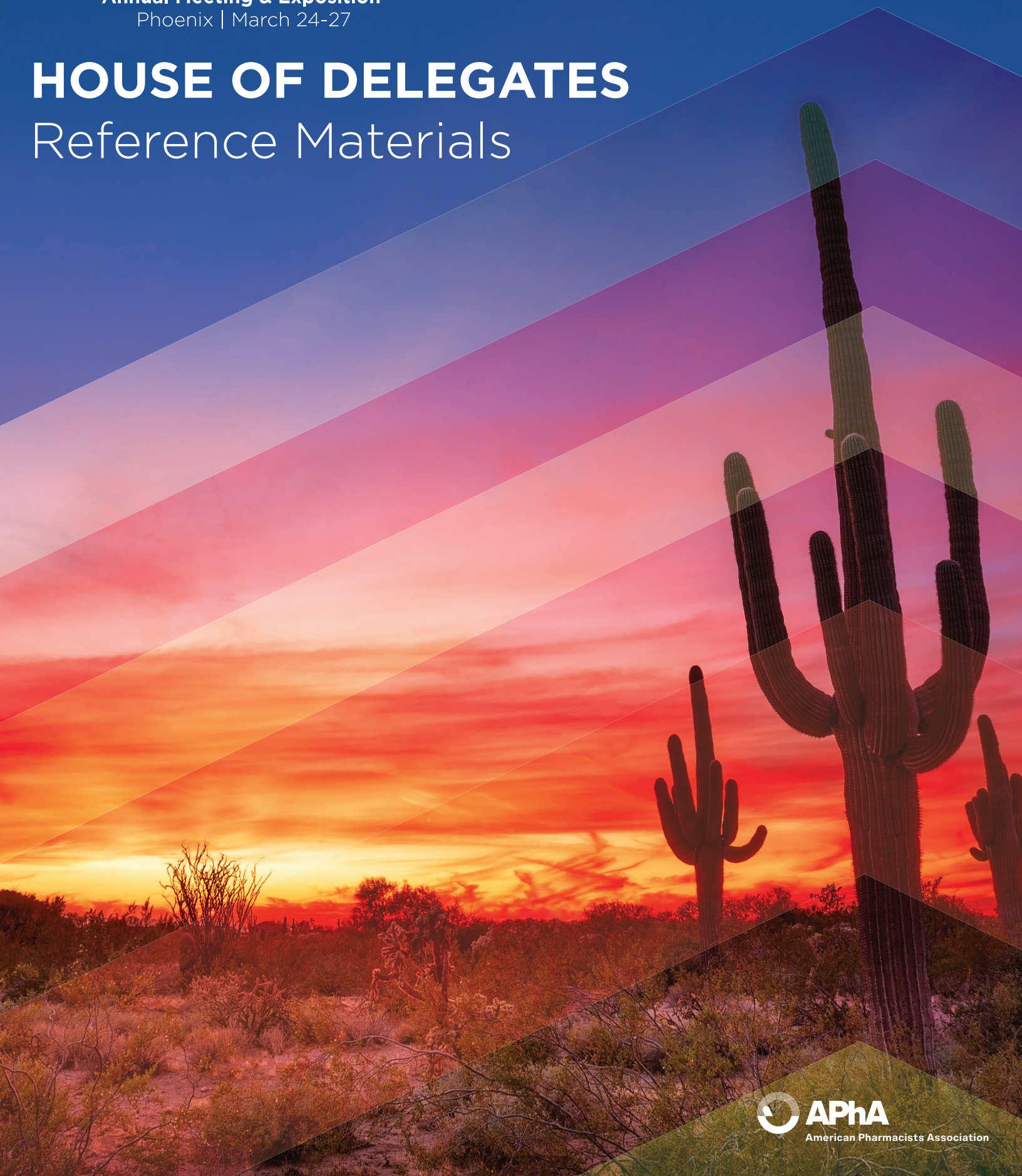
APhA2023
Annual Meeting & Exposition
Phoenix | March 24-27

HOUSE OF DELEGATES
Reference Materials



APhA
American Pharmacists Association

House of Delegates

MEMORANDUM

TO: Delegates and Alternate Delegates to the APhA House of Delegates
FROM: Melissa Skelton Duke, 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;
- 2022-2023 APhA House Rules Review Committee Report;
- 2022-2023 APhA Policy Review Committee Report;
- 2022-2023 APhA Policy Reference Committee Report;
- 2022-2023 APhA Policy Committee Background Papers:
- 2022-2023 APhA New Business Items received;
- 2022-2023 APhA New Business Review Committee Report; and
- 2022-2023 APhA Urgent New Business Item Received.

Amendment Forms** - **New Process for 2023

*New for 2023, 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of the committee-related webinars, I encourage you to visit https://pharmacist.com/About/Leadership/HOD/Learn to view an archived version of the webinars conducted to date.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 – Outside of Room 301AB

Registration for the First Session will open from **12:00pm-3:00pm on Friday**, **March 24, 2023.** Delegate registration will be located at the **Phoenix Convention Center** (100 N 3rd Street, Phoenix, AZ 85004).

Registration for the Final session is in the same location, from **11:00am-1:30pm on Monday, March 27, 2023**. 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 outside of the **Room 301AB**. Please remember to bring your delegate reference materials and your APhA2023 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.

Delegate Networking Resource

As requested, a networking resource has been developed and included within these Delegate Reference Materials, in an effort to connect delegates from various practice settings and states. As you may recall from previous APhA webinars, this resource was assembled using existing APhA member profile information, as of February 2023. If the content you see next to your name is out of date, you may log into your APhA Member Profile to adjust in future iterations.

Planning for the 2024 House

It's never too early to plan ahead! In mid-April, APhA will begin the policy development process for 2024. With that in mind, I encourage you to begin thinking about the potential policy topics that should be addressed by the House of Delegates. Within this booklet, you will find a call for potential policy topics. I encourage you to bring your completed form to the meeting, or submit the form electronically by early **April 7, 2023** at https://apha.secure-platform.com/a/solicitations/1584/home.

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 2023-2024 policy development process, I encourage you to complete the committee volunteer interest form **by April 7, 2023** at https://apha.secure-platform.com/a/solicitations/1587/home.

Thank you again for your interest and service to the 2023 House of Delegates! I look forward to seeing you in Phoenix, AZ! If you have any questions about House activities, please visit https://pharmacist.com/hod or contact APhA staff at hod@aphanet.org.

Sincerely,

Melissa Skelton Duke, PharmD, MS, BCPS, FAPhA
Speaker of the House of Delegates

Ilisa Bernstein, PharmD, JD, FAPhA
Secretary, APhA House of Delegates
APhA Interim Executive Vice President & Chief Executive Officer

cc:

Brandi Hamilton, Speaker-elect, APhA House of Delegates
Brian Wall, Senior Director, APhA Executive Office, Governance & Foundation Programs bwall@aphanet.org)
Brittany Botescu, Senior Manager, Governance and Policy
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 24		
12:00 pm – 3:00 pm	Outside Room 301AB	Delegate Registration
1:00 pm – 2:30 pm	Room 221C	APhA-APPM Delegate Caucus
1:00 pm – 2:30 pm	Room 131B	APhA-APRS Delegate Caucus
2:45 pm – 5:15 pm	Room 301AB	House of Delegates – First Session (Be seated by 2:45pm)

SATURDAY, MARCH 25		
1:00 pm – 2:30 pm	Room 224AB	New Business Review Committee Open Hearing

SUNDAY, MARCH 26		
1:00 pm – 3:00 pm	Room 224AB	Policy Reference Committee Open Hearing

MONDAY, MARCH 27		
9:00 am – 11:30 am	Room 221C	APhA-APPM Delegate Caucus
9:00 am – 11:30 am	Room 131B	APhA-APRS Delegate Caucus
9:45 am - 10:45 am	Room 222C	HOD Caucus Group - Midwest
9:45 am - 10:45 am	Room 132C	HOD Caucus Group - Northeast
9:45 am - 10:45 am	Room 131C	HOD Caucus Group - South
9:45 am - 10:45 am	Room 226C	HOD Caucus Group - West
11:00 am – 1:30 pm	Outside Room 301AB	Delegate Registration
1:30 pm – 4:30 pm	Room 301AB	House of Delegates – Final Session (Be seated by 1:15pm)

HOUSE OF DELEGATES OFFICE HOURS - ROOM 300 FOYER	
Thursday, March 23	3:00 pm – 6:00 pm
Friday, March 24	7:30 am – 3:00 pm
Saturday, March 25	8:00 am – 3:00 pm
Sunday, March 26	8:00 am – 3:00 pm
Monday, March 27	7:30 am – 1:00 pm

FRIDAY, MARCH 24 • 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. Unfinished/Referred Business Items
10. APhA Policy Review Committee Report*
11. APhA Policy Reference Committee and New Business Review Committee Reports - Consent Agenda*
12. APhA Policy Reference Committee Report - Items not Added to Consent Agenda or that were Pulled Out for Separate Consideration*
13. APhA New Business Review Committee Report - Items not Added to Consent Agenda or that were Pulled Out for Separate Consideration*
14. Recognition of APhA and Academy Officers
15. Meet the Candidates for the 2023 APhA Board of Trustees Election
16. Housekeeping Announcements
17. Adjournment of the First House Session

MONDAY, MARCH 27 • 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*
   b. APhA New Business Review Committee Report*
6. Installation of the 2023-2025 Speaker
7. Installation of the APhA Board of Trustees
8. Installation of the 2023-2024 APhA President
9. Recommendations from APhA Members
10. Closing Announcements
11. Adjournment of the 2023 APhA House of Delegates

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

As of Date: 3/15/2023

AACP (*Delegates-2 Out of 2*)
Craig Cox
Russell Melchert

AACP (*Alt. Delegates*)
Lynette Bradley-Baker
Lee Vermeulen

AAPP (*Delegates-1 Out of 2*)
Julie Dopheide

AAPS (*Delegates-1 Out of 1*)
Edmund Elder

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

ACCP (*Delegates-2 Out of 2*)
Elizabeth Farrington
Katherine Pham

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

ACVP (*Alt. Delegates*)
Natalie Young

AIHP (*Delegates-2 Out of 2*)
Cynthia Boyle
William Zellmer

AIR FORCE (*Delegates-0 Out of 2*)

ALABAMA (*Delegates-4 Out of 4*)
Darrell Craven
Pamela Reeve
Rebecca Sorrell
Ralph Sorrell

ALABAMA (*Alt. Delegates*)
Charles Thomas

ALASKA (*Delegates-1 Out of 2*)
Brandy Seignemartin

ALASKA (*Alt. Delegates*)
Karen Miller

AMCP (*Delegates-2 Out of 2*)
Vyishali Dharbhamalla
Marissa Schlaifer

APC - Formerly IACP (*Delegates-1 Out of 2*)
Joseph Navarra

APC - Formerly IACP (*Alt. Delegates*)
Saad Dinno
Barbara Knightly

APhA Board (*Delegates-15 Out of 15*)
Vibhuti Arya
Ilisa Bernstein
Stephen Carroll
Melissa Duke
Kennedy Erickson
Gregory Fox
Andrew Gentles
Spencer Harpe
Sandra Leal
Randal McDonough
Wendy Mobley-Bukstein
Valerie Prince
Magaly Rodriguez De Bittner
Alex Varkey
Theresa Wells-Tolle

APhA-APPM (*Delegates-28 Out of 28*)
Kevin Aloysius
Hillary Blackburn
Lauren Bristow
Andrew Bzowyckyj
Trisha Chandler
Denise Clayton
Aimee Dawson
Nicholas Dorich
Patricia Fabel
Christopher Johnson
Amy Kennedy
Olivia Kinney
William Lee
Nicholas Lehman
Emily Leppien
Taylor Mathis
Cody Morcom
Traci Poole
Jordan Rowe
Tessa Schnelle
Adrienne Simmons
Amy Thompson
Scott Tomerlin
Deanna Tran
Jennifer Wilson
Bibi Wishart
Cathy Worrall
Natalie Young

APhA-APPM (*Alt. Delegates*)
Cheryl Clarke
Byrdena Dugan
Jessica Finke
Sridhar Rao Gona
Jeffrey Gonzales
Kabrea Jones
Laura Knockel
Robin Murphy
Sheena Patel
Ashley Pugh
Laura Rhodes
Larry Selkow
Nora Stelter
Morgan Stewart

APhA-APRS (*Delegates-28 Out of 28*)
Edward Bednarczyk
Deepak Bhatia
Michelle Blakely
Antoinette Coe
Jackoline Costantino
Mark Decerbo
Robert DiCenzo
Karen Farris
Marc Fleming
Caroline Gaither
Mary Gurney
Adriane Irwin
Anandi Law
Yifei Liu
Kevin Lu
Mary McManus
Dustin Miracle
Meena Murugappan
Karen Nagel-Edwards
David Nau
Julie Oestreich
Anthony Olson
Lourdes Planas
Smita Rawal
Melody Ryan
Michael Smith
Terri Warholak
Henry Young

