American Pharmacists Association

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2023 House of Delegates

Report of the New Business Review Committee

Committee Members

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Shane Garrettson
Mary Gurney
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American Pharmacists Association
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American Pharmacists Association
House of Delegates – March 24-27, 2023

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

Item No.: I
Date received: 1/23/2023
Time received: 11:51 AM

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Brenda Jensen and Gigi Davidson, ACVP. Natalie Young, APPM
(Name)

Jan 22, 2023 **APPM Delegation, American College of Veterinary Pharmacists**
(Date) **(Organization)**

Subject: Development of veterinary pharmacy curricula in schools and colleges of pharmacy and pharmacy technology.

Motion: Adopt the following policy statement:

APhA encourages schools and colleges of pharmacy and pharmacy technology to develop curriculums that educate pharmacists, student pharmacists, and pharmacy technicians in the principles of veterinary pharmacotherapy.

Background:

On March 15, 2021, APhA HOD approved ACVP's proposal to expand the definition of a "patient" to include both human and non-human species. While this expansion highlights the wide scope of care provided by pharmacists, a paucity in veterinary pharmacotherapy education remains. In two independent surveys[1,2], 77% of pharmacists reported that they routinely filled prescriptions for animals. In a 2021, only 26.7% of colleges and schools of pharmacy surveyed responded that veterinary pharmacotherapy training was provided in their curricula[3], implying that almost three-quarters of pharmacy graduates are not trained to care for non-human patients during pharmacy school. Surveys of veterinarians indicate that they have a low confidence in pharmacists' ability to fill their prescriptions correctly[4]. Both NABP[5] and the American Veterinary Medical Association[6] have expressed resolutions emphasizing the need for pharmacist education in veterinary pharmacotherapy.

Thus, APhA encourages schools and colleges of pharmacy and pharmacy technology to develop curriculums that provide pharmacists, pharmacy students, and pharmacy technicians with training adequate to provide safer and more meaningful care to all patients regardless of species.

References

1. Sorah, E. and Davidson, G., 2015, June. Royal K. Dispensing errors for non-human patients in the community pharmacy setting: A survey of pharmacists and veterinarians. In Poster presented at: Society of Veterinary Hospital Pharmacists, 34th Annual Meeting.
2. Mingura, M., 2017, June. Community pharmacists and veterinary prescriptions: An analysis of prevalence, type, training, and knowledge retention. In Poster presented at: Society of Veterinary Hospital Pharmacists 36th Annual Meeting.
3. Elaimy, C., Melton, B., Davidson, G., Persky, A. and Meyer, E., 2022. Availability of Didactic and Experiential Learning Opportunities in Veterinary Practice at US Pharmacy Programs. American Journal of Pharmaceutical Education, 86(4).
4. American Veterinary Medical Association. Surveys describe harm from differences between prescriptions and drugs dispensed. Available at: https://www.avma.org/javma-news/2014-09-01/substitution-errors. Accessed on Jan 22, 2023.
5. National Association of Boards of Pharmacy. Veterinary pharmacy education (Resolution 110-5-14). Available at: https://nabp.pharmacy/news/news-releases/veterinary-pharmacy-education-resolution-110-5-14/. Accessed Jan 22, 2023.
6. American Veterinary Medical Association. Resolution #8 guidance to pharmacy stakeholders. Available at: https://www.avma.org/javma-news/2012-09-15/hod-wants-better-communication-nonveterinary-pharmacies. Accessed Jan 22, 2023.

Current APhA Policy & Bylaws:

2022, 2004, 1988 Pharmacists' Relationship to Veterinarians (p. 74, 2022 APhA Policy Manual)

1. APhA encourages pharmacists and student pharmacists 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)

2021 Definition of Patient (p. 74, 2022 APhA Policy Manual)

1. 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**)***

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House of Delegates – March 24-27, 2023

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

Item No.: 2
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NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Randy McDonough, Magaly Rodriguez de Bittner, Stephen Carroll
(Name)

November 30, 2022 — **(Date)**
American Pharmacists Association Board of Trustees — **(Organization)**

Subject: Uncompensated Care Mandates in Pharmacy

Motion:

1. APhA expects that all government, manufacturer, and payor policies for the provision of patient care, medical products and supplies, and related administrative services, appropriately recognize the role of pharmacists and pharmacies, and have adequate funding and accompanying mechanisms for reimbursement for pharmacist and pharmacy-provided services.
2. APhA expects that all government entities, manufacturers, and payors incorporate transparent and comprehensive cost analyses associated with the implementation of new programs in establishing reimbursements for pharmacist-provided patient care services, medical products and supplies, and related administrative services.

Background:

The American Pharmacists Association (APhA) Board of Trustees has charged a task force of the Board to recommend policy to the APhA House of Delegates surrounding uncompensated health care mandates. This proposed policy topic comes as a direct result from feedback the APhA Board of Trustees has received from APhA members across the country, urging that policy be developed on this subject. Reimbursement for pharmacy services has been an ongoing advocacy topic for APhA, especially related to efforts to recognize pharmacists as providers. However that being said, uncompensated care mandates is an additional issue that does not currently have sufficient adopted policy. Pharmacies pride themselves on being accessible health care resources for their communities, however if this accessibility is exploited without compensation, this could potentially lead to pharmacy closures negatively impacting entire communities of patients.

Uncompensated health care refers to services provided by health care professionals in any setting, which is not reimbursed by the patient or their insurance plan. This is most prevalent in instances where patients do not have insurance and do not pay the cost of care. For health care professionals recognized by the government as providers, the costs incurred by uncompensated care may be offset by several public funds and programs. However pharmacists are often not included in such mechanisms because of their lack of provider status, and therefore may be more negatively impacted by uncompensated care in a state of emergency – especially when mandated by regulatory policies.

