeAnna Leikach

ACCP (*Delegates-2 Out of 2*)
Marcia Buck
Brian Hemstreet

ACCP (*Alt. Delegates*)
Michael Maddux

ACVP (*Delegates-2 Out of 2*)
Gigi Davidson
Brenda Jensen

AIHP (*Delegates-2 Out of 2*)
Cynthia Boyle
John Clark

AIR FORCE (*Delegates-2 Out of 2*)
Christian Banasky
Brandy Renner

ALABAMA (*Delegates-3 Out of 3*)
Darrell Craven
Allison Souders
Casey Souders

ALABAMA (*Alt. Delegates*)
Byrdena Dugan

ALASKA (*Delegates-0 Out of 2*)

AMCP (*Delegates-2 Out of 2*)
Christina Barrington
Susan Cantrell

APC - Formerly IACP (*Delegates-0 Out of 2*)

APhA Board (*Delegates-15 Out of 15*)
Vibhuti Arya
Lauren Bode
Stephen Carroll
Patricia Fabel
Gregory Fox
Andrew Gentles
Brandi Hamilton
Spencer Harpe
Michael Hogue
Victoria Lyle
Valerie Prince
Magaly Rodriguez De Bittner
Alex Varkey
Theresa Wells-Tolle
Cathy Worrall

APhA-APPM (*Delegates-28 Out of 28*)
Kelechi Aguwa
Kari Allan
Jeffrey Bratberg
Andrew Bzowyckyj
Trisha Chandler
Denise Clayton
Jessica Comstock
Nicholas Dorich
Jessica Finke
Wendy Galbraith
Gretchen Garofoli
Jeffrey Hamper
Christine Hong
Christopher Johnson
Amy Kennedy
Laura Knockel
Lauren Lakdawala
Wendy Mobley-Bukstein
Molly Nichols
Erin Pauling
Traci Poole
Emily Prohaska
Ashley Pugh
R. Taylor Reed
Marissa Salvo
Tessa Schnelle
Deanna Tran
Mahwish Yousaf

APhA-APPM (*Alt. Delegates*)
Zachary Krauss
Jeffrey Reagan Snow

APhA-APRS (*Delegates-25 Out of 28*)
Edward Bednarczyk
Deepak Bhatia
Morgan Carson-Marino
Antoinette Coe
Jackoline Costantino
Karen Farris
Stephanie Gernant
Marsha Gilbreath
Mary Gurney
Adriane Irwin
Anand Iyer
Anandi Law
Yifei Liu
Kevin Lu
Heidi Mansour
Dustin Miracle
Karen Nagel-Edwards
Julie Oestreich
Helen Omuya
Smita Rawal
Nathaniel Rickles
Michael Smith
Tyler Wagner
Thomas Worrall
Henry Young

APhA-APRS (*Alt. Delegates*)
Roudabeh Latifpour

APhA-ASP (*Delegates-28 Out of 28*)
Ellie Balken
Alexandra Cochran
Caroline Culpepper
Philip Do
Jennifer Estrellado
Heather Faulkner
Ellie Flynn
Megan Godfrey
Bryan Gomez
Kylie Juenger
Nicole Kayrala
Nicole Larroza
Ngoc Phuong Mai Le
Ashley McKechan
Camille Mercado
Miranda Montoya
Mark Nagel
Tiffany Preda
Stephen Presti
Cristian Rodriquez
Annajita Rubio
Danny Schreiber
Yasmin Siwy
Grant Smith
Charleigh Steverson
Jian Weng
Leeann Williamson
Alexandria Wingler

* The numbers reflect the allotted delegates per delegation, not the actual listed delegates.

APhA-ASP (*Alt. Delegates*)

Alleah Al-Amery
Maethe Butterfield
Nikki Chen
Francisco Damacio
Lauren Gravert
Desiree Herman
Heather Howell
Jailyn Jones
Jenna Knutson
Katie McDuffie
Anthony Morant
Nick Sebree
Xinyue Shen
Robyn Turner
Selena Zhuo

ARIZONA (*Delegates-4 Out of 4*)

Matthew Gotfryd
Kimberly Langley
Kimberly Smith
Lorri Walmsley

ARKANSAS (*Delegates-0 Out of 2*)

ARMY (*Delegates-2 Out of 2*)

Jon Bartlett
Rachel Ibrahimovic

ASCP (*Delegates-2 Out of 2*)

Jeanne Manzi
Deborah Milito

ASHP (*Delegates-1 Out of 2*)

Jessie Hipple Rosario

ASHP (*Alt. Delegates*)

Gabrielle Pierce

ASPL (*Delegates-0 Out of 2*)

CALIFORNIA (*Delegates-8 Out of 8*)

Kathleen Besinque
Michael Conner
Jennifer Courtney
Amy Hohmann
Brian Kawahara
Sarah McBane
Larry Selkow
Chris Woo

CALIFORNIA (*Alt. Delegates*)

Richard Dang

COLORADO (*Delegates-3 Out of 3*)

Ashley Mains Espinosa
Kelsey Schwander
Sara Wettergreen

COLORADO (*Alt. Delegates*)

Jody Adams

CONNECTICUT (*Delegates-0 Out of 3*)

DELAWARE (*Delegates-2 Out of 2*)

Kevin Musto
Kimberly Robbins

DISTRICT OF COLUMBIA (*Delegates-3 Out of 3*)

Alsean Bryant
Yolanda McKoy-Beach
Carolyn Rachel-Price

DISTRICT OF COLUMBIA (*Alt. Delegates*)

Michael Kim

FLORIDA (*Delegates-6 Out of 6*)

James Alcorn
Daniel Buffington
Eric Larson
William Mincy
Katherine Petsos
Joy Wright

FLORIDA (*Alt. Delegates*)

Scott Tomerlin

FORMER PRESIDENTS (*Delegates-32 Out of 35*)

Nancy Alvarez
Lowell Anderson
Marialice Bennett
J Bootman
Lawrence Brown
Bruce Canaday
R David Cobb
Robert Davis
George Denmark
James Doluisio
Janet Engle
Philip Gerbino
Harold Godwin
Kelly Goode
Charles Green
Ed Hamilton
Nicki Hilliard
Ronald Jordan
Gary Kadlec
Calvin Knowlton
Winnie Landis
Eugene Lutz
James Main
Thomas Menighan
Matthew Osterhaus
Robert Osterhaus
Marily Rhudy
Steven Simenson
Jenelle Sobotka
Bradley Tice
Lisa Tonrey
Timothy Vordenbaumen

FORMER SPEAKERS (*Delegates-12 Out of 15*)

Susan Bartlemay
Bethany Boyd
Leonard Camp
Melissa Duke
Lucinda Maine
Joey Mattingly
Michael Mone
Craig Pedersen
Adele Pietrantoni
William Riffee
Pamela Whitmire
Wilma Wong

GEORGIA (*Delegates-4 Out of 4*)

Joe Ed Holt
Jordan Khail
Ben Ross
Jonathan Sinyard

GUAM (*Delegates-0 Out of 2*)

HAWAII (*Delegates-1 Out of 2*)

Jarred Prudencio

HOPA (*Delegates-2 Out of 2*)

Heidi Finnes
LeAnne Kennedy

IDAHO (*Delegates-2 Out of 2*)

Jennifer Adams
Lucas Snell

IDAHO (*Alt. Delegates*)

Donald Smith

ILLINOIS (*Delegates-5 Out of 5*)

Starlin Haydon-Greatting
Garth Reynolds
Jennifer Rosselli
J. Cody Sandusky
Carrie Wiggins

ILLINOIS (*Alt. Delegates*)

Emily Wetherholt

INDIANA (*Delegates-4 Out of 4*)

Stephanie Arnett
Daniel Degnan
Laura Sosinski
Veronica Vernon

IOWA (*Delegates-3 Out of 3*)

John Hamiel
Morgan Herring
Robert Nichols

KANSAS (*Delegates-3 Out of 3*)

Amanda Applegate
Jessica Bates
Christian Williams

KENTUCKY (*Delegates-3 Out of 3*)

Kimberly Croley
Chris Harlow
Nicole Miracle

KENTUCKY (*Alt. Delegates*)

Catherine Hanna

LOUISIANA (*Delegates-2 Out of 3*)

Nancy Caddigan
Anthony Walker

MAINE (*Delegates-2 Out of 2*)

Wendy Boynton
Wallace Marsh

MARYLAND (*Delegates-5 Out of 5*)

Matthew Balish
William Charles
Kerry Cormier
Marci Strauss
Hoai-An Truong

* The numbers reflect the allotted delegates per delegation, not the actual listed delegates.

MARYLAND (*Alt. Delegates*)

Kinbo Lee
Eriny Victor

MASSACHUSETTS (*Delegates-2 Out of 2*)

Courtney Doyle-Campbell
Trisha LaPointe

MICHIGAN (*Delegates-4 Out of 4*)

Keith Binion
Sarah Hill
Farah Jalloul
Brittany Stewart

MINNESOTA (*Delegates-3 Out of 3*)

Michelle Aytay
Ameer El-Afandi
Rebecca Pickler

MINNESOTA (*Alt. Delegates*)

Katherine Schimnich

MISSISSIPPI (*Delegates-3 Out of 3*)

Tripp Dixon
Olivia Strain
Anna Touchstone

MISSOURI (*Delegates-4 Out of 4*)

Laura Butkievich
Sarah Cox
Catherine Gilmore
Carson Vonalst

MISSOURI (*Alt. Delegates*)

Francisco Franco

MONTANA (*Delegates-2 Out of 2*)

Jenner Minto
Monica Orsborn

NAVY (*Delegates-1 Out of 2*)

Yasdel Ortiz Rivera

NCPA (*Delegates-2 Out of 2*)

Hannah Fish
Rebecca Snead

NEBRASKA (*Delegates-3 Out of 3*)

Ally Dering-Anderson
Drew Prescott
Jennifer Tilleman

NEVADA (*Delegates-3 Out of 3*)

Mark Decerbo
Amy Hale
Christina Quimby

NEVADA (*Alt. Delegates*)

Jeani Smith

NEW HAMPSHIRE (*Delegates-1 Out of 2*)

Amanda Morrill

NEW JERSEY (*Delegates-2 Out of 4*)

Debra Schimpf
Carmela Silvestri

NEW JERSEY (*Alt. Delegates*)

Elise Barry
Lucio Volino

NEW MEXICO (*Delegates-3 Out of 3*)

Jana Behrens
Stephanie Headrick
Mark Poling

NEW YORK (*Delegates-0 Out of 5*)

NORTH CAROLINA (*Delegates-5 Out of 5*)

Evan Colmenares
Ouita Davis Gatton
Macary Marciniak
Beth Mills
Katie Trotta

NORTH CAROLINA (*Alt. Delegates*)

Penny Shelton

NORTH DAKOTA (*Delegates-1 Out of 1*)

Elizabeth Skoy

NPhA (*Delegates-2 Out of 2*)

Cory Holland
Frank North

NPhA (*Alt. Delegates*)

Tamara Foreman

NRPhA (*Delegates-0 Out of 2*)

OHIO (*Delegates-6 Out of 6*)

Juanita Draime
Jessica Hinson
Mitchell Howard
James Kirby
Jennifer Seifert
Jeff Steckman

OKLAHOMA (*Delegates-3 Out of 3*)

Randy Curry
Eric Johnson
Katherine O'Neal

OKLAHOMA (*Alt. Delegates*)

Krista Brooks

OREGON (*Delegates-3 Out of 3*)

Dan Kennedy
Jill McClellan
Amanda Meeker

PENNSYLVANIA (*Delegates-6 Out of 6*)

Howard Cook
John Dejames
Thomas Franko
Brenda Gruver
Danielle Kieck
Darren Mensch

PENNSYLVANIA (*Alt. Delegates*)

Victoria Elliott
Elena Patestos

PHS (*Delegates-2 Out of 2*)

Briana Rider
Juliette Taylor

PHS (*Alt. Delegates*)

Hillary Duvivier
Patrick Harper

PPA (*Delegates-2 Out of 2*)

Mary Cober
Bob Hanson

PUERTO RICO (*Delegates-1 Out of 3*)

Elda Sierra

RHODE ISLAND (*Delegates-2 Out of 2*)

Christopher Federico
Matthew Lacroix

RHODE ISLAND (*Alt. Delegates*)

Jeffrey Del Ricci

SOUTH CAROLINA (*Delegates-3 Out of 3*)

Brian Clark
Anthony Declue
William Wynn

SOUTH CAROLINA (*Alt. Delegates*)

Cheryl Anderson
Emily Russell

SOUTH DAKOTA (*Delegates-1 Out of 1*)

Jessica Strobl

SPEAKER APPOINTED (*Delegates-14 Out of 20*)

Samm Anderegg
Timothy Aungst
Nicholas Capote
Dalton Fabian
Steve Firman
Heather Free
Sridhar Rao Gona
Nimit Jindal
Brooke Kulusich
William Lee
Sara McElroy
Charles Mollien
John Pieper
Natalie Young

TENNESSEE (*Delegates-5 Out of 5*)

Mary Jo Collins
Jeff Lewis
Robert Monahan
Jerry Phipps
Brian Winbigler

TENNESSEE (*Alt. Delegates*)

Olivia Welter

TEXAS (*Delegates-6 Out of 6*)

Kevin Aloysius
Jay Bueche
Carter High
Mary Klein
Carol Reagan
May Woo

TEXAS (*Alt. Delegates*)

Sarah Nguyen

USP (*Delegates-1 Out of 2*)

Nakia Eldridge

UTAH (*Delegates-0 Out of 2*)

VERMONT (*Delegates-2 Out of 2*)

Brittany Allen
Alicia Bautista

VETERANS ADMIN (*Delegates-2 Out of 2*)

Heather Ourth
John Santell

VETERANS ADMIN (*Alt. Delegates*)

Anthony Morreale
Ronald Nosek

* The numbers reflect the allotted delegates per delegation, not the actual listed delegates.

VIRGINIA (*Delegates-5 Out of 5*)

Sharon Gatewood
Roger Pritchard
Allie Shipman
Dominic Solimando
Adrian Wilson

WASHINGTON (*Delegates-2 Out of 3*)

Jennifer Bacci
Christina Schwartz

WEST VIRGINIA (*Delegates-3 Out of 3*)

Krista Capehart
Betsy Elswick
Michael Lemasters

WISCONSIN (*Delegates-2 Out of 3*)

Nicholas Olson
Zachary Pape

WYOMING (*Delegates-0 Out of 1*)

* The numbers reflect the allotted delegates per delegation, not the actual listed delegates.

American Pharmacists Association House of Delegates
FIRST SESSION
Friday, March 22, 2024 / 2:30PM – 5:00PM
SEATING CHART

Speaker of the House

1 AL-3 AZ-4 (S)	17 MI-4 MA-2 SD-1	33 OK-3 OH-6
2 CA-8	18 LA-3 MD-5 (S)	34 OR-3 PA-6
3 AK-2 CO-3 CT-3 ND-1	19 ME-2 MO-4 MS-3	35 (S) RI-2 SC-3 UT-2
4 DC-3 FL-6	20 (S) NC-5 NE-3	36 PR-2 TN-5
5 AR-2 DE-2 GA-4 (S)	21 MT-2 NH-2 NJ-4	37 (S) TX-6
6 IA-3 IL-5	22 NM-3 NY-5	38 VA-5 WA-3
7 IN-4 ID-2 HI-2 (S)	23 MN-3 NV-4 (S)	39 VT-2 WV-3 WI-3 WY-1
8 GU-2 KS-3 KY-3	24 PPA, USP, Speaker Appointed-5	40 (S) Speaker Appointed-8
9 HOPA, NCPA, NPhA, NRPhA	25 ACCP, ACVP, AIHP,AMCP	41 Speaker Appointed- 7, Army
10 AACP, AAPP, AAPS, ACA	26 APC, ASCP, ASHP, ASPL	42 Air Force, Navy, PHS, Veterans
11 APhA-APPM-7 (S)	27 APhA-ASP-7 (S)	43 APhA-APRS 7
12 APhA-APPM-7	28 APhA-ASP-7	44 (S) APhA-APRS-7
13 APhA-APPM-7	29 (S) APhA-ASP-7	45 APhA-APRS-7
14 APhA-APPM-7 (S)	30 APhA-ASP-7	46 APhA-APRS-7
15 Former Presidents-9	31 Former Speakers-8	47 (S) Board of Trustees-8
16 Former Presidents-9	32 Former Speakers-9	48 Board of Trustees-8

KEY

+ = Seat reserved for State Pharmacy Association Executive (Non-voting)

*** = Seat reserved for State Pharmacy Association Executive (Voting)** **(S) = APhA Staff Member**

American Pharmacists Association House of Delegates
FIRST SESSION
Friday, March 22, 2024
2:30PM – 5:00PM

SEATING CHART BY DELEGATION NAME

Alabama – Table 1
Alaska – Table 3
Arizona – Table 1
Arkansas – Table 5
California – Table 2
Colorado – Table 3
Connecticut – Table 3
Delaware – Table 5
District of Columbia – Table 4
Florida – Table 4
Georgia – Table 5
Guam – Table 8
Hawaii – Table 7
Idaho – Table 7
Illinois – Table 6
Indiana – Table 7
Iowa – Table 6
Kansas – Table 8
Kentucky – Table 8
Louisiana – Table 18
Maine – Table 19
Maryland – Table 18
Massachusetts – Table 17
Michigan – Table 17
Minnesota – Table 23
Mississippi – Table 19
Missouri – Table 19
Montana – Table 21
Nebraska – Table 20
Nevada – Table 23
New Hampshire – Table 21
New Jersey – Table 21
New Mexico – Table 22
New York – Table 22
North Carolina – Table 20
North Dakota – Table 3
Ohio – Table 33
Oklahoma – Table 33
Oregon – Table 34
Pennsylvania – Table 34
Puerto Rico – Table 36
Rhode Island – Table 35
South Carolina – Table 35
South Dakota – Table 17
Tennessee – Table 36
Texas – Table 37
Utah – Table 35
Vermont – Table 39
Virginia – Table 38
Washington – Table 38
West Virginia - 39
Wisconsin – Table 39
Wyoming – Table 39
AAPS – Table 10
AACP – Table 10
AAPP – Table 10
ACA – Table 10
ACCP – Table 25
ACVP – Table 25
APC – Table 26
AIHP – Table 25
AMCP – Table 25
ASHP – Table 26
ASCP – Table 26
ASPL – Table 26
HOPA – Table 9
NCPA – Table 9
National Pharmaceutical Assn. – Table 9
National Pharmacists Assn. – Table 9
PPA – 24
Air Force – Table 42
Army – Table 41
Navy – Table 42
PHS – Table 42
USP – Table 24
Veterans Administration – Table 42
APhA-APPM – Tables 11, 12, 13 & 14
APhA-APRS – Tables 43, 44, 45, & 46
APhA-ASP – Tables 27, 28, 29, & 30
APhA Board of Trustee – Tables 47 & 48
APhA Former Presidents – Tables 15, & 16
APhA Former Speakers – Tables 31 & 32
Speaker Appointed – Tables 24, 40 & 41

American Pharmacists Association House of Delegates
FINAL SESSION
Monday, March 25, 2024 / 1:30PM – 4:30PM
SEATING CHART

Speaker of the House

1 GU-2 KS-3 KY-3	17 MN-3 NV-4 (S)	33 VT-2 WV-3 WI-3 WY-1
2 IN-4 ID-2 HI-2	18 NM-3 NY-5	34 VA-5 WA-3
3 IA-3 IL-5 (S)	19 MT-2 NH-2 NJ-4	35 (S) TX-6
4 AR-2 DE-2 GA-4	20 (S) NC-5 NE-3	36 PR-2 TN-5
5 DC-3 FL-6	21 ME-2 MO-4 MS-3	37 (S) RI-2 SC-3 UT-2
6 AK-2 CO-3 CT-3 ND-1 (S)	22 LA-3 MD-5	38 OR-3 PA-6
7 CA-8	23 MI-4 MA-2 SD-1	39 OK-3 OH-6
8 AL-3 AZ-4 (S)	24 PPA, USP, Speaker Appointed-5	40 (S) Speaker Appointed-8
9 HOPA, NCPA, NPhA, NRPhA	25ACCP, ACVP, AIHP, AMCP (S)	41 Speaker Appointed- 7, Army
10 AACP, AAPP, AAPS, ACA	26 APC, ASCP, ASHP, ASPL	42 Air Force, Navy, PHS, Veterans
11 APhA-APPM-7 (S)	27 APhA-ASP-7 (S)	43 APhA-APRS 7
12 APhA-APPM-7	28 APhA-ASP-7	44 (S) APhA-APRS-7
13 APhA-APPM-7	29 APhA-ASP-7	45 APhA-APRS-7
14 APhA-APPM-7	30 (S) APhA-ASP-7	46 APhA-APRS-7
15 Former Presidents-8 (S)	31 Former Speakers-9	47 (S) Board of Trustees-8
16 Former Presidents-9	32 Former Speakers-9	48 Board of Trustees-8

KEY

+ = Seat reserved for State Pharmacy Association Executive (Non-voting)

*** = Seat reserved for State Pharmacy Association Executive (Voting)** **(S) = APhA Staff Member**

American Pharmacists Association House of Delegates
FINAL SESSION
Monday, March 25, 2024
1:30PM – 4:30PM

SEATING CHART BY DELEGATION NAME

Alabama – Table 8
Alaska – Table 6
Arizona – Table 8
Arkansas – Table 4
California – Tables 7
Colorado – Table 6
Connecticut – Table 6
Delaware – Table 4
District of Columbia – Table 5
Florida – Table 5
Georgia – Table 4
Guam – Table 1
Hawaii – Table 2
Idaho – Table 2
Illinois – Table 3
Indiana – Table 2
Iowa – Table 3
Kansas – Table 1
Kentucky – Table 1
Louisiana – Table 22
Maine – Table 21
Maryland – Table 22
Massachusetts – Table 23
Michigan – Table 23
Minnesota – Table 17
Mississippi – Table 21
Missouri – Table 21
Montana – Table 19
Nebraska – Table 20
Nevada – Table 17
New Hampshire – Table 19
New Jersey – Table 19
New Mexico – Table 18
New York – Table 18
North Carolina – Table 20
North Dakota – Table 6
Ohio – Table 39
Oklahoma – Table 39
Oregon – Table 38
Pennsylvania – Table 38
Puerto Rico – Table 36
Rhode Island – Table 37
South Carolina – Table 37
South Dakota – Table 23
Tennessee – Table 36
Texas – Table 35
Utah – Table 37
Vermont – Table 33
Virginia – Table 34
Washington – Table 34
West Virginia - 33
Wisconsin – Table 33
Wyoming – Table 33
AAPS – Table 10
AACP – Table 10
AAPP – Table 10
ACA – Table 10
ACCP – Table 25
ACVP – Table 25
APC – Table 26
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National Pharmacists Assn. – Table 9
PPA – Table 24
Air Force – Table 42
Army – Table 41
Navy – Table 42
PHS – Table 42
USP – Table 24
Veterans Administration – Table 42
APhA-APPM – Tables 11, 12, 13 & 14
APhA-APRS – Tables 43, 44, 45, & 46
APhA-ASP – Tables 27, 28, 29, & 30
APhA Board of Trustee – Tables 47 & 48
APhA Former Presidents – Tables 15, & 16
APhA Former Speakers – Tables 31, & 32
Speaker Appointed – Tables 24, 40 & 41

House of Delegates

General Information for Delegates

DUTIES OF THE HOUSE OF DELEGATES	The APhA House of Delegates performs a major role in developing policy for the Association. With Delegates representing all segments of the profession, the House serves as a forum for discussion of key issues and articulation of positions reflecting input from a broad cross-section of pharmacy. The APhA House of Delegates is charged by the APhA Bylaws to serve as a legislative body in the development of Association policy. Policies adopted by the House guide the Association and its Board of Trustees in matters relating to educational, professional, scientific, and public health policy. These policies help to establish the role of the profession and its relationship with other elements of the contemporary health care system and set the objectives and future agenda of APhA in the continuous evolution of health care.
COMPOSITION OF THE HOUSE OF DELEGATES	The approximately 400-member APhA House of Delegates is composed of delegates representing state pharmacy associations, recognized national and federal organizations, APhA's Academies and Board of Trustees, former APhA Presidents, and former Speakers of the APhA House. Each state-affiliated organization appoints two Delegates, plus one additional Delegate for each 200 APhA Members residing in the state. Recognized national organizations and recognized Federal organizations appoint two Delegates each. Each of the Association's three Academies appoints 28 Delegates. Every member of the current APhA Board is a Delegate. Every Delegate must be an APhA member. Delegates are appointed to serve a term of one year, June 1-May 31of the following year. As a result, the appointment date for submitting delegates is June 1. In 2013, APhA amended its Bylaws (Article IV, Section 2) to increase member engagement in the Association's policy development process of the House of Delegates; delegations that have one or more seats unfilled during both House sessions for 3 consecutive years, shall have those seats removed from their delegate allocation. While the initial delegate allocations outlined in the APhA Bylaws will always stand, the actual number of delegate seats for each delegation may vary from year-to-year based on this change to the Bylaws (Article VI, Section 2, G).
CERTIFICATION OF DELEGATES	Organizations will be able to certify Alternate Delegates as Delegates upon notification to the Secretary of the APhA House of Delegates as late as 1:00PM on, Monday the day of the last House session. No Alternate Delegates will be seated after the Final Session of the House commences. The Secretary will announce the number of Delegates in attendance and whether a quorum has been reached based on the electronic system or roll call cards. Delegates who arrive after the quorum announcement should check in with APhA staff at the registration table.
OFFICERS OF THE HOUSE OF DELEGATES	The APhA Bylaws provide that the officers of the APhA House of Delegates shall be the Speaker, the Speaker-elect, and the Secretary. The Speaker and Speaker-elect are elected by the House. The Bylaws provide that the Executive Vice President of APhA shall serve as Secretary. The position of Speaker spans three years: the first year as Speaker-elect (a non-Trustee position) and the subsequent two years as Speaker and Trustee. Elections for Speaker-elect are held on even-numbered years. The Speaker, Speaker-elect, and the Secretary of the House are members of the APhA House of Delegates and, as such, may claim the floor and are entitled to vote.

DELEGATE ORIENTATION	Delegates and Alternate Delegates who are new to the policy process or want a refresher course on the rules and procedures of the APhA House of Delegates may review a posted webinar on the House website.
APhA HOUSE RULES REVIEW COMMITTEE	The House Rules Review Committee is charged to review and establish rules and procedures for the conduct of business at each House session. The Committee meets via conference call at least twice a year: • Within 30 days after the conclusion of the Final Session of the House, to review and approve language of adopted House policy and to discuss observations of House operations for potential improvement. • To review and approve the House of Delegates Schedule, make recommendations regarding the proceedings of the House, and to issue a Final Report to the APhA House of Delegates. The Committee is comprised of 6 APhA members from diverse pharmacy practice backgrounds and is appointed prior to the beginning of the First Session of the House. The Committee's term concludes prior to the First Session of the House the following year.
APhA POLICY COMMITTEE	The Policy Committee is charged with analyzing specific topics assigned by the Board of Trustees and proposing policy on those topics for consideration by the House of Delegates. • Committee members meet in-person, to develop policy statements. • Committee members prepare a report of policy recommendations for presentation to the APhA House of Delegates. • The Committee is comprised of 7-10 APhA members from diverse pharmacy practice backgrounds.
APhA POLICY REFERENCE COMMITTEE	The APhA Policy Reference Committee is charged with providing greater participation in the policy development process and ensuring objective consideration of APhA member comments. • Committee members receive delegate comments from open hearing webinars, virtual discussion forums, the first session of the House of Delegates, and during the in-person Open Hearing at the APhA Annual Meeting. • The Committee may issue their report in advance of the Annual Meeting having taken into consideration feedback provided from webinar open hearings and virtual discussion comments. This report may be handled via an electronic poll and considered during the first session of the House of Delegates. • Following further discussion from the in-person Open Hearing during APhA Annual Meeting, committee members will draft a final report for consideration during the final session of the House. • The Committee is comprised of the Chair of the Policy Committee, two or three other members of the Policy Committee, and three or four new members.

APhA POLICY REVIEW COMMITTEE	The APhA Policy Review Committee is charged to ensure that adopted policy is relevant and reflects the opinion of the contemporary pharmacy community.
	• The Committee meets via conference call to determine whether adopted policy statements should be amended, retained, archived, or rescinded. The Committee can propose New Business Items for those statements needing an amendment.
	  ○ The Committee reviews adopted policy statements according to the schedule outlined in the House of Delegates Rules of Procedure.
	  ○ The Committee reviews adopted policy related to the policy topics assigned to APhA's Policy Committee.
	• The Policy Review Committee is comprised of 7-10 APhA members from diverse pharmacy practice backgrounds.