APhA-APRS (*Alt. Delegates*)
Stephanie Gernant
Helen Omuya
Elliott Sogol
Tyler Wagner
Andrew Wash
Rohan Zaveri

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

APhA-ASP (*Delegates-28 Out of 28*)

Zoona Ahmad
Olunife Akinmolayan
Sewit Araia
Tia Belvin
Xochitl Benitez
Alanna Bramwell
Bobby Christodoulopoulos
Rachel Dittrich
Nancy Henin
Ngoc Phuong Mai Le
Ronald Levinson
Shirly Ly
Victoria Lyle
Hadia Malik
Emma Meyer
Miranda Montoya
Bryce Mortera
Jacob Noble
Elizabeth Rayes
Serena Roberts
Edgardo Rodriguez
Cristian Rodriquez
Sabrina Ruoyao Chen Zhang
Danny Schreiber
Carissa Teeters
Kiara Torres García
McCaffery Townsend
Elaina Vitale

APhA-ASP (*Alt. Delegates*)

Shaye Fowler
Kendall McKenzie
Maria Nguyen
Hailey Roup
William Tondre
Janette Wadolowski
Emily Weyenberg
Courtney Woo

ARIZONA (*Delegates-4 Out of 4*)

Anthony Ball
Kelly Fine
Kimberly Langley
Lorri Walmsley

ARKANSAS (*Delegates-2 Out of 2*)

Brenna Neumann
Megan Smith

ARKANSAS (*Alt. Delegates*)

Dylan Jones

ARMY (*Delegates-2 Out of 2*)

Jon Bartlett
Mingzohn Ellen Kaland

ASCP (*Delegates-2 Out of 2*)

Hedva Barenholtz
Jeanne Manzi

ASCP (*Alt. Delegates*)

Arnold Clayman
Chad Worz

ASHP (*Delegates-1 Out of 1*)

Georgia Luchen

ASPL (*Delegates-2 Out of 2*)

Gina Moore
Michael Podgurski

CALIFORNIA (*Delegates-8 Out of 9*)

Michael Conner
Jennifer Courtney
Richard Dang
Micah Hata
Sarah McBane
Rajan Vaidya
Chris Woo
George Yasutake

COLORADO (*Delegates-3 Out of 3*)

Randy Knutsen
Ashley Mains Espinosa
Sara Wettergreen

CONNECTICUT (*Delegates-1 Out of 3*)

Philip Hritcko

DELAWARE (*Delegates-2 Out of 2*)

Kevin Musto
Kimberly Robbins

DELAWARE (*Alt. Delegates*)

Mark Freebery

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-5 Out of 6*)

James Alcorn
Daniel Buffington
Jeanette Connelly
Carol Motycka
Katherine Petsos

FLORIDA (*Alt. Delegates*)

Karen Whalen

FORMER PRESIDENTS (*Delegates-33 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
Joey Mattingly
Thomas Menighan
Jacob Miller
Robert Osterhaus
Matthew Osterhaus
Marily Rhudy
Steven Simenson
Jenelle Sobotka
Lisa Tonrey
Timothy Vordenbaumen

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

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

GEORGIA (*Delegates-4 Out of 4*)

Liza Chapman
Johnathan Hamrick
Joe Ed Holt
Jonathan Sinyard

GEORGIA (*Alt. Delegates*)

David Carver

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
Donald Smith

IDAHO (*Alt. Delegates*)

Lucas Snell

ILLINOIS (*Delegates-5 Out of 6*)

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

ILLINOIS (*Alt. Delegates*)

Emily Wetherholt

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

INDIANA (*Delegates-4 Out of 4*)

Stephanie Arnett
Cory Holland
Laura Sosinski
Veronica Vernon

INDIANA (*Alt. Delegates*)

Jordan Smith

IOWA (*Delegates-3 Out of 3*)

John Hamiel
Diane Reist
Stevie Veach

IOWA (*Alt. Delegates*)

Steve Firman

KANSAS (*Delegates-3 Out of 3*)

Amanda Applegate
Jessica Bates
Emily Prohaska

KENTUCKY (*Delegates-4 Out of 4*)

Nicole Barratiere
Kyle Bryan
Kimberly Croley
Chris Harlow

KENTUCKY (*Alt. Delegates*)

Catherine Hanna

LOUISIANA (*Delegates-3 Out of 3*)

Nancy Caddigan
Anthony Walker
Beverly Walker

LOUISIANA (*Alt. Delegates*)

Peggy Van

MAINE (*Delegates-2 Out of 2*)

Wendy Boynton
Wallace Marsh

MARYLAND (*Delegates-5 Out of 5*)

Richard DeBenedetto
Lauren Haggerty
Seema Kazmi
Lauren Lakdawala
Hoai-An Truong

MASSACHUSETTS (*Delegates-2 Out of 2*)

Courtney Doyle-Campbell
Trisha LaPointe

MICHIGAN (*Delegates-5 Out of 5*)

Hope Broxterman
Farah Jalloul
Matthew McTaggart
Heather Rickle
Brittany Stewart

MINNESOTA (*Delegates-4 Out of 4*)

Michelle Aytay
Erika Harvey
Connie Khong
Rebecca Pickler

MINNESOTA (*Alt. Delegates*)

Jason Varin

MISSISSIPPI (*Delegates-3 Out of 3*)

Tripp Dixon
Olivia Strain
Anna Touchstone

MISSISSIPPI (*Alt. Delegates*)

Laurie Fleming

MISSOURI (*Delegates-3 Out of 4*)

Josh Berry
Francisco Franco
Roxane Took

MISSOURI (*Alt. Delegates*)

Anne Eisenbeis

MONTANA (*Delegates-2 Out of 2*)

Lyndee Fogel
Monica Orsborn

NAVY (*Delegates-1 Out of 2*)

Daniel Roth

NCPA (*Delegates-2 Out of 2*)

John Beckner
Hannah Fish

NEBRASKA (*Delegates-3 Out of 3*)

Ally Dering-Anderson
Drew Prescott
Jennifer Tilleman

NEBRASKA (*Alt. Delegates*)

Marcia Mueting

NEVADA (*Delegates-3 Out of 3*)

Lindsey Benedict
Amy Hale
Jeani Pulsipher

NEVADA (*Alt. Delegates*)

Kenneth Kunke

NEW HAMPSHIRE (*Delegates-0 Out of 2*)

NEW JERSEY (*Delegates-5 Out of 5*)

Elise Barry
Aakash Gandhi
Javier Rodriguez
Carmela Silvestri
Lucio Volino

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

Kelsea Aragon
Jana Behrens
Allen Plymale

NEW YORK (*Delegates-3 Out of 6*)

Christopher Daly
Karl Fiebelkorn
Steven Moore

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

David Catalano
Evan Colmenares
Macary Marciniak
Beth Mills
Katie Trotta

NORTH CAROLINA (*Alt. Delegates*)

Ouita Davis Gatton

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

Elizabeth Skoy

NORTH DAKOTA (*Alt. Delegates*)

Michael Schwab

NPhA (*Delegates-2 Out of 2*)

Tamara Foreman
Frank North

NRPhA (*Delegates-0 Out of 2*)

OHIO (*Delegates-6 Out of 6*)

Sarah Aldrich
Juanita Draime
Jessica Hinson
Mitchell Howard
Jennifer Seifert
Jeff Steckman

OHIO (*Alt. Delegates*)

James Kirby
Catherine Kuhn

OKLAHOMA (*Delegates-3 Out of 3*)

Krista Brooks
Eric Johnson
Katherine O'Neal

OREGON (*Delegates-3 Out of 3*)

Dan Kennedy
Jill McClellan
Amanda Meeker

PENNSYLVANIA (*Delegates-6 Out of 6*)

Howard Cook
John Dejames
Thomas Franko
Sophia Herbert
Daniel Hussar
Darren Mensch

PENNSYLVANIA (*Alt. Delegates*)

Victoria Elliott
Brenda Gruver
Danielle Kieck

PHS (*Delegates-2 Out of 2*)

Hillary Duvivier
Briana Rider

PHS (*Alt. Delegates*)

Juliette Taylor

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

Idalia Bonilla

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

Christopher Federico
Matthew Lacroix

RHODE ISLAND (*Alt. Delegates*)

Jeffrey Bratberg
Ginger Lemay

SOUTH CAROLINA (*Delegates-4 Out of 4*)

Cheryl Anderson
Deborah Bowers
Alyssa Norwood
Emily Russell

SOUTH CAROLINA (*Alt. Delegates*)

Donna Avant

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

melissa gorecki

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

SPEAKER APPOINTED (*Delegates-19 Out of 20*)

Grace Baek
Nicholas Capote
Sarah Derr
Dalton Fabian
Heather Free
Shane Garrettson
Marsha Gilbreath
Brandi Hamilton
Nimit Jindal
Kelly Kent
Loren Kirk
Alison Knutson
Brooke Kulusich
Julia Miller
Charles Mollien
Terri Moore
John Pieper
Lucianne West
Taylor Williams

TENNESSEE (*Delegates-5 Out of 5*)

Stacey Grant
Kim Jones
Jerry Phipps
Chelsea Renfro
Olivia Welter

TENNESSEE (*Alt. Delegates*)

Anthony Pudlo

TEXAS (*Delegates-7 Out of 7*)

M. Lynn Crismon
Jason Davis
Carter High
Mary Klein
Michael Muniz
Carol Reagan
May Woo

TEXAS (*Alt. Delegates*)

Kevin Aloysius

USP (*Delegates-2 Out of 2*)

Nakia Eldridge
Sohail Mosaddegh

UTAH (*Delegates-0 Out of 2*)

VERMONT (*Delegates-2 Out of 2*)

Brittany Allen
Sandra Rosa

VERMONT (*Alt. Delegates*)

Amy Stoll

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

Anthony Morreale
Ronald Nosek

VETERANS ADMIN (*Alt. Delegates*)

Heather Ourth
John Santell

VIRGINIA (*Delegates-5 Out of 5*)

Sharon Gatewood
Roger Pritchard
Allie Shipman
Dominic Solimando
Adrian Wilson

WASHINGTON (*Delegates-3 Out of 4*)

Julie Akers
C A Leon Alzola
Sara McElroy

WEST VIRGINIA (*Delegates-2 Out of 3*)

Betsy Elswick
Michael Lemasters

WEST VIRGINIA (*Alt. Delegates*)

Krista Capehart

WISCONSIN (*Delegates-2 Out of 3*)

Kayla Hensley
Karen MacKinnon

WYOMING (*Delegates-1 Out of 1*)