The issues surrounding uncompensated health care mandates were exacerbated during the COVID-19 pandemic, when pharmacists were called on by the government to provide mandatory services such as distribution of PPE, COVID-19 immunizations, COVID-19 Test to Treat clinical assessments, among other roles. Despite the clear value these services had for pharmacy patients, these services were neither consistently nor optimally resourced, jeopardizing viability of pharmacies and pharmacy services. For example, when the temporary HRSA funding for COVID-19 vaccine administration for uninsured patients ran out in spring of 2022, pharmacists were largely still expected to provide the same vaccine administration service and assessment without compensation. While many pharmacists continued to do so out of the best interests of their patients and public health, this presented a substantial sustainability problem to pharmacies who now were mandated to absorb the associated costs, among all other costs to their businesses. Pharmacy teams were also called upon to distribute free materials such as masks to all patients, regardless of whether they'd received, or run out of, materials supplied by their state and federal government. This often forced pharmacies to absorb additional costs in order to fulfill promises made to the public on their behalf. Even in situations where pharmacists were compensated to provide critical services, such as the Test to Treat services for COVID-19 therapeutics, pharmacists were met with dismal compensation rates that often failed to account for the extensive time and resources taken to conduct such services.

The proposed policy is meant to encompass all aspects of uncompensated care mandates, both from the retroactive and prospective lenses. This includes medical products, administration, dispensing, and more. Medical products are defined by the World Health Organization as any instrument, apparatus, implement, machine, appliance, implant, reagent for in vitro use, software, material or other similar or related article, intended by the manufacturer to be used, alone or in combination for a medical purpose. Comprehensive cost analyses recommended to assess fairness and adequacy of compensation are intended to include considerations of geography, practice setting, required resources, and more.

References:

1. HealthCare.gov. Uncompensated Care. https://www.healthcare.gov/glossary/uncompensated-care/#:~:text=Health%20care%20or%20services%20provided,pay%20the%20cost%20of%20care (Accessed November 23, 2022)
2. Kaiser Family Fund. Sources of Uncompensated Care for the Uninsured. https://www.kff.org/uninsured/issue-brief/sources-of-payment-for-uncompensated-care-for-the-uninsured/ April 2021 (Accessed November 23, 2022)
3. Health Resources & Services Administration. COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured. https://www.hrsa.gov/provider-relief/about/covid-uninsured-claim. May 2022. (Accessed November 23, 2022)

4. Feldman N, Yu A. How pharmacies and labs are scrambling to manage loss of federal COVID funds. https://whyy.org/articles/pharmacies-and-labs-scrambling-manage-loss-of-federal-covid-funds/ March 2022 (Accessed November 23, 2022)
5. American Pharmacists Association. Inequity to COVID-19 Test to Treat Access – Pharmacists Can Help if Permitted. https://www.pharmacist.com/Advocacy/Issues/Inequity-to-COVID-19-Test-to-Treat-Access-Pharmacists-can-help-if-permitted (June 2022)
6. World Health Organization. Medical Devices. https://www.who.int/health-topics/medical-devices#tab=tab_1 (Accessed November 23, 2022)

Current APhA Policy & Bylaws:

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)

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Item No.: 3
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Time received: 8:00PM

American Pharmacists Association
House of Delegates – March 24-27, 2023

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

Introduced by: Veronica Vernon
(Name)

1/23/20 **American Pharmacists Association Task Force on Reproductive Health Care Access**
(Date) **(Organization)**

Subject: Access to comprehensive reproductive health care

Motion:

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, sterilization, and 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 that ensures patient access to comprehensive reproductive health care services.

Background:

Reproductive health care plays a vital role in the overall health and well-being of all patients, whether it be disease prevention, or management of acute, chronic, or emergency conditions. As a result, patient access to these services is an important component of health care. When discussing comprehensive reproductive health care services, this may encompass a variety of evidence-based practices, such as the management of pregnancy loss (miscarriage), ectopic pregnancy, infertility, pregnancy termination, sterilization, and contraception. Patients may opt to engage in varying extents of these health care services, based on factors such as cultural, social and religious considerations. However, health care professionals such as pharmacists have a duty to facilitate access to such services as clinically indicated and appropriate through patient education, as well as ordering, dispensing, and counseling patients on pertinent medication therapy. Ultimately, such services should be rendered in support of shared decision making between pharmacists and their patients, guided by principles of bodily autonomy.

The 2022 U.S. Supreme Court's ruling on Dobbs v Jackson Women's Health Organization overturned Roe v Wade, posing implications on the complete span of reproductive health services, as abortion regulation turned to individual states. Multiple states have consequently implemented new laws limiting patient access to selected reproductive services, which may consequently cause negative impacts on the health, safety, and autonomy of patients seeking these reproductive services.

APhA, along with other professional organizations, has recognized the unique and important role pharmacists have in public health, and reproductive health care is no exception. The pharmacy profession prides itself on

its unique accessibility to patients, and has a role to play in ensuring equitable patient access to reproductive health care services through services such as pharmacist-prescribed hormonal contraception offered in many states to help address patient gaps. This is reaffirmed by the currently adopted APhA policy, which notes pharmacists' role in public health awareness to "provide services, education, and information on public health issues." Studies identify that accessing reproductive health services already poses difficulties given the threats of stigma, violence, exclusion, and other discrimination toward patients and health care professionals alike. Therefore, it is important that patients are supported in autonomous health care decisions as a core tenant of patient care, as delineated in the Pharmacist Code of Ethics.

Current APhA Policy & Bylaws:

1990, 2004 **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)

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)

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

1. APhA recognizes the unique role and accessibility of pharmacist 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)

References:

1. American College of Obstetricians and Gynecologists. Restrictions to Comprehensive Reproductive Health Care. 2018. https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2018/restrictions-to-comprehensive-reproductive-health-care
2. Centers for Disease Control and Prevention. Women's Reproductive Health. May 2022. https://www.cdc.gov/reproductivehealth/womensrh/index.htm
3. American Public Health Association. The Role of the Pharmacist in Public Health. American Public Health Association. November 2006. https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/07/13/05/the-role-of-the-pharmacist-in-public-health%20/

4. Agency for Health Care Research and Quality. Shared Decisionmaking. https://www.ahrq.gov/cahps/quality-improvement/improvement-guide/6-strategies-for-improving/communication/strategy6i-shared-decisionmaking.html June 2013
5. Barr-Walker J, Jayaweera R et al. Experiences of women who travel for abortion: A mixed methods systematic review. PLoS One. Link: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0209991
6. Odum T, Hemann O, et al. Assessing psychosocial costs: Ohio patients' experiences seeking abortion care. Contraception. 2022. Link: https://www.sciencedirect.com/science/article/pii/S001078242200244X
7. Pharmacist Prescribing: Hormonal Contraceptives. National Association of State Pharmacy Associations. https://naspa.us/resource/contraceptives/

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Item No.: 4
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American Pharmacists Association
House of Delegates – March 24-27, 2023

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

Introduced by: Veronica Vernon
(Name)

1/23/20 **American Pharmacists Association Task Force on Reproductive Health Care Access**
(Date) **(Organization)**

Subject: **Pharmacist Protection Related to Reproductive Health Care Access**

Motion:

1. APhA opposes legal actions against pharmacies, pharmacists, and pharmacy personnel that provide patient access to reproductive health care services that are within pharmacist scope of practice.