APhA NEW BUSINESS REVIEW COMMITTEE	The New Business Review Committee is charged to review proposed policy submitted by Delegates and recommend action on those items. • Committee members participate in the New Business Review Committee Open Hearing at the Annual Meeting and meet in an executive session to finalize their report to the House. • The Committee is comprised of 7 APhA members from diverse pharmacy practice backgrounds.
HOUSE OF DELEGATES COMMITTEE ON NOMINATIONS	The House of Delegates Committee on Nominations is charged to nominate candidates for the office of Speaker-elect of the House of Delegates each even-numbered year. • The Committee is appointed by the immediate former (non-incumbent) Speaker of the House and is comprised of 5 members. • The Committee only slates 2 candidates, but additional nominations may be made from the floor of the House. Candidates for Speaker-elect must be current Delegates to the APhA House. • The Committee presents its report, including the slate of candidates, during the First Session of the House. Each candidate is given 2 minutes to introduce him/herself to the Delegates. • At the Final Session of the APhA House, each candidate is given 3 minutes to address the APhA House. The election for the office of Speaker-elect is conducted electronically at the Final Session of the APhA House of Delegates.
COMMITTEE OF CANVASSERS	The Committee of Canvassers is charged to observe the administration of the electronic voting process for the election of Speaker-elect during the Final Session of the APhA House. APhA members are appointed each even-numbered year to perform the responsibilities of this position.
SUBMISSION OF NEW BUSINESS ITEMS	Items of New Business must be submitted to the Speaker of the House no later than 60 days before the start of the First Session of the House of Delegates. An urgent item can be considered, without a suspension of the House rules, if presented to the Speaker, with necessary background information, at least 24 hours prior to the beginning of the first session of the House. Urgent items are defined as matters, which due to the nature of their content must be considered by the House outside of normal policy procedures. The submission of urgent new business items will be determined at the discretion of House leadership.
DISTRIBUTION OF MATERIALS IN THE HOUSE OF DELEGATES	Materials may only be distributed in the APhA House of Delegates with the approval of the Secretary of the APhA House of Delegates. Individuals seeking to distribute material in the APhA House must submit a sample to the APhA House of Delegates Office prior to the start of the House Session. Materials to be distributed must relate to subjects and activities that are proposed for House action or information.
HOUSE OF DELEGATES RULES OF ORDER	The rules contained in *Robert's Rules of Order Newly Revised* govern the deliberations of the APhA House of Delegates in all cases in which they are applicable and not in conflict with special APhA House Rules or Bylaws. The Speaker of the APhA House appoints a Parliamentarian whose principal duty is to advise the Speaker. It is proper for the Parliamentarian to state his opinion to the APhA House of Delegates only when requested to do so by the Speaker. A parliamentary procedure reference guide is provided with the Delegate materials.
ACCESS TO THE FLOOR OF THE HOUSE OF DELEGATES	Each Delegate has the right to speak and vote on every issue before the APhA House of Delegates. The Speaker shall announce at the opening session of each House meeting the procedure he/she will follow in recognizing requests from the floor. During the APhA House sessions, the procedure for seeking recognition by the Speaker will be for the Delegate to approach a floor microphone and, when recognized by the Speaker, to state his/her name and delegation affiliation. Only Delegates or individuals recognized by the Speaker shall have access to the microphone.
AVAILABILITY OF REPORTS	The final report of the APhA Policy Reference Committee will be sent electronically to members and hard copies can be obtained at the House of Delegates Office beginning at 8:00AM on Monday. The final report of the APhA New Business Review Committee will also be sent electronically to members and hard copies

	can be obtained at the House of Delegates Office beginning 8:00AM on Sunday.
VOTING PROCEDURES	Voting will occur via voice vote or by electronic tabulation. For action on Association policy and items of New Business, votes will be cast using voice votes. If the Speaker is unable to determine the outcome of the voice vote, or a Delegate calls for a vote count, the electronic voting system will be used. Actual vote numbers will be utilized versus percentages to determine vote outcomes. Voting for the election of Speaker-elect will occur using the electronic voting system.

American Pharmacists Association
House of Delegates
Rules of Procedure

Approved March 24, 2023

The following information reflects the final language adopted by the APhA House of Delegates during its House sessions on from March 24-27, 2023

Rule 1 Delegate Appointment

All delegates, except APhA Membership Organization delegates, shall be appointed no later than June 1 of each year and will continue to function in that role until May 31 of the following year. APhA Membership Organizations have the flexibility to appoint their delegates based upon their existing processes with a delegate appointment deadline of no later than August 1, or these seats will also be subject to Speaker appointment as described in Rule 3 of the APhA House Rules of Procedure. APhA's student Academy delegates must be appointed no later than November 30.

Rule 2 Unfilled Delegate Seats

Unfilled delegate seats of any delegation, as defined by APhA Bylaws Article VI, Section 2, Subsection G, shall become inactive if unfilled during in-person Annual Meeting and virtual House sessions for three consecutive House cycles (March–March). This historical information shall be reported annually to the House Rules Review Committee and the APhA Board of Trustees, in addition to being made available to the representative of any delegation being impacted. The Speaker may issue exceptions to this rule in response to extenuating circumstances, in consultation with the House Rules Review Committee. Delegation Coordinators shall be notified 60 days prior to the inactivation of delegate seats and may petition the Secretary of the House for reappointment of any inactive seats.

Rule 3 Speaker Appointment of Unfilled Delegate Seats

Per APhA Bylaws Article VI, Section 2, subsection A.i, the Speaker may appoint delegates to unfilled delegate seats of Affiliated State Organizations (ASO). The Speaker will give preference to appointing delegates who served the delegation in previous House sessions. The Speaker must select an individual who resides or works within the state represented by the ASO and for which they will represent in the House. This process also applies to delegations who have an inactive delegate seat per APhA Bylaws Article VI, Section 2, Subsection G. The Speaker will make a reasonable attempt to notify the ASO executive staff of the Speaker appointment. In the event the ASO has a preferred individual to serve in the House after the Speaker has made the appointment, then the ASO's choice will take precedence if it is received not less than 30 days

prior to any House session. All individuals appointed under this rule will be seated with their ASO's delegation, irrespective of whether the ASO or the Speaker appointed them into the seat.

Rule 4 Delegates and Voting

At each session of the House of Delegates, the Secretary shall report the number of authorized delegates who shall then compose the House of Delegates. Each delegate shall be entitled to one (1) vote. No delegate shall act as proxy of another delegate nor as delegate for more than one (1) association or organization. During in-person House sessions, a member registered as an alternate may, upon proper clearance by the Secretary of the House, be transferred from alternate to delegate at any time during the continuance of business. During virtual House sessions, a member registered as an alternate may, upon proper clearance by the Secretary of the House, be transferred from alternate to delegate if the request is provided at least 24 hours prior to the scheduled virtual session meeting time. Only authorized delegates shall have access to voting technology during House sessions.

Rule 5 Delegate Identification

Each delegate is required to wear a delegate ribbon attached to the convention name badge while seated in an in-person session of the House of Delegates. Only authorized delegates will receive access to the virtual platform to vote during virtual House sessions and must display their first and last name within the virtual platform. Any APhA member will be allowed access to observe any House session whether in person or virtual.

Rule 6 Consideration of Committee Reports

The order for consideration of Committee Reports and recommendations in any House of Delegates session agenda shall be determined by the Speaker in consultation with the Secretary of the House. The House shall receive any Committee Reports prior to Committee open forums or webinars and any session where debate on a Committee Report would occur. The Policy Reference Committee, Policy Review Committee, and New Business Review Committee shall consider delegate input received through open forums, webinars, and other communication means and will develop recommendations for consideration by the House on each whole-numbered statement or recommendation. During House sessions, the Committee chair will recommend adoption of policy statements and recommendations and preside over the debate. Action on the report will be governed by Robert's Rules of Order (current edition).

Rule 7 Privilege of the Floor

Only delegates may introduce business on the floor of the House of Delegates. Any individual that is duly recognized by the Speaker and/or the House may have the privilege of the floor in

order to address the delegates during a session of the House of Delegates. Any individual may present testimony during an open hearing.

Rule 8 Nomination and Election of Speaker-elect

The House of Delegates Committee on Nominations shall consist of five delegates, including the Chair, and shall be appointed by the Immediate Past (nonincumbent) Speaker of the House of Delegates, and that Committee shall meet preceding the House session at which election-related activities shall occur to select candidates for the office of Speaker-elect of the House of Delegates.

Elections for Speaker-elect will occur every even-numbered year. Only two candidates for the office of Speaker-elect of the House of Delegates shall be nominated by the Committee on Nominations, and this report shall be presented prior to the House session at which election-related activities shall occur. No member of the Committee on Nominations shall be nominated by that Committee. All candidates examined by the Committee shall be notified of the results as soon as possible after the nominees have been selected by the Committee on Nominations. Nominations may then be made from the floor by any delegate immediately following the presentation of the Report of the Committee on Nominations. Candidates must have been interviewed by the House of Delegates Committee on Nominations to be eligible to be nominated from the floor after the announcements of the slate.

All candidates must be an APhA member as defined in Article III, Section 2, of the APhA Bylaws, and a seated delegate in the House of Delegates. During in-person House sessions, candidates will be introduced and permitted to speak to the House for no more than two (2) minutes following announcements of the slate of candidates. Candidates will then be permitted to address the House for a maximum of three (3) minutes at the House session at which election-related activities shall occur. Candidates shall be listed in alphabetical order on the ballot, regardless of whether they were slated by the Committee on Nominations or nominated from the floor of the House. A majority vote of delegates present and voting is required for election. If no majority is obtained on the first ballot, a second ballot shall be cast for the two candidates who received the largest vote on the first ballot. If electronic voting mechanisms are available, then the election shall be conducted utilizing the technology, with the results not publicly displayed. During extenuating circumstances where a vote for Speaker-elect cannot occur during an in-person House session, the Speaker and Secretary of the House, in consultation with the House Rules Review Committee, may recommend alternative methods to collect vote tallies.

If a vacancy occurs in the office of Speaker, the vacancy process detailed in Article VI, Section 5,

of the APhA Bylaws shall be followed.

Rule 9 Amendments to Resolutions

All amendments to Committee recommendations or New Business Item Statements shall be submitted in writing, handwritten or provided electronically, to the Secretary through a designated process confirmed by the Speaker for each House session. There are no secondary amendments or "friendly" amendments. The Speaker will rule any delegates out of order who express a desire to make a secondary amendment or "friendly" amendment.

Rule 10 Rules of Order

The procedures of the House of Delegates shall be governed by the latest edition of Robert's Rules of Order, provided they are consistent with the APhA Bylaws and the House of Delegates Rules of Procedure.

Rule 11 Amendments to House of Delegates Rules of Procedure

Every proposed amendment of these rules shall be submitted in writing and will require a two-thirds vote for passage. A motion to suspend the rules shall require an affirmative vote of two-thirds of the total number of delegates present and voting.

Rule 12 Grammar/Punctuation Corrections

The House shall allow the APhA Speaker and staff to the APhA House to make grammar and punctuation corrections to adopted House policy immediately after the conclusion of any House session. To ensure that these corrections do not inadvertently change the meaning of the adopted policy statement, the current sitting APhA House Rules Review Committee will review and approve the corrected statements

Rule 13 New Business

The New Business Review Committee shall consist of 7–10 delegates, including the Chair, and are appointed by the Speaker. The Committee members should be present for open forum sessions held in person or virtually. After reviewing feedback provided from APhA members, the Committee will meet in executive session to develop recommendations on assigned New Business Items. New Business Items are due to the Speaker of the House no later than 60 days before the start of any House session where regular action on New Business Items (not urgent items) are scheduled to take place. An urgent item can be considered, without a suspension of the House rules, if presented to the Speaker, with necessary background information, at least 24 hours prior to the beginning of any House session. Urgent items are defined as matters that, due to the nature of their content, must be considered by the House outside of the normal policy processes. The House leadership (Speaker, Speaker-elect [when present], and Secretary) will

evaluate submitted urgent items based on the timely and impactful nature of the presented item and determine if the urgent item is to be approved as New Business. The House shall then be informed of any approved urgent items to be considered by the House as soon as is possible by the Speaker. Approved urgent items shall be considered with other New Business Items and discussed during the New Business Open Hearing, if one is scheduled to take place. No immediate action shall be taken on urgent new business items without prior review of proposed statements and background information by all delegates. Appropriate action will be recommended by the New Business Review Committee in the same manner as other New Business Items. Urgent items denied consideration by House Officers may still be addressed by the House, with a suspension of House rules at the House session where New Business will be acted upon.

Delegates wishing to amend existing APhA policy on topics not covered within the Policy Committee or Policy Review Committee agenda may submit proposed policy statements through the New Business Review Process. Restatements of existing policy are discouraged and should be included only as background information.

The New Business Review Committee's report to the House of Delegates shall include one of the following recommended actions for each New Business Item considered:
(a) Adoption of the New Business Item
(b) Rejection of the New Business Item
(c) Referral of the New Business Item
(d) Adoption of the New Business Item as amended by the committee
(e) No action

The New Business Review Committee's recommendations will be addressed by the House of Delegates in the following order:
1. New Items submitted by the Policy Review Committee
2. General New Business Items
3. Urgent New Business Items

If the New Business Review Committee recommends no action on a New Business Item, the Speaker of the House shall place the New Business Item before the House of Delegates for consideration and action. Each whole-numbered statement within the New Business Item should be considered separately. A consent agenda process may be used to consider multiple recommendations within a single New Business Item, in accordance with Robert's Rules of Order. New Business Items can be considered at a virtual session of the House of Delegates at the discretion of the Speaker, in accordance with these rules of procedure. Debate on new

business items in a virtual session will be time limited. At the Speaker's discretion, proposed New Business items may be referred to the next session of the House for further deliberation

Rule 14 Policy Review Committee

The Policy Review Committee shall consist of 7–10 delegates, including the Chair, and are appointed by the Speaker. The Committee members should be present for open forum sessions held in person or virtually. The Policy Review Committee shall meet annually and review any policy that has (1) not been reviewed or revised in the past 10 years; (2) policy related to statements adopted in the most recent House session; and (3) if applicable, contemporary issues identified by the Speaker.

The House shall receive and consider the recommendations of the House Policy Review Committee to archive, rescind, retain, or amend existing policy. A singular motion to archive, rescind, or retain all such existing policy, with limited debate, shall be in order. Items identified by the Policy Review Committee as needing any amendments will be introduced as separate motions for consideration.

If the Policy Review Committee Report is considered in a virtual House of Delegates session, the debate will be time limited. At the Speaker's discretion, recommendations of the Policy Review Committee may be referred to the next House session for further deliberation.

Rule 15 Policy Reference Committee

The House of Delegates Policy Reference Committee shall consist of the chair of the Policy Committee, two or three members of the Policy Committee, and three or four new members appointed by the Speaker of the House. Members of the Committee must be delegates and should be present for open forum sessions held in person or virtually. The Policy Reference Committee shall consider delegate comments received through open forums, webinars, and other communication means and meet in executive session to issue their report and recommendations prior to the House session where those recommendations would be considered by the House.

Rule 16 Virtual House of Delegates

As defined by APhA Bylaws Article VI, Section 7, the House of Delegates, at the discretion of the Speaker, may conduct electronic meetings prior to the regular meeting of the House, in accordance with these House Rules of Procedure. The Secretary of the House must notify delegates at least 30 days prior to any virtual session.

Rule 17 Unfinished and Referred Business Items

Debate in any session of the House may be time limited, as designated by the Speaker. If the Speaker, the Committee chair, or any Delegates feel additional debate on the policy statement is warranted, the item may be carried over to an open hearing or a future session of the House. The remaining items requiring action will be brought back for final consideration at the next House session as "Unfinished Business."

Upon confirmation of an "Unfinished Business Item", the Speaker must clearly identify within the "Actions of the House Report" how Unfinished Business Items will receive further action. Unless defined within a motion from a Delegate, the Speaker, in consultation with the Secretary of the House, has the authority to assign "Unfinished Business Items" to an appropriate House Committee, the Board of Trustees, or a future session of House business for further action. An update on "Unfinished Business Items" or any "Referred Business Items" from any prior House session should be provided by the Speaker at future House sessions until action has been taken by the House or no further action is recommended on the item.

Parlimentary Procedures At A Glance

To Do This:	*You Say This:*	*Must you interrupt speaker?*	*Must you be seconded?*	*Debatable?*	*Amendable?*	*Vote Required*
Introduce business (primary motion)	"I move that…"	No	Yes	Yes	Yes	Majority
Amend a motion	"I move that this motion be amended by…"	No	Yes	Yes	Yes	Majority
End debate	"I move the previous question."	No	Yes	No	No	Two-thirds
Request information	"Point of information."	Yes	No (urgent)	No	No	No vote
Verify a voice vote	"I call for division of the House."	No	No	No	No	No vote
Complain about noise, room temperature, smoking	"Question of privilege."	Yes	No	No	No	Chair decides
Object to procedure or to a personal affront	"Point of order."	Yes	No	No	No	Chair decides
Lay aside an issue temporarily because of emergency	"I move to lay on the table …"	No	Yes	No	No	Majority
Take up a matter previously tabled	"I move to take from the table…	No	Yes	No	No	Majority
Consider something out of scheduled order	"I move to suspend the rules to consider…"	No	Yes	No	No	Two-thirds
Vote on a ruling by the Chair	"I appeal the decision."	Yes	Yes	Yes	No	Majority
Postpone consideration of something	"I move we postpone this matter until…"	No	Yes	Yes	Yes	Majority
Reconsider something already disposed of	"I move to reconsider the vote on issue X…"	Yes	Yes	Yes	No	Majority
Have something studied further	"I move to refer this to…"	No	Yes	Yes	Yes	Majority

APhA
American Pharmacists Association

2023-24 House of Delegates

Report of the House Rules Review Committee

Committee Members

Michael A. Mone, Chair
Sara McElroy, Vice Chair
Nancy A. Alvarez
Lawrence "LB" Brown
Charlie Mollien
Garth Reynolds
Veronica Vernon

Ex Officio Member
Brandi Hamilton, Speaker of the House

2023-2024

APhA House Rules Review Committee Report

The 2023-2024 APhA House Rules Review Committee (HRRC) consists of the following APhA members and long-time Delegates:

Michael A. Mone, Chair
Powell, OH

Sara McElroy, Vice Chair
Seattle, WA

Nancy A. Alvarez
Phoenix, AZ

Lawrence "LB" Brown
Irvine, CA

Charlie Mollien
Hudsonville, MI

Garth Reynolds
Springfield, IL

Veronica Vernon
Pittsboro, IN

Overall Charge and Duties

The HRRC is appointed each year to review and establish rules and procedures for the conduct of business at each House of Delegates (House) session (Adopted 1995). The APhA Speaker may assign year-specific charges to the HRRC as warranted. Acceptance of this report will record these recommendations in the actions of the House Session and be retained for future reference by the Speaker, APhA staff, and members.

The HRRC met via web conference call on May 23, May 24, June 12, June 29, and July 18, 2023 and made the following recommendations.

Guidance to the APhA House of Delegates

After thorough consideration, and in conjunction with the feedback received from Delegates, members, leaders, and staff (via surveys, live discussions and other mechanisms regarding the activities of the House over the past year), the HRRC

unanimously recommends the following guidance be accepted by the APhA House of Delegates.

- Process and criteria for future parliamentarian selection
    - The recent departure of APhA's longtime parliamentarian introduces an opportunity for the Committee to evaluate existing procedures and specifications of appointing parliamentarians in the future.
    - The Committee reviewed existing processes as specified in the APhA Bylaws and reflected on variables that might be relevant to consider in selection of future parliamentarians.
    - Upon reflection of existing APhA Bylaws, the Committee recommended handling of this process as a Board Policy.
- Best practice for taking actions on Committee recommendations to proposed policy statements
    - The Committee reflected on the actions of the previous House of Delegates and observed opportunities to standardize and streamline the handling of proposed amendments to committee reports.
    - Related to this guidance, the proposed changes to Rules 10, 11, 15 and 17 are intended to alleviate confusion that was noted during the 2023 House of Delegates, and perceptions of secondary amendments.
    - The Committee recommends language in Rule 15 – New Business and Rule 17 – Policy Reference Committee to specify that all recommendations presented in these committees' reports should be to either adopt or reject an individual policy statement.
    - Recommendations made by the Policy Reference and New Business Review Committees may be adopted, rejected, amended or referred by the House of Delegates once introduced.
    - The Committee also noted the opportunity, during development of committee reports, for the Policy Reference and New Business Review committees to work with original authors and potentially integrate recommended edits where appropriate. This opportunity occurs prior to the introduction of reports to the House or to the development of a consent agenda. In doing so, this revised language replaces the original language submitted for consideration by the Policy Reference and New Business Review Committee.
    - Should there be a desire to revert to the originally submitted language, a motion to amend must be made, to amend the statement on the floor accordingly.
- Unfilled delegate seats
    - The Committee reviewed the current history of unfilled delegate seats per a standard annual review process following March 2023 House sessions. The Committee noted the continued impact of the COVID-19 pandemic on delegations and delegates. Like what was approved in 2020, there was

agreement not to inactivate any delegate seats due to the pandemic and external strains put on delegates that may have prevented them from attending House- related sessions.
    - Any existing inactivated delegate seats prior to March 2020 will remain in effect, and delegation coordinators are able to follow the existing processes to reactivate those seats upon request. Additionally, the Committee reviewed and confirmed that no updates are needed to the process for requesting reactivation of an inactivated delegate seat.
    - The Committee contemplated the practice of auditing unfilled seats annually, noting a general desire to fill as many seats as possible in the House rather than remove seats.
    - Existing language in the APhA Bylaws and House Rules (Rule 2 – Unfilled Delegate Seats and Rule 3 – Speaker Appointment of Unfilled Delegate Seats) regarding delegate appointment timelines was reviewed, reaffirming the Speaker of the House's right to directly appoint unfilled delegate seats, should Affiliated State Organizations be unable to appoint their delegates by the requested due date. The proposed deadline for consideration, before Speaker appointments are made on behalf of the ASO's, is October 1.
    - In this reflection, the committee noted an opportunity to consider engaging ASOs of the same region to socialize delegate appointment reminders among themselves and their neighboring states.
- Consent agenda processes and procedures
    - During the 2022 and 2023 House of Delegates policy cycles, a consent agenda process was trialed through guidance provided by prior House Rules Review Committees. Guidance is not yet codified with the House rules.
    - After reflecting on these prior trials, the committee determined it would be appropriate for the consent agenda process to be outlined and codified in the House rules at this time (Rule 7 – Consent Agenda).
    - The committee recommends continuation of existing guidance to conduct an electronic poll in advance of an in-person March House session to encompass policy recommendations from both the Policy Reference and New Business Review committees.
    - The Committee emphasized the importance of delegate education on House procedures, and opportunities for delegate input on proposed policies being considered.
    - The Speaker, Committee Chairs, and APhA staff should continue to provide clear guidance during webinars and delegate orientation materials to ensure clarity on the electronic poll and consent agenda processes. Additionally, clear guidance should be provided during ongoing and new caucus events.

    - The Committee noted that special attention should be given to how any delegate may make a motion for the removal of a section from the consent agenda for further discussion. It was determined that a "second" to the motion would be required, so that there would not be too great of a barrier for removal, while still maintaining a level of diligence.
- Best practice for handling abstention votes
    - The Committee reflected on the inclusion of "Abstain" as a voting option on the electronic poll sent to members to determine what committee recommendations are included in a consent agenda.
    - During the prior cycles, delegates who selected "Abstain" as their vote for an individual item were counted as abstention and removed from the denominator in each vote's final count.
    - While this calculation breakdown was explained during live webinars, and within the public report of consent agenda poll results itself, there was still a notable amount of delegate questions raised. In particular, questions to determine how these calculations may have influenced whether an individual item met the threshold for inclusion in the consent agenda.
    - As a result, the Committee recommended removal of "Abstain" as an option on the electronic poll, to accomplish the same result, while eliminating unnecessary confusion.
- Timeline for acceptance and review of Speaker-elect candidate applications
    - The Committee reviewed the processes for reviewing and slating Speaker-elect candidates during election years (Rule 9 – Nomination and Election of Speaker-elect).
    - The Committee remarked that the current practice of interviewing prospective Speaker-elect candidates by the Committee on Nominations onsite the day of the first House session can pose challenges to candidates, committee members, and staff involved.
    - The Committee identified an opportunity for added flexibility, by requiring that these interviews take place no later than one day before the first House session at which election-related activities shall occur.
    - Furthermore, the Committee discussed the timeline for accepting applications for consideration to be slated as a candidate for Speaker-elect, noting that this should be an intentional decision that candidates are aware of well in advance. As a result, the Committee recommends specifying that all applications be submitted no later than 30 days before the upcoming House session at which election-related activities shall occur.
    - Regardless of when the Committee on Nominations determines its recommended slate of candidates, it is recommended that formal campaigning shall not begin until the start of the Annual Meeting at which a Speaker-elect is to be elected.

- Recommendations to refer items to the APhA Board of Trustees
    - The Committee noted many delegates have inquired about next steps, after an item from a House session is referred to the APhA Board of Trustees for further action. There is a general sense of confusion as to how follow-up occurs for these items.
    - Recognizing that processes for following up on these items exist, the Committee recommends more explicit mention in the rules (Rule 19 – Unfinished and Referred Business Items), for referred items of business to be included in a Speaker's Report to the House, to inform the House of any action taken regarding such referral. This should occur no later than the conclusion of the subsequent Annual Meeting.
- Renumbering of the Rules
    - As a result of the preceding guidance, the Committee recommends revisions to the existing House of Delegates Rules of Procedure, as well as the addition of two net new rules of procedure.
    - Two additional rules, "Consent Agenda" and "Motion to Reject" have been drafted by the committee.
    - The committee recommends integrating these rules within the existing numbering, in accordance with the overall sequential order of rules. This proposed order of rules would be as follows:
        - Rule 1 – Delegate Appointment
        - Rule 2 – Unfilled Delegate Seats
        - Rule 3 – Speaker Appointment of Unfilled Delegate Seats
        - Rule 4 – Delegates and Voting
        - Rule 5 – Delegate Identification
        - Rule 6 – Consideration of Committee Reports
        - Rule 7 – Consent Agenda
        - Rule 8 – Privilege of the Floor
        - Rule 9 – Nomination and Election of Speaker-elect
        - Rule 10 – Amendments to Resolutions
        - Rule 11 – Motion to Reject
        - Rule 12 – Rules of Order
        - Rule 13 – Amendments to House of Delegates Rules of Procedure
        - Rule 14 – Grammar/Punctuation Corrections
        - Rule 15 – New Business
        - Rule 16 – Policy Review Committee
        - Rule 17 – Policy Reference Committee
        - Rule 18 – Virtual House of Delegates
        - Rule 19 – Unfinished and Referred Business Items

APhA House of Delegates Rules of Procedure

After thorough consideration, and in conjunction with the feedback received from Delegates, members, and staff, the HRRC unanimously recommends the following revisions to the APhA House of Delegates Rules of Procedure. Note: proposed amendments are in red font, deletions are ~~struck through,~~ and proposed additions are underlined.

Rule 3 Speaker Appointment of Unfilled Delegate Seats

Per APhA Bylaws Article VI, Section 2, subsection A.i, the Speaker may appoint delegates to unfilled delegate seats of Affiliated State Organizations (ASO). The Speaker will give preference to appointing delegates who served the delegation in previous House sessions. The Speaker must select an individual who resides or works within the state represented by the ASO and ~~for~~ which they will represent in the House. This process also applies to delegations ~~who~~ that have an inactive delegate seat per APhA Bylaws Article VI, Section 2, Subsection G. The Speaker will ~~make a reasonable attempt to~~ notify the ASO executive staff of the Speaker appointment. ~~In the event the ASO has a preferred individual to serve in the House after the Speaker has made the appointment, then the ASO's choice will take precedence if it is received not less than 30 days prior to any House session.~~ All individuals appointed under this rule will be seated with their ASO's delegation, irrespective of whether the ASO or the Speaker appointed them into the seat.

Rule 7 Consent Agenda

The House of Delegates may use electronic methods to conduct business by Consent.

The items of House business that may be considered by Consent shall be:

1. Policy Reference Committee Report (PRefC) and
2. New Business Review Committee Report (NBRC)

Delegates will be presented with the PRefC and the NBRC Reports not later than thirty (30) days before commencement of the first session of the House of Delegates. Delegates will have not less than ten (10) business days within which to designate their support for or against each whole numbered section of the PRefC and NBRC Reports. Delegates will vote to either "agree" or "disagree" with the inclusion of each whole number section of the PRefC and NBRC reports in a consent agenda. Amendments will not be considered in the electronic consent process.

A quorum consisting of 80% or more of registered Delegates voting shall be required for any whole numbered sections of the PRefC or NBRC to be added to the Consent Agenda. The Consent Agenda shall be further comprised of any whole numbered section of the PRefC or NBRC reports that receive votes of approval of 75% or more. Any whole numbered section of the PRefC or NBRC report that has not received a quorum of votes or fails to reach a 75% approval vote shall be included on the regular House Agenda for individual consideration.

The House of Delegates will receive an electronic report that contains the entire subject matter

of the recommendations including the whole numbered items approved for placement on the Consent Agenda, and those for individual consideration that have not been included on the Consent Agenda.

At the House of Delegates session where the Consent Agenda is considered, any Delegate may make a motion for the removal of any whole numbered section(s) contained on the Consent Agenda for separate debate and voting by Delegates. Once a second is received, the item will be considered separately.

Rule 9 Nomination and Election of Speaker-elect

The House of Delegates Committee on Nominations shall consist of five Delegates, including the Chair, and shall be appointed by the Immediate Past (non-incumbent) Speaker of the House of Delegates~~,~~. ~~and that~~ The Committee shall meet either in person or using technology assisted meeting platforms no later than one day before the first ~~preceding the~~ House session at which election-related activities shall occur to interview and slate ~~select~~ up to two (2) candidates for the office of Speaker-elect of the House of Delegates.

Nominees for the office of Speaker-elect of the House of Delegates shall submit or shall cause to be submitted a declaration of intent to be nominated for the office of Speaker-elect not less than thirty (30) days preceding the House session at which election-related activities of the Speaker-elect occur. The declaration of intent shall be made on forms electronically available on the House of Delegates web page. Incomplete or late forms will not be considered by the Committee on Nominations.

Elections for Speaker-elect will occur every even-numbered year. ~~Only~~ Up to two (2) candidates for the office of Speaker-elect of the House of Delegates shall be slated ~~nominated~~ by the Committee on Nominations, and this report shall be presented prior to the House session at which election-related activities shall occur. No member of the Committee on Nominations shall be nominated by that Committee. All ~~candidates~~ nominees ~~examined~~ interviewed by the Committee shall be notified of the results as soon as possible after the ~~nominees~~ candidates have been ~~selected~~ slated by the Committee on Nominations.

Formal campaigning for the office of Speaker-elect shall be in accordance with APhA's campaign guidance and rules and shall not begin until the start of the Annual Meeting at which a Speaker-elect is to be elected.

All candidates must be an APhA member as defined in Article III, Section 2, of the APhA Bylaws, and a seated delegate in the House of Delegates. During in-person House sessions, candidates will be introduced and permitted to speak to the House for no more than two (2) minutes following announcements of the slate of candidates. Candidates will then be permitted

to address the House for a maximum of three (3) minutes at the House session at which election-related activities shall occur. Candidates shall be listed in alphabetical order on the ballot, regardless of whether they were slated by the Committee on Nominations or nominated from the floor of the House. A majority vote of delegates present and voting is required for election. If no majority is obtained on the first ballot, a second ballot shall be cast for the two candidates who received the ~~largest vote~~ most votes on the first ballot. If electronic voting mechanisms are available, then the election shall be conducted utilizing the technology, with the results not publicly displayed. During extenuating circumstances where a vote for Speaker-elect cannot occur during an in-person House session, the Speaker and Secretary of the House, in consultation with the House Rules Review Committee, may recommend alternative methods to collect vote tallies.