Reshmi Singh

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

APhA
House of Delegates

Delegate Networking Resource

LABEL_NAME	FIRST_NAME	LAST_NAME	JOB_FUNCTION_CODE	PRIMARY_JOB_TITLE	POSITION_CODE
HOD - AACP	Lynette	Bradley-Baker	Other		ALTDELEGATE
HOD - AACP	Craig	Cox			DELEGATE
HOD - AACP	Russell	Melchert	Educator		DELEGATE
HOD - AACP	Lee	Vermeulen	Administration/Administrative	CEO	ALTDELEGATE
HOD - AAPP	Julie	Dopheide	Clinical Pharmacist		DELEGATE
HOD - AAPS	Edmund	Elder	Director/Assoc OR Asst Director	Director	DELEGATE
HOD - ACA	Brian	Hose	Owner	CEO	DELEGATE
HOD - ACA	DeAnna	Leikach	Owner		DELEGATE
HOD - ACCP	Elizabeth	Farrington	Staff Pharmacist	Clinical Pharmacist - Pediatrics	DELEGATE
HOD - ACCP	Katherine	Pham	Director/Assoc OR Asst Director		DELEGATE
HOD - ACVP	Gigi	Davidson	Educator		DELEGATE
HOD - ACVP	Brenda	Jensen	Technician	Consultant	DELEGATE
HOD - ACVP	Natalie	Young	Director/Assoc OR Asst Director		ALTDELEGATE
HOD - AIHP	Cynthia	Boyle	Educator	Professor Emeritus	DELEGATE
HOD - AIHP	William	Zellmer	President		DELEGATE
HOD - Air Force	Mingzohn Ellen	Kaland		Chief, Outpatient Pharmacies	DELEGATE
HOD - Alabama	Darrell	Craven			DELEGATE
HOD - Alabama	Pamela	Reeve	Staff Pharmacist	Pharmacist	DELEGATE
HOD - Alabama	Ralph	Sorrell	Owner		DELEGATE
HOD - Alabama	Rebecca	Sorrell	Pharmacist, General		DELEGATE
HOD - Alabama	Charles	Thomas	Retired	Licensed Pharmacist	ALTDELEGATE
HOD - Alaska	Karen	Miller	Staff Pharmacist		ALTDELEGATE
HOD - Alaska	Brandy	Seignemartin	Other	Executive Director	DELEGATE
HOD - Alaska	Trish	White	Owner		DELEGATE
HOD - AMCP	Vyishali	Dharbhamalla	Manager		DELEGATE
HOD - AMCP	Marissa	Schlaifer	Director/Assoc OR Asst Director		DELEGATE
HOD - APC	Saad	Dinno	Pharmacist, General		ALTDELEGATE
HOD - APC	Barbara	Knightly	Administration/Administrative	VP of Pharmacy	ALTDELEGATE
HOD - APC	Joseph	Navarra	Owner		DELEGATE
HOD - APhA Board	Vibhuti	Arya	Educator	Professor/Public Health Practice	DELEGATE
HOD - APhA Board	Ilisa	Bernstein	Director/Assoc OR Asst Director		DELEGATE
HOD - APhA Board	Stephen	Carroll	Owner		DELEGATE
HOD - APhA Board	Melissa	Duke	Director/Assoc OR Asst Director		DELEGATE
HOD - APhA Board	Kennedy	Erickson	Student Pharmacist	Pharmacy Intern	DELEGATE
HOD - APhA Board	Gregory	Fox	Director/Assoc OR Asst Director		DELEGATE
HOD - APhA Board	Andrew	Gentles	Director/Assoc OR Asst Director		DELEGATE
HOD - APhA Board	Spencer	Harpe	Educator	Professor of Pharmacy Administration	DELEGATE
HOD - APhA Board	Sandra	Leal	Administration/Administrative	Vice President, Pharmacy Practice Innovation and Advocacy	DELEGATE
HOD - APhA Board	Randal	McDonough	Owner		DELEGATE
HOD - APhA Board	Wendy	Mobley-Bukstein	Educator		DELEGATE
HOD - APhA Board	Valerie	Prince	Clinical Pharmacist		DELEGATE
HOD - APhA Board	Magaly	Rodriguez De Bittn	Educator		DELEGATE
HOD - APhA Board	Alex	Varkey	Director/Assoc OR Asst Director	Director of Pharmacy Services	DELEGATE
HOD - APhA Board	Theresa	Wells-Tolle	Owner		DELEGATE
HOD - APhA-APPM	Kevin	Aloysius	Manager		DELEGATE
HOD - APhA-APPM	Hillary	Blackburn	Director/Assoc OR Asst Director		DELEGATE
HOD - APhA-APPM	Lauren	Bristow			DELEGATE
HOD - APhA-APPM	Andrew	Bzowyckyj			DELEGATE
HOD - APhA-APPM	Trisha	Chandler	Clinical Pharmacist		DELEGATE
HOD - APhA-APPM	Cheryl	Clarke	Educator		ALTDELEGATE
HOD - APhA-APPM	Denise	Clayton	Clinical Pharmacist		DELEGATE
HOD - APhA-APPM	Aimee	Dawson	Educator		DELEGATE
HOD - APhA-APPM	Nicholas	Dorich	Pharmacist, General		DELEGATE
HOD - APhA-APPM	Byrdena	Dugan	Clinical Pharmacist	Professor Pharmacy Practice	ALTDELEGATE
HOD - APhA-APPM	Patricia	Fabel	Educator	Clinical Associate Professor	DELEGATE
HOD - APhA-APPM	Jessica	Finke	Other		ALTDELEGATE
HOD - APhA-APPM	Sridhar Rao	Gona		Pharmacy Supply Chain, Finance & Analytics	ALTDELEGATE
HOD - APhA-APPM	Jeffrey	Gonzales			ALTDELEGATE
HOD - APhA-APPM	Christopher	Johnson	Pharmacist, General	Assistant Professor of Pharmacy Practice	DELEGATE
HOD - APhA-APPM	Kabrea	Jones			ALTDELEGATE
HOD - APhA-APPM	Amy	Kennedy	Educator	Associate Professor	DELEGATE
HOD - APhA-APPM	Olivia	Kinney	Manager	Clinical Program Development Manager	DELEGATE
HOD - APhA-APPM	Laura	Knockel	Educator		ALTDELEGATE
HOD - APhA-APPM	William	Lee	Other	System Director	DELEGATE
HOD - APhA-APPM	Nicholas	Lehman	Clinical Pharmacist	Associate Professor	DELEGATE
HOD - APhA-APPM	Emily	Leppien	Clinical Pharmacist		DELEGATE

HOD - APhA-APPM	Taylor	Mathis	Educator	Assistant Professor of Pharmacy Practice	DELEGATE
HOD - APhA-APPM	Cody	Morcom	Administration/Administrative	Captain and Clinical Pharmacist	DELEGATE
HOD - APhA-APPM	Robin	Murphy		Deputy General Counsel	ALTDELEGATE
HOD - APhA-APPM	Sheena	Patel	Clinical Pharmacist	Ambulatory Clinical Pharmacist	ALTDELEGATE
HOD - APhA-APPM	Traci	Poole	Educator	Associate Professor Pharmacy Practice	DELEGATE
HOD - APhA-APPM	Ashley	Pugh	Educator		ALTDELEGATE
HOD - APhA-APPM	Laura	Rhodes	Educator	Teaching Assistant Professor	ALTDELEGATE
HOD - APhA-APPM	Jordan	Rowe	Clinical Pharmacist	Clinical Assistant Professor	DELEGATE
HOD - APhA-APPM	Tessa	Schnelle	Clinical Pharmacist	Director of Pharmacy	DELEGATE
HOD - APhA-APPM	Larry	Selkow	Pharmacist, General		ALTDELEGATE
HOD - APhA-APPM	Adrienne	Simmons	Other	Director of Programs	DELEGATE
HOD - APhA-APPM	Nora	Stelter	Pharmacist, General	Associate Professor, Pharmacy Practice	ALTDELEGATE
HOD - APhA-APPM	Morgan	Stewart	Clinical Pharmacist		ALTDELEGATE
HOD - APhA-APPM	Amy	Thompson	Director/Assoc OR Asst Director	Clinical Associate Professor	DELEGATE
HOD - APhA-APPM	Scott	Tomerlin	Manager	Pharmacy Manager	DELEGATE
HOD - APhA-APPM	Deanna	Tran	Pharmacist, General		DELEGATE
HOD - APhA-APPM	Jennifer	Wilson	Educator		DELEGATE
HOD - APhA-APPM	Bibi	Wishart	Administration/Administrative	Program Director, 340B	DELEGATE
HOD - APhA-APPM	Cathy	Worrall	Administration/Administrative		DELEGATE
HOD - APhA-APPM	Natalie	Young	Director/Assoc OR Asst Director		DELEGATE
HOD - APhA-APRS	Edward	Bednarczyk	Educator		DELEGATE
HOD - APhA-APRS	Deepak	Bhatia	Other	Professor of Pharmacogenomics	DELEGATE
HOD - APhA-APRS	Michelle	Blakely		Assistant Professor	ALTDELEGATE
HOD - APhA-APRS	Antoinette	Coe	Researcher		DELEGATE
HOD - APhA-APRS	Jackoline	Costantino			DELEGATE
HOD - APhA-APRS	Mark	Decerbo	Educator		DELEGATE
HOD - APhA-APRS	Robert	DiCenzo	Educator	Dean and Professor	DELEGATE
HOD - APhA-APRS	Karen	Farris	Educator		DELEGATE
HOD - APhA-APRS	Marc	Fleming	Staff Pharmacist	Professor and Chair	DELEGATE
HOD - APhA-APRS	Caroline	Gaither	Educator		ALTDELEGATE
HOD - APhA-APRS	Stephanie	Gernant			ALTDELEGATE
HOD - APhA-APRS	Mary	Gurney	Educator	Associate Professor	DELEGATE
HOD - APhA-APRS	Adriane	Irwin	Educator		DELEGATE
HOD - APhA-APRS	Anandi	Law	Educator		DELEGATE
HOD - APhA-APRS	Minghui "sam"	Li	Educator	Assistant Professor	DELEGATE
HOD - APhA-APRS	Yifei	Liu	Educator	Associate Professor	DELEGATE
HOD - APhA-APRS	Kevin	Lu		Associate Professor	DELEGATE
HOD - APhA-APRS	Heidi	Mansour	Educator	Professor & Program Leader of Drug Discovery & Delivery	DELEGATE
HOD - APhA-APRS	Mary	McManus	Other	Associate Professor	DELEGATE
HOD - APhA-APRS	Dustin	Miracle	Researcher		DELEGATE
HOD - APhA-APRS	Meena	Murugappan		Research Associate	DELEGATE
HOD - APhA-APRS	Karen	Nagel-Edwards	Postgrad/BSPharm		DELEGATE
HOD - APhA-APRS	David	Nau	Educator	Professor	DELEGATE
HOD - APhA-APRS	Julie	Oestreich	Educator		DELEGATE
HOD - APhA-APRS	Anthony	Olson	Researcher	Associate Research Scientist	DELEGATE
HOD - APhA-APRS	Helen	Omuya			ALTDELEGATE
HOD - APhA-APRS	Lourdes	Planas	Educator	Associate Professor	ALTDELEGATE
HOD - APhA-APRS	Ana	Quinones-Boex	Educator	Professor of Pharmacy Administration	ALTDELEGATE
HOD - APhA-APRS	Smita	Rawal	Postgrad/BSPharm		DELEGATE
HOD - APhA-APRS	Melody	Ryan	Educator		DELEGATE
HOD - APhA-APRS	Karen	Smith	Educator		DELEGATE
HOD - APhA-APRS	Michael	Smith	Educator		DELEGATE
HOD - APhA-APRS	Elliott	Sogol	Director/Assoc OR Asst Director	Sr. V.P. Strategy	ALTDELEGATE
HOD - APhA-APRS	Tyler	Wagner	Researcher		ALTDELEGATE
HOD - APhA-APRS	Terri	Warholak	Educator		DELEGATE
HOD - APhA-APRS	Andrew	Wash			ALTDELEGATE
HOD - APhA-APRS	Henry	Young	Educator	Department Head & Associate Professor	DELEGATE
HOD - APhA-APRS	Rohan	Zaveri		Global Medical Affairs Fellow	ALTDELEGATE
HOD - APhA-ASP	Zoona	Ahmad			DELEGATE
HOD - APhA-ASP	Olunife	Akinmolayan	Student Pharmacist	APhA-ASP National Project Coordinator	DELEGATE
HOD - APhA-ASP	Sewit	Araia			DELEGATE
HOD - APhA-ASP	Tia	Belvin			DELEGATE
HOD - APhA-ASP	Xochitl	Benitez			DELEGATE
HOD - APhA-ASP	Alanna	Bramwell			DELEGATE
HOD - APhA-ASP	Bobby	Christodoulopoulos			DELEGATE
HOD - APhA-ASP	Rachel	Dittrich			DELEGATE
HOD - APhA-ASP	Shaye	Fowler			ALTDELEGATE
HOD - APhA-ASP	Nancy	Henin			DELEGATE
HOD - APhA-ASP	Ngoc Phuong Ma	Le			DELEGATE
HOD - APhA-ASP	Ronald	Levinson	Student Pharmacist		DELEGATE
HOD - APhA-ASP	Shirly	Ly			DELEGATE
HOD - APhA-ASP	Victoria	Lyle			DELEGATE
HOD - APhA-ASP	Hadia	Malik			DELEGATE
HOD - APhA-ASP	Kendall	McKenzie			ALTDELEGATE
HOD - APhA-ASP	Emma	Meyer			DELEGATE
HOD - APhA-ASP	Miranda	Montoya			DELEGATE
HOD - APhA-ASP	Bryce	Mortera			DELEGATE
HOD - APhA-ASP	Maria	Nguyen			ALTDELEGATE
HOD - APhA-ASP	Jacob	Noble			DELEGATE
HOD - APhA-ASP	Elizabeth	Rayes			DELEGATE