Background:

On June 24, 2022, the U.S. Supreme Court's ruling on Dobbs v Jackson Women's Health Organization overturned Roe v Wade. This decision has implications on the complete span of reproductive health care services, as it leaves abortion regulation to individual states, creating a new landscape for health care professionals to navigate. Pharmacists, and other health care professionals, are specifically concerned by new legal implications and threats to their standard patient care services.

In states with laws restricting abortion access for example, health care professionals are concerned they may be subject to criminal penalties for helping to provide abortion care, both knowingly and unknowingly. Likewise, there is also concern about preserving rights to exercise professional judgment and conscientious refusal when providing patient care. Mifepristone and misoprostol are FDA-approved for medication abortion and the preferred regimen, but these medications also have other indications, such as the treatment of pregnancy loss (miscarriage), or stomach ulcers (in the case of misoprostol). Concerns have been raised about access to other medications, such as methotrexate, given its former use for medication abortions. In states where abortion is strictly regulated, pharmacists may be hesitant to dispense these medications out of fear of legal ramifications, imposing delays and burdens to patient care. Additional uncertainty surrounds medications that are known to cause fetal abnormalities, such as isotretinoin, a medication under REMS management.

This proposed policy addresses a need for protections of pharmacists practicing within the scope of their practice, and guidance to help them navigate varying regulations with due diligence and responsibility for patients. The proposed policy is intended to be inclusive of protection for all pharmacy personnel (pharmacists, pharmacy technicians, pharmacy interns, clerks, and others), as well as pharmacies as a business. Although specific to reproductive health care services in these statements, these same principles are encouraged to be applied to other contexts (i.e. assisted suicide).

Current APhA Policy & Bylaws:

2004, 1998 **Pharmacist Conscience Clause**

1. APhA recognizes the individual pharmacist's right to exercise conscientious refusal and supports the establishment of systems to ensure patient's access to legally prescribed therapy without compromising the pharmacist's right of conscientious refusal
2. APhA shall appoint a council on an as needed basis to serve as a resource for the profession in addressing and understanding ethical issues.

(JAPhA. 38(4):417; July/August 1998) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015)

2022 **Pharmacists Application of Professional Judgement**

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 that limit a pharmacist's responsibility to exercise professional judgement 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 judgement is limited by state or federal laws.

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

References:

1. United States Department of Health and Human Services. HHS issues guidance to the nation's retail pharmacies clarifying their obligations to ensure access to comprehensive reproductive health care services. https://www.hhs.gov/about/news/2022/07/13/hhs-issues-guidance-nations-retail-pharmacies-clarifying-their-obligations-ensure-access-comprehensive-reproductive-health-care-services.html July 2022
2. Dreher A. Axios. Post-Roe drug delays weigh on patients, providers. https://www.axios.com/2022/07/26/post-roe-drug-delays-weigh-on-patients-providers July 2022
3. JAPhA 2021. Pharmacists' knowledge, perspectives, and experiences with mifepristone dispensing for medication abortion. https://pubmed.ncbi.nlm.nih.gov/34281806/
4. 2022 Minnesota pharmacist sued for discrimination after refusing the morning-after pill: https://www.mtsu.edu/first-amendment/article/2152/religious-rights-of-pharmacists-and-morning-after-pills
5. Illinois General Assembly https://ilga.gov/legislation/billstatus.asp?DocNum=4664&GAID=16&GA=102&DocTypeID=HB&LegID=138825&SessionID=110 January 2023

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

Item No.: 5
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American Pharmacists Association
House of Delegates – March 24-27, 2023

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

Introduced by: Veronica Vernon
(Name)

1/23/20 **American Pharmacists Association Task Force on Reproductive Health Care Access**
(Date) **(Organization)**

Subject: Employer Responsibilities Regarding Comprehensive Reproductive Health Care Access

Motion:

1. APhA advocates for employers to provide coverage and access to comprehensive reproductive health care services.

2. APhA demands that pharmacists and pharmacy personnel receive accommodations before, during and after pregnancy, including but not limited to sufficient time and space for breaks, opportunities to sit while working, and access to food and water between breaks.

Background:

A remarkable majority of the pharmacy profession is composed of individuals of child-bearing potential; the United States Bureau of Labor Statistics reports that 58% of all pharmacists and 78% of pharmacy technicians in the year 2020 were women. This poses a significant need and opportunity for employers to take responsibility for accommodations to their personnel related to comprehensive reproductive health care services.

The recent U.S. Supreme Court ruling on Dobbs v Jackson Women's Health Organization in 2022 led to the overturn of Roe v Wade, thus directing abortion regulation to individual states to regulate. In certain states where abortion has been restricted, many patients have found themselves taking extraordinary efforts to receive care across home state lines. However, pursuing reproductive health care in another state poses significant challenges. This challenge impacts pharmacists as patients themselves.

Although APhA has existing policy related to employment standards and employee benefits, the intention behind this proposed policy is to address gaps in employer responsibilities related to reproductive health care services, and the potential challenges to accessible care as a result of state or local laws. These accommodations for personnel may include, but are not limited to travel out of state to access reproductive health care services (i.e. medical or surgical abortions), adequate time off for recovery, support and accommodations for fertility treatment (such as assisted reproductive technology), and more. Additionally, employers need to ensure policies and benefits are provided to employees of all genders, and not focused just on cisgendered women.