If a vacancy occurs in the office of Speaker, the vacancy process detailed in Article VI, Section 5, of the APhA Bylaws shall be followed.

Rule 10 Amendments to Resolutions

All amendments to Motions to Adopt made by the Policy Reference Committee or Motions to Adopt made by the New Business Review Committee ~~recommendations or New Business Item Statements~~ shall be submitted in writing, handwritten or provided electronically, to the Secretary through a designated process confirmed by the Speaker for each House session. There are no secondary amendments or "friendly" amendments. The Speaker will rule any delegates out of order who express a desire to make a secondary amendment or "friendly" amendment.

Rule 11 Motion to Reject

A Motion to Reject made by a Committee in its Report shall be considered the same priority as a Motion to Adopt and shall be subject to all other Robert's Rules, except for those that conflict with these House Rules of Procedure.

Upon ADOPTION of the Motion to Reject, the item is no longer in business and can only be subject to a successful Motion to Reconsider, properly made, seconded and adopted. Whereupon the Motion to Reject remains the status of the action before the House. The Motion to Reject must be defeated before a motion to Adopt is in order.

Upon DEFEAT of the Motion to Reject, the item reverts to any original language of the Delegate or Committee and is considered in business when a Delegate makes a Motion to Adopt and it is properly seconded, whereupon the item is subject to all other Robert's Rules except those that conflict with these House Rules of Procedure.

Rule 15 New Business

The New Business Review Committee shall consist of 7–10 delegates, including the Chair, and are appointed by the Speaker. The Committee members should be present for open forum sessions held in person or virtually. After reviewing feedback provided from APhA members, the Committee will meet in executive session to propose motions to the House of Delegates on ~~develop recommendations on assigned~~ New Business Items. New Business Items are due to the Speaker of the House no later than 60 days before the start of any House session where regular action on New Business Items (not urgent items) are scheduled to take place. An urgent item can be considered~~, without a suspension of the House rules~~, if presented to the Speaker, with necessary background information, at least 24 hours prior to the beginning of any House session. Urgent items are defined as matters that, due to the nature of their content, must be considered by the House outside of the normal policy processes. The House leadership (Speaker, Speaker-elect [when present], and Secretary) will evaluate submitted urgent items based on the timely and impactful nature of the presented item and determine if the urgent item is to be agendaed ~~approved~~ as New Business. The House shall then be informed of any approved urgent items to be ~~considered~~ agendaed ~~by the House~~ as soon as is possible by the Speaker. ~~Approved~~ Agendaed urgent items shall be considered with other New Business Items and discussed during the New Business Open Hearing, if one is scheduled to take place. No immediate action shall be taken on urgent new business items without prior review of proposed statements and background information by all delegates. ~~Appropriate action will be recommended by~~ The New Business Review Committee shall consider the urgent new business item in the same manner as other New Business Items. Urgent items denied consideration by House Officers may still be addressed by the House, with a suspension of House rules at the House session where New Business will be acted upon.

Delegates wishing to amend existing APhA policy on topics not covered within the Policy Committee or Policy Review Committee agenda may submit proposed policy statements through the New Business Review Process. Restatements of existing policy are discouraged and should be included only as background information.

The New Business Review Committee's report to the House of Delegates shall be either a

Motion to:

A. Adopt, or

B. Reject.

C. ~~include one of the following recommended actions for each New Business Item considered:~~

   a) ~~Adoption of the New Business Item~~
   b) ~~Rejection of the New Business Item~~
   c) ~~Referral of the New Business Item~~
   d) ~~Adoption of the New Business Item as amended by the committee~~
   e) ~~No action~~

The New Business Review Committee's ~~recommendations~~ motions will be addressed by the House of Delegates in the following order:

1. New Items submitted by the Policy Review Committee
2. General New Business Items
3. Urgent New Business Items

~~If the New Business Review Committee recommends no action on a New Business Item, the Speaker of the House shall place the New Business Item before the House of Delegates for consideration and action.~~ Each whole-numbered statement within the New Business Item ~~should~~ will be considered separately, unless a Motion to consider all whole-numbered statements as a single item is properly made, seconded and agreed to by the House ~~A consent agenda process may be used to consider multiple recommendations within a single New Business Item,~~ in accordance with Robert's Rules of Order. New Business Items can be considered at a virtual session of the House of Delegates at the discretion of the Speaker, in accordance with these rules of procedure. Debate on new business items in a virtual session will be time limited. At the Speaker's discretion, proposed New Business items may be referred to the next session of the House for further deliberation.

Rule 19 Unfinished and Referred Business Items

Debate in any session of the House may be time limited, as designated by the Speaker. If the Speaker, the Committee chair, or any Delegates feel additional debate on the policy statement is warranted, the item may be carried over to an open hearing or a future session of the House. The remaining items requiring action will be brought back for final consideration at the next House session as "Unfinished Business."

Upon confirmation of an "Unfinished Business Item", the Speaker must clearly identify within the "Actions of the House Report" how Unfinished Business Items will receive further action. Unless defined within a motion from a Delegate, the Speaker, in consultation with the Secretary of the House, has the authority to assign "Unfinished Business Items" to an appropriate House Committee, the Board of Trustees, or a future session of House business for further action. An update on "Unfinished Business Items" ~~or any "Referred Business Items"~~ from any prior House session should be provided by the Speaker at future House sessions until action has been taken by the House on that item. ~~or no further action is recommended on the item.~~

Where a motion is made to refer an item of business and properly passed by delegates during a House of Delegates session, the Speaker shall in a Speaker's Report to the House inform the House of any action taken regarding such referral, no later than the conclusion of the subsequent Annual Meeting.

2024 House of Delegates
Report of the Policy Review Committee

- *Policies related to newly adopted policy from the 2023 APhA House of Delegates*
- *Current adopted policies containing the word "furnished"*
- *Current adopted policies containing "Regulatory" language*
- *Current adopted policies related to "People-Centric" language*

Committee Members

Jennifer Adams, Chair
Krista Capehart
Evan Colmenares
Jennifer Courtney
Hannah Fish
Sridhar Rao Gona
Nimit Jindal
Traci Poole
Stephen Presti

Ex Officio

Brandi Hamilton, Speaker of the House

This report is disseminated for consideration by the APhA House of Delegates and does not represent the position of the Association. Only those statements adopted by the House are considered official Association policy.

Overall Charge and Duties

The Policy Review Committee is charged each year to review any (1) policy that has not been reviewed or revised in the past 10 years; (2) policy related to statements adopted in the most recent House session (from March 2023); and (3) contemporary issues, if applicable, as identified by the Speaker.

Based on these charges, the Committee reviewed 122 total policies. As of April 2023, all policies within the APhA policy manual have been reviewed or revised since 2013 resulting in zero policies with a need for review according to the first Committee charge. As part of the second committee charge, thirty-seven policies were related to newly adopted policy from the March 2023 session. As part of the third committee charge, the Speaker of the House also charged the Committee to review and standardize all APhA policy containing the word "furnish" (3 policies were identified), policies needing amendments related to "Regulatory" language (63 policies were identified), and policies needing amendments related to "People-Centric" language (18 policies were identified).

The Committee met nine times via web conference call to conduct its work and provides the following recommendations. The report is organized roughly in order of the three charges and also by recommendation type.

Charge 1: 0 Items
Charge 2: Recommendations 1-37
Charge 3: Recommendations 38-122

Recommendations to Retain: 27 (Items 1-27)
Recommendations to Amend: 94 (Items 28-36 and 38--122)
Recommendations to Archive: 1 (Item 37)

Recommendations to Retain

1. **The Committee Recommends RETAINING the following policy statement as written.**
   2021 Diversity, Equity, Inclusion, and Belonging

   1. APhA denounces all forms of racism.
   2. APhA affirms that racism is a social determinant of health that contributes to persistent health inequities.
   3. APhA urges the entire pharmacy community to actively work to dismantle racism.
   4. APhA urges the integration of anti-racism education within pharmacy curricula, post-graduate training, and continuing education requirements.
   5. APhA urges pharmacy leaders, decision-makers, and employers to create sustainable opportunities, incentives, and initiatives in education, research, and practice to address racism.

6. APhA urges pharmacy leaders, decision-makers, and employers to routinely and systematically evaluate organizational policies and programs for their impact on racial inequities.
(JAPhA. 61(4):e15; July/August 2021)

2. The Committee Recommends RETAINING the following policy statement as written.
2019 Increasing Awareness and Accountability to End Harassment, Intimidation, Abuse of Power, Position or Authority in Pharmacy Practice

1. APhA calls on all national and state pharmacy organizations, colleges/schools of pharmacy, and other stakeholders to support the development of a profession-wide effort to address harassment, intimidation, and abuse of power or position.

2. APhA supports the development of a profession-wide guideline on reporting harassment, intimidation, or abuse of power or position in their pharmacy education and training, professional practice, or volunteer service to pharmacy organizations.

3. APhA recommends all pharmacy organizations incorporate harassment, intimidation, and abuse training in their member professional development and education activities.
(JAPhA. 61(4):e15-e16; July/August 2021)

3. The Committee Recommends RETAINING the following policy statement as written.
2019 Pharmacist and Pharmacy Personnel Safety and Well-Being

1. APhA calls for employers to develop policies and resources to support pharmacy personnel's ability to retreat or withdraw, without retaliation, from interactions that threaten their safety and well-being.
2. APhA encourages the development or utilization of educational programs and resources by the Association, employers, and other institutions to prepare pharmacy personnel to respond to situations that threaten their safety and well-being.
(JAPhA. 59(4):e17; July/August 2019) (Reviewed 2021)

4. The Committee Recommends RETAINING the following policy statement as written.
2019 Pharmacists' Role in Mental Health and Emotional Well-Being

1. APhA encourages all health care personnel to receive training and provide services to identify, assist, and refer people at risk for, or currently experiencing, a mental health crisis.
2. APhA encourages employers and policy makers to provide the support, resources, culture, and authority necessary for all pharmacy personnel to engage and assist individuals regarding mental health and emotional well-being.
3. APhA supports integration of a mental health assessment as a vital component of pharmacist-provided patient care services.
(JAPhA. 59(4):e16; July/August 2019)

5. **The Committee Recommends RETAINING the following policy statement as written.**
2019 Qualification Standards for Pharmacists

APhA adamantly opposes the basic education requirement within the Office of Personnel Management's Classification and Qualifications –General Schedule Qualification Standard – Pharmacy Series, 0660, requiring a Doctor of Pharmacy degree as the minimum qualifications to practice pharmacy that are inconsistent with pharmacist licensure requirements by state boards of pharmacy.
(JAPhA. 59(4):e17; July/August 2019)

6. **The Committee Recommends RETAINING the following policy statement as written.**
2017 Pharmacy Performance Networks

1. APhA supports performance networks that improve patient care and health outcomes, reduce costs, use pharmacists as an integral part of the health care team, and include evidence-based quality measures.
2. APhA urges collaboration between pharmacists and payers to develop distinct, transparent, fair, and equitable payment strategies for achieving performance measures associated with providing pharmacists' patient care services that are separate from the reimbursement methods used for product fulfillment.
3. APhA advocates for prospective notification of evidence-based quality measures that will be used by a performance network to assess provider and practice performance. Furthermore, updates on provider and practice performance against these measures should be provided in a timely and regular manner.
4. APhA supports pharmacists' professional autonomy to determine processes that improve performance on evidence-based quality measures.
(JAPhA. 57(4):441; July/August 2017) (Reviewed 2019)

7. **The Committee Recommends RETAINING the following policy statement as written.**
2017, 2012, 1989 Equal Rights and Opportunities for Pharmacy Personnel

APhA reaffirms its unequivocal support of equal opportunities for employment and advancement, compensation, and organizational leadership positions. APhA opposes discrimination based on sex, gender identity or expression, race, color, religion, national origin, age, disability, genetic information, sexual orientation, or any other category protected by federal or state law.
(Am Pharm. NS 29(7):464; July 1989) (Reviewed 2001) (Reviewed 2007) (JAPhA. NS52(4):459; July/August 2012) (JAPhA. 57(4):441; July/August 2017) (Reviewed 2022)

8. **The Committee Recommends RETAINING the following policy statement as written.**
2012, 2001, 1969 Pharmacist Workforce Census

1. APhA recognizes the need for an ongoing census of pharmacists to establish and track changes in workforce demographics and practice characteristics.

2. APhA urges the federal government or other stakeholders to establish funding mechanisms to conduct an ongoing census of pharmacists to establish and track changes in workforce demographics and practice characteristics.
(JAPhA. NS9:361; July 1969) (JAPhA. NS41(5)(suppl 1):S9; September/October 2001) (Reviewed 2007) (JAPhA. NS52(4):458; July/August 2012) (Reviewed 2017)

9. **The Committee Recommends RETAINING the following policy statement as written.**
2001 Employee Benefits

2. APhA encourages employers to offer benefit packages that provide dependent-care benefits, including, but not limited to, flexible spending accounts, voucher systems, referral services, on-site dependent care, and negotiated discounts for use of day care facilities, to improve workforce conditions.
(JAPhA. NS(5)(suppl 1):S10; September/October 2001)(Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2019)

10. **The Committee Recommends RETAINING the following policy statement as written.**
2015 Interoperability of Communications Among Health Care Providers to Improve Quality of Patient Care

1. APhA supports the establishment of secure, portable, and interoperable electronic patient health care records.
2. APhA supports the engagement of pharmacists with other stakeholders in the development and implementation of multidirectional electronic communication systems to improve patient safety, enhance quality care, facilitate care transitions, increase efficiency, and reduce waste.
3. APhA advocates for the inclusion of pharmacists in the establishment and enhancement of electronic health care information technologies and systems that must be interoperable, HIPAA compliant, integrated with claims processing, updated in a timely fashion, allow for data analysis, and do not place disproportionate financial burden on any one health care provider or stakeholder.
4. APhA advocates for pharmacists and other health care providers to have access to view, download and transmit electronic health records. Information shared among providers using a health information exchange should utilize a standardized secure interface based on recognized international health record standards for the transmission of health information.
5. APhA supports the integration of federal, state, and territory health information exchanges into an accessible, standardized, nationwide system.
6. APhA opposes business practices and policies that obstruct the electronic access and exchange of patient health information because these practices compromise patient safety and the provision of optimal patient care.
7. APhA advocates for the development of systems that facilitate and support electronic communication between pharmacists and prescribers concerning patient adherence, medication discontinuation, and other clinical factors that support quality care transitions.

8. APhA supports the development of education and training programs for pharmacists, student pharmacists, and other health care professionals on the appropriate use of electronic health records to reduce errors and improve the quality and safety of patient care.
9. APhA supports the creation and non-punitive application of a standardized, interoperable system for voluntary reporting of errors associated with the use of electronic health care information technologies and systems to enable aggregation of protected data and develop recommendations for improved quality.
(JAPhA. N55(4):364; July/August 2015) (Reviewed 2019)

11. **The Committee Recommends RETAINING the following policy statement as written.**
2012 Medication Verification

APhA encourages including a description of a medication's appearance on the pharmacy label or receipt as a means of reducing medication errors and distribution of counterfeit medications.
(JAPhA. NS52(4): 458; July/August 2012) (Reviewed 2017) (Reviewed 2018)

12. **The Committee Recommends RETAINING the following policy statement as written.**
2022 Procurement Strategies and Patient Steerage

1. APhA opposes mandated procurement strategies that restrict patients' and providers' ability to choose treatment options and that compromise patient safety and quality of care.
2. APhA calls for procurement strategies and care models that lower total costs, do not restrict or delay care, and ensure continuity of care.
(JAPhA. 62(4):942; July 2022)

13. **The Committee Recommends RETAINING the following policy statement as written.**
2019 Consolidation Within Health Care

1. APhA advocates that health care mergers and acquisitions must preserve the pharmacist–patient relationship.
2. APhA supports optimizing the role of pharmacists in the provision of team-based care following health care mergers and acquisitions in order to:
   (a) enhance patient experience and safety;
   (b) improve population health;
   (c) reduce health care costs; and
   (d) improve the work life of health care providers.
3. APhA asserts that the scope of review by federal agencies must have a focus on the impact of health care mergers and acquisitions on patient access and the provision of care to ensure optimal patient outcomes. Therefore, APhA calls for
   (a) reform of the pre–health care mergers and acquisitions process;
   (b) implementation of an ongoing post–health care mergers and acquisitions evaluation process to preserve patient choice and access to established patient–pharmacist relationships, and

(c) continuous transparent dialogue among stakeholders throughout the process.

4. APhA calls for the Federal Trade Commission (FTC) to develop a task force to monitor health care mergers and acquisitions activity.

(JAPhA. 59(4):e16; July/August 2019) (Reviewed 2021)

14. The Committee Recommends RETAINING the following policy statement as written.

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)

15. The Committee Recommends RETAINING the following policy statement as written.

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)

16. The Committee Recommends RETAINING the following policy statement as written.

2004, 1990 Freedom to Choose

1. APhA supports the patient's freedom to choose a provider of health care services and a provider's right to be offered participation in governmental or other third-party programs under equal terms and conditions.
2. APhA opposes government or other third-party programs that impose financial disincentives or penalties that inhibit the patient's freedom to choose a provider or health care services.
3. APhA supports that patients who must rely upon governmentally financed or administered programs are entitled to the same high quality of pharmaceutical services as are provided to the population as a whole.
(Am Pharm. NS30(6):45; June 1990) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015) (Reviewed 2018) (Reviewed 2021)

17. **The Committee Recommends RETAINING the following policy statement as written.**
2022, 2004, 1988 Pharmacists' Relationship to Veterinarians

APhA encourages pharmacists, student pharmacists, and pharmacy technicians to become more knowledgeable about veterinary drugs and their usage.
(Am Pharm. NS28(6):395; June 1988) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015) (Amended 2022)

18. **The Committee Recommends RETAINING the following policy statement as written.**
2021 Definition of Patient

APhA calls for the adoption, by pharmacy organizations and regulatory and professional entities, of the expanded definition for patient to include human or non-human species.
(JAPhA. 61(4):e16; July/August 2021)

19. **The Committee Recommends RETAINING the following policy statement as written.**
2009 Disparities in Health Care

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

20. **The Committee Recommends RETAINING the following policy statement as written.**
2015 Prenatal and Perinatal Care and Maternal Health

APhA supports pharmacists, in collaboration with the health care team, providing adequate and comprehensive prenatal and perinatal care for overall maternal and newborn health and wellness.
(JAPhA. N55(4):365; July/August 2015)

21. **The Committee Recommends RETAINING the following policy statement as written.**
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)

22. The Committee Recommends RETAINING the following policy statement as written.

2013 Pharmacists Providing Primary Care Services

APhA advocates for the recognition and utilization of pharmacists as providers to address gaps in primary care.

(JAPhA. 53(4):365; July/August 2013) (Reviewing 2018) (Reviewed 2019) (Reviewed 2020)

23. The Committee Recommends RETAINING the following policy statement as written.

2001 Syringe Disposal

APhA supports collaboration with other interested health care organizations, public and environmental health groups, waste management groups, syringe manufacturers, health insurers, and patient advocacy groups to develop and promote safer systems and procedures for the disposal of used needles and syringes by patients outside of health care facilities.

(JAPhA. NS41(5)(suppl 1):S9; September/October 2001) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2020)

24. The Committee Recommends RETAINING the following policy statement as written.

1979 Consideration of the Equal Rights Amendment

APhA supports efforts to ensure equal rights of all persons.

(AmPharm. NS19(7):60; June 1979) (Reviewed 2009) (Reviewed 2014) (Reviewed 2018) (Reviewed 2022)

25. **The Committee Recommends RETAINING the following policy statement as written.**
2022 Data to Advance Health Equity

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)

26. **The Committee Recommends RETAINING the following policy statement as written.**
2021 People First Language

APhA encourages the use of people first language in all written and oral forms of communication.
(JAPhA. 61(4):e15; July/August 2021)

27. **The Committee Recommends RETAINING the following policy statement as written.**
2021 Social Determinants of Health

1. APhA supports the integration of social determinants of health screening as a vital component of pharmacy services.
2. APhA urges the integration of social determinants of health education within pharmacy curricula, post-graduate training, and continuing education requirements.
3. APhA supports incentivizing community engaged research, driven by meaningful partnerships and shared decision-making with community members.
4. APhA urges pharmacists to create opportunities for community engagement to best meet the needs of the patients they serve.
5. APhA encourages the integration of community health workers in pharmacy practice to provide culturally sensitive care, address health disparities, and promote health equity.
(JAPhA. 61(4):e16; July/August 2021)

Recommendations to Amend

28. The Committee Recommends AMENDING the following policy statement as written.

2018 Pharmacist Workplace Environment and Patient Safety

1. APhA supports staffing models that promote safe provision of patient care services and access to medications.
2. APhA encourages the adoption of patient centered quality and performance measures that align with safe delivery of patient care services ~~and opposes the setting and use of operational quotas or time-oriented metrics that negatively impact patient care and safety~~.
3. APhA denounces any policies or practices of third-party administrators, processors, and payers that contribute to a workplace environment that negatively impacts patient safety. APhA calls upon public and private policy makers to establish provider payment policies that support the safe provision of medications and delivery of effective patient care.
4. APhA urges pharmacy personnel ~~practice employers~~ to establish collaborative mechanisms that engage the pharmacist in charge of each practice, pharmacists, pharmacy technicians, and pharmacy staff in addressing workplace issues that may have an impact on patient safety.
5. APhA urges employers to collaborate with the pharmacy staff to regularly and systematically examine and resolve workplace issues that may have a negative impact on patient safety.
6. APhA opposes retaliation against pharmacy ~~staff~~ personnel for reporting workplace issues that may negatively impact patient safety.

(JAPhA. 58(4):355; July/Augu st 2018) (Reviewed 2020) (Reviewed 2021) (Reviewed 2022)

Comments: The Policy Review Committee recommends AMENDING statements #2, 4 and 6 for clarity and brevity, to align with the new "2023 Workplace Conditions" policy. These proposed amendments are also intended to be inclusive of all pharmacy personnel.

29. The Committee Recommends AMENDING the following policy statement as written.

2013, 2001, 1994 Stakeholder Responsibilities in Appropriate Medication Use ~~Pharmacist-Patient-Prescriber-Payer Responsibilities in Appropriate Drug Use~~

1. Recognizing pharmacists work in all facets of the medication use system and have varying responsibilities, APhA advocates pharmacist responsibilities align with the Joint Commission of Pharmacy Practitioners (JCPP) Pharmacist Patient Care Process and the Oath of a Pharmacist.
2. Recognizing patients are the focus of the medication use system, APhA advocates patients and caregivers assume responsibility for their health and well-being, actively engage in their care plan, communicate with health professionals, and learn more about their options for accessing care and associated costs for products and services.
3. Recognizing prescribers play a vital role in the medication use system, APhA advocates prescribers engage with patients and caregivers, in the assessment, development and

implementation of the patient care plan. APhA also advocates that prescribers communicate, engage, and provide necessary information for pharmacists to engage in the care plan to ensure optimal patient care.

4. Recognizing payers' role in the medication use system, APhA advocates payers fairly design coverage benefits for products and services utilizing patient, pharmacist, and prescriber input to optimize health outcomes. Additionally, APhA advocates payers assume responsibility for providing efficient, clear, and uniform communication, as well as administrative and payment processes that are adaptable for advances in care.

~~1. APhA advocates the following guidelines for pharmacist-patient-prescriber-payer responsibilities in appropriate drug use:~~

~~(a) Pharmacists' Responsibilities~~

- ~~Serve as a drug information resource;~~
- ~~Provide primary care;~~
- ~~Collaborate with the prescriber and patient in the design of cost-effective treatment regimens that produce beneficial outcomes;~~
- ~~Identify formulary or generic products as a means to reduce costs;~~
- ~~Intervene on behalf of the patient to identify alternate therapies;~~
- ~~Educate the patient about the treatment regimen and expectations, and verify the patient's understanding;~~
- ~~Identify, prevent, resolve, and report drug-related problems;~~
- ~~Document and communicate pharmaceutical care activities;~~
- ~~Monitor drug therapy in collaboration with the patient and prescriber to ensure compliance and assess therapeutic outcomes;~~
- ~~Maintain an accurate and efficient drug distribution system; and~~
- ~~Maintain proficiency through continuing education.~~

~~(b) Patients' Responsibilities~~

- ~~Assume a responsibility for wellness;~~
- ~~Understand the coverage policies of their benefit plan;~~
- ~~Share complete information with providers, including demographics and payment mechanism(s);~~
- ~~Share complete information regarding medical history, lifestyle, diet, use of prescription and over-the-counter medications, and other substances;~~
- ~~Participate in the design of the treatment regimen;~~
- ~~Understand the treatment regimen and expected outcomes;~~
- ~~Adhere to the treatment regimen; and~~
- ~~Alert prescribers and pharmacists to possible drug-related problems or changes in health status.~~

~~(c) Prescribers' Responsibilities~~

- ~~Assess and diagnose the patient;~~
- ~~Share pertinent information in collaboration with the pharmacist and patient in the design of cost-effective treatment regimens that produce beneficial outcomes;~~

- ~~Clearly communicate the treatment plan and its intended outcomes to the patient directly or in collaboration with the pharmacist;~~
- ~~Remain alert to the possible occurrence of drug-related problems and initiate needed changes in therapy;~~
- ~~Collaborate with the patient and the pharmacist in drug therapy monitoring; and~~
- ~~Maintain proficiency through continuing medical education.~~

~~(d) Payers' Responsibilities~~

- ~~Determine the objectives and desired benefits of pharmacy service;~~
- ~~Design the coverage with patient and provider input using products and services to produce beneficial outcomes;~~
- ~~Contract with providers on the basis of outcomes and efficient use of resources;~~
- ~~Adopt efficient, clear, and uniform administrative processes;~~
- ~~Communicate requirements of compensation for levels of care;~~
- ~~Educate patients and providers about current eligibility and benefit information;~~
- ~~Expeditiously process payments; and~~
- ~~Be responsive to advances in contemporary practice.~~

(Am Pharm. NS34(6):57; June 1994) (JAPhA NS41(5)(suppl 1):S9; September/October 2001) (Reviewed 2008) (Reviewed 2010) (Reviewed 2011) (Reviewed 2012) (JAPhA. 53(4):367; July/August 2013) (Reviewed 2018)

Comments: The Policy Review Committee recommends AMENDING the existing policy language to make it more contemporary with current standards of pharmacy practice. The committee also felt that consolidating the current policy language would make it more concise in line with the original intent.

30. The Committee Recommends AMENDING the following policy statement as written.

2012, 2007, 1970 Employment Standards Policy Statement

The employment relationship between pharmacists and their employers must start with the principle that pharmacists have a professional, inherent right to practice in a manner that will engender self-respect in pursuit of their professional and economic objectives.

It is the policy of APhA to further the following basic employment standards:

1. Employers are obligated to respect the professional status, privileges, and responsibilities of employed pharmacists.

2. Employers are obligated to provide working conditions that enhance the ability of employed pharmacists to utilize their full professional capacity in providing patient care service to the public.

3. Employers are obligated to provide employed pharmacists opportunities to increase their professional knowledge and experience.

4. Employers are obligated to fairly compensate employed pharmacists commensurate with their duties and performances. Such compensation should include benefits generally available to other professionals including, but not limited to, vacation, sick leave, insurance plans, and retirement programs.
5. Employed pharmacists are obligated to use their best efforts to further the services offered to the public by their employers.
6. Employed pharmacists are obligated to ~~unhesitantly~~ bring to the attention of their employers all matters that will assist the employers in maintaining professional standards and successful practices.
7. Employed pharmacists are obligated, when negotiating compensation, to consider not only prevailing economic conditions in their community, but also their economic position relative to other health care professionals.
8. Employed pharmacists are obligated to recognize that their responsibility includes not depriving the public of their patient care services by striking in support of their economic demands or those of others.
9. Both employers and employed pharmacists are obligated to reach and maintain definite understandings with regards to their respective economic rights and duties by resolving employment issues fairly, promptly, and in good faith.

It is the policy of APhA to support these basic employment standards by:

1. Encouraging and assisting state and national ~~pharmacists associations and national specialty~~ associations to establish broadly representative bodies to study the subject of professional and economic relations and to establish locally responsive guidelines to assist employers and employed pharmacists in developing satisfactory employment relationships.
2. Encouraging and assisting state and national ~~pharmacists~~ pharmacy associations ~~and national specialty associations~~ to use their good offices, whenever invited, to resolve specific issues that may arise.
~~3. Assisting state pharmacists associations and national specialty associations to use their good offices, whenever invited, to resolve specific issues that may arise.~~
3 ~~4.~~ Assisting state pharmacists associations and national specialty associations to develop procedures for mediation or arbitration of disputes that may arise between employers and employed pharmacists so that pharmacists can call on their profession for such assistance when required.
4 ~~5.~~ Increasing its activities directed towards educating the profession about the mutual employment responsibilities of employers and employed pharmacists.
5 ~~6.~~ Developing benefits programs wherever possible to assist employers in providing employed pharmacists with economic security.

6 ~~7.~~ Continuously reminding pharmacists that the future development and status of pharmacy as a health profession rests in their willingness and ability to maintain control of their profession.
(JAPhA. NS10:363; June 1970) (Reviewed 2001) (JAPhA. NS45(5):580; September-October 2007) (JAPhA. NS52(4): 458; July/August 2012) (Reviewed 2017) (Reviewed 2018) (Reviewed 2020)

Comments: The Policy Review Committee recommends AMENDING the policy statement to condense existing statements #2 and #3 of the second half of this policy to remove redundant language and clarify the original intent.