HOD - APhA-ASP	Serena	Roberts			DELEGATE
HOD - APhA-ASP	Edgardo	Rodriguez			DELEGATE
HOD - APhA-ASP	Cristian	Rodriquez			DELEGATE
HOD - APhA-ASP	Hailey	Roup			ALTDELEGATE
HOD - APhA-ASP	Sabrina	Ruoyao Chen Zhang			DELEGATE
HOD - APhA-ASP	Danny	Schreiber			DELEGATE
HOD - APhA-ASP	Carissa	Teeters			DELEGATE
HOD - APhA-ASP	William	Tondre			ALTDELEGATE
HOD - APhA-ASP	Kiara	Torres García			DELEGATE
HOD - APhA-ASP	McCaffery	Townsend			DELEGATE
HOD - APhA-ASP	Elaina	Vitale			DELEGATE
HOD - APhA-ASP	Janette	Wadolowski			ALTDELEGATE
HOD - APhA-ASP	Emily	Weyenberg			ALTDELEGATE
HOD - APhA-ASP	Courtney	Woo	Student Pharmacist	Chair of the APhA-ASP National Standing Committee on Awards	ALTDELEGATE
HOD - Arizona	Anthony	Ball	Manager	Pharmacy Manager	DELEGATE
HOD - Arizona	Kelly	Fine	Director/Assoc OR Asst Director	Chief Executive Officer	DELEGATE
HOD - Arizona	Kimberly	Langley			DELEGATE
HOD - Arizona	Lorri	Walmsley	Director/Assoc OR Asst Director		DELEGATE
HOD - Arkansas	Dylan	Jones	Manager		ALTDELEGATE
HOD - Arkansas	Brenna	Neumann	Manager	Pharmacist in Charge Collier Drug Stores Willow Creek	DELEGATE
HOD - Arkansas	Megan	Smith	Educator	Assistant Professor	DELEGATE
HOD - Army	Jon	Bartlett			DELEGATE
HOD - ASCP	Hedva	Barenholtz	Clinical Pharmacist	Director	DELEGATE
HOD - ASCP	Arnold	Clayman	Director/Assoc OR Asst Director	VP Pharmacy Practice & Government Affairs	ALTDELEGATE
HOD - ASCP	Jeanne	Manzi	Clinical Pharmacist		DELEGATE
HOD - ASCP	Chad	Worz	Clinical Pharmacist	Executive Director	ALTDELEGATE
HOD - ASHP	Georgia	Luchen	Director/Assoc OR Asst Director		DELEGATE
HOD - ASPL	Gina	Moore	Director/Assoc OR Asst Director	Vice Dean/Chief Operations Officer	DELEGATE
HOD - ASPL	Michael	Podgurski	President	Principal	DELEGATE
HOD - California	Michael	Conner		Pharmacy Services Manager, President-Elect	DELEGATE
HOD - California	Jennifer	Courtney			DELEGATE
HOD - California	Richard	Dang			DELEGATE
HOD - California	Micah	Hata			DELEGATE
HOD - California	Sarah	McBane	Educator	Associate Dean of Pharmacy Education	DELEGATE
HOD - California	Rajan	Vaidya	Administration/Administrative	Vice President, Practice & Professional Development	DELEGATE
HOD - California	Chris	Woo	Other		DELEGATE
HOD - California	George	Yasutake	Other		DELEGATE
HOD - Colorado	Randy	Knutsen	Educator		DELEGATE
HOD - Colorado	Ashley	Mains Espinosa	Administration/Administrative	VP, Clinical Operations	DELEGATE
HOD - Colorado	Sara	Wettergreen	Clinical Pharmacist		DELEGATE
HOD - Connecticut	Philip	Hritcko	Administration/Administrative	Dean & Clinical Professor	DELEGATE
HOD - Delaware	Mark	Freebery	Pharmacist, General	MSL Regional Director	ALTDELEGATE
HOD - Delaware	Kevin	Musto	Pharmacist, General		DELEGATE
HOD - Delaware	Kimberly	Robbins	Owner		DELEGATE
HOD - District of Columbia	Alsean	Bryant	Clinical Pharmacist	Strategic Support Team Clinical Pharmacist	DELEGATE
HOD - District of Columbia	Michael	Kim	President		ALTDELEGATE
HOD - District of Columbia	Yolanda	McKoy-Beach	Clinical Pharmacist		DELEGATE
HOD - District of Columbia	Carolyn	Rachel-Price	Consultant	Executive Director	DELEGATE
HOD - Florida	James	Alcorn	Consultant	Advanced Clinical Pharmacist	DELEGATE
HOD - Florida	Daniel	Buffington	Owner		DELEGATE
HOD - Florida	Jeanette	Connelly	Clinical Pharmacist		DELEGATE
HOD - Florida	Carol	Motycka	Director/Assoc OR Asst Director		DELEGATE
HOD - Florida	Katherine	Petsos	Retired		DELEGATE
HOD - Florida	Karen	Whalen	Educator		ALTDELEGATE
HOD - Former Presidents	Nancy	Alvarez	Administration/Administrative		DELEGATE
HOD - Former Presidents	Lowell	Anderson	President		DELEGATE
HOD - Former Presidents	Marialice	Bennett	Consultant		DELEGATE
HOD - Former Presidents	J	Bootman	Educator		DELEGATE
HOD - Former Presidents	Lawrence	Brown	Administration/Administrative	Lawrence Brown	DELEGATE
HOD - Former Presidents	Bruce	Canaday			DELEGATE
HOD - Former Presidents	R David	Cobb	Educator		DELEGATE
HOD - Former Presidents	Robert	Davis	Retired		DELEGATE
HOD - Former Presidents	George	Denmark	Retired		DELEGATE
HOD - Former Presidents	James	Doluisio	Educator		DELEGATE
HOD - Former Presidents	Janet	Engle	Administration/Administrative	Executive Director	DELEGATE
HOD - Former Presidents	Philip	Gerbino	President		DELEGATE
HOD - Former Presidents	Harold	Godwin	Educator	Professor Emeritus	DELEGATE
HOD - Former Presidents	Kelly	Goode	Educator		DELEGATE
HOD - Former Presidents	Charles	Green	Retired		DELEGATE
HOD - Former Presidents	Ed	Hamilton	Director/Assoc OR Asst Director		DELEGATE
HOD - Former Presidents	Nicki	Hilliard	Educator	Director of Professional Affairs	DELEGATE
HOD - Former Presidents	Ronald	Jordan	President		DELEGATE
HOD - Former Presidents	Gary	Kadlec	President		DELEGATE
HOD - Former Presidents	Calvin	Knowlton	Staff Pharmacist		DELEGATE
HOD - Former Presidents	Winnie	Landis	Pharmacist, General		DELEGATE

HOD - Former Presidents	Eugene	Lutz	Pharmacist, General	Relief Pharmacist	DELEGATE
HOD - Former Presidents	James	Main	Other	retired	DELEGATE
HOD - Former Presidents	Joey	Mattingly	Educator		DELEGATE
HOD - Former Presidents	Thomas	Menighan	President		DELEGATE
HOD - Former Presidents	Jacob	Miller			DELEGATE
HOD - Former Presidents	Matthew	Osterhaus	Owner		DELEGATE
HOD - Former Presidents	Robert	Osterhaus	Owner		DELEGATE
HOD - Former Presidents	Marily	Rhudy	President		DELEGATE
HOD - Former Presidents	Steven	Simenson	Owner	Managing Partner	DELEGATE
HOD - Former Presidents	Jenelle	Sobotka	Educator	PharmD	DELEGATE
HOD - Former Presidents	Lisa	Tonrey			DELEGATE
HOD - Former Presidents	Timothy	Vordenbaumen	Staff Pharmacist		DELEGATE
HOD - Former Speakers	Susan	Bartlemay	Director/Assoc OR Asst Director		DELEGATE
HOD - Former Speakers	Bethany	Boyd	Clinical Pharmacist		DELEGATE
HOD - Former Speakers	Leonard	Camp	Retired		DELEGATE
HOD - Former Speakers	Lucinda	Maine	President		DELEGATE
HOD - Former Speakers	Joey	Mattingly	Educator		DELEGATE
HOD - Former Speakers	Michael	Mone	Director/Assoc OR Asst Director	Senior Legal Counsel - Healthcare	DELEGATE
HOD - Former Speakers	Craig	Pedersen	Educator		DELEGATE
HOD - Former Speakers	Adele	Pietrantoni	Pharmacist, General		DELEGATE
HOD - Former Speakers	Valerie	Prince	Clinical Pharmacist		DELEGATE
HOD - Former Speakers	William	Riffee	Educator	Dean Emeritus	DELEGATE
HOD - Former Speakers	Pamela	Whitmire	Manager		DELEGATE
HOD - Former Speakers	Wilma	Wong			DELEGATE
HOD - Georgia	David	Carver	Director/Assoc OR Asst Director	Sr. Director of Pharmacy Compliance & Contracting	ALTDELEGATE
HOD - Georgia	Liza	Chapman	Pharmacist, General		DELEGATE
HOD - Georgia	Johnathan	Hamrick	Pharmacist, General		DELEGATE
HOD - Georgia	Joe Ed	Holt	Clinical Pharmacist	Clinical Manager	DELEGATE
HOD - Georgia	Jonathan	Sinyard	Pharmacist, General		DELEGATE
HOD - Guam					
HOD - Hawaii	Jarred	Prudencio	Clinical Pharmacist	Associate Professor of Pharmacy Practice	DELEGATE
HOD - HOPA	Heidi	Finnes			DELEGATE
HOD - HOPA	LeAnne	Kennedy	Clinical Pharmacist	Clinical Specialist, Stem Cell Transplant and Cellular Therapy	DELEGATE
HOD - Idaho	Jennifer	Adams	Administration/Administrative		DELEGATE
HOD - Idaho	Donald	Smith	Owner	Owner/ RPh	DELEGATE
HOD - Idaho	Lucas	Snell	Owner		ALTDELEGATE
HOD - Illinois	Starlin	Haydon-Greatting	Consultant	Pharmacoepidemiologist/Health Economics	DELEGATE
HOD - Illinois	Garth	Reynolds	Director/Assoc OR Asst Director	Executive Director	DELEGATE
HOD - Illinois	Jennifer	Rosselli			DELEGATE
HOD - Illinois	J. Cody	Sandusky	Director/Assoc OR Asst Director	Pharmacy Manager	DELEGATE
HOD - Illinois	Emily	Wetherholt	Staff Pharmacist		ALTDELEGATE
HOD - Illinois	Carrie	Wiggins	Manager		DELEGATE
HOD - Indiana	Stephanie	Arnett	Director/Assoc OR Asst Director		DELEGATE
HOD - Indiana	Cory	Holland	Director/Assoc OR Asst Director	Director of Pharmacy	DELEGATE
HOD - Indiana	Jordan	Smith	Pharmacist, General	Healthcare Supervisor	ALTDELEGATE
HOD - Indiana	Laura	Sosinski			DELEGATE
HOD - Indiana	Veronica	Vernon	Clinical Pharmacist	Assistant Professor of Pharmacy Practice/Clinical Pharmacy Specialist	DELEGATE
HOD - Iowa	Steve	Firman	Administration/Administrative		ALTDELEGATE
HOD - Iowa	John	Hamiel	Director/Assoc OR Asst Director		DELEGATE
HOD - Iowa	Diane	Reist	Clinical Pharmacist		DELEGATE
HOD - Iowa	Stevie	Veach	Clinical Pharmacist		DELEGATE
HOD - Kansas	Amanda	Applegate	Consultant	Director of Practice Development	DELEGATE
HOD - Kansas	Jessica	Bates	Coordinator	Clinical Assistant Professor	DELEGATE
HOD - Kansas	Emily	Prohaska		Pharmacist	DELEGATE
HOD - Kentucky	Nicole	Barratiere	Staff Pharmacist	Pharmacist	DELEGATE
HOD - Kentucky	Kyle	Bryan	Other	Practice Implementation Pharmacist	DELEGATE
HOD - Kentucky	Kimberly	Croley	Director/Assoc OR Asst Director	Clinical Pharmacist	DELEGATE
HOD - Kentucky	Catherine	Hanna	Other	Vice President of Professional	ALTDELEGATE
HOD - Kentucky	Chris	Harlow			DELEGATE
HOD - Louisiana	Nancy	Caddigan	Clinical Pharmacist	VACCINE COORDINATOR	DELEGATE
HOD - Louisiana	Peggy	Van	Pharmacist, General		ALTDELEGATE
HOD - Louisiana	Anthony	Walker	Clinical Pharmacist	Clinical Associate Professor	DELEGATE
HOD - Louisiana	Beverly	Walker	Clinical Pharmacist	Past President	DELEGATE
HOD - Maine	Wendy	Boynton	Director/Assoc OR Asst Director		DELEGATE
HOD - Maine	Wallace	Marsh	Educator	Assistant Dean for Assessment and Accreditation	DELEGATE
HOD - Maryland	Richard	DeBenedetto	Educator		DELEGATE
HOD - Maryland	Lauren	Haggerty	Pharmacist, General	Clinical Coordinator	DELEGATE
HOD - Maryland	Seema	Kazmi	Clinical Pharmacist		DELEGATE
HOD - Maryland	Lauren	Lakdawala	Clinical Pharmacist	Clinical Coordinator II	DELEGATE
HOD - Maryland	Hoai-An	Truong	Educator		DELEGATE
HOD - Massachusetts	Courtney	Doyle-Campbell	Educator	Clinical Associate Professor	DELEGATE
HOD - Massachusetts	Trisha	LaPointe			DELEGATE
HOD - Michigan	Hope	Broxterman	Clinical Pharmacist		DELEGATE
HOD - Michigan	Farah	Jalloul	Other		DELEGATE
HOD - Michigan	Matthew	McTaggart	Clinical Pharmacist	Oncology Pharmacy Specialist	DELEGATE
HOD - Michigan	Heather	Rickle	Clinical Pharmacist	Clinical Pharmacy Specialist	DELEGATE
HOD - Michigan	Brittany	Stewart			DELEGATE