Current APhA Policy & Bylaws:

2017, 2012, 1989 **Equal Rights and Opportunities for Pharmacy Personnel**

1. 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)

2015 **Prenatal and Perinatal Care and Maternal Health**

1. 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)

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 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 pharmacists 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.
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.
5. Increasing its activities directed towards educating the profession about the mutual employment responsibilities of employers and employed pharmacists.
6. Developing benefits programs wherever possible to assist employers in providing employed pharmacists with economic security.
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)

2001
Employee Benefits

1. APhA encourages employers to offer benefit packages that provide dependent-care benefits, including, but not limited to, flexible spending accounts, voucher systems, referral services, onsite 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)

References:

1. U.S. Bureau of Labor Statistics. Labor Force Statistics from the Current Population Survey. Available: https://www.bls.gov/cps/cpsaat11.htm
2. Goldberg E. The New York Times. These Companies Will Cover Travel Expenses for Employee Abortions. https://www.nytimes.com/article/abortion-companies-travel-expenses.html August 2022.
3. Fitzgerald J. National Bureaus of Economic Research. Pharmacy and the Evolution of a Family-Friendly Occupation. https://www.nber.org/digest/feb13/pharmacy-and-evolution-family-friendly-occupation February 2013

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House of Delegates – March 24-27, 2023

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

Item No.: 6
Date received: 1/23/2023
Time received: 3:44PM

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Hillary Duvivier
(Name)

January 23, 2023
(Date)

United States Public Health Service
(Organization)

Subject: Pharmacist Representation on Medical Staff

Motion: To adopt the following policy statement under: Section Employer / Employee Relations

1. APhA advocates for pharmacists to be included as members of the medical staff and to be eligible to vote on bylaws, standards, rules, regulations, and policies that govern the medical staff.
2. APhA supports that pharmacists, as part of the medical staff, have parity in their opportunity to be credentialed and privileged as independent medical providers.

Background:

Problem

Pharmacists working in advanced practice roles delivering high quality Comprehensive Medication Management (CMM) and direct patient care has grown significantly over the past decade. Official inclusion as a medical staff member would be a milestone in recognizing those roles and could serve as a steppingstone to provider status and subsequently remuneration for their services. However, such inclusion is inconsistently applied, even within states that require compensation under major medical insurance for pharmacists providing health services. Medical staff or allied health staff membership creates an avenue for pharmacists to mirror the processes used by physicians and other providers for granting prescriptive authority and receiving reimbursement for services – chiefly, the credentialing and privileging process.

Background

The process of credentialing and privileging is well-established and foundational to quality assurance in healthcare. Hospitals and health systems usually manage credentialing and privileging through a medical staff office under the authority of the medical executive committee of the medical staff.[2] Since 2012, the Centers for Medicare and Medicaid Services (CMS) allowed the inclusion of pharmacists as credentialed and privileged practitioners within a hospital or health system to be a member in the organization's medical staff, provided it is consistent with state law and the organizational bylaws governing medical staff.[3]

Traditionally, pharmacist credentialing has been limited to verification that the pharmacist graduated from an accredited school of pharmacy and has a current pharmacy license in good standing. However, expanded clinical responsibilities, the opportunity for reimbursement for medical services, and an increasingly complex health care system call for an expanded credentialing process to ensure that pharmacists practicing in such roles have the knowledge and skills necessary to provide care in a team-based environment. In addition, use of a credentialing process for pharmacists that mirrors the process used by physicians and other providers promotes consistency and increases understanding and credibility among providers, insurers, and health systems.[4]

A key component of membership within an organized medical staff is the credentialing process and privileging of pharmacists. Credentialing and privileging are necessary components for pharmacist recognition as providers of care and subsequent payment for services. Membership within the hospital or health system medical staff provides a standardized avenue for credentialing and privileging which other healthcare providers must undergo. While accrediting bodies (e.g., The Joint Commission) and payers (e.g., CMS) guide and even mandate the credentialing process, each state may vary in who can practice as a licensed independent practitioner, to whom the credentialing process will apply. Privileging pharmacists must define the scope of care provided at the organization, identify the pharmacist's scope of practice as defined by state law, determine the scope of practice for pharmacists within the organization and define the qualifications and competencies necessary to provide quality care for the tasks, duties, or privileges designed in the scope of practice. Abiding by the bylaws of the organized medical staff would place pharmacists on par with other providers of an organization.

Select Existing Examples

The Veterans Health Administration[5], the Indian Health Service[6], and the United States Public Health Service[7] have established programs allowing pharmacists to take ownership of certain clinical services. Federal laws do not regulate health professionals and therefore do not dictate the specific patient care services that pharmacists are authorized to provide. This has long allowed federal pharmacists to practice at the top of their license, including prescriptive and laboratory ordering privileges.

Civilian organizations such as Johns Hopkins Hospital in Baltimore Maryland[8], Truman Medical Centers in Kansas City, Missouri[8], and The Ohio State University Wexner Medical Center[9] each have an established method to become privileged through the medical department they work with. In all cases, pharmacists undergo credentialing and privileging through an organized medical staff that recognizes pharmacists as a provider and holds them accountable for their outcomes.

Benefits

Medical staff membership with privileges allows the pharmacist to function with a high level of autonomy and independent clinical decision-making for activities included in their scope of practice and collaboratively with the health team for the overall care of the patient. Membership in an organized medical staff would consistently apply the same credentialing and privileging process to pharmacists as physicians and other medical professionals. This process would only aid pharmacists in receiving reimbursement for health services provided.

Current APhA Policy & Bylaws:

There are no APhA policies concerning pharmacist inclusion in membership of the medical staff of hospital or health systems.

Medical staff membership by pharmacists supports the following APhA policy statements:

- Ensuring Access to Pharmacists' Services (2013)

- (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

- Pharmacists Providing Primary Care Services (2013)
  - APhA advocates for the recognition and utilization of pharmacists as providers to address gaps in primary care.
- Employment Standards Policy Statement (2012, 2007, 1970)
  - (1) Employers are obligated to respect the professional status, privileges, and responsibilities of employed pharmacists.