31. The Committee Recommends AMENDING the following policy statement as written.
2001 Administrative Contributions to Medication Errors

1. APhA encourages implementation of a standard pharmacy benefit card ~~prescription drug card~~ to improve the dispensing process and encourages the use of technology in this implementation.
2. APhA supports the use of technology to facilitate record-keeping of patient prescription information for third-party audit purposes and regulatory compliance.
3. APhA supports education of the public regarding the responsibility to be informed consumers of their pharmacy benefits provided through third-party plans.
4. APhA encourages third-party plans to provide pharmacies all information necessary for benefits administration in a timely organized manner or to provide access to the information through the Internet or similar technologies at no cost to the pharmacy.
5. APhA supports clear communication during the pharmacy claims adjudication process ~~supports the distinction of plan management messages (e.g., days' supply limitations or formulary management) from drug utilization review messages (e.g., drug-drug interactions)~~. APhA supports the communication of all plan management options available ~~(e.g.,) approved formulary alternatives)~~ from the claims processor to the pharmacist.
6. APhA supports the development and use of systems to communicate in-pharmacy drug utilization review messages with online claims processing systems to eliminate redundant and/or repetitive messages.
7. APhA encourages the transmission of pre-adjudication drug utilization review messages (i.e., drug utilization review communication between the prescriber and claims processor) to the pharmacist.
8. APhA supports efforts to:
(a) improve on-line drug utilization review messages by the establishment of evidence-based criteria to prevent drug-related conflicts that have the potential for causing serious harm; and
(b) eliminate drug utilization review messages that have questionable or inconsequential impact on patient outcomes.
(JAPhA. NS4(5)(suppl 1):57; September/October 2001) (Reviewed 2003) (Reviewed 2007) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

Comments: The Policy Review Committee recommends AMENDING the term "prescription drug card" in Statement #1 to with "pharmacy benefit card", as this term is more contemporary and inclusive. The Committee further recommends modifications to Statement #5 to update standards of practice to encompass the full adjudication process.

32. The Committee Recommends AMENDING the following policy statement as written.

2011 Requiring ~~Influenza~~ Vaccination for All Pharmacy Personnel

APhA supports ~~an annual influenza vaccination~~ vaccinations, as recommended by the Centers for Disease Control and Prevention, as a condition of employment, training, or volunteering within an organization that provides pharmacy services or operates a pharmacy or pharmacy department (unless a valid medical or religious reason precludes vaccination).

(JAPhA. NS51(4):482; July/August 2011) (Reviewed 2012) (Reviewed 2017)

Comments: The committee recommends AMENDING existing policy to broaden the scope beyond influenza to any recommended vaccination, including annual vaccines or vaccine series. The Committee considered multiple sources of vaccine recommendations, (e.g., CDC, ACIP, FDA) and determined the CDC recommendations would be most current and applicable. The committee's intent is that this proposed language as written would be inclusive of the CDC's regular Morbidity and Mortality Weekly Report (MMWR) updates, which are often published between meetings of the ACIP. While FDA is part of the vaccine approval process, it would not serve as the final source for guidance on vaccine recommendations intended for this policy.

33. The Committee Recommends AMENDING the following policy statement as written.

2000 Medication Errors

1. APhA~~, as the national professional society of pharmacists,~~ will work to ensure pharmacy is the profession responsible for providing leadership in developing a safe, error-free medication use process.
2. APhA supports continuation and expansion of medication error reporting programs.
~~3. Medication error reporting programs should be non-punitive in nature and allow appropriate anonymity to facilitate error reporting and development of solutions to eliminate error.~~
4. APhA supports identifying the system-based causes of errors and building systems to support safe medication practice.

(JAPhA. NS(9):40; September/October 2000) (Reviewed 2007) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

Comments: The Policy Review Committee recommended AMENDING policy statement #1 to remove unnecessary language. The Committee also recommended striking statement #3, noting this language is covered within the "*2023 Just Culture Approach in Pharmacy*" policy.

34. The Committee Recommends AMENDING the following policy statement as written.

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

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

Comments: The Policy Review Committee recommended AMENDING the terms "Pharmacists" and, "student pharmacists" throughout the current existing policy, to be replaced with "Pharmacy personnel". This change would standardize the individual statements to be inclusive of pharmacy technicians and all other pharmacy personnel.

35. The Committee Recommends AMENDING the following policy statement as written.

2017 Drug Disposal Program Involvement

APhA urges pharmacists to expand patient access to secure, convenient, and environmentally ~~ecologically~~ responsible drug disposal options, in accordance with the Secure and Responsible Drug Disposal Act of 2010, by implementing disposal programs they deem appropriate for their individual practice sites, patient care settings, and business models in an effort to reduce the amount of dispensed but unused prescription drug product available for diversion and misuse.

(JAPhA. 57(4):441; July/August 2017)

Comments: The Policy Review Committee recommends AMENDING the current existing policy to more accurately convey the policy intent by replacing the word "ecologically" with "environmentally".

36. The Committee Recommends AMENDING the following policy statement as written.

2007, 1992 Recycling of Pharmaceutical Packaging

APhA supports ~~aggressive~~ research and development of pharmaceutical packaging disposal by pharmacists, pharmaceutical manufacturers, waste product managers, and other stakeholders ~~appropriate parties of mechanisms~~ to increase recycling, ~~of non-hazardous, pharmaceutical, packaging materials, to~~ reduce unnecessary waste ~~in pharmaceutical product packaging~~, and ~~to~~ minimize the opportunity for counterfeiters to use discarded packaging.

(Am Pharm. NS32(6):516; June 1992) (Reviewed 2004) (JAPhA. NS45(5):580; September/October 2007) (Reviewed 2012) (Reviewed 2017)

Comments The Policy Review Committee recommends AMENDING the current existing policy to strike the word "aggressive", as it is not clear what is meant by aggressive research or how it would be implemented. The committee further recommended broadening policy language to be more inclusive of all opportunities for reducing unnecessary waste.

Recommendation to Archive

37. The Committee Recommends ARCHIVING the following policy statement as written.

2001 Medication Error Reporting

1. APhA strongly encourages participation in error reporting at the organizational (pharmacy/institution) level and in other established state and national reporting programs.
2. APhA encourages direct error reporting by the individual(s) involved in the incident to ensure that the most relevant and detailed information is available for evaluation of the incident and for systems improvement.
3. Error reporting programs should regularly analyze and report information about the leading types and causes of errors reported to their system so that practitioners can utilize this information for systems enhancements and quality improvement.
4. APhA encourages state boards of pharmacy and other responsible entities to consider pharmacists participation in reporting of errors as a mitigating factor in determining any legal or disciplinary action related to the incident.

(JAPhA. NS4(5)(suppl 1):S8; September/October 2001) (Reviewed 2007) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

Comments: The Policy Review Committee recommends ARCHIVING current existing policy as the newly adopted *"2023 Just Culture Approach in Pharmacy"* policy is contemporary and more effectively addresses medication error reporting and pharmacist protection.

Policy Statements Using the Word "Furnish"

The Committee was charged with amending policy language containing the word "furnish", in favor of more contemporary language to capture pharmacists' ability to independently prescribe and dispense medications without dependence of a collaborative practice agreement.

38. The Committee Recommends AMENDING the following policy statement as written.

2014 Controlled Substances and Other Medications with the Potential for 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 overdose, drug diversion, and substance-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, 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~~ independently prescribe 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) (Reviewed 2022)

39. The Committee Recommends AMENDING the following policy statement as written.

2016 Opioid Overdose Prevention

1. APhA supports access to third-party (non-patient recipient) prescriptions for opioid reversal agents that are ~~furnished~~ independently prescribed by pharmacists.
2. APhA affirms that third-party (non-patient-recipient) prescriptions should be reimbursed by public and private payers.

(JAPhA. 56(4):370; July/August 2016) (Reviewed 2020) (Reviewed 2022)

40. The Committee Recommends AMENDING the following policy statement as written.

2015 Role of the Pharmacist in the Care of Patients Using Cannabis

1. APhA supports regulatory changes to further facilitate clinical research related to the clinical efficacy and safety associated with the use of cannabis and its various components.
2. APhA encourages health care provider education related to the clinical efficacy, safety, and management of patients using cannabis and its various components.

3. APhA advocates that the pharmacist collect and document information in the pharmacy patient profile about patient use of cannabis and its various components and provide appropriate patient counseling.
4. APhA supports pharmacist participation in ~~furnishing~~ independently prescribing cannabis and its various components when scientific data support the legitimate medical use of the products and delivery mechanisms, and federal, state, or territory laws or regulations permit pharmacists to ~~furnish~~ independently prescribe them.
5. APhA opposes pharmacist involvement in ~~furnishing~~ independently prescribing cannabis and its various components for recreational use.
(JAPhA. N55(4):365; July/August 2015)

Policy Statements related to "Regulatory" Language.

The Committee was charged with reviewing the entire policy manual to standardize policy language that related to laws, regulation, or policies.

41. The Committee Recommends AMENDING the following policy statement as written.

2016, 1997 Use of the Word "Pharmacy" in Unlicensed Environments

APhA supports the establishment and enforcement of laws, regulations, and policies through Boards of Pharmacy that restrict the use of the words "pharmacy", "drug store", "apothecary" or any other words or symbols of similar meaning or signage and business names to entities in which the practice of pharmacy is conducted.
(JAPhA. NS37:460; July/August 1997) (Reviewed 2002) (Reviewed 2006) (Reviewed 2011) (JAPhA. 56(4): 380; July/August 2016)

42. The Committee Recommends AMENDING the following policy statement as written.

1999 Direct-to-Consumer Advertising of Medications

1. APhA supports laws, regulations, and policies ~~legislative and regulatory activities~~ permitting direct-to-consumer advertising concerning medical or health conditions treatable by prescription or nonprescription drug products. These advertisements must conform to existing laws, regulations, and policies that ensure complete, comprehensive, and understandable information that informs consumers of potential benefits and risks of the product.
2. APhA opposes false or misleading advertising for prescription or nonprescription drugs or any promotional efforts that encourage indiscriminate use of medication.
3. APhA supports the availability of accurate information to consumers about medication use and recognizes the responsibility of pharmacists to provide appropriate responses to consumer inquiries stimulated by direct-to-consumer advertising as a compensated pharmaceutical service. In addition, APhA recommends that health care professionals, including but not limited to pharmacists, receive new product information on direct-to-consumer advertising campaigns prior to this information being made available to consumers
(JAPhA. 39(4):447; July/August 1999) (Reviewed 2004) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016)

43. The Committee Recommends AMENDING the following policy statement as written.

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

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 legal, regulatory, and policy 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) (Reviewed 2023)

44. The Committee Recommends AMENDING the following policy statement as written.
2020, 2010 E-prescribing Standardization

1. APhA supports the standardization of user interfaces to improve quality and reduce errors unique to e-prescribing.
2. APhA supports reporting mechanisms and research efforts to evaluate the effectiveness, safety, and quality of e-prescribing systems, computerized prescriber order entry (CPOE) systems, and the e-prescriptions that they produce, in order to improve health information technology systems and, ultimately, patient care.
3. APhA supports the development of financial incentives for pharmacists and prescribers to provide high quality e-prescribing activities.
4. APhA supports the inclusion of pharmacists in quality improvement and meaningful use activities related to the use of e-prescribing and other health information technology that would positively impact patient health outcomes.
5. APhA supports laws, ~~and~~ regulations, and policies that require e-prescribing of controlled substances to reduce fraudulent prescriptions.

(JAPhA. NS40(4):471; July/August 2010) (Reviewed 2012) (Reviewed 2014) (Reviewed 2015) (JAPhA. 60:(5):e10); September/October 2020)

Comments This policy statement was also part of the Committee's second charge. The Committee had no changes and recommended to retain the existing language as it related to those newly adopted policies from the March 2023 House of Delegates. The Committee recommends amending Statement 5 however, as part of their third charge to standardize language throughout the policy manual.

45. The Committee Recommends AMENDING the following policy statement as written.

2021 Multi-state Practice of Pharmacy

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 and policies 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)

46. The Committee Recommends AMENDING the following policy statement as written.

2020 Protecting Pharmaceuticals as a Strategic Asset

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 legal regulatory, policy 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 and regulations 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)

47. The Committee Recommends AMENDING the following policy statement as written.
2018, 2013 Revisions to the Medication Classification System

1. APhA supports the Food and Drug Administration's (FDA) efforts to revise the drug and medical device classification paradigms for prescription and nonprescription medications and medical devices to allow greater access to certain medications and medical devices under conditions of safe use while maintaining patients' relationships with their pharmacists and other health care providers.
2. APhA supports the implementation or modification of state laws, ~~and~~ regulations, and policies to facilitate pharmacists' implementation and provision of services related to a revised drug and medical device classification system.
3. APhA supports a patient care delivery model built on coordination and communication between pharmacists and other health care team members in the evaluation and management of care delivery.
4. APhA affirms that pharmacists are qualified to provide clinical interventions on medications and medical devices under FDA's approved conditions of safe use.

5. APhA urges manufacturers, FDA, and other stakeholders to include pharmacists' input in the development and adoption of technology and standardized processes for services related to medications and medical devices under FDA's defined conditions of safe use.
6. APhA supports the utilization of best practices, treatment algorithms, and clinical judgment of pharmacists and other health care providers to guide the evaluation and management of care delivery related to medications and medical devices under FDA's approved conditions of safe use.
7. APhA encourages the inclusion of medications, medical devices, and their associated services provided under FDA's defined conditions of safe use within health benefit coverage.
8. APhA supports compensation of pharmacists and other health care professionals for the provision of services related to FDA's defined conditions of safe use programs.
(JAPhA. 53(4):365; July/August 2013) (JAPhA. 58(4):356; July/August 2018) (Reviewed 2022)

48. The Committee Recommends AMENDING the following policy statement as written.
2006 2004, 1978 Dispensing Criteria

APhA supports vigorous enforcement of laws, regulations, and policies to ensure that all those who sell or dispense prescription and non-prescription drugs comply with legal criteria.
(Am Pharm. NS18(8):42; July 1978) (JAPhA. NS44(5):551; September/October 2004) JAPhA. NS46(5):562; September/October 2006) (Reviewed 2015)

49. The Committee Recommends AMENDING the following policy statement as written.
2005, 1998 Administration of Medications

1. APhA recognizes and supports pharmacist administration of prescription and non-prescription drugs as a component of pharmacy practice.
2. APhA supports the development of educational programs and practice guidelines for student pharmacists and practitioners for the administration of prescription and non-prescription drugs.
3. APhA supports pharmacist compensation for administration of prescription and non-prescription drugs and services related to such administration.
4. APhA urges adoption of ~~state~~ laws, ~~and~~ regulations, and policies authorizing pharmacist administration of prescription and non-prescription drugs.
(JAPhA. 38(4):417; July/August 1998) (JAPhA. NS45(5):559; September/October 2005) (Reviewed 2006)(Reviewed 2011) (Reviewed 2012) (Reviewed 2017) (Reviewed 2020)

50. The Committee Recommends AMENDING the following policy statement as written.
1979 Out-of-State Prescription Orders

APhA supports the repeal of state laws, regulations, and policies that prohibit the dispensing of an otherwise legal prescription order, issued by a prescriber licensed in another state.
(Am Pharm. NS19(7):67; June 1979) (Reviewed 2004) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016)

51. The Committee Recommends AMENDING the following policy statement as written.

1980 Medicinal Use of Marijuana

1. APhA supports research by properly qualified investigators operating under the investigational new drug (IND) process to explore fully the potential medicinal uses of marijuana and its constituents or derivatives.
2. APhA opposes state by state, marijuana specific, or other drug specific legislation intended to circumvent the federal laws, regulations, and policies pertaining to:
(a) marketing approval of new drugs based on demonstrated safety and efficacy, or
(b) controlling restrictions relating to those substances having a recognized hazard of abuse.

(Am Pharm. NS20(7):71; July 1980) (Reviewed 2003) (Reviewed 2006) (Reviewed 2011) (Reviewed 2015)

52. The Committee Recommends AMENDING the following policy statement as written.

1986 Use of Performance-Enhancing Drugs by Athletes

1. APhA is opposed to the use of performance-enhancing drugs by athletes.
2. APhA should educate the public on the dangers of the use of performance-enhancing drugs by athletes.
3. APhA encourages enforcement of laws, regulations, and policies related to the use of performance-enhancing drugs by athletes.

(Am Pharm. NS26(6):420; June 1986) (Reviewed 2003) (Reviewed 2006) (Reviewed 2015)

53. The Committee Recommends AMENDING the following policy statement as written.

2021 Increasing Access to and Affordability of Naloxone

1. APhA supports laws, regulations, policies and practices that increase the availability of naloxone.
2. APhA supports the availability of naloxone as both a prescription and non-prescription medication.
3. APhA encourages pharmacists and payers to ensure equitable access to and affordability of at least one naloxone formulation regardless of prescription status.
4. APhA encourages payers to provide fair reimbursement to dispensers of naloxone.

(JAPhA. 61(4):e16; July/August)

54. The Committee Recommends AMENDING the following policy statement as written.

2005, 1998 Administration of Medications

1. APhA recognizes and supports pharmacist administration of prescription and non-prescription drugs as a component of pharmacy practice.

2. APhA supports the development of educational programs and practice guidelines for student pharmacists and practitioners for the administration of prescription and non-prescription drugs.

3. APhA supports pharmacist compensation for administration of prescription and non-prescription drugs and services related to such administration.

4. APhA urges adoption of ~~state~~ laws, ~~and~~ regulations, and policies authorizing pharmacist administration of prescription and non-prescription drugs.
(JAPhA. 38(4):417; July/August 1998) (JAPhA. NS45(5):559; September/October 2005) (Reviewed 2006)(Reviewed 2011) (Reviewed 2012) (Reviewed 2017) (Reviewed 2020)

55. The Committee Recommends AMENDING the following policy statement as written.
2014 Controlled Substances and other Medications with the Potential for Access 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 overdose, drug diversion, and substance-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, 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 and policies that permit pharmacists to furnish opioid reversal agents to prevent opioid-related deaths due to overdose.

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) (Reviewed 2022) (Reviewed 2023)

56. The Committee Recommends AMENDING the following policy statement as written.
2012 Drug Supply Shortages and Patient Care

1. APhA supports the immediate reporting by manufacturers to the U.S. Food and Drug Administration (FDA) of disruptions that may impact the market supply of medically necessary drug products to prevent, mitigate, or resolve drug shortage issues and supports the authority for FDA to impose penalties for failing to report.

2. APhA supports revising current laws, ~~and~~ regulations, and policies that restrict the FDA's ability to provide timely communication to pharmacists, other health care providers, health systems, and professional associations regarding potential or real drug shortages.

3. APhA encourages the FDA, the Drug Enforcement Administration (DEA), and other stakeholders to collaborate in order to minimize barriers (e.g., aggregate production quotas, annual assessment of needs, unapproved drug initiatives) that contribute to or exacerbate drug shortages.

4. APhA should actively support legislation to hasten the development of an efficient regulatory process to approve therapeutically equivalent generic versions of biologic drug products.

5. APhA encourages pharmacists and other health care providers to assist in maintaining continuity of care during drug shortage situations by

(a) creating a practice site drug shortage plan as well as policies and procedures;
(b)using reputable drug shortage management and information resources in decision making;
(c) communicating with patients and coordinating with other health care providers;
(d) avoiding excessive ordering and stockpiling of drugs;
(e) acquiring drugs from reputable distributors; and
(f) heightening their awareness of the potential for counterfeit or adulterated drugs entering the drug distribution system.

6. APhA encourages accrediting and regulatory agencies and the pharmaceutical science and manufacturing communities to evaluate policies/procedures related to the establishment and use of drug expiration dates and any impact those policies/procedures may have on drug shortages.

7. APhA encourages the active investigation and appropriate prosecution of entities that engage in price gouging and profiteering of medically necessary drug products in response to drug shortages.

(JAPhA. NS52(4): 457; July/August 2012) (Reviewed 2017) (Reviewed 2021)

57. The Committee Recommends AMENDING the following policy statement as written.

2004, 1966 Distribution Programs: Circumvention of the Pharmacist

APhA opposes distribution programs, laws, regulations, and policies by manufacturers, governmental agencies, and voluntary health groups that circumvent the pharmacist and promote the dispensing of prescription, legend drugs by non-pharmacists. These programs and policies should, in the public interest, be eliminated.

(JAPhA. NS6:293; June 1966) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016) (Reviewed 2021)

58. The Committee Recommends AMENDING the following policy statement as written.

2004 Protecting the Integrity of the Medication Supply

3. APhA supports public education about the risk of using medications whose production, distribution, or sale does not comply with U.S. federal and state laws, regulations, and policies.

4. APhA urges pharmacists and other health care professionals to report suspected counterfeit products to the Food and Drug Administration.

(JAPhA. NS6:293; June 1966) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016) (Reviewed 2021)

59. The Committee Recommends AMENDING the following policy statement as written.

1978 Post-Marketing Requirements (Restricted Distribution)

APhA opposes any ~~legislation~~ laws, regulations, and policies that would grant FDA authority to restrict the channels of drug distribution for any prescription drug as a condition for approval for marketing the drug under approved labeling.

(Am Pharm. NS18(8):30; July 1978) (Reviewed 2004) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016) (Reviewed 2021) (Reviewed 2023)

Comments This policy statement was also part of the Committee's second charge. The Committee had no changes and recommended to retain the existing language as it related to those newly adopted policies from the March 2023 House of Delegates. The Committee recommends amending Statement 5 however, as part of their third charge to standardize language throughout the policy manual.

60. The Committee Recommends AMENDING the following policy statement as written.

2019, 2006, 2003 Unit-of-Use Packaging

1. APhA supports development, distribution, and use of unit-of-use packaging as the pharmaceutical industry standard to enhance patient safety, patient adherence, drug distribution efficiencies, and Drug Supply Chain Security Act (DSCSA) regulations.

2. APhA encourages collaboration with the pharmaceutical industry, repackagers, third-party payers, and appropriate federal agencies to effect the changes necessary for the adoption of unit-of-use packaging as the industry standard.

3. APhA supports the enactment of ~~legislation and regulations~~ laws, regulations, and policies to permit pharmacists to modify prescribed quantities to correspond with commercially available unit-of-use packages.

(JAPhA. NS43(5:)(suppl 1):S57; September/October 2003) (JAPhA. NS46(5):562; September/October 2006) (Reviewed 2007) (Reviewed 2012) (Reviewed 2013) (Reviewed 2018) (JAPhA. 59(4):e17; July/August 2019) (Reviewed 2020)

61. The Committee Recommends AMENDING the following policy statement as written.
2004, 1971 Anti-Substitution Laws: Pharmacists' Responsibility

APhA supports state substitution laws, regulations, and policies that emphasize pharmacists' professional responsibility for determining, on the basis of available evidence, including professional literature, clinical studies, drug recalls, manufacturer reputation and other pertinent factors, that the drug products they dispense are therapeutically effective.
(JAPhA. NS11:260; May 1971) (JAPhA. NS 44(5):551; September/October 2004) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016) (Reviewed 2017)

62. The Committee Recommends AMENDING the following policy statement as written.
2017, 1982 Legislative Restrictions on Clinical Judgment

APhA opposes the enactment of ~~legislation~~ laws, regulations, and policies that would act to restrict the clinical judgments of medical practitioners and other health professionals.
(Am Pharm. NS22(7):32; July 1982) (Reviewed 2004) (Reviewed 2006) (Reviewed 2007) (Reviewed 2012) (JAPhA. 57(4):441; July/August 2017)

63. The Committee Recommends AMENDING the following policy statement as written.
2009 Non-FDA-Approved Drugs and Patient Safety

1. APhA calls for education and collaboration among health professional organizations, federal agencies, and other stakeholders to ensure that all manufacturer, distributor, and repackaged marketed prescription drugs used in patient care have been FDA-approved as safe and effective.
2. APhA supports initiatives aimed at closing legislative, regulatory, policy and distribution-system loopholes that facilitate market entry of new prescription drugs products without FDA approval.
3. APhA encourages health professionals to consider FDA approval status of prescription drug products when making decisions about prescribing, dispensing, substitution, purchasing, formulary development, and in the development of pharmacy/medical education programs and drug information compendia.
(JAPhA. NS49(4):492; July/August 2009) (Reviewed 2014) (Reviewed 2019) (Reviewed 2023)

64. The Committee Recommends AMENDING the following policy statement as written.
2023 Just Culture Approach to Patient Safety

1. APhA calls for employers to adopt and implement just culture principles to improve patient safety and support pharmacy personnel.
2. APhA encourages transparency between employers and employees by sharing deidentified medication error and near-miss data and trends as well as actions taken to promote continuous quality improvement.
3. APhA urges the integration of non-disciplinary and non-punitive mechanisms for use by boards of pharmacy to promote just culture principles when addressing people, systems, and processes involved in medication errors.

4. APhA encourages national and state associations to advocate for laws, regulations, and policies ~~legislation~~ to provide protections to individuals utilizing error reporting systems to promote just culture.
5. APhA encourages the creation of a mechanism for an industrywide effort to engage in confidential and transparent sharing of learnings and root cause findings helpful in reducing the risk of medication errors.
6. APhA supports the integration of just culture principles in PharmD and pharmacy technician education, postgraduate training, and continuing professional development programs.
(JAPhA. 63(4):1265; July/August 2023)

65. The Committee Recommends AMENDING the following policy statement as written.

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~~ laws, regulations, and policies 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) (Reviewed 2023)

Comments This policy statement was also part of the Committee's second charge. The Committee had no changes and recommended to retain the existing language as it related to those newly adopted policies from the March 2023 House of Delegates. The Committee recommends amending Statement 5 however, as part of their third charge to standardize language throughout the policy manual.

66. The Committee Recommends AMENDING the following policy statement as written.

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 and appropriate related ~~laws~~ laws, regulations, and policies 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) (Reviewed 2023)

67. The Committee Recommends AMENDING the following policy statement as written.

2014 The Use and Sale of Electronic Cigarettes (e-cigarettes)

1. APhA opposes the sale of e-cigarettes and other vaporized nicotine products in pharmacies until such time that scientific data support the health and environmental safety of these products.

2. APhA opposes the use of e-cigarettes and other vaporized nicotine products in areas subject to current clean air laws, regulations, and policies for combustible tobacco products until such time that scientific data support the health and environmental safety of these products.

3. APhA urges pharmacists to become more knowledgeable about e-cigarettes and other vaporized nicotine products.

(JAPhA. 54(4): 358; July/August 2014) (Reviewed 2019)

68. The Committee Recommends AMENDING the following policy statement as written.

2013, 2009 Independent Practice of Pharmacists

1. APhA recommends that health plans and payers contract with and appropriately compensate individual pharmacist providers for the level of care rendered without requiring the pharmacist to be associated with a pharmacy.

2. APhA supports adoption of ~~state~~ laws, regulations and policies pertaining to the independent practice of pharmacists when those laws, regulations and policies and rules are consistent with APhA policy.

3. APhA, recognizing the positive impact that pharmacists can have in meeting unmet needs and managing medical conditions, supports the adoption of laws, regulations, and policies and the creation of payment mechanisms for appropriately trained pharmacists to

autonomously provide patient care services, including prescribing, as part of the health care team.
(JAPhA. NS49(4):492; July/August 2009) (Reviewed 2012) (JAPhA. 53(4):366; July/August 2013) (Reviewed 2018) (Reviewed 2023)

69. The Committee Recommends AMENDING the following policy statement as written.
2018 Pharmacist Workplace Environment and Patient Safety

1. APhA supports staffing models that promote safe provision of patient care services and access to medications.

2. APhA encourages the adoption of patient centered quality and performance measures that align with safe delivery of patient care services and opposes the setting and use of operational quotas or time-oriented metrics that negatively impact patient care and safety.

3. APhA denounces any policies or practices of third-party administrators, processors, and payers that contribute to a workplace environment that negatively impacts patient safety. APhA calls upon public and private policy makers to establish provider payment laws, regulations, and policies that support the safe provision of medications and delivery of effective patient care.

4. APhA urges pharmacy practice employers to establish collaborative mechanisms that engage the pharmacist in charge of each practice, pharmacists, pharmacy technicians, and pharmacy staff in addressing workplace issues that may have an impact on patient safety.

5. APhA urges employers to collaborate with the pharmacy staff to regularly and systematically examine and resolve workplace issues that may have a negative impact on patient safety.

6. APhA opposes retaliation against pharmacy staff for reporting workplace issues that may negatively impact patient safety.
(JAPhA. 58(4):355; July/August 2018) (Reviewed 2020) (Reviewed 2021) (Reviewed 2022)

70. The Committee Recommends AMENDING the following policy statement as written.
2013 Medication Take-Back/Disposal Programs

1. APhA encourages pharmacist involvement in the planning and coordination of medication take-back programs for the purpose of disposal.
2. APhA supports increasing public awareness regarding medication take-back programs for the purpose of disposal.
3. APhA urges public and private stakeholders, including local, state, and federal agencies, to coordinate and create uniform, standardized laws, regulations and policies, including issues related to liability and sustainable funding sources, for the proper and safe disposal of unused medications.

4. APhA recommends ongoing medication take-back and disposal programs.
(JAPhA. 53(4):365; July/August 2013) (Reviewed 2018)

71. The Committee Recommends AMENDING the following policy statement as written.
2004, 1985 Pharmacist Involvement in Execution by Lethal Injection

1. APhA opposes the use of the term "drug" for chemicals when used in lethal injections.
2. APhA opposes laws, regulations, and policies that mandate or prohibit the participation of pharmacists in the process of execution by lethal injection.
(Am Pharm. NS25(5):51; May 1985) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015)

72. The Committee Recommends AMENDING the following policy statement as written.
2004, 1997 Physician-Assisted Suicide

1. APhA supports informed decision-making based upon the professional judgment of pharmacists, rather than endorsing a particular moral stance on the issue of physician-assisted suicide.
2. APhA opposes laws, regulations, and policies that mandate or prohibit the participation of pharmacists in physician-assisted suicide.
(JAPhA. NS37(4):459; July/August 1997) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015)

73. The Committee Recommends AMENDING the following policy statement as written.
2004, 1980 Internal Revenue Service Drug Deduction

APhA supports amendment of ~~the federal and state~~ personal income tax laws, regulations, and policies to permit all personal expenditures for medicines and drugs to be totally deductible and exempt from any exclusionary limits.
(Am Pharm. NS20(7):61; July 1980) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015

74. The Committee Recommends AMENDING the following policy statement as written.
1985 Reduction of Federal Laws and Regulations (Paperwork Burden)

APhA supports the reduction and simplification of laws, regulations, and policies for record-keeping requirements that affect pharmacy practice and are not beneficial in protecting the public welfare.
(Am Pharm. NS25(5):51; May 1985) (Reviewed 2001) (Reviewed 2004) (Reviewed 2010) (Reviewed 2015)(Reviewed 2021)

75. The Committee Recommends AMENDING the following policy statement as written.
2023 Access to Comprehensive Reproductive Health Care

1. APhA supports equitable patient access to evidence-based comprehensive reproductive health care, including, but not limited to, the management of pregnancy loss, ectopic pregnancy, infertility, pregnancy termination, contraception, and permanent contraception.