HOD - Minnesota	Michelle	Aytay	Clinical Pharmacist		DELEGATE
HOD - Minnesota	Erika	Harvey			DELEGATE
HOD - Minnesota	Connie	Khong	Student Pharmacist		DELEGATE
HOD - Minnesota	Rebecca	Pickler	Manager	Pharmacy District Manager	DELEGATE
HOD - Minnesota	Jason	Varin	Educator	Community Pharmacy Liaison	ALTDELEGATE
HOD - Mississippi	Tripp	Dixon			DELEGATE
HOD - Mississippi	Laurie	Fleming			ALTDELEGATE
HOD - Mississippi	Olivia	Strain	Pharmacist, General	Clinical Services Pharmacist	DELEGATE
HOD - Mississippi	Anna	Touchstone	Staff Pharmacist		DELEGATE
HOD - Missouri	Josh	Berry		Executive Fellow	DELEGATE
HOD - Missouri	Anne	Eisenbeis	Pharmacist, General	Director of Practice Development	ALTDELEGATE
HOD - Missouri	Francisco	Franco	Staff Pharmacist	Pharmacy Manager	DELEGATE
HOD - Missouri	Roxane	Took	Clinical Pharmacist		DELEGATE
HOD - Montana	Lyndee	Fogel	Clinical Pharmacist		DELEGATE
HOD - Montana	Monica	Orsborn			DELEGATE
HOD - Navy	Daniel	Roth		Director of Pharmacy	DELEGATE
HOD - NCPA	John	Beckner	Director/Assoc OR Asst Director		DELEGATE
HOD - NCPA	Hannah	Fish		Associate Director, Strategic Initiatives	DELEGATE
HOD - Nebraska	Ally	Dering-Anderson	Pharmacist, General		DELEGATE
HOD - Nebraska	Marcia	Mueting	Director/Assoc OR Asst Director		ALTDELEGATE
HOD - Nebraska	Drew	Prescott		Clinical Assistant Professor	DELEGATE
HOD - Nebraska	Jennifer	Tilleman	Educator	Associate Professor	DELEGATE
HOD - Nevada	Lindsey	Benedict	Manager	Pharmacy Manager	DELEGATE
HOD - Nevada	Amy	Hale	Other	Principal Scientific Account Lead	DELEGATE
HOD - Nevada	Kenneth	Kunke	Director/Assoc OR Asst Director		ALTDELEGATE
HOD - Nevada	Jeani	Pulsipher	Clinical Pharmacist		DELEGATE
HOD - New Hampshire					
HOD - New Jersey	Elise	Barry	Other	CEO	DELEGATE
HOD - New Jersey	Aakash	Gandhi	Director/Assoc OR Asst Director		DELEGATE
HOD - New Jersey	Javier	Rodriguez	Consultant		DELEGATE
HOD - New Jersey	Carmela	Silvestri	Clinical Pharmacist		DELEGATE
HOD - New Jersey	Lucio	Volino	Clinical Pharmacist		DELEGATE
HOD - New Mexico	Kelsea	Aragon			DELEGATE
HOD - New Mexico	Jana	Behrens	Staff Pharmacist		DELEGATE
HOD - New Mexico	Allen	Plymale	Clinical Pharmacist	clinician	DELEGATE
HOD - New York	Christopher	Daly	Technician		DELEGATE
HOD - New York	Karl	Fiebelkorn	Educator	Associate Dean	DELEGATE
HOD - New York	Steven	Moore	Owner		DELEGATE
HOD - North Carolina	David	Catalano	Director/Assoc OR Asst Director		DELEGATE
HOD - North Carolina	Evan	Colmenares	Coordinator	Clinical Manager, Pharmacy Analytics & Outcomes	DELEGATE
HOD - North Carolina	Ouita	Davis Gatton	Clinical Pharmacist		ALTDELEGATE
HOD - North Carolina	Macary	Marciniak	Educator		DELEGATE
HOD - North Carolina	Beth	Mills	Clinical Pharmacist		DELEGATE
HOD - North Carolina	Katie	Trotta	Educator		DELEGATE
HOD - North Dakota	Michael	Schwab			ALTDELEGATE
HOD - North Dakota	Elizabeth	Skoy	Educator	Associate Professor	DELEGATE
HOD - NPhA	Tamara	Foreman			DELEGATE
HOD - NPhA	Frank	North	Pharmacist, General		DELEGATE
HOD - NRPhA					
HOD - Ohio	Sarah	Aldrich	Clinical Pharmacist		DELEGATE
HOD - Ohio	Juanita	Draime	Educator	Assistant Professor of Pharmacy Practice	DELEGATE
HOD - Ohio	Jessica	Hinson			DELEGATE
HOD - Ohio	Mitchell	Howard	Educator		DELEGATE
HOD - Ohio	James	Kirby	Director/Assoc OR Asst Director		ALTDELEGATE
HOD - Ohio	Catherine	Kuhn	President		ALTDELEGATE
HOD - Ohio	Jennifer	Seifert	Director/Assoc OR Asst Director	Director of Continuing Professional Development	DELEGATE
HOD - Ohio	Jeff	Steckman	Manager	Price & Cost Strategy Manager	DELEGATE
HOD - Oklahoma	Krista	Brooks			DELEGATE
HOD - Oklahoma	Eric	Johnson		Sr. Associate Dean for Administration and Finance	DELEGATE
HOD - Oklahoma	Katherine	O'Neal	Educator		DELEGATE
HOD - Oregon	Dan	Kennedy	Manager		DELEGATE
HOD - Oregon	Jill	McClellan	Staff Pharmacist	Pharmacy Manager	DELEGATE
HOD - Oregon	Amanda	Meeker	Clinical Pharmacist		DELEGATE
HOD - Pennsylvania	Howard	Cook	Clinical Pharmacist	Clinical Pharmacist - Consultant	DELEGATE
HOD - Pennsylvania	John	Dejames	Manager	Manger of Clinical Programs and Development	DELEGATE
HOD - Pennsylvania	Victoria	Elliott		CEO	ALTDELEGATE
HOD - Pennsylvania	Thomas	Franko		Associate Professor of Pharmacy Practice	DELEGATE
HOD - Pennsylvania	Brenda	Gruver			ALTDELEGATE
HOD - Pennsylvania	Sophia	Herbert	Educator	Assistant Professor, Pharmacy and Therapeutics	DELEGATE
HOD - Pennsylvania	Daniel	Hussar	Educator	Dean Emeritus and Remington Professor Emeritus	DELEGATE
HOD - Pennsylvania	Danielle	Kieck	Educator	Assistant Professor of Pharmacy Practice	ALTDELEGATE
HOD - Pennsylvania	Darren	Mensch	Clinical Pharmacist	Ambulatory Care Pharmacist - Population Health	DELEGATE
HOD - PHS	Hillary	Duvivier	Pharmacist, General	Clinical Pharmacist	DELEGATE
HOD - PHS	Briana	Rider			DELEGATE

HOD - PHS	Juliette	Taylor	Consultant		ALTDELEGATE
HOD - Puerto Rico	Idalia	Bonilla	Pharmacist, General	Pharmacist/President	DELEGATE
HOD - Rhode Island	Jeffrey	Bratberg	Educator	Clinical Professor	ALTDELEGATE
HOD - Rhode Island	Christopher	Federico	Educator		DELEGATE
HOD - Rhode Island	Matthew	Lacroix	Director/Assoc OR Asst Director	Past president	DELEGATE
HOD - Rhode Island	Ginger	Lemay	Clinical Pharmacist		ALTDELEGATE
HOD - South Carolina	Cheryl	Anderson	Consultant		DELEGATE
HOD - South Carolina	Donna	Avant	Pharmacist, General		ALTDELEGATE
HOD - South Carolina	Deborah	Bowers	Owner		DELEGATE
HOD - South Carolina	Alyssa	Norwood	Clinical Pharmacist	Clinical Pharmacist	DELEGATE
HOD - South Carolina	Emily	Russell	Clinical Pharmacist		DELEGATE
HOD - South Dakota	melissa	gorecki			DELEGATE
HOD - Speaker Appointed	Grace	Baek	Clinical Pharmacist	Clinical Oncology Pharmacist	DELEGATE
HOD - Speaker Appointed	Nicholas	Capote	Manager	Director, Oncology and Infusion Services	DELEGATE
HOD - Speaker Appointed	Sarah	Derr	Director/Assoc OR Asst Director	Executive Director	DELEGATE
HOD - Speaker Appointed	Dalton	Fabian	Pharmacist, General	Data Scientist	DELEGATE
HOD - Speaker Appointed	Heather	Free	Director/Assoc OR Asst Director		DELEGATE
HOD - Speaker Appointed	Shane	Garrettson			DELEGATE
HOD - Speaker Appointed	Marsha	Gilbreath			DELEGATE
HOD - Speaker Appointed	Brandi	Hamilton	Director/Assoc OR Asst Director	Director of Pharmacy	DELEGATE
HOD - Speaker Appointed	Nimit	Jindal	Other		DELEGATE
HOD - Speaker Appointed	Kelly	Kent		COO	DELEGATE
HOD - Speaker Appointed	Loren	Kirk		Senior Director, Strategic Partnerships	DELEGATE
HOD - Speaker Appointed	Alison	Knutson	Pharmacist, General		DELEGATE
HOD - Speaker Appointed	Brooke	Kulusich			DELEGATE
HOD - Speaker Appointed	Julia	Miller			DELEGATE
HOD - Speaker Appointed	Charles	Mollien	Director/Assoc OR Asst Director	Director of Pharmacy Compliance, Accreditation and Patient Safety	DELEGATE
HOD - Speaker Appointed	Terri	Moore	Director/Assoc OR Asst Director	Senior Director	DELEGATE
HOD - Speaker Appointed	John	Pieper	Educator		DELEGATE
HOD - Speaker Appointed	Lucianne	West			DELEGATE
HOD - Speaker Appointed	Taylor	Williams			DELEGATE
HOD - Tennessee	Stacey	Grant	Clinical Pharmacist		DELEGATE
HOD - Tennessee	Kim	Jones	Educator	Assistant Dean of Student Services	DELEGATE
HOD - Tennessee	Jerry	Phipps	Owner		DELEGATE
HOD - Tennessee	Anthony	Pudlo	Director/Assoc OR Asst Director	Executive Director	ALTDELEGATE
HOD - Tennessee	Chelsea	Renfro	Educator	Assistant Professor	DELEGATE
HOD - Tennessee	Olivia	Welter	Other	Director of Professional Affairs	DELEGATE
HOD - Texas	Kevin	Aloysius	Manager		ALTDELEGATE
HOD - Texas	M. Lynn	Crismon	Consultant		DELEGATE
HOD - Texas	Jason	Davis		Manager, Rx Compliance and Regulatory Affairs	DELEGATE
HOD - Texas	Carter	High			DELEGATE
HOD - Texas	Mary	Klein	Educator		DELEGATE
HOD - Texas	Michael	Muniz	Owner		DELEGATE
HOD - Texas	Carol	Reagan	Consultant		DELEGATE
HOD - Texas	May	Woo	Pharmacist, General	Pharmacist	DELEGATE
HOD - USP	Nakia	Eldridge			DELEGATE
HOD - USP	Sohail	Mosaddegh			DELEGATE
HOD - Utah					
HOD - Vermont	Brittany	Allen			DELEGATE
HOD - Vermont	Sandra	Rosa	Staff Pharmacist	Director-Pharmacy Practice Experiences VT	DELEGATE
HOD - Vermont	Amy	Stoll	Clinical Pharmacist		ALTDELEGATE
HOD - VETERANS ADMIN	Anthony	Morreale	Pharmacist, General		DELEGATE
HOD - VETERANS ADMIN	Ronald	Nosek	Administration/Administrative		DELEGATE
HOD - VETERANS ADMIN	Heather	Ourth		Assistant Chief Consultant, Clinical Pharmacy Practice Program & Outcomes Assess	ALTDELEGATE
HOD - VETERANS ADMIN	John	Santell	Director/Assoc OR Asst Director		ALTDELEGATE
HOD - Virginia	Sharon	Gatewood	Pharmacist, General		DELEGATE
HOD - Virginia	Roger	Pritchard			DELEGATE
HOD - Virginia	Allie	Shipman	Director/Assoc OR Asst Director	Senior Director, Policy & Professional Affairs	DELEGATE
HOD - Virginia	Dominic	Solimando	Other		DELEGATE
HOD - Virginia	Adrian	Wilson	Director/Assoc OR Asst Director		DELEGATE
HOD - Washington	Julie	Akers	Pharmacist, General		DELEGATE
HOD - Washington	C A Leon	Alzola	Director/Assoc OR Asst Director	Director of Pharmacy	DELEGATE
HOD - Washington	Sara	McElroy	Administration/Administrative	Associate Director Pharmacy Strategy and Programs	DELEGATE
HOD - West Virginia	Krista	Capehart	Educator	Clinical Associate Professor	ALTDELEGATE
HOD - West Virginia	Betsy	Elswick	Educator	Clinical Associate Professor	DELEGATE
HOD - West Virginia	Michael	Lemasters	Other	Chief Compliance Officer	DELEGATE
HOD - Wisconsin	Kayla	Hensley	Manager		DELEGATE
HOD - Wisconsin	Karen	MacKinnon			DELEGATE
HOD - Wyoming	Reshmi	Singh	Postgrad/BSPharm	Associate Professor	DELEGATE