References:

1. Independent Pharmacists Licenses may include: Advanced Practice Pharmacist (California), Pharmacist Clinician (New Mexico), Clinical Pharmacist Practitioner (North Carolina)
2. American Medical Association policy: "AMA Principles for Physician Employment H-225.950" section 4(a). Available at: https://policysearch.ama-assn.org/policyfinder/detail/medical%20staff?uri=%2FAMADoc%2FHOD.xml-0-1535.xml
3. Department of Health and Human Services, Centers for Medicare & Medicaid Services. Final Rule. Federal Register 2012; 77:29034–76. Available from: https://www.cms.gov/regulations-and-guidance/legislation/cfcsandcops/downloads/cms-3244-f.pdf
4. Engle J, Dick T, et al. Credentialing and privileging for clinical pharmacists. Journal of the American College of Clinical Pharmacy Vol 3, Issue 1. Feb 2020. Pages 133-144. **https://doi.org/10.1002/jac5.1201**
5. Veterans Health Administration, US Department of Veterans Affairs. VHA Handbook 1108.11(1) Clinical Pharmacy Services. Available here: https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=3120
6. Indian Health Service, US Department of Health and Human Services. Indian Health manual. Part 3, Chapter 7; Section on Clinical pharmacy Services. Available here: https://www.ihs.gov/ihm/pc/part-3/p3c7/#3-7.11
7. National Clinical Pharmacy Specialist Committee, US Public Health Service. Available at: https://dcp.psc.gov/OSG/pharmacy/ncps-handbook.aspx
8. Implementation essentials for pharmacist credentialing and privileging. 20th Annual ASHP Conference for Pharmacy Leaders. American Society of Health-System Pharmacists. Available at: http://www.ashpmedia.org/leaders15/docs/LC15-BK3-Credentialing-Handout.pdf

9. Jordan TA, Hennenfent JA, Lewin JJ 3rd, Nesbit TW, Weber R. Elevating pharmacists' scope of practice through a health-system clinical privileging process. Am J Health Syst Pharm. 2016 Sep 15;73(18):1395-405. doi: 10.2146/ajhp150820. Epub 2016 Jul 13.

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House of Delegates – March 24-27, 2023

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

Item No.: 7
Date received: 1/23/2023
Time received: 3:42

NEW BUSINESS

(To be submitted and introduced by Delegates only)

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

January 23, 2023 **United States Public Health Service**
(Date) **(Organization)**

Subject: Greenhouse Gas Emissions

Motion: To adopt the following proposed policy under:

Section Environment Concerns

APhA urges stakeholders within the pharmaceutical supply chain to reduce their greenhouse gas emissions.

Background:

Climate change is harming human health (e.g., extreme weather and climate events, infectious diseases, food and water safety and insecurity) and is listed by the World Health Organization as an urgent health challenge.[1] Notable greenhouse gas emissions that cause climate change include carbon dioxide and methane. The health care sector contributes 8.5% of total U.S. emissions.[2] In 2021, the U.S. Department of Health and Human Services (HHS) established the Office of Climate Change and Health Equity. In 2022, HHS launched an initiative for members of the healthcare sector to voluntarily pledge to reduce their greenhouse gas emissions. Around 80% of the sector's emissions come from the supply chain.[2] Thus, a holistic approach that captures the entire pharmaceutical supply chain (e.g., manufacturing, packaging, transportation, disposal of pharmaceuticals), is needed. All stakeholders within the pharmaceutical supply chain (e.g., manufacturers, distributors, pharmacies, health systems) can take actions to reduce their greenhouse gas emissions.[3,4]

References:
1. https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health
2. https://www.advisory.com/daily-briefing/2022/04/29/climate-change
3. Roy, C. (2021). The pharmacist's role in climate change: A call to action. *Canadian pharmacists journal: CPJ = Revue des pharmaciens du Canada: RPC, 154*(2), 74–75. https://doi.org/10.1177/1715163521990408
4. https://www.pharmaceutical-technology.com/features/cutting-carbon-footprint-pharma-supply-chain/

Current APhA Policy & Bylaws: suggesting new title under Environmental Concerns

2017 Drug Disposal Program Involvement

1. APhA urges pharmacists to expand patient access to secure, convenient, and 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)

2007, 1992 Recycling of Pharmaceutical Packaging

1. APhA supports aggressive research and development by pharmacists, pharmaceutical manufacturers, waste product managers, and other 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)

2001 Syringe Disposal

1. 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)

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

Item No.: 8
Date received: 1/23/2023
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NEW BUSINESS

(To be submitted and introduced by Delegates only)

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

January 23, 2023 **United States Public Health Service**
(Date) **(Organization)**

Subject: Access to Essential Medicines as a Fundamental Human Right

Motion: To amend 2016, 1994 - Pharmacy Services Benefits in Health Care Reform under:

Section: Other Public Health Issues

with "APhA encourages access to quality and affordable essential medicines as a fundamental human right."

Background:

At the 2015 United Nations General Assembly, 193 nations (including the United States) adopted the 2030 Agenda for Sustainable Development. The 2030 Agenda for Sustainable Development includes 17 Sustainable Development Goals (SDG) and 169 targets. The SDGs are a universal call to action to end poverty, protect the planet, and ensure that by 2030 all people enjoy peace and prosperity. SDG #3 is to ensure healthy lives and promote well-being for all at all ages. 3.8 sets an ambitious and transformational target of achieving universal health coverage. Access to quality and affordable essential medicines is a fundamental element of the right to universal health coverage and to health – which is a human right. The 1946 Constitution of the World Health Organization (WHO) and the 1948 Universal Declaration of Human Rights both recognize the right to health. Essential medicines are defined by the WHO as "those that satisfy the priority health care needs of a population". The WHO maintains a list of essential medicines that is updated every two years. The WHO essential medicines list is intended to guide the development or updating of national essential medicines list. The U.S. Food and Drug Administration maintains the U.S.' list of essential medicines. According to Chan

(2017), globally, nearly two billion people cannot access the medicines they need, which results in prolonged illness in communicable and non-communicable diseases, disability, deaths, and negative economic consequences.

References:

- https://sdgs.un.org/2030agenda
- https://www.who.int/publications/i/item/WHO-MHP-HPS-EML-2021.02
- Chan M. (2017). in Years in Public Health, 2007-2017— Access to Medicines: Making Market Forces Serve the Poor (Geneva, Switzerland: World Health Organization). Available at: https://cdn.who.int/media/docs/default-source/essential-medicines/fair-price/chapter-medicines.pdf?sfvrsn=adcffc8f_4&download=true
- https://www.hhrguide.org/2017/06/09/access-to-medicines-and-human-rights/

Current APhA Policy & Bylaws:

Other Public Health Issues

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 to enable pharmacists to establish systems that balance provider needs relative to corporate and governmental interests;

Am Pharm. NS34(6):58; June 1994) (Reviewed 2004) (Reviewed 2010) (Reviewed 2011) (JAPhA. 56(4):379; July/August 2016)

(Reviewed 2018) (Reviewed 2021)

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American Pharmacists Association
House of Delegates – March 24-27, 2023

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

Item No.: 9
Date received: 1/23/2023
Time received: 3:42PM

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: LCDR Briana Rider
(Name)

January 23, 2023
(Date)

United States Public Health Service
(Organization)

Subject: Enforcing antidiscrimination in the dispensing of medications

Motion: To adopt the following proposed policy statements:

Section: Prescriptions and Prescription Orders

1. APhA affirms its support of patients obtaining prescription medication from pharmacies, free from discrimination.
2. APhA opposes discrimination on the basis of disability, pregnancy or related conditions.