2. APhA recognizes patient autonomy in choosing reproductive health care services and the essential role of all health care professionals in facilitating access and advancing informed decision making.
3. APhA supports evidence-based ~~legislation~~ laws, regulations, and policies that ensures patient access to comprehensive reproductive health care services.
4. APhA opposes legal actions against pharmacies, pharmacists, and pharmacy personnel that provide patient access to, or information regarding, reproductive health care services that are within pharmacist scope of practice.
(JAPhA. 63(4):1266; July/August 2023)

76. The Committee Recommends AMENDING the following policy statement as written.
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 laws, regulations, and policies.
(JAPhA. 60(5):e11; September/October 2020) (Reviewed 2022)

Comments This policy statement was also part of the Committee's second charge. The Committee had no changes and recommended to retain the existing language as it related to those newly adopted policies from the March 2023 House of Delegates. The Committee recommends amending Statement 5 however, as part of their third charge to standardize language throughout the policy manual.

77. The Committee Recommends AMENDING the following policy statement as written.
2016, 1994 Pharmacy Services Benefits in Health Care Reform

APhA supports reform of the U.S. health care system and believes that any reform at the state or national level must provide for the following.
1. Universal coverage for pharmacy service benefits that include both medications and pharmacists' services;
2. Specific provisions for the access to and payment for pharmacists' patient care services;
3. A single set of pricing rules, eliminating class-of-trade distinctions, for medications, medication delivery systems, and other equipment so that no payer, patient, or provider is disadvantaged by cost shifting;
4. The right for every American to choose his/her own provider of medications and pharmacists' services and for all pharmacists to participate in the health plans of their choice under equally applied terms and conditions;
5. Quality assurance mechanisms to improve and substantiate the effectiveness of medications and health services;

6. Information and administrative systems designed to enhance patient care, eliminate needless bureaucracy, and provide patients and providers price and quality information needed to make informed patient-care decisions;
7. Relief from antitrust laws, ~~and~~ regulations, and policies to enable pharmacists to establish systems that balance provider needs relative to corporate and governmental interests;
8. Reform in the professional liability system, including caps on non-economic damages, attorneys' fees, and other measures;
9. Representation on the controlling board of each plan by an active health care practitioner from each discipline within the scope of the plan; and
10. Recognition of the pharmacist's role in delivering primary health care services.
(Am Pharm. NS34(6):58; June 1994) (Reviewed 2004) (Reviewed 2010) (Reviewed 2011) (JAPhA. 56(4):379; July/August 2016) (Reviewed 2018) (Reviewed 2021)

Comments This policy statement was also part of the Committee's second charge. The Committee had no changes and recommended to retain the existing language as it related to those newly adopted policies from the March 2023 House of Delegates. The Committee recommends amending Statement 5 however, as part of their third charge to standardize language throughout the policy manual.

78. The Committee Recommends AMENDING the following policy statement as written.
2005, 2004, 1999 Telemedicine/Telehealth/Telepharmacy

1. APhA supports the pharmacist as the only appropriate provider of telepharmacy services, a component of telehealth, for which compensation should be provided. Telepharmacy is defined as the provision of pharmaceutical care to patients through the use of telecommunications and information technologies.
2. AphA shall assist pharmacists and student pharmacists in becoming knowledgeable about telepharmacy and telehealth.
3. AphA shall participate in the ongoing development of the telehealth infrastructure, including but not limited to laws, regulations, policies, standards development, security guidelines, information systems, and compensation.
4. AphA acknowledges that state boards of pharmacy are primarily responsible for the regulation of the practice of telepharmacy, encourages appropriate laws, regulations, and policies ~~regulatory action~~ that facilitate~~s~~ the practice of telepharmacy and maintain~~s~~ appropriate guidelines to protect the public health and patient confidentiality.
(JAPhA. 39(4):447; July/August 1999) (JAPhA. NS44(5):551; September/October 2004) (JAPhA. NS45(5):559; September/October 2005) (Reviewed 2009) (Reviewed 2012) (Reviewed 2014) (Reviewed 2019)

79. The Committee Recommends AMENDING the following policy statement as written.
2019, 1997 Collaborative Practice Agreements

1. APhA supports the establishment of collaborative practice agreements between pharmacists and other health care professionals designed to optimize patient care outcomes.

2. APhA supports the establishment of collaborative practice agreements between one or multiple pharmacists and one or multiple prescribers or entities.
3. APhA supports state laws, regulations, and policies that do not require a referral or a prior provider–patient relationship as a prerequisite to access services provided under a collaborative practice agreement.
4. APhA opposes state laws, regulations, and policies that limit collaborative practice agreements to specific patients.
5. APhA supports state laws, regulations, and policies that allow for pharmacists' prescriptive authority.
6. APhA supports state collaborative practice laws, regulations, and policies that allow all licensed pharmacists, in all practice settings, to establish collaborative practice agreements with other health care professionals or entities.
7. APhA shall promote the establishment and dissemination of guidelines and information to pharmacists and other health care professionals to facilitate the development of collaborative practice agreements.
(JAPhA. NS37(4):459; July/August 1997) (Reviewed 2003) (Reviewed 2007) (Reviewed 2009) (Reviewed 2011) (Reviewed 2012) (Reviewed 2017) (JAPhA. 59(4):e17; July/August 2019) (Reviewed 2020)

80. The Committee Recommends AMENDING the following policy statement as written.
1967 State and Local Boards of Health

Because of the broad implications of the pharmacist's role in public health, the committee recommends that pharmacists and pharmacy associations seek to have the state laws, regulations, and policies amended to require that a pharmacist serve on the state and local boards of health. One part of this effort should be an increased interest on the part of the pharmacist in his local health boards and commissions.
(JAPhA. NS7:324; June 1967) (Reviewed 2002) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

81. The Committee Recommends AMENDING the following policy statement as written.
2004, 1980 Identification of Prescription Drug Products

APhA supports a federal ~~legislative or regulatory~~ requirement that a name, trademark, number, or code be included on the drug dosage form.
(Am Pharm. NS20(7):62; July 1980) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015)

82. The Committee Recommends AMENDING the following policy statement as written.
2004, 1969 Manufacturer's Name Included on Labels

APhA supports ~~legislation that would require~~ requirements for the name of the actual manufacturer of the dosage forms on all drug products.
(JAPhA. NS9:361; July 1969) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015

83. The Committee Recommends AMENDING the following policy statement as written.

2004, 1970 Disclosure of Ingredients in Drug Products

APhA supports ~~legislation or regulation to require~~ requirements for ~~a~~ full disclosure of therapeutically inactive, as well as active ingredients of all drug products.
(JAPhA. NS10:357; June 1970) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015) (Reviewed 2019)

84. The Committee Recommends AMENDING the following policy statement as written.

2017 Pharmacy Technician Education, Training, and Development

1. APhA supports the following minimum requirements for all new pharmacy technicians:
   (a) Successful completion of an accredited or state-approved education and training program.
   (b) Certification by the Pharmacy Technician Certification Board (PTCB).
2. APhA supports state board of pharmacy laws, regulations, and policies that require pharmacy technicians to meet minimum standards of education, training, certification, and recertification. APhA encourages state boards of pharmacy to develop a phase-in process for current pharmacy technicians. APhA also encourages boards of pharmacy to delineate between pharmacy technicians and student pharmacists for the purposes of education, training, certification, and recertification.
3. APhA recognizes the important contribution and role of pharmacy technicians in assisting pharmacists and student pharmacists with the delivery of patient care.
4. APhA supports the development of resources and programs that promote the recruitment and retention of qualified pharmacy technicians.
5. APhA supports the development of continuing pharmacy education programs that enhance and support the continued professional development of pharmacy technicians.
6. APhA encourages the development of compensation models for pharmacy technicians that promote sustainable career opportunities.

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

85. The Committee Recommends AMENDING the following policy statement as written.

2012 Registration of Facilities

APhA supports ~~state and federal~~ laws, ~~and~~ regulations, and policies that require registration with the state boards of pharmacy of all facilities involved in the storage, wholesale distribution, and issuance of legend drugs to patients, provided that such registration does not restrict the pharmacists from providing professional services independent of a facility.
(JAPhA. NS52(4):458; July/August 2012) (Reviewed 2017)

86. The Committee Recommends AMENDING the following policy statement as written.

1985 Registration of Facilities Involved in the Storage and Issuing of Legend Drugs to Patients

APhA supports enactment of ~~state and federal~~ laws, regulations, and policies that would require registration with the state boards of pharmacy of all facilities involved in the storage and issuing of legend drugs to patients, provided that such registration does not restrict the pharmacist from providing professional services independent of a facility.
(Am Pharm. NS25(5):51 May; 1985) (Reviewed 2004) (Reviewed 2010) (Reviewed 2012) (Reviewed 2013) (Reviewed 2018) (Reviewed 2023)

87. The Committee Recommends AMENDING the following policy statement as written.
1985 Regulation of Mobile Facilities

APhA supports enactment of ~~state and federal~~ laws, regulations and policies which would govern the dispensing and issuing of legend drugs from mobile facilities.
(Am Pharm. NS25(5):51; May 1985) (Reviewed 2004) (Reviewed 2010) (Reviewed 2015) (Reviewed 2023)

88. The Committee Recommends AMENDING the following policy statement as written.
2002 Professional Practice Regulation

1. APhA encourages the revision of pharmacy laws, regulations, and policies to assign the responsibility and accountability to the pharmacy license holder for the operations of the pharmacy, including but not limited to quality improvement, staffing, inventory, and financial activities. Further, APhA supports the responsibility and accountability of the pharmacist for dispensing of the pharmaceutical product and for the provision of pharmaceutical care services.
2. APhA encourages the pharmacy license holder to provide adequate resources and support for pharmacists to meet their professional responsibilities, and for pharmacists to utilize the resources and support appropriately and efficiently. APhA encourages state boards of pharmacy to hold pharmacy license holders accountable for failure to provide such adequate resources and support.
(JAPhA. NS42(5)(suppl 1):S60; September/October 2002) (Reviewed 2007) (Reviewed 2008) (Reviewed 2011) (Reviewed 2016) (Reviewed 2021)

89. The Committee Recommends AMENDING the following policy statement as written.
2007 Privacy of Pharmacists' Personal Information

1. APhA supports protecting pharmacist, student pharmacist, and pharmacy technician personal information (e.g. home address, telephone, and personal email address).
2. APhA opposes ~~legislative or regulatory~~ legal, regulatory, and policy requirements that mandate the publication of pharmacist, student pharmacist and pharmacy technician personal information (e.g., home address, telephone, and personal email address).
3. APhA encourages state boards of pharmacy to remove from their websites personal addresses, phone numbers, email, and other non-business contact information of pharmacists, student pharmacists, and pharmacy technicians.
(JAPhA. NS45(5):580; September-October 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2023)

90. The Committee Recommends AMENDING the following policy statement as written.
2017 Support for Clinically Validated Blood Pressure Measurement Devices

1. APhA supports the use of manual and automated blood pressure measurement devices that are clinically validated initially and then undergo routine calibration to ensure accurate results.
2. APhA supports laws, regulations, policies, and peer-reviewed clinical validation testing for automated blood pressure measurement devices.
3. APhA promotes public awareness of accuracy of automated blood pressure measurement devices.

(JAPhA. 57(4):442; July/August 2017)

91. The Committee Recommends AMENDING the following policy statement as written.
2022 Pharmacists' Application of Professional Judgment

1. APhA supports pharmacists, as licensed health care professionals, in their use of professional judgment throughout the course of their practice to act in the best interest of patients.
2. APhA asserts that a pharmacist's independent medication review and use of professional judgment in the medication distribution process is essential to patient safety.
3. APhA opposes ~~state and federal~~ laws, regulations, and policies that limit a pharmacist's responsibility to exercise professional judgment in the best interest of patients.
4. APhA calls for civil, criminal, and professional liability protections for pharmacists and pharmacies if the pharmacist's responsibility to use professional judgment is limited by ~~state or federal~~ laws, regulations, and policies.

(JAPhA. 62(4):942; July 2022)

92. The Committee Recommends AMENDING the following policy statement as written.
2012, 2003 The Pharmacist's Role in Laboratory Monitoring and Health Screening

1. APhA supports pharmacist involvement in appropriate laboratory testing and health screening, including pharmacists directly conducting the activity, supervising such activity, ordering and interpreting such tests, and communicating such tests results.
2. APhA supports revision of relevant laws, regulations, and policies to facilitate pharmacist involvement in appropriate laboratory testing and health screening as essential components of patient care.
3. APhA encourages research to further demonstrate the value of pharmacist involvement in laboratory testing and health screening services.
4. APhA supports public and private sector compensation for pharmacist involvement in laboratory testing and health screening services.
5. APhA supports training and education of pharmacists and student pharmacists to direct, perform, and interpret appropriate laboratory testing and health screening services. Such education and training should include proficiency testing, quality control, and quality assurance.

6. APhA encourages collaboration and research with other health care providers to ensure appropriate interpretation and use of laboratory monitoring and health screening results.
(JAPhA. NS43(5)(suppl 1):S58; September/October 2003) (Reviewed 2007) (Reviewed 2009) (Reviewed 2010) (JAPhA. NS52(4):460; July/August 2012) (Reviewed 2013) (Reviewing 2016) (Reviewed 2017) (Reviewed 2023)

93. The Committee Recommends AMENDING the following policy statement as written.
1971 Prescription Department Security

The committee recommends that APhA support ~~state legislation~~ laws, regulations, and policies to require that a prescription department must be secured whenever the pharmacist or persons authorized by the pharmacist are not present.
(JAPhA. NS11:267; May 1971) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016)

94. The Committee Recommends AMENDING the following policy statement as written.
2001, 1990 Regulatory Infringements on Professional Practice

1. APhA, in cooperation with other national pharmacy organizations, shall take a leadership role in the establishment and maintenance of standards of practice for existing and emerging areas in the profession of pharmacy.
2. APhA encourages a cooperative process in the development, enforcement, and review of ~~rules and~~ laws, regulations, and policies by agencies that affect any aspect of pharmacy practice, and this process must utilize the expertise of affected pharmacist specialists and their organizations.
3. APhA supports the right of pharmacists to exercise professional judgment in the implementation of standards of practice in their practice settings.
(Am Pharm. NS30(6):45; June 1990) (JAPhA. NS4(5)(suppl 1):S7; September/October, 2001) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2020) (Reviewed 2023)

95. The Committee Recommends AMENDING the following policy statement as written.
2012, 2005, 1969 Medicare and Patient Care Service

1. APhA believes that Health care, including the essential component of patient care services, should be made available to as many people as possible in our society through the most economical system compatible with an acceptable standard of quality.
2. APhA should support the Part B mechanism which is the voluntary supplementary medical insurance program financed equally by beneficiaries and the government.
3. APhA should oppose laws, regulations, and policies that would restrict the Medicare drug benefit to specific, chronic diseases.
4. APhA should support the inclusion of patient care services under Medicare or any other federal financing mechanism, providing the program is designed to help persons who need it most and is administratively efficient and economical.
(JAPhA. NS9:363; July 1969) (JAPhA. NS45(5):558; September/October 2005) (Reviewed 2009) (JAPhA. NS52(4):460; July/August 2012) (Reviewed 2017) (Reviewed 2018

96. The Committee Recommends AMENDING the following policy statement as written.
1975 Periodic Adjustments of Professional Fees in Federal Programs

It is essential that ~~federal~~ laws, regulations, and policies governing pharmacist professional fees in federally-supported, health care programs require review and equitable adjustments on a regularized, periodic basis.
(JAPhA. NS15:330; June 1975) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

97. The Committee Recommends AMENDING the following policy statement as written.
1984 Exemption from the Employee Retirement Income Security Act (ERISA)

APhA seeks introduction of laws, regulations, and policies exempting state, third-party, and prescription programs ~~legislation~~ from preemption by ERISA.
(Am Pharm. NS24(7):61; July 1984) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

98. The Committee Recommends AMENDING the following policy statement as written.
1981 Third-party Reimbursement Legislation

APhA supports enactment of laws, regulations, and policies requiring that third-party program reimbursement to pharmacists be at least equal to the pharmacists prevailing charges to the self-paying public for comparable services and products, plus additional documented direct and indirect costs, which are generated by participating in the program.
(Am Pharm. NS21(5):40; May 1981) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019) (Reviewed 2021) (Reviewed 2022)

99. The Committee Recommends AMENDING the following policy statement as written.
2005, 1986, 1981 Use of Animals in Drug Research

1. APhA recognizes that animal experiments continue to be an essential, and indeed irreplaceable, component of biomedical research and testing.
2. When animals must be used for biomedical research and testing, APhA strongly supports humane treatment and adequate ~~regulation~~ laws, regulations, and policies, controls, and enforcement of appropriate measures relating to animal procurement, transportation, housing, care, and treatment.
3. APhA encourages the further development of methods of biomedical research and testing which do not require the use of animals.
4. APhA opposes ~~legislative provisions~~ laws, regulations, and policies that would penalize the properly controlled and conducted use of animals for biomedical research and testing.
(Am Pharm. NS21(5):41; May 1981) (Am Pharm. NS26(6):420; June 1986) (JAPhA. NS45(5):559; September/October 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

100. The Committee Recommends AMENDING the following policy statement as written.
1989 Pharmacists as Principal Investigators in Clinical Drug Research

1. APhA urges the sponsors of drug research to permit pharmacists to serve as principal investigators.
2. APhA encourages ~~state and federal~~ agencies to eliminate laws, regulations, and policies that prohibit pharmacists from being investigators, including principal

investigators, in drug research or sponsors of Investigational New Drug Applications, Investigational Device Evaluations, and Animal Investigational New Drug Applications.
(Am Pharm. NS29(7):465; July 1989) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019) (Reviewed 2022)

101. The Committee Recommends AMENDING the following policy statement as written.

1980 Nuclear Pharmacy Regulations

1.APhA supports the concept of state boards of pharmacy retaining their authority to regulate all aspects of professional pharmacy practice including nuclear pharmacy practice.
2. APhA urges state boards of pharmacy to promptly adopt appropriate laws, regulations, and policies for the practice of nuclear pharmacy, using the NABP Model Regulations for the Licensure of Nuclear Pharmacies as a model.
(Am Pharm. NS20:69; July 1980) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016)

102. The Committee Recommends AMENDING the following policy statement as written.

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

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 conditions ~~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)

103. The Committee Recommends AMENDING the following policy statement as written.

2020 Transfer of Schedule III–V Prescriptions for Purposes of Initial Fill as Well as Refill

APhA supports laws, regulations, and policies that would allow pharmacies to transfer prescriptions for controlled substances for the purposes of an initial fill.
(JAPhA. 60(5):e10); September/October 2020)

Policy Statements related to "People-centric" Language.

The Committee was charged with reviewing the entire policy manual to standardize policy language from a "People Centric" perspective.

104. The Committee Recommends AMENDING the following policy statement as written.

2019 Creating Safe Work and Learning Environments for Student Pharmacists, Pharmacists, and Pharmacy Technicians

1. APhA strongly believes that all pharmacists, student pharmacists, and pharmacy technicians should be safe in their work and learning environments and be free from firearm-related violence.
2. APhA strongly recommends that technician training programs, schools and colleges of pharmacy, postgraduate training programs, and employers should develop programs to increase readiness in the event of an active shooter.
3. APhA strongly believes pharmacists, student pharmacists, and pharmacy technicians should be trained to recognize and refer patients at high risk of violence to themselves or others.
4. APhA encourages pharmacists, student pharmacists, and pharmacy technicians who are ~~victims~~ survivors of firearm-related violence to seek the help of counselors and other trained mental health professionals.

(JAPhA. 59(4):e17; July/August 2019)

105. The Committee Recommends AMENDING the following policy statement as written.

2020 Non-execution-Related Use of Pharmaceuticals in Correctional Facilities

1. APhA opposes drug manufacturers' refusal to supply certain drugs to correctional health services units necessary to provide medical treatment of those who are incarcerated ~~inmates~~.

(JAPhA. 60(5):e11; September/October 2020) (Reviewed 2023)

106. The Committee Recommends AMENDING the following policy statement as written.

1972 Boards of Pharmacy: Consumer Representation

APhA encourages state pharmaceutical associations to actively seek appointment of ~~lay representation of the~~ public members to their respective boards of pharmacy and other health profession licensing and regulatory agencies.

(JAPhA. NS12:281; June 1972) (Reviewed 2004) (Reviewed 2010) (Reviewed 2015)

107. The Committee Recommends AMENDING the following policy statement as written.

1988 Drug Usage Evaluation (DUE)

1. APhA supports drug usage evaluation (DUE) as one element of a quality assurance program for medication use.

2. APhA advocates that DUE must address enhancement of the quality of care as well as the control of costs.
3. APhA advocates pharmacists' participation along with other health care providers and ~~consumers~~ patients or caregivers in the development, implementation, and administration of DUE programs.
4. APhA encourages further development of data collection systems to improve the extent and accuracy of DUE programs.
5. APhA maintains that the primary emphasis of DUE intervention should be educational with the goal of positive behavior modification.
(Am Pharm. NS28(6):394; June 1988) (Reviewed 2004) (Reviewed 2010) (Reviewed 2015)

108. The Committee Recommends AMENDING the following policy statement as written.
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 patients with opioid-use disorder ~~for patients~~, including healthcare professionals in and out of the workplace, for as long as needed to treat their disease.
(JAPhA. 60(5):e11; September/October 2020)

109. The Committee Recommends AMENDING the following policy statement as written.
2012, 2002, 1964 Health Education: Selection of Pharmacist

APhA supports education of ~~consumers~~ patients or caregivers about the importance of selecting their personal pharmacist to assist them in the proper use of all medications and medical devices.
(JAPhA. NS4:429; August 1964) (JAPhA. NS42(5)(suppl 1):S62; September/October 2002) (Reviewed 2007) (JAPhA. NS52(4):459; July/August 2012) (Reviewed 2017) (Reviewed 2018)

110. The Committee Recommends AMENDING the following policy statement as written.
2005, 2003, 1996 Pharmacist's Role in Immunizations

1. APhA encourages pharmacists to take an active role in achieving the goals of the Healthy People program regarding immunizations through
(a) advocacy;
(b) contracting with other health care professionals; or
(c) administering vaccines to patients facing barriers to health
(JAPhA. NS36(6):395; June 1996) (JAPhA. NS43(5)(suppl 1):S57; September/October 2003) (JAPhA. NS45(5):556; September/October 2005) (Reviewed 2007) (Reviewed 2009) (Reviewed 2012) (Reviewed 2014) (Reviewed 2019) (Reviewed 2020) (Reviewed 2021)

111. The Committee Recommends AMENDING the following policy statement as written.
2019, 2005, 1990 Use of Representative Populations in Clinical Studies

1. APhA supports the use of representative populations in clinical studies, including, but not limited to protected populations such as women, persons who are underrepresented

or historically marginalized, ~~minorities, the~~ older adults ~~elderly~~, persons who are transgender and gender-diverse ~~individuals~~, and children when appropriate.
(Am Pharm. NS30(6):46; June 1990) (JAPhA. NS45(5):559; September/October 2005) (Reviewed 2009) (Reviewed 2014) (JAPhA. 59(4):e28; July/August 2019)

Comments This policy statement was also part of the Committee's second charge. The Committee had no changes and recommended to retain the existing language as it related to those newly adopted policies from the March 2023 House of Delegates. The Committee recommends amending Statement 5 however, as part of their third charge to standardize language throughout the policy manual.

112. The Committee Recommends AMENDING the following policy statement as written.
2016 Biologic, Biosimilar, and Interchangeable Biologic Drug Products

1. APhA urges the development of ~~programs~~ laws, regulations, and policies that facilitate patient access to and affordability of biologic products.

2. APhA urges the Food and Drug Administration (FDA) to expedite the development of standards and pathways that will evaluate the interchangeability of biologic products.

3. APhA recognizes the Food and Drug Administration's (FDA) Purple Book as an authoritative reference about biologic product interchangeability within the United States.

4. APhA opposes interchangeable biologic product substitution processes that require authorization, recordkeeping, or reporting beyond generic product substitution processes.

5. APhA encourages scientific justification for extrapolation of indications for biologic products to ensure patient safety and optimal therapeutic outcomes.
(JAPhA. 56(4):369; July/August 2016)

113. The Committee Recommends AMENDING the following policy statement as written.
2020 Pharmaceutical Safety and Access During Emergencies

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, regulations and policies 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)

114. The Committee Recommends AMENDING the following policy statement as written.

2015 Role of the Pharmacist in the Care of Patients Using Cannabis

1. APhA supports legal, regulatory, and policy changes to further facilitate clinical research related to the clinical efficacy and safety associated with the use of cannabis and its various components.
2. APhA encourages health care provider education related to the clinical efficacy, safety, and management of patients using cannabis and its various components.

3. APhA advocates that the pharmacist collect and document information in the pharmacy patient profile about patient use of cannabis and its various components and provide appropriate patient counseling.

4. APhA supports pharmacist participation in furnishing cannabis and its various components when scientific data support the legitimate medical use of the products and delivery mechanisms, and federal, state, or territory laws or regulations permit pharmacists to furnish them.

5. APhA opposes pharmacist involvement in furnishing cannabis and its various components for recreational use.
(JAPhA. N55(4):365; July/August 2015)

115. The Committee Recommends AMENDING the following policy statement as written.

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, regulations, and policies 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) (Reviewed 2023)

116. The Committee Recommends AMENDING the following policy statement as written.
2023 Access to Essential Medicines

APhA advocates for laws, regulations, and policies ~~and legislation~~ that recognize access to quality and affordable essential medicines as a fundamental human right.
(JAPhA. 63(4):1266; July/August 2023)

117. The Committee Recommends AMENDING the following policy statement as written.
2019 Pharmacist and Pharmacy Personnel Safety and Well-Being

1. APhA calls for employers to develop policies and ~~resources~~ procedures to support pharmacy personnel's ability to retreat or withdraw, without retaliation, from interactions that threaten their safety and well-being.
2. APhA encourages the development or utilization of educational programs and resources by the Association, employers, and other institutions to prepare pharmacy personnel to respond to situations that threaten their safety and well-being.
(JAPhA. 59(4):e17; July/August 2019) (Reviewed 2021)

118. The Committee Recommends AMENDING the following policy statement as written.
2000 Regulation of Dietary Supplements

1. APhA shall work with Congress to modify the Dietary Supplement Health and Education Act or enact other laws, regulation, or policies ~~legislation~~ to require that dietary supplement manufacturers provide evidence of efficacy and safety for all products, including products currently in the marketplace.
2. APhA supports the establishment and implementation of clear and effective enforcement policies to remove promptly unsafe or ineffective dietary supplement products from the marketplace.
3. APhA shall work with the FDA to improve dietary supplement product labeling to ensure full disclosure of all product components and their source with associated strengths and recommendations for use in specific patient populations.
4. APhA supports the development and enforcement of dietary supplement good manufacturing practices (GMPs) and compliance with USP/NF standards to ensure quality, safe, contaminant-free products.

5. APhA encourages health care professionals, manufacturers, and consumers to report adverse health events associated with dietary supplements. APhA encourages the FDA to create a database with this information and make it available to all interested parties.
(JAPhA. NS1(9):40; September/October 2000) (Reviewed 2005) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

119. The Committee Recommends AMENDING the following policy statement as written.
2019 Expanding Technician Roles

1. APhA encourages state boards of pharmacy to develop laws, regulations, and policies allowing expanded pharmacy technician roles that allow both technicians and pharmacists to practice at the top of their training and license or certification.
2. APhA supports state board of pharmacy regulations that standardize and set minimum didactic and experiential standards for technicians to allow for functioning in expanded roles.
(JAPhA. 59(4):e17; July/August 2019)

120. The Committee Recommends AMENDING the following policy statement as written.
2019, 2016 Substance Use Disorder

APhA supports ~~legislative, regulatory~~ laws, regulations, policies, and private sector efforts that include pharmacists' input and that will balance patient~~/consumer~~s' need for access to medications for legitimate medical purposes with the need to prevent the diversion, misuse, and abuse of medications.
(JAPhA. 56(4):369; July/August 2016) (JAPhA. 59(4): e28; July/August 2019) (Reviewed 2022)

121. The Committee Recommends AMENDING the following policy statement as written.
1972 Boards of Pharmacy: Consumer Representation

APhA encourages state pharmaceutical associations to actively seek appointment of ~~lay representation of the~~ public members to their respective boards of pharmacy and other health profession licensing and regulatory agencies.
(JAPhA. NS12:281; June 1972) (Reviewed 2004) (Reviewed 2010) (Reviewed 2015)

Policy Statements related to both "People-centric" language and "regulatory" language.

The following statement contains amendments related to both "people-centric" and "regulatory" language subject matter. To avoid repetition, the amendments are combined in this statement.