American Pharmacists Association House of Delegates
FIRST SESSION
Friday, March 24, 2023 / 2:45PM – 5:15PM
SEATING CHART

Speaker of the House

1 AL-4 AZ-4 (S)	17 MI-5+ MA-2* SD-1	33 OK-3 OH-6
2 CA-9	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-4 UT-2
4 DC-3 FL-6	20 (S) NC-5 NE-3	36 PR-3 TN-5+
5 AR-2 DE-2* GA-4 (S)	21 MT-2 NH-2 NJ-5	37 (S) TX-7+
6 IA-3 IL-6*	22 NM-3 NY-6	38 VA-5 WA-4
7 IN-4 ID-2 HI-2 (S)	23 MN-4 NV-3+ (S)	39 VT-2 WV-3 WI-3 WY-1
8 GU-2 KS-3 KY-4+	24 USP, Speaker Appointed -6	40 (S) Speaker Appointed-8
9 HOPA, NCPA, NPhA, NRPhA (S)	25 ACCP, ACVP, AIHP, AMCP	41 Speaker Appointed- 6, Army
10 AACP, AAPP, AAPS, ACA	26 (S) APC, ASCP, ASHP, ASPL	42 (S) Air Force, Navy, PHS, Veterans
11 APhA-APPM-7	27 APhA-ASP-7 (S)	43 APhA-APRS 7
12 APhA-APPM-7 (S)	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 (S)	30 APhA-ASP-7	46 APhA-APRS-7
15 Former Presidents-9	31 (S) 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 24, 2023
2:45PM – 5:15PM

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 – Tables 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
Air Force – Table 42
Army – Table 41
Navy – Table 42
Public Health Service – Table 42
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 27, 2023 / 1:30PM – 4:30PM
SEATING CHART

Speaker of the House

1 GU-2 KS-3 KY-4+	17 MN-4 NV-3+ (S)	33 VT-2 WV-3 WI-3 WY-1
2 IN-4 ID-2 HI-2 (S)	18 NM-3 NY-6	34 VA-5 WA-4
3 IA-3 IL-6*	19 MT-2 NH-2 NJ-5	35 (S) TX-7+
4 AR-2 DE-2* GA-4 (S)	20 (S) NC-5 NE-3	36 PR-3 TN-5+
5 DC-3 FL-6	21 ME-2 MO-4 MS-3	37 (S) RI-2 SC-4 UT-2
6 AK-2* CO-3 CT-3 ND-1	22 LA-3 MD-5	38 OR-3 PA-6
7 CA-9	23 MI-5+ MA-2* SD-1	39 OK-3 OH-6
8 AL-4 AZ-4 (S)	24 USP, Speaker Appointed -6 (S)	40 (S) Speaker Appointed-8
9 HOPA, NCPA, NPhA, NRPhA	25 ACCP, ACVP, AIHP, AMCP	41 Speaker Appointed- 6, Army
10 AACP, AAPP, AAPS, ACA (S)	26 (S) APC, ASCP, ASHP, ASPL	42 (S) Air Force, Navy, PHS, Veterans
11 APhA-APPM-7	27 APhA-ASP-7	43 APhA-APRS 7
12 APhA-APPM-7 (S)	28 APhA-ASP-7 (S)	44 APhA-APRS-7
13 APhA-APPM-7	29 APhA-ASP-7	45 (S) 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 27, 2023
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 – Tables 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
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
Air Force – Table 42
Army – Table 41
Navy – Table 42
Public Health Service – Table 42
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

APhA 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 virtually, 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 30 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 21, 2022

The following information reflects the final language adopted by the APhA House of Delegates during its House sessions on from March 18-21, 2022.

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. 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 shall be considered separately. Consideration of the New Business Item in its entirety requires suspension of House rules.

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.

2022-23 House of Delegates

Report of the House Rules Review Committee

Committee Members

Lucinda Maine, Chair
Adriane Irwin
Nimit Jindal
Cathy Kuhn
Terri Moore
Kevin Musto
Brent Reed

Ex Officio Members
Melissa Duke, Speaker of the House
Brandi Hamilton, Speaker-elect of the House

2022-2023
APhA House Rules Review Committee Report

The 2022-2023 APhA House Rules Review Committee (HRRC) consists of the following APhA members and long-time Delegates:

Lucinda Maine, Chair
Mineral, VA

Adriane Irwin
Albany, OR

Nimit Jindal
Washington, DC

Cathy Kuhn
Dublin, OH

Terri Moore
Arlington, VA

Kevin Musto
Smyrna, DE

Brent Reed
Charlotte, NC

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 session (Adopted 1995). The APhA Speaker may assign year-specific charges to the Committee 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 3, 2022, July 6, 2022, and July 7, 2022, 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 of Delegates over the past year, the HRRC unanimously recommends the following guidance be accepted by the APhA House of Delegates.

- Unfilled Delegate Seats
    - The Committee reviewed the current history of unfilled delegate seats per a standard annual review process following March 2022 House sessions. The Committee noted the continued impact of the COVID-19 pandemic on delegations and delegates. Similar to what was approved in 2020, the Committee agreed to not inactivate any delegate seats due to the pandemic and external strains put on delegates that may have prevented them from attending House of Delegates 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.
- Urgent New Business Item Process
    - Access to proposed policy language and background information of urgent new business items was an issue observed in the March 2022 House sessions. Only a handful of delegates had access to background information prior to discussion of the urgent new business item. This created inequities among delegations and limited the ability for quality debate on the subject matter.
    - The Committee discussed ways to address this issue and agreed that when two house sessions are scheduled to handle regular business of the House then no action should be taken on urgent new business items during the first session of the House. Existing House Rule 13 already outlines how urgent new business items are to be handled when a new business open hearing is scheduled to take place.
        - "*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. Appropriate action will be recommended by the New Business Review Committee in the same manner as other New Business Items*."
    - Existing House Rule 13 does not address what should occur when a new business open hearing is not scheduled nor when only a single session of the House is scheduled. The Committee recommends that any urgent new business item have adequate time for review by delegates of background material prior to debate on any item.
    - The Committee recognizes the issue of addressing an urgent item in a timely fashion while balancing time for review of background materials. In addition to existing House Rule 6 where the Speaker develops the agenda for all House session in consultation with the Secretary, the Committee recommends the Speaker of the House integrate time for Delegate review for any urgent new business items accepted by House leadership for consideration.
    - The Committee recommends an addition to House Rule 13 to emphasize the need for adequate time for review of urgent new business items, which can be found in the last section of this report.
- Motion to Refer
    - The Committee observed an abundance of referrals during the March 2022 House session. Additionally, there were multiple items where additional delegates were still present at microphones to participate in debate. In

these instances, the motion to refer, per Robert's Rules if approved overrides continued debate.
    - The Committee recommends the Speaker of the House have the ability to facilitate further discussion on an item based on the flow of the House session.
- State Caucus Support / expansion efforts
    - The committee recommends APhA staff develop additional opportunities for delegations to caucus during the annual meeting or during virtual house sessions. The committee discussed virtual opportunities to caucus and to expand onsite caucus opportunities for delegations that may need support to facilitate an opportunity to connect with other delegates. One idea to consider is to develop broader caucus events that may not be delegation specific, but rather have a regional focus or just an opportunity to discuss policy topics further.
- Guidance to Speaker for a Fall 2022 Virtual House of Delegates session
    - The Committee discussed the need for earlier engagement in the policy development process but cautioned that virtual engagement is not the same as in-person engagement. The impact of COVID-19 on the House processes warranted usage of the virtual house to handle referred business in the Fall of 2020 and 2021.
    - The committee agreed that a strong rationale for convening a virtual house session needs to be in place with a focus on addressing a specific topic or timely issue that cannot wait for discussion during in-person sessions at the APhA annual meeting. Additionally, the subject matter should be of the nature that will allow for effective debate in a virtual House setting.
    - The committee continues to recommend the Speaker have the prerogative to determine the agenda of a virtual house session, but encourages additional guidance be obtained from former leaders or the house rules review committee, if available, to develop a recommendation to conduct a virtual house. The committee noted that this is the process that has been used to-date to develop an agenda and schedule a virtual house session.
    - The Committee discussed the timing of a virtual house and noted that there will never be a single day or time that will work for all delegates. Additionally, the committee is not recommending an annual virtual house at this time due to the reasons mentioned in previous notes where some subjects may not be best handled in a virtual house format.
    - The Committee recommends incorporation of additional virtual feedback options similar to open hearings be considered by the Speaker and staff to solicit feedback on timely issues that may need further development. This model would provide a feedback process similar to existing House committee reports and provide an additional virtual engagement opportunity for delegates.

- Policy Review Committee
    - The Committee reviewed the processes for the Policy Review Committee and noted a gap in the rules related to reviewing existing policies by topic with the purpose of ensuring uniformity across related policy statements or for the purpose of amending to contemporary language.
    - The Committee noted that the Speaker does have the authority to assign topics to the Policy Review Committee, but acknowledged that the Policy Review Committee, by design, does not engage subject matter experts and instead engages delegates with a policy process background and broad subject matter knowledge of pharmacy.
    - The Committee identified two methods for addressing this issue. The first would be through the new business item process. A delegate would introduce amendments to existing language. Should multiple amendments be necessary to different statements and policy topics then the new business item should be handled as a consent agenda where delegates can vote on all of the individual recommendations as a block, instead of as individual votes. This would allow delegates to pull any statement or recommendation within the new business item out for separate debate. To facilitate this, an additional change to House Rule 13 is recommended by the Committee and is outlined in the last section of this report.
    - The second method would be facilitated by the Speaker of the House through existing House Rule 14. The Speaker may engage a separate group of subject matter experts or delegates to review a subset of existing policies to provide proposed recommendations that are referred to the current Policy Review Committee. The Policy Review Committee would then review these recommendations as contemporary issues assigned to them by the Speaker and make a formal recommendation for consideration by the House.
- Consent Agenda Process
    - The committee reviewed the consent agenda process used in advance of the March 2022 House sessions and noted the guidance is not codified with the House rules, but rather has been in operation through guidance provided by prior House Rules Review Committees.
    - 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 committees. The Committee specifically noted the success in streamlining processes by using this format to handle business of the 2021-2022 Policy Reference Committee, which allowed for discussion of policy implementation to occur during the 2022 APhA Annual Meeting and Exposition open hearing session for the policy reference committee.

- The committee further recommends including recommendations of the New Business Review Committee to be incorporated into the electronic poll process and handled through the consent agenda process for the March 2023 House sessions.
- In order to ensure clarity on the electronic poll and consent agenda processes the Speaker, Committee Chairs, and APhA staff should continue to provide clear guidance during webinars. Additionally, clear guidance should be provided during ongoing and new caucus events. Special attention should be given to how any delegate can pull an item from the consent agenda for further discussion.

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 and deletions are ~~struck through~~ and proposed additions are underlined.

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 ~~shall~~ 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. ~~Consideration of the New Business Item in its entirety requires suspension of House rules.~~

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.

2023 House of Delegates
Policy Review Committee Report

- Policies related to newly adopted policy from the 2022 APhA House of Delegates
- Review of adopted policies related to the Scope of Practice of other health care professional organizations

Committee Members

Christopher Harlow, Chair
Grace Baek
Kelly Fine
Jessica Hinson
Cory Holland
Mary Klein
Adrienne Simmons
Scott Tomerlin
Taylor Williams

Ex Officio

Missy Skelton Duke, Speaker of the House
Brandi Hamilton, Speaker-elect 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 2022); and (3) contemporary issues, if applicable, as identified by the Speaker.

Based on these charges, the Committee reviewed 65 total policies. As of April 2022, all policies within the APhA policy manual have been reviewed or revised since 2012 resulting in zero policies with a need for review according to the first Committee charge. Thirty-eight policies (Items 1-32, 60-65) were related to newly adopted policy from the March 2022 session. Lastly, based on feedback from Delegates, the Speaker of the House charged the Committee to review all APhA policies for potential statements that may impact the scope of practice of non-pharmacist health care professionals. Upon conducting this review, twenty-seven policies (Items 33-59) were related to this contemporary review.