Background:

Since the Supreme Court's ruling on Dobbs v. Jackson, the U.S. Department of Health and Human Services (HHS) has received complaints about pharmacies not complying with their federal obligations to fill prescriptions. As recipients of federal financial assistance (e.g., Medicare and Medicaid payments), pharmacies are prohibited from discriminating against pharmacy customers on the bases of disability or sex, among other bases, including with regard to supplying medications.

In July 2022, HHS issued guidance to retail pharmacies clarifying their obligations under federal civil rights law. The guidance reaffirms that:

- A pharmacy may be discriminating on the basis of disability if the pharmacy refuses to fill an individual's prescription or does not stock the medication (e.g., misoprostol, methotrexate) because of its alternate uses (e.g., termination of pregnancy) if the individual has a condition (e.g., rheumatoid

arthritis, severe and chronic stomach ulcers) that meets the definition of a disability under civil rights laws.

- Discrimination against people on the basis of pregnancy or related conditions (e.g., miscarriage, ectopic pregnancy) is a form of sex discrimination prohibited by federal law. Further, a pharmacy may be discriminating on the basis of sex if they refuse to fill a certain type of contraceptive (e.g., emergency contraception) because it may prevent pregnancy but provides other contraceptives (e.g., condoms).

References:

- https://www.hhs.gov/sites/default/files/pharmacies-guidance.pdf

Current APhA Policy & Bylaws: suggesting new subject under Prescriptions and Prescription Orders

2017, 2012, 1989 Equal Rights and Opportunities for Pharmacy Personnel

1. 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)

1979 Consideration of the Equal Rights Amendment

1. APhA supports efforts to ensure equal rights of all persons.

(Am Pharm. NS19(7):60; June 1979) (Reviewed 2009) (Reviewed 2014) (Reviewed 2018)

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

Item No.: 10
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NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Cory Holland
(Name)

January 23, 2023 **(Date)**

APhA-APPM Public Health SIG **(Organization)**

Subject: Pharmacy Shortage Areas

Motion: To adopt the following policy statement as listed below:

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.

Background:

Community pharmacies are a key access point for timely preventative care, acute and chronic disease management. They offer essential public health services such as immunizations, contraception, and naloxone, and treat common illnesses such as strep throat, influenza, and COVID-19. The COVID-19 pandemic demonstrated the significant, direct impact pharmacists have in life-saving care. Pharmacists are estimated to have administered >50% of COVID-19 vaccinations in the United States by providing >270 million vaccinations (Grabenstein). Pharmacists also tested >42 million patients for COVID-19 and provided >100,000 COVID-19 monoclonal antibody treatments (Grabenstein). Pharmacies also offer services to manage a variety of chronic conditions like diabetes and hypertension.

Despite their importance, there are significant disparities in access to pharmacies in the U.S. We commonly hear that 90% of Americans live within 5 miles of a pharmacy. In fact, 48.1% of people lived within one mile of any pharmacy, 73.1% within 2 miles, 88.9% within 5 miles, and 96.5% within 10 miles (Berenbrok). However, distance alone does not adequately determine access to a pharmacy. Access is also impacted by the ability to spend money and time traveling to a pharmacy. Areas where access to pharmacies is especially difficult are referred to as pharmacy shortage areas or pharmacy deserts. While definitions for these designations vary, one study found that over 40% of counties are pharmacy deserts, where most people have to drive more than 15 minutes to reach nearby pharmacies (Nguyen). Using the Pharmacy Access Initiative-led standards, 1 in 4 neighborhoods in the United States are pharmacy deserts or pharmacy shortage areas (NCPA). In a study that considered travel time in four major cities, half a million people lived in pharmacy deserts (Ying).

Moreover, narrow networks determined by pharmacy benefit managers (PBMs) significantly impact patients' ability to access pharmacy services. In 2022, TRICARE beneficiaries faced unforeseen challenges when more than 15,000 independent pharmacies were no longer in the TRICARE retail pharmacy network (TRICARE Communications). Affected patients may have lived near a pharmacy but were forced to travel farther distances to a pharmacy that accepted their insurance. In these cases, independent pharmacies lost loyal patients negatively impacting business sustainability and, in turn, patients lost trusted pharmacies. It is important to note that not all pharmacies offer the same types and levels of patient care services. Access to clinical services such as immunizations and disease management, as well as operational services such as home delivery, interpreter services, and multilingual staff, vary between pharmacies. In a 2017 study, chain pharmacies were significantly less likely than independent pharmacies to report offering home-delivery (6.2% vs. 64.2%) or multilingual staff (1.8% vs. 30.6%) (Qato, 2017). While many pharmacies offer essential public health services, narrow networks and other PBM practices impact the variety and quality of services that patients receive.

Pharmacy shortage areas, which are exacerbated by pharmacy closures, disproportionately affect low-income communities, communities of color, and those without access to a vehicle (Guadamuz, 2021). Between 2009 and 2015, one in eight pharmacies in the U.S. shut down. Most closures occurred at independently owned pharmacies located in low-income urban areas (Guadamuz, 2019). In urban areas, pharmacy closures were more common in Black and Latino neighborhoods (Guadamuz, 2021). Pharmacy closures have real

impacts on clinical outcomes; for example, one study found declines in adherence to cardiovascular medications (Qato, 2019). Pharmacy closures are expected to worsen due to increasing competition, preferred pharmacy networks, and declining reimbursement rates (Schulman).