122. The Committee Recommends AMENDING the following policy statement as written.

2023 Transgender and Nonbinary Health Care

1. APhA supports the enactment ~~by state and federal legislatures to establish~~ of laws, regulations, and policies to end discriminatory practices that limit access to care for persons who are transgender or ~~and~~ gender-diverse ~~nonbinary people~~.
2. APhA encourages equity in care for persons who are transgender or ~~and~~ gender-diverse ~~nonbinary~~ ~~individuals~~ through:
a. Continuing education on the pharmacist's role in transgender care, gender-affirming therapy, and health disparities in patients who are transgender or gender-diverse ~~nonbinary~~ ~~patients~~.
b. Systematic integration and utilization of affirmed name and pronouns, gender identity, and anatomical inventory.
c. Availability and implementation of education and resources related to gender-diverse care for all persons employed in health care settings.
(JAPhA. 63(4):1266; July/August 2023)

APhA 2024 MARCH HOUSE OF DELEGATES – DELEGATE POLL RESULTS

Recommendations of the Policy Reference Committee				
Item	**Yes**	**Percentage Approval**	**No**	**STATUS**
Policy Topic 1 - Statement 1	148	85.06%	26	**Included in Consent Agenda**
Policy Topic 1 - Statement 2	170	97.70%	4	**Included in Consent Agenda**
Policy Topic 1 - Statement 3	163	93.68%	11	**Included in Consent Agenda**
Policy Topic 1 - Statement 4	167	95.98%	7	**Included in Consent Agenda**
Policy Topic 1 - Statement 5	160	91.95%	14	**Included in Consent Agenda**
Policy Topic 1 - Statement 6	169	97.13%	5	**Included in Consent Agenda**
Policy Topic 1 - Statement 7	160	91.95%	14	**Included in Consent Agenda**
Policy Topic 1 - Statement 8	161	92.53%	13	**Included in Consent Agenda**
Policy Topic 2 - Statement 1	170	97.70%	4	**Included in Consent Agenda**
Policy Topic 2 - Statement 2	158	90.81%	16	**Included in Consent Agenda**
Policy Topic 2 - Statement 3	160	91.95%	14	**Included in Consent Agenda**
Policy Topic 2 - Statement 4	162	93.10%	12	**Included in Consent Agenda**
Recommendations of the New Business Review Committee				
Item	**Yes**	**Percentage Approval**	**No**	**STATUS**
NBI #1 – Statement 1	160	91.95%	14	**Included in Consent Agenda**
NBI #2 – Statement 1	140	80.46%	34	**Included in Consent Agenda**
NBI #2 – Statement 2	159	91.38%	15	**Included in Consent Agenda**
NBI #2 – Statement 3	154	88.51%	20	**Included in Consent Agenda**
NBI #2 – Statement 4	154	88.51%	20	**Included in Consent Agenda**
NBI #3 – Statement 1	145	83.33%	29	**Included in Consent Agenda**
NBI #4 – Statement 1	126	72.41%	48	**Pulled from Consent Agenda for Individual Action**
NBI #4 – Statement 2	169	97.13%	5	**Included in Consent Agenda**
NBI #4 – Statement 3	162	93.10%	12	**Included in Consent Agenda**
NBI #5 – Statement 1	168	96.56%	6	**Included in Consent Agenda**
NBI #6 – Statement 6	162	93.10%	12	**Included in Consent Agenda**
NBI #7 – Statement 1	161	92.53%	13	**Included in Consent Agenda**
NBI #8 – Statement 1	168	96.56%	6	**Included in Consent Agenda**
NBI #8 – Statement 2	161	92.53%	13	**Included in Consent Agenda**
NBI #8 – Statement 3	164	94.25%	10	**Included in Consent Agenda**
NBI #8 – Statement 4	152	87.36%	22	**Included in Consent Agenda**
NBI #8 – Statement 5	153	87.93%	21	**Included in Consent Agenda**
NBI #9 – Statement 1	135	77.59%	39	**Included in Consent Agenda**
NBI #10 – Statement 1	152	87.36%	22	**Included in Consent Agenda**
NBI #10 – Statement 2	155	89.08%	19	**Included in Consent Agenda**
NBI #10 – Statement 3	158	90.81%	16	**Included in Consent Agenda**
NBI #10 – Statement 4	153	87.93%	21	**Included in Consent Agenda**
NBI #10 – Statement 5	157	90.23%	17	**Included in Consent Agenda**
NBI #11 – Statement 1	151	86.78%	23	**Included in Consent Agenda**
NBI #11 – Statement 2	159	91.38%	15	**Included in Consent Agenda**

APhA 2024 MARCH HOUSE OF DELEGATES – DELEGATE POLL RESULTS

Process for Poll Result Tabulation

The poll was sent to **339 registered delegates**. A quorum is defined as 170 of those delegates completing the poll. As of March 11, 2024, 3:00pm Eastern Time, **174 delegates completed the poll**. Therefore, a quorum was established.

Results were tabulated for this poll as follows:

1. All delegates who complete the poll will be considered in the total number of respondents for each poll question.
2. For each poll item, the total number of "Approve" votes and "Not Approve" votes are added together and will represent the denominator for that poll item.
3. The total number of "Approve" votes represents the numerator in the final count for that poll item.

2023–2024 House of Delegates

Report of the Policy Reference Committee

- Artificial Intelligence Use in Pharmacy Practice
- Cybersecurity in Pharmacy

Committee Members

Mary Klein, Chair
Nicholas Capote
Dalton Fabian
Neelam "Nelly" Gazarian
Christopher Harlow
Amy Kennedy
Matthew Lacroix
Scott Tomerlin

Ex Officio

Brandi Hamilton, Speaker of the House

Overall Charge and Duties

The APhA House of Delegates Policy Reference Committee reviewed feedback provided directly via email and from two open hearing webinars that took place on December 6, 2023, and December 13, 2023. The Committee then met on Monday, January 8, 2024, and Friday, January 12, 2024, to develop the following recommendations. Proposed amendments will become primary language acted on by the House of Delegates and are shown in red font (deletions are ~~**struck through**~~ and proposed additions are **underlined**).

The APhA House of Delegates Policy Reference Committee presents the following report:

Topic #1 – Artificial Intelligence Use in Pharmacy Practice

The APhA Policy Reference Committee recommends adoption of the following as amended.

1. APhA opposes use of artificial intelligence in place of the pharmacist's professional judgment ~~or access to a pharmacist~~.
   (*Refer to Summary of Discussion items: 1–21*)

The Policy Reference Committee recommends adoption as amended, to reflect delegate feedback around clarity and tone. The committee's intent is to convey clear opposition for the replacement of a pharmacists' professional judgment by artificial intelligence, while being mindful not to set an alarmist tone. The committee considers patient access to a pharmacist to be implied by mention of pharmacist's professional judgment.

The APhA Policy Reference Committee recommends adoption of the following as written.

2. APhA calls on the profession of pharmacy and all related organizations to proactively assess and respond to the evolving role of artificial intelligence in pharmacy practice and workforce dynamics.
   (*Refer to Summary of Discussion items: 1–16, 22–24*)

The Policy Reference Committee recommends adoption as written, commending its innovative and proactive spirit. The committee also notes this statement as written is appropriately broad to include all of pharmacy and all related parties who may play a role in development of the role of artificial intelligence in pharmacy practice.

The APhA Policy Reference Committee recommends adoption of the following as written.

3. APhA encourages judicious use of artificial intelligence by pharmacists and pharmacy personnel as a tool to elevate pharmacy practice and enhance patient care.

(Refer to Summary of Discussion items: 1–16, 25–31)

The Policy Reference Committee recommends adoption as written, as the proposed statement balances judicious use of artificial intelligence with an innovative and open approach to enhancing the profession.

The APhA Policy Reference Committee recommends adoption of the following as written.

4. APhA advocates for the integration of pharmacists into the development, design, validation, implementation, and maintenance of artificial intelligence solutions.
(*Refer to Summary of Discussion items: 1–16, 32–40*)

The Policy Reference Committee recommends adoption as written, supporting pharmacists' involvement and agency in the creation of artificial intelligence solutions, as opposed to these solutions being imposed on them by another party. The committee considers all aspects of artificial intelligence solutions to be captured within the broad categories outlined in the language as written.

The APhA Policy Reference Committee recommends adoption of the following as amended.

5. APhA calls on regulatory bodies, employers, and other relevant parties to develop laws, regulations, and policies~~, procedures, and~~ as applicable ~~rules~~ for artificial intelligence to ensure patient safety, privacy, public awareness, and public protection.
(*Refer to Summary of Discussion items: 1–16, 41–48*)

The Policy Reference Committee recommends adoption as amended, to reflect standardized regulatory language, "laws, regulations and policies", as recommended by the 2023-2024 APhA Policy Review Committee.

The APhA Policy Reference Committee recommends adoption of the following as written.

6. APhA calls on those providing artificial intelligence solutions to implement processes that identify and mitigate bias and misinformation in artificial intelligence.
(*Refer to Summary of Discussion items: 1–16, 49–53*)

The Policy Reference Committee recommends adoption as written. While the committee considered questions posed by delegates around limitations of data inputs, this concept is effectively captured in the proposed statement as written.

The APhA Policy Reference Committee recommends adoption of the following as amended.

7. APhA advocates for education providers to facilitate, and pharmacy personnel to seek out, education and training on trustworthy artificial intelligence and its lawful, ethical, and clinical use.
   (Refer to Summary of Discussion items: 1–16, 31, 54–62)

The Policy Reference Committee recommends adoption as amended, following delegate feedback to combine the concepts of Topic #1 Statements #7 and #8. The committee is in alignment with the original intent to place responsibility on both education providers to create education content, and also on individual pharmacy practitioners to seek out artificial intelligence content. After some discussion, an opportunity was identified to consolidate both concepts into one statement as amended.

The APhA Policy Reference Committee recommends rejection of the following as written.

8. ~~APhA calls on pharmacists and pharmacy personnel to seek out education and training on trustworthy artificial intelligence and its lawful, ethical, and clinical use.~~
   (Refer to Summary of Discussion items: 1–16, 54–62)

The Policy Reference Committee recommends rejection as written, following delegate feedback to combine the concepts of Topic #1 Statements #7 and #8. The committee is in alignment with the original intent to place responsibility on both education providers to create education content, and also on individual pharmacy practitioners to seek out artificial intelligence content. After some discussion, an opportunity was identified to consolidate both concepts into one statement as amended. (Statement #7)

Topic #2 – Cybersecurity in Pharmacy

The APhA Policy Reference Committee recommends adoption of the following as written.

1. APhA advocates for implementation and maintenance of cybersecurity systems, safeguards, and response mechanisms to mitigate risk and minimize harm or disruption for all pharmacies and related parties who manage or access electronic health and business information.
   (Refer to Summary of Discussion items: 1–15)

The Policy Reference Committee recommends adoption as written. The committee determined that this language effectively captures the intent to advocate for implementation of all cybersecurity measures necessary to protect electronic health and business information.

The APhA Policy Reference Committee recommends adoption of the following as written.

2. APhA advocates for all pharmacies and related business entities responsible for electronic health and business information to have cyber liability insurance or an equivalent self-funded plan to protect all relevant parties in the event of a cyberattack and data breach.
(Refer to Summary of Discussion items: 1–6, 13–20)

The Policy Reference Committee recommends adoption as written, noting that this statement captures the intent to advocate for appropriate protections and insurances in as evergreen a manner as possible.

The APhA Policy Reference Committee recommends adoption of the following as amended.

3. APhA advocates for education providers to ~~integrate~~ facilitate, and pharmacy personnel to seek out, education and training on cybersecurity laws, regulations, and best practices. ~~on protection of electronic health and business information into their education and training programs.~~
(Refer to Summary of Discussion items: 1–6, 13, 20–26)

The Policy Reference Committee recommends adoption as amended, following delegate feedback to combine the concepts of Topic #2 Statements #3 and #4. The committee is in alignment with the original intent to place responsibility on both education providers to create education content and individual pharmacy practitioners to seek out this content. After some discussion, an opportunity was identified to consolidate both concepts into one statement as amended.

The APhA Policy Reference Committee recommends rejection of the following as written.

~~4. APhA calls for the pharmacy workforce to seek out education and training on cybersecurity laws, regulations, and best practices on protection of electronic health and business information.~~
(Refer to Summary of Discussion items: 1–6, 26)

The Policy Reference Committee recommends rejection as written, following delegate feedback to combine the concepts of Topic #2 Statements #3 and #4. The committee is in alignment with the original intent to place responsibility on both education providers to create education content and individual pharmacy practitioners to seek out this content. After some discussion, an opportunity was identified to consolidate both concepts into one statement as amended. (Statement #3)

Summary of Discussion – Artificial Intelligence in Pharmacy Practice

1. The committee broadly defined artificial intelligence (AI) as a branch of computer science that deals with problem-solving with the aid of symbolic programming, and a machine's ability to perform cognitive functions associated with human minds. This definition reflects established definitions and studies from researchers of leading institutions such as Stanford University and Cambridge University. The committee discussed large language models as a type of AI potentially used by pharmacies. (1–8)
2. Following the creation of draft proposed statements, the committee referenced generative AI programs to explore their crafted language. (1–8)
3. In addition to the proposed policy statements, topics such as academic implications, liability, and pharmaceutical industry implications were mentioned during APhA Open Forum webinars and committee discussions. The committee opted to focus the scope of these proposed policy statements on the use of AI and engagement of pharmacists for the purposes of this policy. (1–8)
4. The overarching intent of the committee when developing these proposed policy statements is to take a proactive approach to ensure AI is effectively utilized to support pharmacy practice in an ethical manner, as opposed to being reactionary. (1–8)
5. Furthermore, from a scope perspective, the committee acknowledged the expectation that given rapid evolution of AI technology developments, policies proposed at this time will likely be foundational policy to be further reviewed and updated by future committees. (1–8)
6. The committee discussed the order of the statements to highlight the importance of APhA's stance on the appropriate use of AI. (1–8)
7. The committee worked to arrange statements from broadest to narrowest, following a similar structure as cybersecurity. In doing so, the committee opted to lead this collection of policy statements with the strong statement of opposition against pharmacists being replaced by AI. (1–8)
8. The general order was negative / strong statement, positive statement, call to action, then education pieces. (1–8)
9. As part of the review of existing policy gaps, the committee reviewed the following relevant APhA policies, noting topics pertaining to (1–8):
    a. 2022 - Standard of Care Regulatory Model for State Pharmacy Practice Acts (JAPhA. 62(4):941; July 2022)
    b. 2022 - Pharmacists' Application of Professional Judgment (JAPhA. 62(4):942; July 2022)
    c. 2020 Digital Health Integration in Pharmacy (JAPhA. 60(5): e11; September/October 2020)
    d. 2004 - Automation and Technology in Pharmacy Practice (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2006) (Reviewed 2008) (Reviewed 2013) (Reviewed 2014) (Reviewed 2015) (Reviewed 2019)
    e. 1998 Access and Contribution to Health Records (JAPhA. 38(4):417; July/August 1998) (Reviewed 2005) (Reviewed 2009) (Reviewed 2010) (Reviewed 2013) (Reviewed 2014) (Reviewed 2015)
    f. 1991 - Pharmaceutical Care and the Provision of Cognitive Services with Technologies (Am Pharm. NS32(6):515; June 1991) (Reviewed 2001) (Reviewed 2007) (Reviewed 2009) (Reviewed 2013) (Reviewed 2014) (Reviewed 2019)
    g. 1991 - Emerging Technologies (Am Pharm. NS31(6):28; June 1991) (Reviewed 2004) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)
    h. 1991 - Biotechnology (Am Pharm. NS31(6):29; June 1991) (Reviewed 2004) (Reviewed 2007) (Reviewed 2010) (Reviewed 2015) (Reviewed 2016) (Reviewed 2017)
10. The committee discussed ethical and equitable access to AI patient care. However, concern was raised against inclusion of a statement to mandate utilization of AI in all delivery systems, and therefore the committee opted not to move forward with that direction at this time. (1–8)

11. The committee addressed the necessity of creating a statement of informed consent although language already exists in other government entity guidance documents. (1–8)
12. The committee reflected on an overarching workforce concern that AI may potentially assume certain pharmacist tasks (such as prescription verification), and lead to lower job security. (1–8)
13. The committee opposes AI use that would eliminate the role of the pharmacist and emphasized the importance of directly stating concerns of potential elimination of a pharmacist's clinical role through legislation or other governing bodies. Similarly, the committee was intentional to highlight pharmacists' professional judgment. (1)
14. The committee discussed whether to focus on the impact on pharmacy practice or impact on pharmacy workforce dynamics. The committee ultimately opted to focus on impacts on workforce dynamics, as it is more narrowly focuses on the impact that AI can have on pharmacist job outlook. (1–8)
15. The committee referred to a variety of resources to inform the development of proposed policy statements, including content and concepts featured in the Washington Post's October 2023 summit, "The Futurist Summit: The Rise of AI," featuring influential policymakers and innovative leaders shaping the future of AI. (1–8)
16. The committee noted that proposed statements aligned with current pharmacy practice literature, such as "Role of artificial intelligence in pharmacy practice: a narrative review" by authors Wong, Palisano, Elsamadisi, and Badawi, published in the Journal of the American College of Clinical Pharmacology. (1–8)
17. The committee considered developing a single statement which conveyed support for certain elements of AI use and opposition of others. However, the committee was intentional to separate these points into two statements, to strengthen both statements by their own merit. (1,3)
18. The committee discussed if APhA should oppose AI in place of professional judgment entirely, or more specifically the opposition to use of AI in place of professional judgment. Ultimately from a spirit of innovation and forward-thinking, the committee supports AI use as part of pharmacy practice, so long as it does not replace the professional judgment of a pharmacist. (1)
19. The committee considered including "pharmacist's services" in addition to "professional judgment"; however, the committee wanted to ensure that pharmacist professional judgment is being used regardless of setting and the type of service being provided. (1)
20. The committee discussed liability concerns should AI make a medication error, noting the connection to informed patient consent when AI is being used. (1)
21. The committee discussed amending statement #1 to include "or access to" to avoid patients having limited access to a pharmacist. Considerations were made to include "pharmacy personnel" within this leading statement as well; however, were ultimately opted against to specify expertise, role, and responsibility of the pharmacist. (1)
22. When discussing the potential role of AI in pharmacy practice, the committee reflected on the impacts of prior technological advancements on the pharmacy profession and workforce – such as printing and automated medication dispensing. (2)
23. The committee emphasized the necessity of a forward-thinking approach to AI by the pharmacy profession, which encourages both proactive assessment and implementation of AI use in pharmacy practice. In doing so, the committee was intentional to utilize language around the "evolving role of artificial intelligence," as opposed to language such as "impact of artificial intelligence," which may have a more reactionary connotation. (2)
24. The committee discussed the concept of pharmacy working groups that can be charged with reviewing research and potential solutions involving AI and the role of a pharmacist. The committee determined this recommendation was better suited as a consideration for potential implementation of AI policy. (2)
25. The committee encourages "judicious use" of AI, to convey the appropriate balance of consideration and precaution, while still embracing opportunities for implementation. Other adjectives such as

"cautious" were considered, but opted against, because of negative and less proactive connotations. (3)

26. When discussing how AI may be used to support pharmacy practice, the committee recommended language to indicate that AI may be used "as a tool" to improve patient care. An intentional distinction was made not to include such a qualifier such in the leading opposition statement (1), so that *any* use of AI to replace pharmacist judgment was covered in the statement's opposition. (3)
27. When discussing the development and application of emerging AI, the committee referred to existing policy, 1991 Emerging Technologies, to reaffirm the forward-thinking inclusion of pharmacists in development and application of the emerging AI technologies in the delivery of pharmaceutical care. (3)
28. The committee considered multiple verbs such as enhance, expand, and improve when describing how the practice of pharmacy may be affected by AI use in pharmacy practice. The committee opted against "improve" or "expand," which could inadvertently imply current practices are not functional. Ultimately the committee recommended "elevate" in the spirit of aspirational language, which also captures expansion. (3)
29. The committee considered noting "scope of practice" among pharmacy practice and patient care when listing areas where AI may be applied. However, the committee opted against it in this context, as scope of practice is continually evolving and varying from state to state. (3)
30. When describing who should be using AI judiciously, the committee considered pharmacy personnel or pharmacy workforce. The committee opted for "by pharmacists and pharmacy personnel" to include all professionals in the pharmacy workforce. The committee defines "pharmacy personnel" to include all individuals including pharmacy clerks and other non-clinical administrative roles, recognizing this definition may vary by state. (3)
31. The committee discussed the merits of "supporting" or "recommending" judicious use of AI. The committee decided that "encourages" is all-encompassing and is a better verb to further prompt and promote pharmacy personnel to utilize AI technologies. (3)
32. The committee referenced the White House Blueprint for an AI Bill of Rights in doing so. The committee decided that pharmacists should be included in the conversation and the construction of these rights. (4)
33. The committee referred to existing policy from the American Medical Association (AMA) relating to physician involvement with AI, which states that the AMA will "identify opportunities to integrate the perspective of practicing physicians into the development, design, validation and implementation of health care AI." The committee discussed adding a statement advocating for the integration of pharmacists in the "validation of AI models," to be consistent. (4)
34. The committee suggested APhA should advocate for pharmacist integration into AI use, as they currently may not be incorporated as extensively into artificial health intelligence. The committee raised concerns of other health care professionals opting to use AI tools in place of pharmacist's services, such as patient counseling, hence emphasizing the necessity of integrating pharmacists into the development and design. (4)
35. The committee discussed that language to integrate pharmacists within AI technologies also conveys that pharmacists are innovators in development, design, validation, and implementation of AI technologies. (4)
36. The committee discussed specifying "ethical use" of educational and training opportunities in its proposed language, to incorporate the concern of clinical decision-making AI replacing pharmacists. The term "its ethical use" also implies the necessity of informed consent so as not to blindside patients with the use of AI for a patient's care. The committee discussed concepts of patient-informed consent and data use transparency, contemplating patients' potential satisfaction or dissatisfaction in utilizing AI technology. (4,7,8)
37. The committee discussed the need for differentiation when a patient is speaking with an AI chatbot vs. a pharmacist, to ensure that patients have awareness of who they are talking to and that they can

opt in or out of using talking to AI. (4)

38. The committee raised the question of what data is used to input and build AI databases, and considerations of informed consent in this data use. (4,5)
39. The committee discussed the use of the terms "AI solutions," "AI models," and "AI technologies" and determined the use of "AI" is inclusive of all components of the AI lifecycle. However, the committee decided "AI solutions" serves as a final product after development and therefore was retained. (4,6)
40. The committee discussed whether to explicitly specify pharmacists' role in integrating AI into standards of care, anticipating that AI will eventually be integrated into pharmacy standards of care. Ultimately the committee opted to not include that piece, citing existing APhA policy (2020 Digital Health Integration in Pharmacy and 2022 Standard of Care Regulatory Model for State Pharmacy Practice Acts) that already cover the intent of this suggestion. (4)
41. The committee discussed the use of "regulatory bodies, employers, and other relevant stakeholders" to be all-encompassing of the bodies that will develop the policies and procedures for AI. It would also include pharmacists and their involvement with development. It was discussed that "NABP" would be too specific and wouldn't necessarily encompass everything we would like stakeholders to do. (5)
42. Concepts of patient-informed consent were considered and discussed in developing these statements. The committee considered explicit mention of it in a statement; however, they concluded that "informed consent" is encompassed by calling for public awareness and protection. The committee also recognized that principles of private patient data are covered by existing 1998 Access and Contribution to Health Records, which states "APhA supports public policies that protect the patient's privacy yet preserve access to personal health data for research when the patient has consented to such research or when the patient's identity is protected." (5)
43. The committee raised concerns of using patient data in AI; however, the statement aims to address that APhA supports the transparency of use. (5)
44. The committee discussed entities that AI implementation could affect such as medical device organizations, pharmaceutical companies, pharmacies, or regulatory bodies. (5,6)
45. The committee intentionally opted against referring to relevant parties providing AI solutions as "stakeholders," to align with the overarching movement away from such a term, which may imply a power differential between groups and have stigmatizing connotations. (5)
46. The committee's intention was to be as broad as possible to encompass all partnerships involved in developing policies, procedures and applicable. (5)
47. The committee considered whether there is merit in addressing a subset of AI called machine learning (ML) explicitly in the policy statement. However, the committee opted against this, as this subset is already captured by the broader term of AI. (5)
48. The committee referenced the National Institute of Health's definition of what is or is not considered protected health information (PHI) in AI technology. 1) De-identified health information, as described in the Privacy Rule, is not PHI, and thus is not protected by the Privacy Rule. 2) PHI may be used and disclosed for research with an individual's written permission in the form of an Authorization. 3) PHI may be used and disclosed for research without an Authorization in limited circumstances: Under a waiver of the Authorization requirement, as a limited data set with a data use agreement, preparatory to research, and for research on decedents' information. (5)
49. When discussing the policy language for bias, the committee utilized the American Academy of Family Physician's policy on Ethical Application of AI, which states that companies providing AI/ML solutions must address implicit bias in their design. We understand implicit bias cannot always be completely eliminated. Still, the company should have standard processes in place to identify implicit bias and to mitigate the AI/ML models from learning those same biases. In addition, when applicable, companies should have processes for monitoring for differential outcomes, particularly those that affect vulnerable patient populations." (6)

50. The committee noted potential biases and implications to principles of diversity, equity, inclusion, and belonging – particularly as it relates to algorithmic bias. (6)
51. When discussing parties which provide AI solutions, the committee deliberated whether to refer to these as "companies" or "entities." While "entities" may be more all-encompassing, the use of the term "companies" puts the responsibility on those who use and produce the AI. The committee decided to change "companies" to call on "those providing AI" to encompass individuals outside of companies who may develop AI tools. (6)
52. The committee recognizes bias in data sets, and therefore calls on those providing AI solutions to implement processes that identify and mitigate bias in AI models. They considered whether it would be necessary to explicitly recognize these biases in the statement itself; however, determined that this is implied by calling on parties to mitigate bias. Furthermore, while the committee discussed both implicit and explicit bias the use of "bias" alone encompasses all forms. (6)
53. The committee discussed the use of "training data" vs. "data sets" vs. "all data sets"; in their discussions, the committee defined data sets as requiring training, testing, and validation. The committee discussed having a diverse data set and capturing the diversity of patient populations when addressing bias therefore "increase diversity" was included. However, by acknowledging that bias exists, the committee ultimately decided that this was not necessary to include. (6)
54. The committee recognizes the existence of both trustworthy and non-trustworthy AI, and the importance of distinguishing the two. The committee defines "trustworthy artificial intelligence" according to the Trade and Technology Council (TTC)'s definition, which notes that trustworthy AI has three components: (1) it should be lawful, ensuring compliance with all applicable laws and regulations (2) it should be ethical, demonstrating respect for, and ensure adherence to, ethical principles and values and (3) it should be robust, both from a technical and social perspective, since, even with good intentions, AI systems can cause unintentional harm. Global principles have not been established, and the use of "principles" in the statement was intended to keep the policy evergreen. (7,8)
55. By defining trustworthy AI, the committee discussed when it would be appropriate to specify "trustworthy" AI among the proposed statements. The committee opted to specify trustworthiness when advocating for which forms to include in effective education or implantation of AI solutions. (7,8)
56. The committee referenced the GAO global report, which spotlights public health concerns and AI practices within health care. These cover clinical applications such as supporting population health management, monitoring patients, guiding surgical care, predicting health trajectories and administrative applications such as automating laborious tasks, recording digital clinical notes, and optimizing operational processes. This report supports the committee's intention to advocate for training around clinical use. (7,8)
57. The committee considered creating a single statement encompassing learner-driven and provider-driven education pertaining to trustworthy AI. However, the committee ultimately decided to create two statements (one focused on learners and one focused on providers) to note their distinctions. (7,8)
58. The committee discussed appropriate subject-verbs to be consistent with the cybersecurity statement, when considering how to "integrate principles of trustworthy artificial intelligence and its ethical use into education and training programs." The committee then opted for the verb facilitate. (7)
59. The committee discussed that use of both "ethical use" and "trustworthy" may be redundant, as the Trade and Technology Council definition of trustworthy AI includes ethics as criteria. (7)
60. The committee discussed the need to include "education providers" and development of education and training, from the question of whether this pushes the profession ahead or retreats to being more passive. The use of "education providers" aims to encompass not only those who provide education in academia but includes organizations which may provide continuing education. (7)
61. The committee discussed the inclusion of "lawful, ethical, and clinical use" to encompass all aspects relating to the development and use of AI. There was further discussion on what happens after the

product has been built and ensuring that once it is implemented, anyone using the technology is using it appropriately. (7,8)

62. The committee discussed whether the policy statements shall call on pharmacists and pharmacy personnel to educate themselves, in addition to calling on education bodies, to take a less passive approach. The committee noted responsibility should be upon the learner to seek out the knowledge to understand and apply the AI tools recognizing that there is not much training available at this time of its use in health care. (7,8)
63. The committee discussed the merits of including pharmacists, interns, and technicians as individuals needing to seek out education and training. (8)

Summary of Discussion – Cybersecurity in Pharmacy

1. The committee broadly defined cybersecurity as referring to measures taken to protect a computer or computer system against unauthorized access or attack, based on relevant authorities on the subject such as the CURES Act. (1–4)
2. As part of the review of existing policy gaps, the committee reviewed the following relevant policies (1–4):
    a. *2022 - Data Security in Pharmacy Practice*
    b. *2022 - Data Use and Access Rights in Pharmacy Practice*
    c. *2010 - Personal Health Records*
    d. *2005, 2004, 1999 - Telemedicine/Telehealth/Telepharmacy*
    e. *2004 - Automation and Technology in Pharmacy Practice*
3. The committee reviewed the following additional background references when developing statements on this topic:
    a. Defining EHI and the Designated Record Set in an Electronic World. American Medical Informatics Association; Electronic Health Record Association, American Health Information Management Association. https://www.ahima.org/media/ztqh1h2q/final-ehi-task-force-report.pdf 2021
    b. ONC's CURES Act Final Rule. The Office of the National Coordinator for Health Information Technology. https://www.healthit.gov/topic/oncs-cures-act-final-rule August 2022
    c. Health IT Regulation Resources. The Office of the National Coordinator for Health Information Technology. https://www.healthit.gov/topic/laws-regulation-and-policy/health-it-regulation-resources September 2023.
    d. FACT SHEET: Biden-Harris Administration Announces National Cybersecurity Strategy. The White House Office of the National Cyber Director. https://www.whitehouse.gov/oncd/ March 2023 (1–4)
4. When describing relevant data in this policy, the committee utilizes the terminology "data record set," which is derived by the 21st Century CURES Act. This terminology encompasses personal health information, medical records, billing records, insurance information, and information used in case management. (1–4)
5. The committee considered cybersecurity implications of the drug supply chain and upcoming implementation of the Drug Supply Chain Security Act (DSCSA) (https://www.pharmacytimes.com/view/fda-announces-delayed-enforcement-of-dscsa-to-2024) on pharmacies and wholesalers in November 2024. The committee also acknowledged that all relevant entities are making efforts to fully implement DSCSA by the November 2024 deadline and therefore, reaffirming DSCSA standards or development of specific proposed statements on this subject is not necessary at this time. (1–4)
6. When discussing the topics overall, the committee considered pharmacists and pharmacy personnel in diverse practice settings, such as the community pharmacy setting, health systems, and consultants, who may have access to relevant data record sets. (1–4)