Charge 1: 0 Recommendations
Charge 2: 38 Recommendations
Charge 3: 27 Recommendations

The Committee met three times via web conference call to conduct its work and provides the following recommendations.

Recommendation to Retain

1. The Committee recommends RETAINING the following policy statement as written.

2004, 1991 Updating of State Pharmacy Practice Acts

1. APhA recommends and supports enactment of state pharmacy practice act revisions enabling pharmacists to achieve the full scope of APhA's Mission Statement for the Pharmacy Profession.
2. APhA supports standards of pharmacy practice reflecting the APhA Mission Statement for the Pharmacy Profession.

(Am Pharm. NS31(6):28; June 1991) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

Comments: The Policy Review Committee recommends RETAINING the above policy statements and further recommends that additional review be considered in conjunction with an ongoing review process of the Mission of Pharmacy policy statement.

2. The Committee recommends RETAINING the following policy statement as written.

2002 National Framework for Practice Regulation

1. APhA supports state-based systems to regulate pharmacy and pharmacist practice.
2. APhA encourages states to provide pharmacy boards with
   (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 supports efforts of state boards of pharmacy to adopt uniform standards and definitions of pharmacy and pharmacist practice.
4. APhA encourages state boards of pharmacy to recognize and facilitate innovations in pharmacy and pharmacist practice.
(JAPhA. NS2(5)(suppl 1):563; September/October 2002) (Reviewed 2007) (Reviewed 2008) (Reviewed 2013) (Reviewed 2015) (Reviewed 2020)

3. The Committee recommends RETAINING 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, 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)

4. The Committee recommends RETAINING the following policy statement as written.

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)

5. The Committee recommends RETAINING the following policy statement as written.

2015, 1994 Confidentiality of Computer-generated Patient Records

APhA, in cooperation with the National Council of Prescription Drug Programs, Inc. (NCPDP) and similar groups, shall encourage the development and implementation of uniform, prescription, computer software standards to prevent unauthorized access to confidential patient

records.
(Am Pharm. NS34(6):60; June 1994) (Reviewed 2005) (Reviewed 2009) (Reviewed 2010) (JAPhA. 55(4):375; July/August 2015)

6. 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)

7. The Committee recommends RETAINING 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 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)

8. The Committee recommends RETAINING the following policy statement as written.

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)

9. The Committee recommends RETAINING the following policy statement as written.

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)

10. The Committee recommends RETAINING the following policy statement as written.

2004, 1978 Roles in Health Care for Pharmacists

1. APhA shall develop and maintain new methods and procedures whereby pharmacists can increase their ability and expand their opportunities to provide health care services.
2. APhA supports legislative and judicial action that confirms pharmacists' professional rights to perform those functions consistent with APhA's definition of pharmacy practice and that are necessary to fulfill pharmacists' professional responsibilities to patients they serve.

(Am Pharm. NS18(8):42; July 1978) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2007) (Reviewed 2011) (Reviewed 2012) (Reviewed 2013) (Reviewed 2018) (Reviewed 2020) (Reviewed 2021)

11. The Committee recommends RETAINING the following policy statement as written.

2012, 1981 Pharmacist Training in Nutrition

1. APhA advocates that all pharmacists become knowledgeable about the subject of nutrition.
2. APhA encourages schools and colleges of pharmacy as well as providers of continuing pharmacy education to offer education and training on the subject of nutrition.

(Am Pharm. NS21(5):40; May 1981) (Reviewed 2003) (Reviewed 2006) (Reviewed 2007) (JAPhA. NS52(4):458; July/August 2012) (Reviewed 2017)

12. The Committee recommends RETAINING 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 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)

13. 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)

14. 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)

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

2021 Anti-Racism in Pharmacy

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)

16. 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)

17. 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):441; July/August 2017) (Reviewed 2019) (Reviewed 2020) (Reviewed 2021)

18. 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)

19. 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)

20. The Committee recommends RETAINING the following policy statement as written.

1989 Impact of Drug Distribution Systems on Integrity and Stability of Drug Products

APhA encourages the development and use of quality-control procedures by all persons or entities involved in the distribution and dispensing of drug products. Such procedures should assure drug product integrity and stability in accordance with official compendia standards.
(Am Pharm. NS29(7):464; July 1989) (Reviewed 2004) (Reviewed 2006) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

21. The Committee recommends RETAINING the following policy statement as written.

1978 Post-Marketing Requirements (Restricted Distribution)

APhA opposes any legislation 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)

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

2020 Accountability of Pharmacists

1. APhA affirms pharmacists' professional accountability within their role in all practice settings.
2. APhA advocates that pharmacists be granted and accept authority, autonomy, and accountability for patient-centric actions to improve health and medication outcomes, in coordination with other health professionals, as appropriate.
3. APhA reaffirms 2017 Pharmacists' Role Within Value-based Payment Models and supports continued expansion of interprofessional patient care models that leverage pharmacists as accountable members of the health care team.
4. APhA advocates for sustainable payment and attribution models to support pharmacists as accountable patient care providers.
5. APhA supports continued expansion of resources and health information infrastructures that empower pharmacists as accountable health care providers.
6. APhA supports the enhancement of comprehensive and affordable professional liability insurance coverage that aligns with evolving pharmacist accountability and responsibility.

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

23. The Committee recommends RETAINING 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 and rules pertaining to the independent practice of pharmacists when those laws 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 and regulations 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)

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

2011, 2002, 1996 Health Mobilization

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)

25. The Committee recommends RETAINING 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 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)

26. The Committee recommends RETAINING the following policy statement as written.

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

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.

These responsibilities include the following:
1. Pharmacists, by their education and training as medication experts, should be involved intimately in all elements of the procurement, storage, handling, compounding, and dispensing of drugs and supplies in planning for as well as during any national emergency.
2. Pharmacists, by their education in anatomy, physiology, and pharmacology, are readily adaptable to assist in the emergency medical treatment of patients and for training the public in medical self-help.
3. Pharmacists, by their constant contact with the members of the health team, as well as a significant portion of their communities, provide the potential for coordinating preparedness measures, and establishing meaningful standby emergency operational plans.
In view of these responsibilities, it shall be the further policy of APhA to:
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)

27. The Committee recommends RETAINING the following policy statement as written.

1979 Dispensing and/or Administration of Legend Drugs in Emergency Situations

1. APhA supports making insect sting kits and other, life-saving, emergency, treatment kits available for lawful dispensing by pharmacists without a prescription order, based on the pharmacist's professional judgment.
2. APhA supports permitting pharmacists to lawfully dispense and administer legend drugs in emergency situations, without an order from a licensed prescriber, provided that:
   (a) there is an assessment on the part of the pharmacist and the patient that the drug is needed immediately to preserve the well-being of the patient; and
   (b) the normal legal means for obtaining authorization to dispense the drug must not be immediately available, such as in cases where the patient's physician is not available; and
   (c) the quantity of the drug, that can be dispensed in an emergency situation, is enough so that the emergency situation can subside, and the patient can be sustained for the immediate emergency, as determined by the pharmacist's professional judgment.
3. APhA supports expansion of state Good Samaritan Acts to provide pharmacists immunity from professional liability for dispensing in emergency situations without order from a licensed prescriber.
4. APhA supports permitting pharmacists to lawfully dispense and/or administer legend drugs

without an order from a licensed prescriber during disaster situations.
(Am Pharm. NS19(7):68; June 1979) (Reviewed 2002) (Reviewed 2006) (Revised 2007) (Reviewed 2012) (Reviewed 2012) (Reviewed 2017) (Reviewed 2021)

28. The Committee recommends RETAINING the following policy statement as written.

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)

29. The Committee recommends RETAINING the following policy statement as written.

2011 Potential Conflicts of Interest in Pharmacy Practice

1. APhA reaffirms that as health care professionals, pharmacists are expected to act in the best interest of patients when making clinical recommendations.
2. APhA supports pharmacists using evidence-based practices to guide decisions that lead to the delivery of optimal patient care.
3. APhA supports pharmacist development, adoption, and use of policies and procedures to manage potential conflicts of interest in practice.
4. APhA should develop core principles that guide pharmacists in developing and using policies and procedures for identifying and managing potential conflicts of interest.

(JAPhA. NS51(4): 482; July/August 2011) (Reviewed 2016)

30. The Committee recommends RETAINING 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 regulatory 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)

31. The Committee recommends RETAINING 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 regulations 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)

32. The Committee recommends RETAINING 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 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)

33. The Committee recommends RETAINING the following policy statement as written.

2014 Care Transitions

1. APhA supports pharmacists leading medication management activities during care transitions to ensure safe and effective medication use.
2. APhA supports the integral role of pharmacists during care transitions for improving quality of patient-centered care and reducing overall costs to the health care system.
3. APhA strongly encourages collaboration and shared accountability among patients, family members, caregivers, pharmacists, and other health care providers during care transitions.
4. APhA supports the development and utilization of standardized processes that facilitate real-time, bidirectional communication of protected health information during care transitions.
5. APhA supports that documentation of health outcomes is an essential component of any care transition program to demonstrate value and ensure continuous quality improvement.
6. APhA supports financially viable payment models that recognize the value of pharmacists' services, including, but not limited to, those provided during care transitions.
7. APhA strongly urges the development and implementation of multidisciplinary, interprofessional, and team-based training for health care professionals and students to improve the quality and consistency of care transition services.
8. APhA urges the collaboration and partnership of community pharmacies with health care systems, institutions, and other entities involved in care transitions.
(JAPhA. 54(4):357; July/August 2014) (Reviewed 2019)

34. The Committee recommends RETAINING the following policy statement as written.

2004, 1984 Center for Human Organ Acquisition

1. APhA supports activities that would increase voluntary human organ donations.
2. APhA encourages all pharmacists to consider becoming organ donors themselves, and to inform and encourage their patients to participate in organ donor programs.
3. APhA strongly urges all pharmacists, especially those in emergency room and intensive/critical care settings, to sensitize the other health care team members to the basic need for asking if a patient is an organ donor as part of the admission.

(Am Pharm. NS24(7):61; July 1984) (JAPhA. NS44(5):551; September/October 2004) (Reviewed 2010) (Reviewed 2015)

35. The Committee recommends RETAINING 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 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)

36. The Committee recommends RETAINING the following policy statement as written.

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)

37. The Committee recommends RETAINING the following policy statement as written.

2022 Data Security in Pharmacy Practice

1. APhA advocates that all organizations and healthcare 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)

38. The Committee recommends RETAINING the following policy statement as written.

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)

39. 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)

40. The Committee recommends RETAINING the following policy statement as written.

1981 Investigational New Drug (IND) Studies

APhA encourages investigators and sponsors who are conducting IND studies to utilize the professional services of pharmacists in carrying out such studies.

(Am Pharm. NS2(5):40; July 1981) (Reviewed 2004) (Reviewed 2009) (Reviewed 2010) (Reviewed 2015)

41. The Committee recommends RETAINING 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 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)

42. The Committee recommends RETAINING the following policy statement as written.

2002 National Framework for Practice Regulation

1. APhA supports state-based systems to regulate pharmacy and pharmacist practice.
2. APhA encourages states to provide pharmacy boards with
(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 supports efforts of state boards of pharmacy to adopt uniform standards and definitions of pharmacy and pharmacist practice.
4. APhA encourages state boards of pharmacy to recognize and facilitate innovations in pharmacy and pharmacist practice.
(JAPhA. NS2(5)(suppl 1):563; September/October 2002) (Reviewed 2007) (Reviewed 2008) (Reviewed 2013) (Reviewed 2015) (Reviewed 2020)

43. The Committee recommends RETAINING 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 inmates.
2. APhA advocates for inmates to have an opportunity, equal to that of non-inmates, to access medications that correctional healthcare providers deem medically necessary for appropriate and humane health care treatment.
3. APhA advocates for correctional healthcare providers to have opportunity, equal to that of non-correctional healthcare providers, to access, prescribe, and procure pharmaceuticals deemed necessary for medical treatment of inmates.
(JAPhA. 60(5):e11; September/October 2020)

44. The Committee recommends RETAINING the following policy statement as written.

1994 Off-Label Use of FDA-Approved Products

1. APhA advocates the collaboration of pharmacists, other health care professionals, industry, and the FDA in developing procedures to evaluate off-label use of FDA-approved products.
2. APhA encourages industry and government cooperation to streamline approval of beneficial off-label therapeutic or diagnostic use of FDA-approved products.
3. APhA advocates removal of restrictions on reimbursement of pharmaceutical services and FDA-approved products when, in the judgment of the pharmacist, those products are for medically acceptable, off-label uses.

(Am Pharm. NS34(6):56; June 1994) (Reviewed 2004) (Reviewed 2010) (Reviewed 2015)

45. The Committee recommends RETAINING the following policy statement as written.

2005 Patient Safety

1. Patient safety is influenced by patients, caregivers, health care providers, and health care systems. APhA recognizes that improving patient safety requires a comprehensive, continuous, and collaborative approach to health care.
2. APhA should promote public and provider awareness of and encourage participation in patient safety initiatives.
3. APhA supports research on a more effective, proactive, and integrated health care system focused on improving patient safety. APhA encourages implementation of appropriate recommendations from that research.