Policy measures are needed to mitigate pharmacy shortage areas. Such policies could include financial incentives to establish pharmacies in shortage areas and prevent the closure of pharmacies. Examples include providing higher reimbursement to pharmacies that are considered critical access pharmacies, establishing payment mechanisms for pharmacist-provided care, and increasing reimbursement for Medicaid and Medicare prescriptions. Consideration should also be given to the role that PBMs play in declining reimbursement and restrictive pharmacy networks. Additionally, access standards that identify pharmacy shortage areas are needed at the federal level. Currently there is no federal designation for pharmacy shortage areas and policy decisions are made based on medically underserved areas and health professional shortage areas. Pharmacy shortage area designations would improve our ability to target pharmacy desert communities.

Although pharmacies are an important access point for vulnerable communities to receive a wide range of health services by a trusted health professional, disparities in pharmacy access exist. Pharmacy closures are disproportionately impacting vulnerable communities, thereby lessening our ability to care for populations who fall through the cracks of our healthcare system. Access is further restricted by lack of recognition of pharmacists as providers and PBM practices such as narrow networks. Efforts to improve access to healthcare services must consider the impact of pharmacy shortage areas. Policy change is needed to ensure equitable access to essential services.

References:

1. Berenbrok, L. A., Tang, S., Gabriel, N., Guo, J., Sharareh, N., Patel, N., Dickson, S., & Hernandez, I. (2022). Access to Community Pharmacies: A nationwide geographic information systems cross-sectional analysis. Journal of the American Pharmacists Association. https://doi.org/10.1016/j.japh.2022.07.003.
2. Grabenstein JD. Essential services: Quantifying the contributions of America's pharmacists in COVID-19 clinical interventions. Journal of the American Pharmacists Association 2022;62(Nov-Dec): in press. doi.org/10.1016/j.japh.2022.08.010.
3. Guadamuz JS, Alexander GC, Zenk SN, Qato DM. Assessment of Pharmacy Closures in the United States From 2009 Through 2015. JAMA Intern Med. 2020;180(1):157–160. doi:10.1001/jamainternmed.2019.4588.

4. Guadamuz JS, Wilder JR, Mouslim MC, Zenk SN, Alexander GC, Qato DM. Fewer pharmacies in Black and Hispanic/Latino neighborhoods compared with white or diverse neighborhoods, 2007–15. Health Aff (Millwood). 2021;40(5).
5. NCPA collaborates with USC on Groundbreaking Pharmacy Mapping Project. National Community Pharmacists Association. https://ncpa.org/newsroom/news-releases/2022/10/24/ncpa-collaborates-usc-groundbreaking-pharmacy-mapping-project. Published October 24, 2022. Accessed January 13, 2023.
6. Nguyen A. Mapping healthcare deserts: 80% of the country lacks adequate access to healthcare. GoodRx. https://www.goodrx.com/healthcare-access/research/healthcare-deserts-80-percent-of-country-lacks-adequate-healthcare-access. Published September 9, 2021. Accessed January 13, 2023.
7. Qato DM, Alexander GC, Chakraborty A, Guadamuz JS, Jackson JW. Association between pharmacy closures and adherence to cardiovascular medications among older US adults. JAMA Netw Open. 2019;2(4):e192606.
8. Qato DM, Zenk S, Wilder J, Harrington R, Gaskin D, Alexander GC. The availability of pharmacies in the United States: 2007–2015. van Wouwe JP, ed. PLoS ONE. 2017;12(8):e0183172.
9. Schulman KA, Richman BD. The evolving pharmaceutical benefits market. JAMA. 2018;319(22): 2269–70.
10. TRICARE Communications. Tricare pharmacy network changes may affect independent pharmacy customers. TRICARE Newsroom. https://newsroom.tricare.mil/Articles/Article/3186908/tricare-pharmacy-network-changes-may-affect-independent-pharmacy-customers#:~:text=%E2%80%93%20Starting%20Oct.,to%20more%20than%2040%2C000%20pharmacies. Published October 13, 2022. Accessed January 27, 2023.
11. Ying X, Kahn P, Mathis WS. Pharmacy deserts: More than where pharmacies are. Journal of the American Pharmacists Association. 2022;62(6):1875-1879.

Current APhA Policy & Bylaws:

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.

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.

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 providers and claims data.

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Item No.: 11
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NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Adrienne Simmons
(Name)

January 23, 2023
(Date)

APhA-APPM
(Organization)

Subject: Decriminalization

Motion: To amend the following policy statement as listed below:

Legalization or Decriminalization of Illicit Drugs 2016, 1990

1. APhA opposes legalization of the possession, sale, distribution, or use of illicit drug substances for non-medical uses. (NO CHANGE)
2. APhA supports decriminalization of the possession or use of illicit drug substances or paraphernalia. (NEW)
3. APhA supports voluntary pathways for the treatment and rehabilitation of individuals who are charged with the possession or use of illicit drug substances and who have substance use or other related medical disorders. (NEW)
4. ~~APhA supports the use of drug courts or other evidence-based mechanisms--when appropriate as determined by the courts--to provide alternate pathways within the legal criminal justice system for the treatment and rehabilitation of individuals who are charged with drug-related offenses and who have substance use or other related medical disorders.~~ (STRIKE)
5. APhA supports criminal penalties for persons convicted of ~~drug-related crimes, including but not limited to~~ drug trafficking, drug manufacturing, ~~and~~ or drug diversion, whenever alternate pathways are inappropriate as determined by the courts. (AMEND)

Background:

This background information was obtained from the following commentary: Bratberg JP, Simmons A, Arya V, Bhatia A, Vakharia SP. Support, don't punish: Drug decriminalization is harm reduction. Journal of the American Pharmacists Association. 2023;63(1):224-229. https://doi.org/10.1016/j.japh.2022.12.017.

Although APhA has taken steps to support providing care to PWUD, such as access to naloxone, nonprescription syringes, and medications for opioid use disorder, the association has a contradictory position on the legalization and decriminalization of drugs (APhA Policy Manual). While these policies were intended to improve care for people with substance use disorder (SUD), their flaw is that they call on courts, not clinicians, to make medical decisions, which are often not centered on evidence-based practice. The additional dissonance of these policy statements is further highlighted by the Association's advocacy to position pharmacists as key leaders in addressing the opioid overdose crisis. To fortify our role as providers of compassionate, humane, and equitable health care, APhA must urgently amend these policies to explicitly support decriminalization of adult drug use and possession.