7. The committee introduced the term "threat assessment" to address the recent hacks on health care and hospital systems. The committee considered using "continuous threat assessment" to ensure that entities are conducting these processes not only when an attack occurs but using a more proactive approach. The committee shared thoughts that threat assessments could be included in disaster plans but debated whether or not they should be explicitly stated in the statement. The committee suggested the use of "threat assessment" vs. "action plan." Ultimately, this language was replaced with cybersecurity systems and safeguards. (1)
8. The committee considered using "cybersecurity framework" when describing appropriate safeguards and ultimately used the phrase "cybersecurity systems and safeguards" to encompass system backups, threat or continuous threat assessments, and disaster plans/incident responses. The committee discussed changing "cybersecurity disaster plan" to "cybersecurity incident response" to better capture that the "plan" addresses recovery and response to an attack; whereas "incidence response" refers to an attack that has already happened. This is the language used by the Cybersecurity and Infrastructure Security Agency (CISA). The committee discussed incorporating "(e.g., incident response plans)" into the statement in such a way to be both proactive (maintaining and implementing systems and safeguards) and reactive (having a response plan). (1)
9. The committee initially considered if it was necessary to specify whether safeguards for mitigating risk apply only to "patients." The term patients were removed to ensure all persons who may be harmed or experience disruption by a cybersecurity attack are not overlooked. (1)
10. The committee agreed that the verbiage to "advocate" is most appropriate given that there are laws and regulations that already require pharmacies and business entities to develop these systems and safeguards. (1)
11. The committee discussed using the terms establishment, development, adoption, maintenance, or implementation when describing the use of cybersecurity systems, and ultimately decided that the term implementation covers both the terms development and adoption of cybersecurity systems. The retention of maintenance is essential to ensure that these systems are still reviewed consistently. (1)
12. The committee discussed the necessity of using the term "appropriate" and noted that its inclusion could eliminate concerns of implementing inappropriate cybersecurity systems but was ultimately unnecessary. (1)
13. The committee discussed the need to include both harm and disruption, and if these two words addressed the same thing. It was decided that disruption does *not* equate to harm. Disruption *can* be harmful but is not always harmful. (1)
14. The committee opted for the verb "advocates" as opposed to "encourages" for these statements. This implies that APhA holds these statements to the same importance. "Advocates" is listed as a strong verb and "encourages" is a medium verb. (1,2,3)
15. The committee originally discussed using the term "stakeholders" and agreed to recommend usage of "all relevant parties" because stakeholders can be a stigmatizing term for some communities. The term "stakeholder" may imply a power differential between groups and could imply a violent connotation for some tribes and tribal members. The two words were deemed interchangeable in intent. (1,2)
16. The committee used the term "related business entities" to encompass any entity that could have access to data record sets. (1,2)
17. The committee questioned the difference between cyber liability insurance and equivalent self-funded plan. It was explained that some companies may not have a specific liability insurance policy, and just have the funds or means to cover a data breach event. The committee decided to leave in both terms. (2)
18. The committee discussed what insurance plans cover to protect patients; an example was given where liability insurance plans can provide credit monitoring systems to protect patients who are potentially impacted by a data breach. (2)
19. The committee discussed the need to include any other groups/individuals that could be affected by

data breaches. The committee decided to be all-expansive and say "all relevant parties" rather than "patients" to encompass any person or persons who could be protected by insurance/self-funded plans. (2)

20. The committee discussed the correct verbiage to use for the relationship between "pharmacies and relevant business entities" and "cyber liability insurance and equivalent self-funded plans." The committee recommended a word change from "utilize" to " 'have' the insurance or an equivalent self-funded plan," to simplify language and make it clear the ask is just to *have* the insurance plan. The committee considered the verbs "maintain" and "use" when addressing cybersecurity responsibilities. The committee opted for "have" as it implies that the pharmacies and business entities will also utilize and maintain the insurance or plan. (2)
21. The committee discussed using the terms "recommends," "advocates," or "should," to determine how strong of a stance APhA should take on the impact on pharmacy curriculum. The committee agreed that "advocates" is the best term to provide a stronger stance and highlight the importance of having education provided on this topic. (2,3)
22. The committee deliberated on whether proposed statements should make recommendations around information-sharing, referencing a possible repository of information about cyber-attacks that occur to be shared and inform others of how the attack was handled. The committee confirmed that despite there not being a single, national cyber-attack repository, the FTC provides information on what should be done in the event of a data breach titled Data Breach Response: A Guide for Business. The committee further reviewed the FTC's health breach notification rule and noted there are several organizations that must be notified of a data breach. Due to these existing processes, the committee felt a specific statement on information sharing is not necessary at this time. (3)
23. The committee agreed that the term "educational providers" would include any person or persons who could be involved in educating pharmacists on cybersecurity and data record sets and would encompass all education – not just CE. (3)
24. When advocating for education related to cybersecurity and protection of the data record set, the committee discussed whether "best practices" or "policies" is most appropriate. While the broad pattern among existing APhA policy language is to opt for "policies" in such a list, the committee prefers "best practices" in this case. The committee determined that best practices may change more frequently, while policies tend to change less frequently. Therefore, to remain more evergreen, the committee decided ultimately to use the term "best practices." (3)
25. The committee initially recommended that education be addressed from a broad perspective. This was shifted to address education providers directly in order to be more actionable. (3)
26. The committee specifically included the terminology "education and training programs" to include not only academic training programs, but to also include postgraduate training and continuing professional education. Using "education and training programs" would also encompass organizations that provide other forms of education as well. (3)
27. The committee decided to divide the cybersecurity statement into two parts – one for education providers and one for learners – to address both parties and their individual responsibilities relating to cybersecurity education and training. The addition of statement 4 puts the action directly on the learner. (3,4)

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

2023-2024 House of Delegates

Report of the Policy Committee

- ❖ Artificial Intelligence Use in Pharmacy Practice
- ❖ Cybersecurity in Pharmacy

Committee Members

Mary Klein, Chair
Samm Anderegg
Timothy Aungst
Dalton Fabian
Olivia Gabrick
Neelam "Nelly" Gazarian
Mary Gurney
Christopher Harlow
Cory Holland
Brian Hose
Sarah McBane

Ex Officio
Brandi Hamilton, Speaker of the House

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Artificial Intelligence (AI) Use in Pharmacy Practice

Background paper prepared for the 2023-2024 APhA Policy Committee
Olunife Akinmolayan, PharmD and Ronald Levinson, PharmD
2023-2024 Executive Residents
American Pharmacists Association

Issue:

The American Pharmacists Association (APhA) Board of Trustees has directed the 2023–2024 Policy Committee to recommend policy to the APhA House of Delegates related to Artificial Intelligence (AI) Use in Pharmacy Practice. The Board's guidance on this topic included, but was not limited to, the applications of artificial intelligence use in health care and other pertinent industries, legal and ethical implications regarding AI use, and the outlook of AI on pharmacy practice.

Executive Summary

AI has advanced tremendously in recent history, and is emerging as a prominent topic of discussion across many fields. In 2021, AI in the health care market was worth around 11 billion U.S. dollars worldwide. It was forecast that the global health care AI market would be worth almost 188 billion U.S. dollars by 2030. As of 2021, around a fifth of health care organizations worldwide indicated they were in an early stage of adopting AI models.[1]

There is a lack of consensus among health care providers, including pharmacists, relating to the development, regulation, liability, and application of AI in health care. While AI presents opportunities to enhance certain aspects of the pharmacy profession and pharmacy education, there are also valid concerns of potentially negative implications.

This background paper aims to:

- Define relevant terms to the topic of AI
- Assess pharmacy applications and implications of AI in health care, as well as alternative applications in other industries
- Review the legal and ethical implications of AI use in pharmacy
- Survey potential impacts of AI in pharmacy practice

Definitions

Artificial Intelligence: Described as a branch of computer science that deals with problem-solving with the aid of symbolic programming. Also known as a machine's ability to perform the cognitive functions associated with human minds.[2]

Machine Learning: A form of artificial intelligence based on algorithms that are trained on data.[2]

Deep Learning: A method in artificial intelligence (AI) that teaches computers to process data in a way that is inspired by the human brain. Deep learning models can recognize complex patterns in pictures, text, sounds, and other data to produce accurate insights and predictions.[2]

Natural Language Processing: Described as a branch of computer science concerned with giving computers the ability to understand text and spoken words the same way human beings can.[3]

Large Language Models: Described as deep learning algorithms that can recognize, summarize, translate, predict, and generate content using large datasets.[4]

Computational Modeling: Described as the use of computers to stimulate and study complex systems using mathematics, physics, and computer science. There are three categories: sequential models, functional models, and concurrent models.[5]

Generative AI: An AI model that generates content in response to a prompt. Examples include ChatGPT and DALL-E (a tool for making AI-generated art).[2]

Sentient AI: AI becomes sentient when an artificial agent achieves the empirical intelligence to think, feel, and perceive the physical world around it just as humans do.[6]

Predictive AI: Method of data analysis, capable of predicting and anticipating the future needs or events of a company. Based exclusively on data, it has capabilities to analyze large volumes of data.[7]

Strong AI: Also called Human-Level AI, it can simplify human intellectual abilities. When it is exposed to an unfamiliar task, it can find the solution.[8]

Weak AI: This AI system is designed and trained to perform narrow tasks, such as facial recognition, driving a car, playing chess, and traffic signaling.[8]

Super Intelligence: Also known as brainpower, superintelligence exceeds the most optimally intelligent human skills in drawing, mathematics, space, science, art, and every field. It ranges from the computer knowing a little less than the human to a trillion times smarter than humans.[8]

Brain-computer Interface: Acquires brain signals, analyzes them, and translates them into commands that are relayed to output devices that carry out desired actions.[9]

Big Data: Refers to massive, complex and high velocity datasets. It is considered the fuel that powers the evolution of AI's decision making.[10]

True AI: Autonomous and does not require human maintenance and works silently in the background.[11]

Public Trust: The institutional, motivational, uncertainty reduction and knowledge pathways that strengthen the responsible use of AI.[12]

Applications and Implications of AI Use in Pharmacy Practice

In order to best assess implications of AI Use in Pharmacy Practice, its potential uses must be outlined across various pharmacy and even non-pharmacy settings.

Community Pharmacy

With the rapid advancement of AI, many experts are developing concepts that may be used in the near future that put local pharmacists in a position to be seen more than their primary care

physician.[13] One such concept includes an app that would determine if an individual has strep throat, by issuing an order for diagnostic testing that is sent to the local pharmacy for a swab and treatment. The app would use AI to assess symptoms and visual evidence to diagnose a patient with strep throat. This eliminates the need to drive to a hospital or wait to be seen in an urgent care setting. While this concept has not yet been actualized, it is indicative of AI's potential and applications in development.[13]

When it comes to implementation in practice today, AI can assist community pharmacists in managing their medication inventory, predict medication demand, and identify potential drug interactions and adverse reactions. This can help pharmacists make more informed decisions about prescribed medications and how to manage medication regimens.[14]

Health System Pharmacy

With the creation of more intuitive interfaces incorporating AI, many processes within the hospital setting can be automated to save time.

Electronic Health Records

Pharmacists and other healthcare professionals spend most of their time on three tasks as it pertains to electronic health records (EHRs): clinical documentation, order entry, and sorting through incoming requests. Tools such as voice recognition and dictation are helping to improve clinical documentation, but natural language processing (NLP) tools still need improvement. Other applications in this setting include using AI and machine learning to index recordings and videos for future information retrieval as well as creating notifications for medication refills and prioritizing tasks that need a clinician's attention. EHR analytics have produced many successful risk scoring and stratification tools, especially when researchers employ deep learning techniques to identify novel connections between unrelated datasets. EHR patient data extraction and analysis in an accurate, timely, and reliable manner has been a continual challenge for providers and developers. EHR data can now be analyzed using AI to identify infection patterns and highlight patients at risk before they begin to show symptoms. By leveraging such tools, infectious disease teams can enhance their accuracy and create faster, more accurate alerts for other health care providers.[15]

Clinical Decision Making

Clinical decision making may also see new developments as the "AI doctor" is incorporated into health systems. AI can provide earlier warnings for conditions like seizures or sepsis which often require intensive analysis of highly complex datasets. Other examples of AI use at the bedside include machine learning that will support decisions around whether to continue care for critically ill patients, such as those who entered a coma after cardiac arrest. Additionally, new AI tools can support risk scoring and early alerting.[15]

Pharmaceutical Industry

Reports show approximately 62% of health care organizations are considering investments in AI, and 72% believe AI will be crucial to business practices in the future. The McKinsey Global Institute estimates that AI and machine learning in the pharmaceutical industry could generate nearly $100 billion annually across the US health care system.[8]

Drug Development and Quality Assurance

AI can aid in drug design and screening by predicting 3D structures, drug activity, and toxicity. AI tools use technology that studies the impact of stress levels in different equipment or solves complex flow problems in the manufacturing process; AI can also be implemented for the regulation of different manufacturing processes.[16]

AI is expected to significantly impact the drug development process, and already has as evidenced by case studies provided by Johnson & Johnson and Pfizer. With AI, the time needed for drug development will be considerably reduced with experts citing that identifying drug targets will be reduced from years to mere months. This will in turn enhance return on investment and may lead to a decrease in cost for end users. Such examples include Johnson & Johnson's Machine Learning Ledger Orchestration for Drug Discovery or the Melloddy Project which leverages the world's largest collection of small molecules known biochemical or cellular activity to enable more accurate predictive models and increase efficiencies in drug discovery.[17]

Regulatory Affairs

Companies like Pfizer are using machine learning to better predict government regulatory inquiries.[18] Other ways that AI is being used in regulatory affairs is to automate regulatory processes such as administrative work, dossier filling, data extraction, auditing, the implementation of regulations, and quality management.[19]

Clinical Trials and Rare Diseases

AI can assist in the enrollment of patients in clinical trials, selecting specific disease populations by using genome profile analyses. Software designed to predict lead compounds before clinical trials begin helps in early predictions of lead molecules that would pass trials with consideration of the selected patient population.[16,19] For example, Pfizer is using a novel prediction model derived from machine learning to identify patients with rare diseases. With this prediction model they are working on a weather map for diseases that can be used to find biological targets for said diseases, understand why certain populations respond to a drug, predict conditions that can be treated using an existing drug, and tracing patterns in molecular bindings between variations of a drug which provides insights on which medications are more likely to perform for selection in clinical trials.[18]

Inventory Management

Improvements in the vaccine supply chain have been identified and solutions may be found in the utilization of AI. Pfizer has been using inventory prediction models in their vaccine supply chain to track exact conditions of sensitive inventory through sophisticated data gathering to predict future supply chain issues. By employing these tools, they identify that they are reducing risk, improving decision-making, improving partnership selection, and improving the overall customer experience.[18] Stakeholder Data cannot yet demonstrate the definitive difference that inventory prediction capabilities have on decreasing risk in an already highly disrupted supply chain. However, this is in the process of being collected and analyzed.[17]

Medical

Other concepts that may find their way into the daily lives of individuals include the use of continuous diagnostic surveillance. Such AI tools can include cell phones that would analyze

shifting patterns to diagnose Alzheimer's; a steering wheel that would sense signs of Parkinson's through small hesitations and tremors; or a bathtub that would perform sequential scans using harmless ultrasound or magnetic resonance to determine if there is a new mass in an ovary that requires investigation.[13]

Another potential concept finding its way into the medical profession is the use of robotic surgery which will enable surgeons to prepare for, perform, and follow up on surgery cases in one pace, significantly leveling up the amount of actionable information at hand for surgeons. This utilization of AI will promote sharing procedure data, best practices, and patient data.[20]

Using brain-computer interfaces, quality of life for patients with ALC, strokes, or locked-in syndrome as well as the 500,000 people (about half the population of South Dakota) worldwide who experience spinal cord injuries every year can be drastically improved. With the development of the next generation of radiology tools integrating AI, clinicals are developing a more accurate understanding of how tumors behave instead of basing treatment decisions on the properties of a small segment of the malignancy. They are also able to define the aggressiveness of cancers and target treatments more appropriately. Progress towards cancer treatment is expected to make major strides with the incorporation of AI with machine learning algorithms which can synthesize highly complex datasets that will identify new options for targeting therapies for an individual's' unique genetic therapy.[15]

AI technology can design effective and suitable treatment plans; IBM Watson for Oncology is a software that analyzes patient data against thousands of other cases and provides treatment options to oncologists to make their own informed decisions.[21] It can also assist in repetitive tasks such as imaging, radiology, ECHOs, etc., for detection and identification of diseases or disorders.[8]

Alternative Applications of AI Use

Education

Artificial intelligence has the potential to transform how schools function and improve some of the education system's most glaring issues. AI may help instructors design courses and analyze student performance data, to create new lesson plans and interventions.[22] AI-powered capabilities such as speech recognition can provide greater support to students with disabilities, multilingual students, and others who could benefit from greater personalization in digital learning tools. School systems are further exploring how AI can enable writing or improving lessons, as well as how AI finds, chooses, and adapts material for use in their lessons.[23]

There are several challenges educators would have to overcome to incorporate AI into coursework. Many schools and universities simply do not have the resources or money to purchase and maintain the technology necessary to incorporate AI into the education system. Training and support will be needed for educators who are not familiar with AI tools. There are also concerns about its impact on privacy, security, and job markets.[24] Worry about AI in the education system is already spreading; many schools have effectively banned the use of the most popular form of AI, ChatGPT, out of concerns of student cheating.[22]

Wearable and Personal Devices

The number of connected wearable devices worldwide has increased substantially in recent history, rising from 929 million in 2021 to around 1.1 billion devices in 2022.[25] Considering this, AI will play a significant role in extracting actionable insights from the big data derived from said devices. One notable feature is the ability of wearables to track a heartbeat or other vital signs, which can potentially be provided to a health care professional for assessment.[15]

Smartphones are also key personal devices. As of August 2023, there are currently 6.92 billion smartphone users in the world today.[26] Images taken from smartphones and other consumer-grade sources will be an important supplement to clinical quality imaging – especially in underserved populations and developing nations. For instance, researchers in the United Kingdom have developed a tool that identifies developmental diseases by analyzing images of a child's face. This algorithm can detect discrete features such as a child's jaw line, eye and nose placement, and other attributes that might indicate a craniofacial abnormality; currently the tool can match images to more than 90 disorders, to provide clinical decision support. In certain cases, the use of smartphones to collect images of eyes, skin lesions, wounds, infections, medications, or other subjects may be able to help underserved areas cope with a shortage of specialists while reducing the time-to-diagnosis for certain complaints.

Legal & Ethical Implications

While there are potential benefits to using AI in a variety of health care settings, AI can also have the potential to cause accidents that may hurt patients or systems.

The FDA already has regulatory frameworks for AI medical devices which outline testing and safety requirements within the review process. The agency regulates software based on its intended use and the level of risk to patients if it is inaccurate. If the software treats, diagnoses, cures, mitigates, or prevents disease or conditions, the FDA considers it a medical device.[27] The Federal Trade Commission (FTC) has proposed guidelines concerning AI regulation, recommending that those who use, or license AI should do so in a way that is "transparent".[28]

Liability

The AI field consists of multiple stakeholders that could be held liable for medical malpractice. There have been no major cases related to the use of medical AI that have been decided by the courts.

A study was conducted by the Journal of the American Medical Informatics Association surveying both the public and physicians on perceived liability in cases of medication errors. The survey indicated that physicians should be held responsible when an error occurs during care delivered by health care providers and AI algorithms. In this study, physicians were more likely to believe that vendors of AI technology and health care organizations should be held liable; in the view of the public, younger individuals were significantly more likely to hold physicians, vendors, and the FDA liable for medical errors resulting from the use of AI.[29]

In 2019, the European Union released their own AI liability guidelines, explaining that application of AI will warrant strict liability – manufacturers of products that incorporate AI should be "liable for damages caused by defects in their products".[30] They have further explained

that additional compliance requirements would apply to higher-risk AI applications such as health care.

A commonly proposed solution to the challenges of the traditional liability system would be to change the standard of care in health systems - reevaluating frameworks and implementing AI frameworks into standards of care that can safely introduce AI into the health care system and reduce risk of liability.[30]

AI Developer Perspective

AI developers face unique challenges in the legal landscape. AI software is traditionally shielded from product liability, thereby pushing liability onto physicians and health care systems. However, as software becomes more integrated into complex care, developers may have to manage potential injury claims.[31] Unclear frameworks or legal decisions against developers in health care could result in developers avoiding industries that place more liability on the developers, ultimately hampering innovation.[32] Developers will also need more patient data since a lot of patients have not been put on medications such immunotherapy drugs.[15]

It will also be important for them to develop a framework and create safeguards for many tools, to prevent AI from eventually acquiring the intelligence to make its own decisions. Algorithm developers must be careful to account for the fact that disparate ethnic groups or residents of different regions may have unique physiologies and environmental factors that will influence the presentation of disease. Entities cannot develop an algorithm based on a single population and expect it to work as well on others.

When determining who could be liable in a case related to the use of medical AI, parallels can be drawn between product liability cases for defective automotive parts and malfunctioning self-driving cars. Just recently, Autoliv Japan, the world's largest manufacturer of automotive airbags and seatbelts, paid $56 million to settle the case *Andrews v. Autoliv* where the court found the plaintiff's husband was killed by the company's defective seatbelt.[33] Tesla is another company that is facing legal issues facing the use of their vehicles with "Full Self-Driving" systems. The company is recalling nearly 363,000 vehicles to fix problems with the way it behaves around intersections and follows posted speed limits. This recall is part of a larger investigation by U.S. safety regulators into Tesla's automated driving systems.[34] Examples such as these are important considerations to be made in the event of an AI medical device is found to be defective and harming a patient.

Data integration across one or multiple institutions is going to be a key factor in augmenting the patient population modeling process. Nonetheless, ensuring public trust will be of utmost importance to make sure such technologies are developed safely and effectively. Stakeholders will need to certify that such algorithms do not confirm hidden biases in the data when deploying tools that will truly improve clinical care.[15]

Health Care Provider Perspective

Many institutions are now employing AI robots along with human supervision to carry out activities that were previously done by humans. Regarding the pharmacy profession, many Americans still think of pharmacies as places where medications are dispensed. The

technological infrastructure for how pharmacists can be reimbursed for important clinical assessment, counseling and other preventive care services is a work in progress.[17]

Patient Perspective

Patient comfort with sharing continual monitoring data may pose a barrier. As AI continues to be integrated through the daily lives of patients, there will be concern of violation of patient advocacy rights.

Research from the public's perspective on AI in health and medicine finds that there is some discomfort among Americans with AI being used in their health. A Pew Research Center survey of 11,000 US adults found only 38% say that AI use to diagnose disease and recommend treatments would lead to better health outcomes for patients. Roughly 60% say they would feel uncomfortable if their own health care provider relied on AI to diagnose their clinical indications, and then and recommend treatments. On the flip side, a plurality of Americans think AI in health and medicine would reduce the number of mistakes made by health care providers, and a majority believe AI would help reduce the problem of unfair treatment and racial/ethnic bias. Though most of the public can identify different pros and cons regarding the use of AI in health care, caution among the public reigns supreme. Three-quarters of Americans say their greatest concern is that health care providers will move too fast implementing AI in health care before understanding the risks of the patient.[35]

Human efforts to create independently intelligent machines may pose a serious threat to the existence of the human race and the pursuit to develop a complete AI could ultimately mean humans' downfall in the future, according to world-renowned physicist Stephen Hawking.[17] The current limitation of AI is that they cannot think, plan, or reason. Challenges presented by the simultaneous global pandemic did not categorically help to hasten the early adoption process. However, the use of AI in the health care system is leveraging technology to deploy more precise, efficient, and impactful interventions at exactly the right moment in patient's care.

Outlook

Pharmacy Practice

The future of pharmacy will see drastic improvements based on their ability to deploy AI in various practice settings. Pharmacists, student pharmacists, and other pharmacy personnel may find it easier to build websites, create instructional videos for patients, and design presentations that improve health care literacy. The profession may also benefit from the recuperation of time for more clinical responsibilities. With the use of AI chat boxes, the profession may see assistance from features like "Ask Your AI Pharmacist" who may field calls, answer basic clinical questions, and perform actions like updating patient profiles all of which can add an extra layer of intelligence. AI technology allows for the automation of routine and manual tasks and provides support for pharmacists across all areas of medication management, including procurement, storage, ordering, verifying, dispensing, administering, and monitoring.[36] As this technology advances, its use could also potentially create new roles for pharmacists and change the scope of pharmacy practice. Time and focus can shift to more complex tasks such as assisting patients in preventative health services, screening and treating common infectious diseases, and developing stronger relationships with patients.[13]

Socioeconomics

Underserved Populations and Communities

Lack of access to AI technologies would exclude certain groups and populations from debate on the responsible governance of AI because the decisions agreed upon would not apply to said groups. Understanding and identifying which groups are excluded from using AI tools will be paramount to ensure that such technologies do not omit their experiences and feedback. There is concern that the use of AI may turn into the form of another arms race. Increasing access to care in underserved or developing regions needs to remain a primary focus when evaluating the safe and effective use of AI. New tools can help to mitigate the impacts of severe deficit of qualified clinical staff by taking diagnostic duties typically allocated to humans.

Cost of AI Implementation

There must also be consideration of associated costs pertaining to the use of AI. The cost of a MEDi Robot is $9000 retail but rises to $15,000 - $30,000 when the applications needed for the robot to help in medical procedures are installed.[17] Those who consider its implementation will likely weigh this cost with a worker's average salary and yearly output production in comparison to the AI.

Conclusion

In conclusion, there are many uses and pharmacy settings that are impacted by the recent introduction of AI. It has already begun to be incorporated into clinical settings, the pharmaceutical industry, community settings, and other industries such as education or business. Considerations for the pharmacy profession to keep in mind include:

- How the application of AI in pharmacy practice will affect pharmacists, their patients, and the subsequent implications of its use.
- Policies that will not only keep the patient safe, but also the pharmacist and other related stakeholders who develop the AI protected.
- The current lack of framework in determining liability for when AI in health care causes harm.

With the complexity of AI use in health care, it is imperative pharmacists develop systems that work to incorporate its use into the health care system to ensure patients are safe and the role of the pharmacist within the system continues to evolve.

Related APhA Policy

Current Adopted Policy Statements, 1963-2023

2004 Automation and Technology in Pharmacy Practice

1. APhA supports the use of automation and technology in pharmacy practice, with pharmacists maintaining oversight of these systems.

2. APhA recommends that pharmacists and other pharmacy personnel implement policies and procedures addressing the use of technology and automation to ensure safety, accuracy, security, data integrity, and patient confidentiality.
3. APhA supports initial and ongoing system-specific education and training of all affected personnel when automation and technology are utilized in the workplace.
4. APhA shall work with all relevant parties to facilitate the appropriate use of automation and technology in pharmacy practice.

(JAPhA. NS44(5):551; September/October 2004) (Reviewed 2006) (Reviewed 2008) (Reviewed 2013) (Reviewed 2014) (Reviewed 2015) (Reviewed 2019)

1991 Pharmaceutical Care and the Provision of Cognitive Services with Technologies

1. APhA supports the utilization of technologies to enhance the pharmacist's ability to provide pharmaceutical care.
2. APhA believes that the use of technologies should not replace the pharmacist/patient relationship.
3. APhA emphasizes that maximizing patient benefit from technologies depends on the pharmacist/patient relationship.
4. APhA affirms that the utilization of technologies by pharmacists shall not compromise the patient's right to confidentiality.

(Am Pharm. NS32(6):515; June 1991) (Reviewed 2001) (Reviewed 2007) (Reviewed 2009) (Reviewed 2013) (Reviewed 2014) (Reviewed 2019)

1991 Emerging Technologies

1. APhA supports programs to monitor the development of emerging technologies and their impact on the delivery of pharmaceutical care.
2. APhA supports education of pharmacists regarding emerging technology including their development and impact on the delivery of pharmaceutical care.
3. APhA supports the inclusion of pharmacists in the development and application of the emerging technologies in the delivery of pharmaceutical care.

(Am Pharm. NS31(6):28; June 1991) (Reviewed 2004) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

1991 Biotechnology

APhA encourages the development of appropriate educational materials and guidelines to assist pharmacists in addressing the ethical issues associated with the appropriate use of biotechnology-based products.

(Am Pharm. NS31(6):29; June 1991) (Reviewed 2004) (Reviewed 2007) (Reviewed 2010) (Reviewed 2015) (Reviewed 2016) (Reviewed 2017)

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Pharmacy Cybersecurity

Background Paper prepared for the 2023-2024 APhA Policy Committee

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Issue

The American Pharmacists Association (APhA) Board of Trustees has directed the 2023–2024 Policy Committee to recommend policy to the APhA House of Delegates related to Cybersecurity in Pharmacy. The Board's guidance on this topic included, but was not limited to, recognition of pharmacies and medications as part of the nation's critical infrastructure, cybersecurity for community/independent pharmacies, education, and cybersecurity for drug manufactures/wholesalers.

Executive Summary

The need for cybersecurity is more important than ever as cyberattacks grow in frequency and complexity. Health care has become a major target for attacks because of the great value of health information. Pharmacies, pharmaceutical drug companies, and drug manufacturers must maintain a secured data system to protect information such as PHI and intellectual property, and to regulate the national supply chain of medications. All of these areas of business need appropriate cybersecurity, but community and independent pharmacies may lack the resources needed to implement security programs. There is room for more advocacy and education on cybersecurity in pharmacy. While APhA has existing policy related to cybersecurity, there is room to expand on the topic as cybersecurity issues and solutions evolve. Areas not yet covered include cyberattack prevention and recovery, backup systems, liability insurance, and cybersecurity for drug manufacturers / developers. Additional policy could help bring pharmacy cybersecurity to the attention of the government and highlight that medications and pharmacies are a major target for cyberattacks and a necessary part of the nation's critical infrastructure.

Definitions

Cybersecurity: Measures taken to protect a computer or computer system against unauthorized access or attack.[1]

Cyberattack: Unwelcome attempts to steal, expose, alter, disable, or destroy information through unauthorized access to computer systems.[2]

Cyber Hygiene: A set of practices focused on regularly maintaining the health and security of an organization's users, devices, networks, and data. Cyber hygiene aims to keep confidential information safe and secure from potential cyber threats and attacks.[3]

Personal Health Information (PHI): An individual's medical records and history which are protected under the Health Insurance Portability and Accountability Act (HIPAA). PHI includes data related to demographics, medical histories, laboratories and other tests, family medical history, health information, and other such data used to identify and treat individuals.