Despite large investments in and policy support for harm reduction including naloxone, syringes, and medications for opioid use disorder, people who use drugs continue to experience unprecedented rates of mortality from overdose and morbidity from infectious diseases. Overall drug overdose deaths reached a record-breaking 107,000 deaths in 2021, according to preliminary data from the Centers for Disease Control and Prevention (Ahmad). Beyond overdose risk, substance use is associated with several other health risks. Among people who inject drugs (PWID), sharing injection equipment is the driving factor for hepatitis C virus (HCV) infections and remains a risk factor for human immunodeficiency virus (HIV) infections. Although HIV infections declined from 2015 to 2019, HCV infection rates have increased for more than a decade (US HHS; HIV.gov).

According to data from the 2021 National Survey on Drug Use and Health, approximately 1 in 5 people older than 12 years in the United States used an illicit drug in the past year—totaling more than 61 million people. Less than a third of this group, 24 million people, met criteria for a SUD relating to their drug use in the past year (SAMHSA). Meanwhile, there were 1.5 million drug-related arrests in the United States in 2019 and they were disproportionately among Black, Indigenous, and Latinx people (FBI). Incarcerated individuals are three times more likely to have HIV/AIDS and other sexually transmitted infections than

nonincarcerated individuals. They are also less likely to receive vaccines for preventable diseases like influenza and COVID-19 (AAFP). Although 2 of every 3 incarcerated people have a diagnosis for an alcohol or other SUD, only approximately 11% of these individuals are treated with evidence-based therapies (Belenko). The relative risk of all-cause mortality was 12 times higher for incarcerated individuals than nonincarcerated individuals (Binswanger). The criminalization of drug use has disproportionately exacerbated these drug-related harms and imposed short- and long-term burdens on already marginalized and vulnerable populations.

A strategy to reduce the number of people who are arrested, convicted, and incarcerated for drug-related offenses is to eliminate criminal penalties for drug use and possession, possession of drug use supplies such as syringes, and low-level drug sales. Drug decriminalization is different from legalization in that it does not establish a legally regulated market or supply chain for the cultivation, production, or sale of drugs (Drug Policy Alliance). At its core, drug decriminalization is a harm reduction strategy, much like wearing seatbelts, the human papillomavirus vaccine, and naloxone. Data from the United States and across the globe suggest that treating problematic drug use as a health issue, rather than a criminal issue, helps keep communities healthy and safe. In 2000, Portugal decriminalized drugs and increased access to sterile syringes, methadone, and other drug therapies. Since then, Portuguese officials have observed no major increase in drug use, reduced rates of adolescent drug use, decreased incidence of HIV/AIDS, reduced drug-related deaths, and an increase in the number of patients receiving SUD treatment (Hughes; Wiessing). In 2020, Oregon became the first state to decriminalize drug possession and expand access to evidence-based harm reduction services.

Pharmacy professionals and students are not immune to the effects of drug criminalization, where one conviction can lead to the loss of their license, employment, or educational progress. Communities become less healthy and stagnate in punitive criminalization systems, further reducing opportunities for growth. Decriminalization of drug use and possession is an urgently needed and effective approach to drug use that shifts resources from punishment to public health. Pharmacists play essential roles in the prevention and management of drug misuse and use disorders. As the overdose crisis worsens and pharmacists' role in public health increases, it is imperative to position pharmacists as advocates for drug decriminalization.

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Current APhA Policy & Bylaws:

2022 Pharmacists Prescribing Authority and Increasing Access to Medications for Opioid Use Disorders

1. APhA advocates for pharmacists' independent prescriptive authority of medications indicated for opioid use disorders (MOUDs) and other substance use disorders to expand patient access to treatment.
   (JAPhA. 62(4):942; July 2022)

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)

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)

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)

2019 Patient-Centered Care of People Who Inject Non-Medically Sanctioned Psychotropic or Psychotropic 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 non medically 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)

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 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)

2016 Medication-Assisted Treatment

1. APhA supports expanding access to medication-assisted treatment (MAT), 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. 56(4):370; July/August 2016) (Reviewed 2021) (Reviewed 2022)

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)

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 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)

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 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)

2013 Pharmacists Providing Primary Care Services

1. 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)

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 healthcare 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)

2011 Role and Contributions of the Pharmacist in Public Health

1. In concert with the American Public Health Association's (APHA) 2006 policy statement, "The Role of the Pharmacist in Public Health," APhA encourages collaboration with APHA and other public health organizations to increase pharmacists' participation in initiatives designed to meet global, national, regional, state, local, and community health goals.
(JAPhA. NS51(4):482; July/August 2011) (Reviewed 2012) (Reviewed 2016) (Reviewed 2020) (Reviewed 2022)

Sale of Sterile Syringes 1999

1. APhA encourages state legislatures and boards of pharmacy to revise laws and regulations to permit the unrestricted sale or distribution of sterile syringes and needles by or with the knowledge of a pharmacist in an effort to decrease the transmission of blood-borne diseases.

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

1. APhA recognizes the unique role and accessibility of pharmacist 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.

The Use of Controlled Substances in the Treatment of Intractable Pain 2003,1983

1. APhA supports the continued classification of heroin as a Schedule I controlled substance.
2. APhA supports research by qualified investigators under the Investigational New Drug (IND) process to explore the potential medicinal uses of Schedule I controlled substances and their analogues.
3. APhA supports comprehensive education to maximize the proper use of approved analgesic drugs for treating patients with chronic pain.

Medicinal Use of Marijuana1980

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 and regulations pertaining to: (a) marketing approval of new drugs based

on demonstrated safety and efficacy, or; (b) control restrictions relating to those substances having a recognized hazard of abuse.

3. APhA recognizes that pharmacists receiving controlled substance prescription orders used for analgesia have a responsibility to ensure that the medication has been prescribed for a legitimate medical use and that patients achieve the intended therapeutic outcomes
4. APhA advocates that pharmacists play an important role on the patient care team providing pain control and management.

Prevention and Control of Sexually Transmitted Infections 2005, 1972

1. APhA calls upon all producers of prophylactic devices to include in or on their packaging adequate instructions for use so as to better ensure the effectiveness of the devices in the prevention of sexually transmitted infections.
2. APhA urges pharmacists to make more readily available to the public educational materials, prophylactic devices, and adequate instructions for use in combating sexually transmitted infections.

****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 23, 2023** (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.