Personally identifiable information (PII): Information that can identify an individual when used alone or with other relevant data. Examples include full name, Social Security Number, driver's license, mailing address, credit card information, passport information, and financial information.

HIPAA Security Rule: Establishes national standards to protect individual's electronic personal health information that is created, received, used, or maintained by a covered entity. The Security Rule requires appropriate administrative, physical, and technological safeguards to ensure the confidentiality, integrity, and security of electronic protected health information. It requires covered entities (pharmacies, health systems, etc.) to conduct a risk assessment of their health care organization.

Drug Supply Chain Security Act (DSCSA): A law enacted by Congress on November 27, 2013. It creates a tighter, closed prescription drug distribution system to prevent harmful drugs from entering the supply chain, detect harmful drugs if they do enter the supply chain, and enable rapid response when such drugs are found. The DSCSA also requires that trading partners exchange transaction information, transaction history, and a transaction statement for each product, and be ready to send and receive this information by November 27, 2023.[4]

Background

Cybersecurity threats and breaches have increased in the last ten years. Health care is one industry that has been particularly exposed. In 2017, Merck fell victim to a ransomware attack that disrupted production and deliveries of medications in several countries. The malware attack caused an estimate of $870 million in losses.[5]

During the COVID-19 pandemic, ransomware and malware attacks reached an unprecedented number. Many professionals were forced to work remotely, which weakened cybersecurity. The pharmaceutical industry was pressured to come up with a solution to the pandemic, which led to attacks primarily targeting clinical research and infrastructure with the intention of conducting intellectual property (IP) theft of key research areas such as vaccines and COVID-19 treatments[6]. Forty-five million people were affected by attacks on the health care sector in 2021[7].

One of the primary attack vectors that health care organizations face is phishing campaigns[7]. There are two types of phishing campaigns: regular phishing and spear phishing. Regular phishing campaigns attempt to target wider masses of people, whereas spear phishing (as the name suggests) is a specific targeted attack on one or a select group of individuals[8]. In 2020, one major American pharmaceutical industry company was a victim of such attacks when North Korean hackers posed as job recruiters on LinkedIn and Whatsapp to send job offers to company staff and gain access to their computers to steal vaccine trade secrets. Pharmacy industry cyberattacks are more costly than other industries and take 257 days on average to detect and contain.[5]

Under the Security Rule of the Health Insurance Portability and Accountability Act (HIPAA)[9], health care professionals are required to reasonably protect patient privacy by setting up safeguards on all equipment, data storage devices, administrative software, and computer systems, as well as proper cybersecurity protection. They must also prevent unauthorized disclosure of private information and unauthorized access to private information (i.e., breaches or hacks). The Security Rule requires covered entities (pharmacies, health systems, etc.) to conduct a risk assessment of their health care organization[9]. Maintaining the privacy of health information not only complies with the HIPAA but ensures patient safety in the face of cyber-attacks[10].

Cybersecurity for pharmacies

Pharmacies tend to have more exposure than that of other businesses because pharmacies combine risks to both retail payment data and health care exposures [1]. The pace of technological change, the increase in automation tools, and the use of third-party vendors pose major cybersecurity challenges to pharmacies and pharma companies. Pharmacies and health systems are especially vulnerable to cyberattacks because of their reliance on technology and ability to connect through e-scribing portals and electronic health records [11]. These connections tie pharmacies into the nation's health infrastructure. If one entity goes down, every other connected system can go down. Infiltrating a pharmacy's security does not only result in the release of private information but can shut down the prescription process. Even an initially small breach can spread and impact thousands of patients.

Cyberattacks that compromise customers' PHI and PII can lead to a loss of customer trust, regulatory fines, and even legal action[2]. Patient health information is not only crucial, but also expensive. Hackers target PHI because it generates 10-20x more revenue on the black market [7]. The collapse of this data can be detrimental, especially for community and independent pharmacies who cannot bounce back as easily as entire health systems.

In a 2020 article on cybersecurity by the American Nurses Association, the organization encourages health professionals to think of protecting PHI as primary prevention, conducting risk assessments, and performing regular maintenance as secondary prevention, and stabilizing and restoring systems after a cyberattack as tertiary prevention [12]. Pharmacies might focus on primary prevention but shrug off secondary and tertiary prevention. Cybersecurity may be thought of as an "add-on" and not a crucial step when running a pharmacy. However, failure to update security systems and respond appropriately to cyberattacks can take down an entire company.

Independent and small-chain pharmacies are especially vulnerable to cyberattacks because they often lack the time and resources to devote to cybersecurity. Cyber criminals are aware of this and may take advantage of these vulnerabilities. Smaller pharmacies have access to valuable data like PHI without having staff dedicated to securing that data. Keeping up with cybersecurity advancements can be a financial burden. Independent pharmacies may be using outdated operating systems and firewalls, making them easier to hack. When small or independent pharmacies are breached, they may never fully recover and some ultimately go out of business [11]. Internal threats, such as an employees clicking on a phishing attack, are among the greatest risks for small businesses.[1] Educating pharmacists and pharmacy owners about the necessity of cybersecurity systems and employee training, ways to prevent a breach, having a backup system for their data, and having appropriate liability insurance in case of an attack will strengthen business operation and security of patient information.

Cybersecurity for drug companies, manufacturers, wholesalers

Enacted in 2013, The Drug Supply Chain Security Act (DSCSA) is approaching its 10-year deadline for full implementation this November. One of the final requirements for every organization in the supply chain is to become interoperable using secure and electronic means. [4] An uptick in electronic usage and data sharing means an increased risk for cyberattacks. Manufacturers and wholesalers need to be ready to implement these new requirements and stay safe. The FDA has released a handful of guidelines and webinars surrounding the DSCSA policies. Bringing cybersecurity to the attention of drug manufacturers and wholesalers will help protect the nation's drug supply chain.

Cybersecurity for drug companies and research

The pharmaceutical industry is home to some of the most sensitive data and highly valuable technology, making it a major target for cyber criminals. Cybersecurity in the pharmaceutical industry is at risk as organizations host sensitive information about patients, patented drugs, clinical trials, research projects, and advances in technology. A 2021 study found that 92% of surveyed pharmaceutical organizations experienced a database breach [6]. Cyberattacks in the industry are costly; the average cost of a breach of a pharmaceutical company is close to $5.3 million dollars. This is 1.3 times more than the average of other industries [6]. The health care sector is consistently one of the biggest investors in research and development (R&D) across the United States. This massive investment in R&D, while contributing to the development of life-saving therapies and products, also creates a large target for intellectual property (IP) and trade secret theft [7]. Medications and pharmacies are a major target for cyberattacks and a necessary part of the nation's critical infrastructure.

Data backup systems

Pharmacists use health IT, provider directories, telehealth, e-prescribing (eRx), electronic health record systems, and certified EHR technology (CEHRT) to help manage patients' health needs. Pharmacists also use health IT for reporting to public health agencies (e.g., immunization reporting), clinical decision support services/knowledge artifacts, drug formulary checking, and comprehensive medication management [13]. Therefore, it is critically important to have data backups in place for pharmacies. Data backups can provide security against unexpected events such as system failure, data corruption, natural disaster, malicious attacks, and more [14]. Along with enhanced security, data backup helps the pharmacy work more efficiently. Automated backups replace the tedious task of manual uploads and give pharmacists more time to focus on providing care. Unexpected electronic system downtimes, or "crashes", are not uncommon in the pharmacy setting, but data backups can help the pharmacy get online faster. Backup systems can reduce costs and losses from corruption or during downtime [14]. Just like PHI storage, data backups with secure encryption help pharmacies become more compliant with HIPAA regulations. By having a reliable and secure data backup system, pharmacists can ensure that their practices remain competitive in the market and maintain patient data's confidentiality, integrity, and availability [14].

Liability insurance

Pharmacies can be held responsible for damage or even perceived damage to the parties whose data has been compromised[1]. If a pharmacy or pharmaceutical company has a data breach, they can be fined by multiple agencies. On average, it takes $1.4 million to recover from a cyberattack. Liability insurance can help pharmacies cover some of these costs if a breach occurs, by covering any legal costs and payouts an insured party is responsible for if they are found legally liable [12]. Pharmacy liability insurance is a type of insurance coverage specifically designed for pharmacists and pharmacy businesses. It provides protection against legal liability for any claims arising from errors, omissions, or other incidents related to the dispensing of medication, including compromised data.

Best practices

Along with the Security Rule requirements, the National Institute of Standards and Technology (NIST) released a cybersecurity framework for businesses to adopt as part of their risk management processes. The framework consists of standards and best practices, including implementation mechanisms, to manage cybersecurity risk [9]. Many organizations are increasing cybersecurity awareness and providing

tools to their members. The American Medical Association (AMA) and American Hospital Association (AHA) have curated resources and tips for physicians and health systems staff to protect patient health records and other data from cyberattacks [15]. The American Dental Association (ADA) recommends that dental practices protect themselves from cyberattacks by following good internet security practices, such as keeping systems up to date with security patches and making sure antivirus signature files are current [16]. The Association also recommends dental offices have multiple recent backups, and that backups are disconnected (inaccessible) from those systems. The American Society of Health-System Pharmacists (ASHP) also released positions on data security [10] (Appendix A).

General best practices for pharmacies include [11]:

- Install anti-virus software, and keep it updated.
- Upgrade to business grade firewall/router
- Do awareness training to pharmacy staff members about security threats (E-mail, Phones, Fax, Internet Browsing etc.)
- Use a policy of least privilege. If they don't need access to it – don't give access.
- Isolate your wireless network from your local area network (where your data resides)
- Reach out to your pharmacy management system. Ask them how they protect your data. What do they recommend?
- If you don't recognize it, delete it – DON'T OPEN IT
- Keep pharmacy private information off social media.
- Look for insurance related to cyber security (liability insurance)

Even with a strong prevention program, any pharmacy is still susceptible to a cyberattack. The current APhA policy addresses data security and ongoing protection but does not mention cyberattack recovery. What should pharmacies do if they *are* a victim of a cyberattack?

The Department of Health and Human Services has created cybersecurity guidance materials, including a Quick-Response guide which includes steps for a HIPAA covered entity to take in response to a cyber-related security incident [9] (Appendix B).

Future of cybersecurity

The future of cybersecurity is hard to predict because the industry is constantly evolving in response to the shifting behaviors of cybercriminals and the new attacks they develop. One of the biggest trends in the future of cybersecurity is the use of artificial intelligence (AI) and machine learning (ML) technologies. Cyberattacks continue to grow in sophistication, scale, and frequency. The pharmacy industry needs to be ready to handle a shifting landscape and react to new cybersecurity threats. Pharmacists need to stay up to date on cybersecurity and cyberattack trends. All employees should receive proper training regarding cybersecurity. APhA currently does not offer training on cybersecurity in the pharmacy.

Conclusion

Current APhA gaps in policy may include backup system requirements, cyberattack recovery, liability insurance, and stances on cybersecurity and the national drug supply chain. Cybersecurity is crucial in all pharmaceutical areas of business, from development to manufacturing to filling and patient interaction. Pharmacies are now more connected with various health systems, making them a crucial part of the nation's health infrastructure and an important area for government recognition. The growing reliance on

health technology will lead to an increase in cyberattacks. Data breaches expose pharmacies to significant risk and place them under scrutiny by regulators, payors, and customers. Consequences of a data breach may include significant financial loss, reputational damage, operational downtime, government investigations, and legal actions [17]. Organizations need to be educated and equipped to not only prevent a cyberattack but how to respond to one.

Related APhA Policy

2022 - Data Security in Pharmacy Practice

1. APhA advocates that all organizations and health care providers adopt best practices in data security to ensure ongoing protection of patient data from loss, alteration, and all forms of cybercrime.
2. APhA recommends that organizations understand the flow of information, both internally and externally, to apply and maintain reasonable and appropriate administrative, technical, and physical safeguards to protect the privacy and identity of their patients.
3. APhA calls on organizations to provide ongoing employee education and training regarding patient data protection, best practices, and cybersecurity standards.

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

2022 - Data Use and Access Rights in Pharmacy Practice

1. APhA supports organization and patient care provider rights to use patient data for improvement of patient and public health outcomes and enhancement of patient care delivery processes in accordance with ethical practices and industry standards regarding data privacy and transparency.
2. APhA urges ongoing transparent, accessible, and comprehensible disclosure to patients by all HIPAA-covered and noncovered entities as to how personally identifiable information may be utilized.
3. APhA calls for all entities with access to patient health data, including those with digital applications, to be required to adhere to established standards for patient data use.
4. APhA supports the right of patients to have full and timely access to their personal health data from all entities.

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

2010 - Personal Health Records

1. APhA supports patient utilization of personal health records, defined as records of health-related information managed, shared, and controlled by the individual, to facilitate self-management and communication across the continuum of care.

2. APhA urges both public and private entities to identify and include pharmacists and other stakeholders in the development of personal health record systems and the adoption of standards, including but not limited to terminology, security, documentation, and coding of data contained within personal health records.

3. APhA supports the development, implementation, and maintenance of personal health record systems that are accessible and searchable by pharmacists and other health care providers, interoperable and

portable across health information systems, customizable to the needs of the patient, and able to differentiate information provided by a health care provider and the patient.

4. APhA supports pharmacists taking the leadership role in educating the public about the importance of maintaining current and accurate medication-related information within personal health records.

(JAPhA. NS40(4):471; July/August 2010) (Reviewed 2013) (Reviewed 2014) (Reviewed 2015) (reviewed 2019)

2005, 2004, 1999 - Telemedicine/Telehealth/Telepharmacy

1. APhA supports the pharmacist as the only appropriate provider of telepharmacy services, a component of telehealth, for which compensation should be provided. Telepharmacy is defined as the provision of pharmaceutical care to patients through the use of telecommunications and information technologies.

2. APhA shall assist pharmacists and student pharmacists in becoming knowledgeable about telepharmacy and telehealth.

3. APhA shall participate in the ongoing development of the telehealth infrastructure, including but not limited to regulations, standards development, security guidelines, information systems, and compensation.

4. APhA acknowledges that state boards of pharmacy are primarily responsible for the regulation of the practice of telepharmacy, encourages appropriate regulatory action that facilitates the practice of telepharmacy and maintains appropriate guidelines to protect the public health and patient confidentiality.

(JAPhA. 39(4):447; July/August 1999) (JAPhA. NS44(5):551; September/October 2004) (JAPhA. NS45(5):559; September/October 2005) (Reviewed 2009) (Reviewed 2012) (Reviewed 2014) (Reviewed 2019)

2004 - Automation and Technology in Pharmacy Practice

1. APhA supports the use of automation and technology in pharmacy practice, with pharmacists maintaining oversight of these systems.

2. APhA recommends that pharmacists and other pharmacy personnel implement policies and procedures addressing the use of technology and automation to ensure safety, accuracy, security, data integrity, and patient confidentiality.

3. APhA supports initial and ongoing system-specific education and training of all affected personnel when automation and technology are utilized in the workplace.

4. APhA shall work with all relevant parties to facilitate the appropriate use of automation and technology in pharmacy practice.

(JAPhA. NS44(5):551; September/October 2004) (Reviewed 2006) (Reviewed 2008) (Reviewed 2013) (Reviewed 2014) (Reviewed 2015) (Reviewed 2019)

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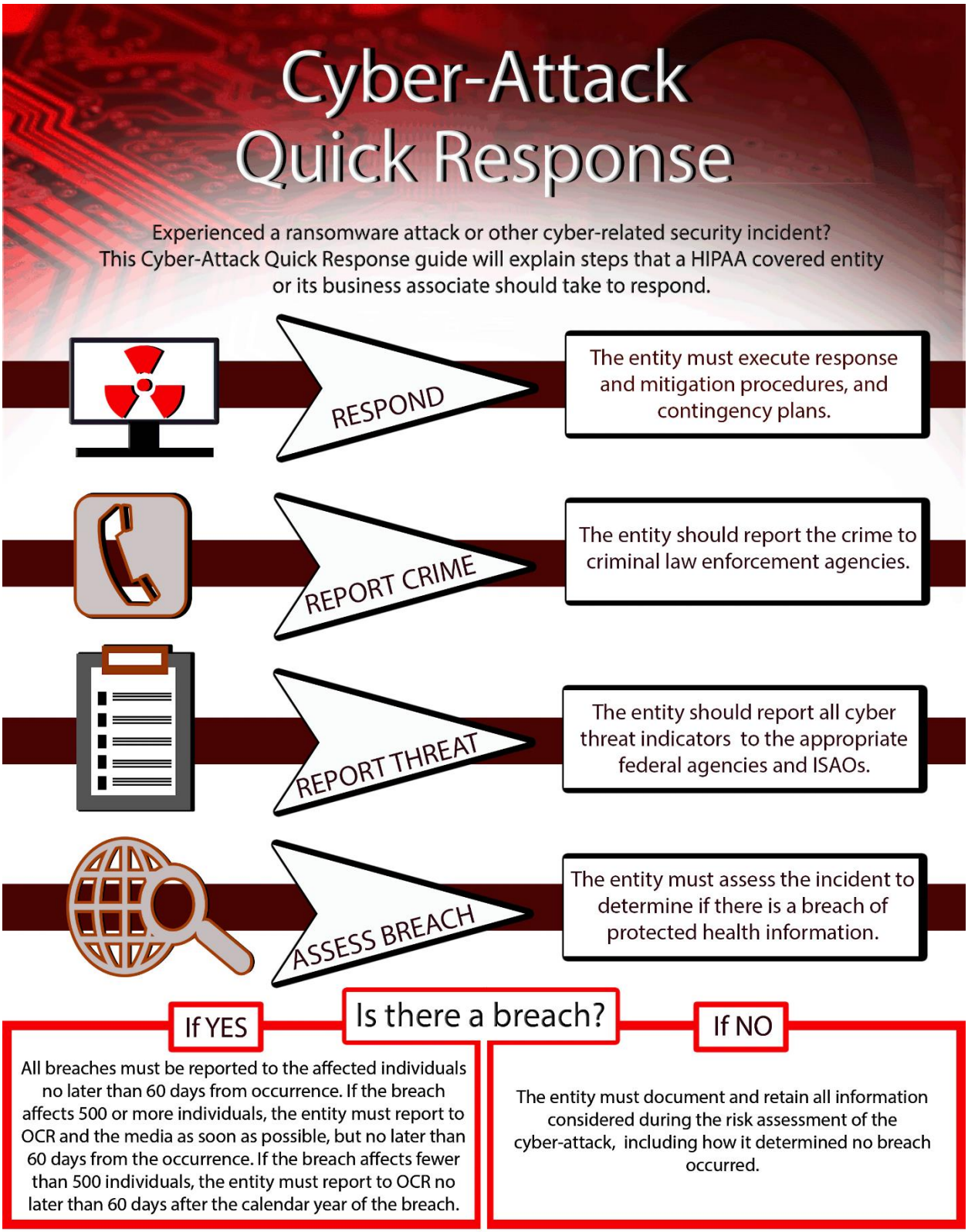
Appendix A


Cyber-Attack
Quick Response
Experienced a ransomware attack or other cyber-related security incident?
This Cyber-Attack Quick Response guide will explain steps that a HIPAA covered entity or its business associate should take to respond.
RESPOND
The entity must execute response and mitigation procedures, and contingency plans.
REPORT CRIME
The entity should report the crime to criminal law enforcement agencies.
REPORT THREAT
The entity should report all cyber threat indicators to the appropriate federal agencies and ISAOs.
ASSESS BREACH
The entity must assess the incident to determine if there is a breach of protected health information.
Is there a breach?
If YES
All breaches must be reported to the affected individuals no later than 60 days from occurrence. If the breach affects 500 or more individuals, the entity must report to OCR and the media as soon as possible, but no later than 60 days from the occurrence. If the breach affects fewer than 500 individuals, the entity must report to OCR no later than 60 days after the calendar year of the breach.
If NO
The entity must document and retain all information considered during the risk assessment of the cyber-attack, including how it determined no breach occurred.

Appendix B

ASHP Policy Positions 2009–2019 (with Rationales): Automation and Information Technology

1701

Ensuring Patient Safety and Data Integrity During Cyber-attacks

Source: Council on Pharmacy Management

To advocate that healthcare organizations include pharmacists in (1) assessing cyber-security systems and procedures for vulnerabilities, (2) implementing cyber-security strategies, and (3) reviewing cyber-security breaches and developing corrective actions; further,

To encourage the development of business continuity plans by pharmacy departments; further,

To advocate that healthcare organizations assess vendor systems to validate the security and integrity of data, including an assessment of the minimum amount of patient health information vendors require to provide services.

Rationale

As use of technology in healthcare has increased, so has the risk of cyber-attacks on this essential infrastructure. The digitization of patient records and the movement to enhance healthcare with technology has increased the risk of cyber-attacks; from 2015 to 2016, there was a 5.2% increase in such attacks against healthcare targets. Moreover, healthcare facilities made up 7.1% of the identified targets in July 2016, a 5.3% increase from the previous month. Maintaining the privacy of health information, in compliance with the Health Insurance Portability and Affordability Act (HIPAA), and ensuring patient safety in the face of cyber-attacks have become essential concerns for every healthcare organization. In July 2016, the U.S. Department of Health and Human Services released guidance on ransomware and HIPAA. Despite this guidance, there remains very little assistance to prevent data breaches or advice on how to respond when an attack occurs. Increased connectivity with vendor systems creates a mutual need to share access to patient information and other vital data, so risk mitigation must be considered at all points of access. Pharmacists and pharmacy departments need to contribute to organizational efforts to prevent and respond to cyber-attacks as well as develop business continuity plans to ensure they can meet patient needs and protect patient privacy in case of such attacks.

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

2023–2024 House of Delegates

Report of the New Business Review Committee

Committee Members

Andrew Bzowyckyj, Chair
Trisha Chandler
Juanita Draime
Jeff Hamper
Christopher Johnson
Brooke Kulusich
William Lee
John Pieper
Natalie Young

Ex Officio

Brandi Hamilton, Speaker of the House

This report is disseminated for consideration by the APhA House of Delegates and does not represent the position of the Association. Only those statements adopted by the House are considered official Association policy.

Overall Charge and Duties

The APhA House of Delegates New Business Review Committee reviewed feedback provided directly via email and from two open hearing webinars that took place on February 7, 2024, and February 14, 2024. The Committee then met on Thursday, February 15, to develop the following recommendations. Proposed amendments will become primary language acted on by the House of Delegates and are shown in red font (deletions are ~~**struck through**~~ and proposed additions are **underlined**).

The APhA House of Delegates New Business Review Committee presents the following report:

NBI #1 – 2015 Disaster Preparedness

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

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~~.

The APhA New Business Review Committee recommends adoption of New Business Item #1 Whole Numbered Statement #1 as written.

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

NBI #2 – Community Pharmacy Methadone Dispensing for Opioid Use Disorder

The APhA New Business Review Committee recommends adoption of New Business Item #2 Whole Numbered Statement #1 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.

The APhA New Business Review Committee recommends adoption of New Business Item #2 Whole Numbered Statement #2 as amended.

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

The New Business Review Committee recommends the term "compensation" when describing appropriate payment of pharmacists for these services.

The APhA New Business Review Committee recommends adoption of New Business Item #2 Whole Numbered Statement #3 as written.

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

The APhA New Business Review Committee recommends adoption of New Business Item #2 Whole Numbered Statement #4 as written.

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.

NBI #3 – Collective Bargaining

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

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

The APhA New Business Review Committee recommends adoption of New Business Item #3 Whole Numbered Statement #1 as written.

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

NBI #4 – Pharmacists Roles in Sexually Transmitted Infection Prevention & Treatment in Underserved Patients

The APhA New Business Review Committee recommends adoption of New Business Item #4 Whole Numbered Statement #1 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.

The APhA New Business Review Committee recommends adoption of New Business Item #4 Whole Numbered Statement #2 as amended.

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~~.

The New Business Review Committee recommends removal of the phrase "particularly in underserved patient populations," to broaden the policy to capture pharmacists' role in development of education and resources for all patient populations.

The APhA New Business Review Committee recommends adoption of New Business Item #4 Whole Numbered Statement #3 as amended.

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~~.

The New Business Review Committee recommends removal of the phrase "particularly in underserved patient populations," to broaden the policy to capture pharmacists' authorities and role in providing this care for all patient populations.

NBI #5 – Access to Radiopharmaceuticals

The APhA New Business Review Committee recommends adoption of the following as amended.

1. APhA advocates for ~~policy and legislation~~ laws, regulations, and policies that increase patient access to radiopharmaceuticals.

The New Business Review Committee recommends amendment to align with the standardized recommendation by the Policy Review Committee around regulatory language.

NBI #6 – 2020, 2015 Integrated Nationwide Prescription Drug Monitoring Program

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

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.

The APhA New Business Review Committee recommends adoption of New Business Item #6 Statement #6 (Statement #6 of original policy language) as amended.

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 identify controlled substance use in a manner other than prescribed, and/or fraud; (b) providing focused provider education and patient referral to treatment programs; and (c) supporting research activities on the impact of PDMPs.

The New Business Review Committee recommends amendment, to more accurately and narrowly capture the policy's intent of identifying controlled substance use in a manner other than prescribed.

NBI #7 – 2019, 2016 Substance Use Disorder

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

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~~.

The APhA New Business Review Committee recommends adoption of New Business Item #7 Statement #1 as amended.

1. APhA supports ~~legislative, regulatory,~~ laws, regulations, policies, and private sector efforts that include pharmacists' input and that will balance patients'~~/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.

The committee recommends incorporation of amendments as proposed by the Policy Review Committee to standardize regulatory language, in addition to amendments proposed by the new business item.

NBI #8 – 2014 Controlled Substances and Other Medications with the Potential for Abuse and Use of Opioid Reversal Agents

NBI Motion: To adopt the following policy statement 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

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.

The APhA New Business Review Committee recommends adoption of New Business Item #8 Statement #1 as written.

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, drug diversion, and substance use disorders.

NBI Motion: To adopt the following policy statement 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

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.

The APhA New Business Review Committee recommends adoption of New Business Item #8 Statement #2 as written.

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 use in a manner other than prescribed and/or diversion.

NBI Motion: To adopt the following policy statement 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

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.

The APhA New Business Review Committee recommends adoption of New Business Item #8 Statement #3 as written.

3. APhA supports pharmacists' access to and use of prescription monitoring programs to identify and prevent drug use in a manner other than prescribed and/or diversion.

NBI Motion: To adopt the following policy statement 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

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~~.

The APhA New Business Review Committee recommends adoption of New Business Item #8 Statement #4 as amended.

4. APhA supports the development and implementation of state and federal laws and regulations that permit pharmacists to ~~furnish~~ independently prescribe opioid reversal agents to prevent deaths due to opioid-associated emergencies.

The New Business Review Committee recommends incorporation of standardized language recommended by the Policy Review Committee, related to the replacement of contemporary language.

NBI Motion: To adopt the following policy statement 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

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-~~opioid-related deaths due to overdose~~ associated emergencies.

The APhA New Business Review Committee recommends adoption of New Business Item #8 Statement #5 as written.

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-associated emergencies.

NBI #9 – 2003, 1971 Security: Pharmacists' Responsibility

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

1. 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.

The APhA New Business Review Committee recommends rejection of New Business Item #9 Statement #1 as written.

1. APhA encourages pharmacists to voluntarily remove all proprietary drug products with potential for 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.

The New Business Review Committee recommends rejection as written, to return to original language:

> 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.

The New Business Review Committee discussed concerns of unintended implications to this policy as written, and thus recommends rejection as written. The committee also recommends ultimate review by a future Policy Review Committee for consideration to either be amended further or archived.

NBI #10 – 2019 Patient-Centered Care of People Who Inject Non-Medically Sanctioned Psychotropic or Psychoactive Substances

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

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.

The APhA New Business Review Committee recommends adoption of New Business Item #10 Statement #1 as written.

1. APhA encourages state legislatures and boards of pharmacy to revise laws and regulations to support the patient-centered care of people who use non-medically sanctioned psychotropic or psychoactive substances.

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

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.

The APhA New Business Review Committee recommends adoption of New Business Item #10 Statement #2 as written.

2. To reduce the consequences of stigma associated with 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.

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

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.

The APhA New Business Review Committee recommends adoption of New Business Item #10 Statement #3 as written.

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 non-medically sanctioned psychotropic or psychoactive substances.

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

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.

The APhA New Business Review Committee recommends adoption of New Business Item #10 Statement #4 as amended.

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 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 reversal ~~medications~~ agents, and medications for opioid use disorder.

The New Business Review Committee recommends amendment, to ensure consistent language of "opioid reversal agents" with this item and New Business Item #8 Statement #5. The committee favored "agents" in this case, to broaden language beyond medications if applicable.

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

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.

The APhA New Business Review Committee recommends adoption of New Business Item #10 Statement #5 as written.

5. APhA urges pharmacists to refer people who use non-medically sanctioned psychotropic or psychoactive substances to specialists in mental health, infectious diseases, and substance use disorder treatment; to housing, vocational, harm reduction, and recovery support services; and to safe consumption facilities and syringe service programs.

NBI #11 – 2017, 2012 Contemporary Pharmacy Practice

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

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.

The APhA New Business Review Committee recommends rejection of New Business Item #11 Statement #1 as written.

APhA supports practice authorities based on the full extent of pharmacists' education, training, and experience to deliver patient care in all practice settings and activities.

The New Business Review Committee recommends rejection as written, to return to original language:

> 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.

The committee considers the original policy language to be stronger and more assertive to ensuring pharmacists' have relevant authority and support to the full extent of their education, training, and experience.

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

2. APhA opposes burdensome legal and regulatory requirements beyond continuing professional development for the provision of patient care services.

The APhA New Business Review Committee recommends adoption of New Business Item #11 Statement #2 as written.

2. APhA opposes burdensome legal and regulatory requirements beyond continuing professional development for the provision of patient care services.

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
Date received: 1/22/24
Time received: 2:38pm ET

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Briana Rider
(Name)

2024 January 14 **(Date)**

U.S. Public Health Service (USPHS) Commissioned Corps, Federal Caucus **(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
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.: **2**
Date received: **1/22/24**
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.

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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.

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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
Date received: 1/22/24
Time received: 9:45pm ET

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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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
For Every Pharmacist. For All of Pharmacy.

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

Item No.: 6
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 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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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.: 7
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 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
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 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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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:. 9
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: 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
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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 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
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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.