(JAPhA. NS45(5):554; September/October 2005) (Reviewed 2009) (Reviewed 2011) (Reviewed 2016) (Reviewed 2019) (Reviewed 2020)

Comments: The Policy Review Committee recommends RETAINING this statement as it discusses collaboration in patient safety and does not infringe on the scope of practice of other health care professionals.

46. The Committee recommends RETAINING 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 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)

47. 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)

48. The Committee recommends RETAINING the following policy statement as written.

2011 Pharmacist's Role in Health Care Reform

1. APhA affirms that pharmacists are the medication experts whose accessibility uniquely positions them to increase access to and improve quality of health care while decreasing overall costs.
2. APhA asserts that pharmacists must be recognized as the essential and accountable patient care provider on the health care team responsible for optimizing outcomes through medication therapy management (MTM).
3. APhA asserts the following:
(a) Medication Therapy Management Services: Definition and Program Criteria is the standard definition of MTM that must be recognized by all stakeholders.
(b) Medication Therapy Management in Pharmacy Practice: Core Elements of an MTM Service Model, as adopted by the profession of pharmacy, shall serve as the foundational MTM service model.
4. APhA asserts that pharmacists must be included as essential patient care provider and compensated as such in every health care model, including but not limited to, the medical home and accountable care organizations.
5. APhA actively promotes the outcomes-based studies, pilot programs, demonstration projects, and other activities that document and reconfirm pharmacists' impact on patient health and well-being, process of care delivery, and overall health care costs.
(JAPhA. NS51(4):482; July/August 2011) (Reviewed 2016) (Reviewed 2021)

Comments: The Policy Review Committee recommends RETAINING this statement as it asserts unique pharmacists' qualifications to optimize medication therapy.

49. The Committee recommends RETAINING the following policy statement as written.

1993 Pharmacists' Services

1. APhA supports development of pharmacy payment systems that include reimbursement of the cost of any medication or device provided; the cost of preparing the medication or device; the costs of administrative services; return on capital investment; and payment for both the dispensing-related and non-dispensing-pharmacy services.

2. APhA believes that appropriate incentives for the pharmacist providing care should be part of any payment system.
(Am Pharm. NS33(7):53; July 1993) (Reviewed 2005) (Reviewed 2007) (Reviewed 2009) (Reviewed 2010) (Reviewed 2011) (Reviewed 2012) (Reviewed 2017) (Reviewed 2022)

50. The Committee recommends RETAINING the following policy statement as written.

2019, 2010 Pharmacogenomics/Personalized Medicine

4. APhA supports the inclusion of pharmacogenomic analysis in the drug development/approval and postmarketing surveillance processes.
(JAPhA. NS50(4):471; July/August 2010) (Reviewed 2015) (JAPhA. 59(4):e17; July/August 2019)

51. The Committee recommends RETAINING the following policy statement as written.

2022 2007 Pharmacy Personnel Immunization Rates

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)

52. The Committee recommends RETAINING the following policy statement as written.

2003 Prior Authorization

1. APhA opposes prior authorization programs that create barriers to patient care.
2. Patients, prescribers, and pharmacists should have ready access to the coverage conditions for medications or devices requiring prior authorization.
3. Prescription drug benefit plan sponsors and administrators should actively seek and integrate the input of network pharmacists in the design and operation of prior authorization programs.
4. APhA supports prior authorization programs that allow pharmacists to provide the necessary information to determine appropriate patient care.
5. APhA expects prescription drug benefit plan sponsors to compensate pharmacy providers who complete third-party payer authorization procedures. Compensation should be in addition to dispensing fee arrangements.
6. APhA should work with relevant groups to improve prior authorization design and decrease prescription processing inefficiencies.
(JAPhA. NS43(5)(suppl 1):S58; September/October 2003) (Reviewed 2008) (Reviewed 2013) (Reviewed 2015)

53. The Committee recommends RETAINING 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 and regulations 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)

54. The Committee recommends RETAINING the following policy statement as written.

1985 Regulation of Mobile Facilities

APhA supports enactment of state and federal laws and regulations 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)

55. 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)

56. 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)

57. The Committee recommends RETAINING 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 and regulations 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)

58. The Committee recommends RETAINING the following policy statement as written.

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)

59. The Committee recommends RETAINING the following policy statement as written.

2018 Use of Genomic Data Within Pharmacy Practice

1. APhA emphasizes genomics as an essential aspect of pharmacy practice.
2. APhA recognizes pharmacists as the health care professional best suited to provide medication-related consults and services based on a patient's genomic information. All pharmacists involved in the care of the patient should have access to relevant genomic information.
3. APhA supports processes to protect patient data confidentiality and opposes unethical utilization of genomic data.
4. APhA demands payers include pharmacists as eligible providers for covered genomic interpretation and related services to support sustainable models that optimize patient care and outcomes.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the exchange, storage, utilization, and documentation of clinically actionable genetic variations and actions taken by the pharmacist in the provision of patient care.
6. APhA recommends pharmacists and pharmaceutical scientists lead the collaborative development of evidence-based practice guidelines for pharmacogenomics and related services.
7. APhA recommends the inclusion of pharmacists and pharmaceutical scientists in the collaborative development of pharmacogenomics clinical support tools and resources.
8. APhA encourages pharmacists to use their professional judgment and published guidelines and resources when providing access to testing or utilizing direct-to-consumer genomic test results in their patient care services.
9. APhA urges schools and colleges of pharmacy to include clinical application of genomics as a required element of the Doctor of Pharmacy curriculum.
10. APhA encourages the creation of continuing professional development and post-graduate education and training programs for pharmacists in genomics and its clinical application to meet varying practice needs.
11. APhA encourages the funding of pharmacist-led research examining the cost effectiveness of care models that utilize pharmacists providing genomic services.
(JAPhA. 58(4):355; July/August 2018)

Comments: The Policy Review Committee recommends RETAINING this policy statement as pharmacists are best suited to provide medication-related consultations. Therefore, the Committee believes this does not inappropriately impede on other health care professionals' scope of practice, and this policy statement should remain active.

Recommendation to Archive

60. The Committee recommends ARCHIVING the following policy statement as written.

2013, 1978 Pharmacists Providing Health Care Services

APhA supports the study and development of new methods and procedures whereby pharmacists can increase their ability and expand their opportunities to provide health care services to patients.

(Am Pharm. NS18(8):47; July 1978) (Reviewed 2007) (Reviewed 2008) (JAPhA. 53(4):366; July/August 2013) (Reviewed 2016)

Comments: The Policy Review Committee recommends ARCHIVING the above policy statement as more contemporary policy exists and this statement is duplicative to statement 1 *in 2004, 1978 Roles in Health Care for Pharmacists.*

61. The Committee recommends ARCHIVING the following policy statement as written.

2013, 1980 Medication Selection by Pharmacists

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)

Comments: The Policy Review Committee recommends ARCHIVING the above statement as there is more contemporary policy (*2022 Standard of Care Regulatory Model for State Pharmacy Practice Acts, 2017; 2012 Contemporary Pharmacy Practice; 2022 Pharmacists' Application of Professional Judgment*) that supports a more expansive role of pharmacists that is not limited to only medication selection.

62. The Committee recommends ARCHIVING the following policy statement as written.

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)

Comments: The Policy Review Committee recommends ARCHIVING the above policy statements as there is more contemporary policy (*2020 Community-Based Pharmacists as Providers of Care; 2017 Patient Access to Pharmacist-Prescribed Medications; 2019 Referral System for the Pharmacy Profession; 2020 Accountability of Pharmacists*) that covers the intent of the existing policy.

63. The Committee recommends ARCHIVING the following policy statement as written.

2004, 1977 Pharmacy Practice Professional Judgment

1. APhA supports a pharmacist's right, regardless of place or style of practice, to exercise individual professional judgment and complete authority for those individual professional responsibilities assumed.
2. APhA supports decision-making processes that ensure the opportunity for input by all pharmacists affected by the decisions.

(JAPhA. NS17:463; July 1977) (JAPhA NS44(5):551; September/October 2004) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2020)

Comments: The Policy Review Committee recommends ARCHIVING the above policy statements as the new *2022 Pharmacists' Application of Professional Judgment* policy is more contemporary and captures the intent of these older policy statements.

64. The Committee recommends ARCHIVING the following policy statement as written.

1999 Sale of Sterile Syringes

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.

(JAPhA. 39(4):447; July/August 1999) (Reviewed 2003) (Reviewed 2006) (Reviewed 2008) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019) (Reviewed 2020)

Comments: The Policy Review Committee recommends ARCHIVING the above policy statements as there is more contemporary policy outlined in statements four and five of the 2019 Patient-Centered Care of people Who Inject Nonmedically Sanctioned Psychotropic or Psychotropic Substances policy, that covers the intent of this older policy.

Recommendations to Amend

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

2016 Medications for Substance Use Disorders Medication-Assisted Treatment

APhA supports expanding access to medications indicated for opioid use disorders (MOUDs) and other substance use disorders, ~~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)

Comments: The Policy Review Committee recommends AMENDING the above policy statement to use more contemporary language to describe this class of medications and align with related policy on this topic.

Recommendations of the Policy Reference Committee					
Item	Yes	Percentage Approval	No	Abstain	STATUS
Policy Topic 1 - Statement 1	204	98.55%	3	3	Consent Agenda
Policy Topic 1 - Statement 2	199	98.03%	4	7	Consent Agenda
Policy Topic 1 - Statement 3	191	93.63%	13	6	Consent Agenda
Policy Topic 1 - Statement 4	202	98.06%	4	4	Consent Agenda
Policy Topic 1 - Statement 5	197	95.63%	9	4	Consent Agenda
Policy Topic 1 - Statement 6	199	97.07%	6	5	Consent Agenda
Policy Topic 1 - Statement 7	172	87.31%	25	13	Consent Agenda
Policy Topic 2 - Statement 1	199	99.00%	2	9	Consent Agenda
Policy Topic 2 - Statement 2	200	99.50%	1	9	Consent Agenda
Policy Topic 2 - Statement 3	168	83.17%	34	8	Consent Agenda
Policy Topic 2 - Statement 4	194	96.52%	7	9	Consent Agenda
Policy Topic 2 - Statement 5	192	94.58%	11	7	Consent Agenda
Policy Topic 2 - Statement 6	187	92.12%	16	7	Consent Agenda
Policy Topic 3 - Statement 1	197	97.52%	5	8	Consent Agenda
Policy Topic 3 - Statement 2	194	96.04%	8	8	Consent Agenda
Recommendations of the New Business Review Committee					
Item	Yes	Percentage Approval	No	Abstain	STATUS
NBI #1 – Statement 1	168	82.76%	35	7	Consent Agenda
NBI #1 – Statement 2	156	78.79%	42	12	Consent Agenda
NBI #2 – Statement 1	184	89.32%	22	4	Consent Agenda
NBI #2 – Statement 2	164	81.19%	38	8	Consent Agenda
NBI #3 – Statement 1	182	91.92%	16	12	Consent Agenda
NBI #3 – Statement 2	188	96.41%	7	15	Consent Agenda
NBI #3 – Statement 3	184	95.34%	9	17	Consent Agenda
NBI #3 – Statement 4	189	94.03%	12	9	Consent Agenda
NBI #4 – Statement 1	177	91.71%	16	17	Consent Agenda
NBI #5 – Statement 1	176	90.72%	18	16	Consent Agenda
NBI #5 – Statement 2	180	90.91%	18	12	Consent Agenda
NBI #6 – Statement 1	195	95.12%	10	5	Consent Agenda
NBI #6 – Statement 2	191	94.55%	11	8	Consent Agenda
NBI #7 – Statement 1	166	84.69%	30	14	Consent Agenda
NBI #8 – Statement 1	184	92.00%	16	10	Consent Agenda
NBI #9 – Statement 1	188	91.71%	17	5	Consent Agenda
NBI #9 – Statement 2	186	93.47%	13	11	Consent Agenda
NBI #10 – Statement 1	194	92.82%	15	1	Consent Agenda
NBI #10 – Statement 2	192	94.12%	12	6	Consent Agenda
NBI #10 – Statement 3	187	92.12%	16	7	Consent Agenda
NBI #11 – Statement 2	112	62.57%	67	31	Individual Motion
NBI #11 – Statement 3	186	93.47%	13	11	Consent Agenda
NBI #11 – Statement 4	162	90.00%	18	30	Consent Agenda
NBI #11 – Statement 5	148	84.10%	28	34	Consent Agenda
NBI #12 – Statement 1	175	88.38%	23	12	Consent Agenda
NBI #12 – Statement 2	144	78.26%	40	26	Consent Agenda
NBI #12 – Statement 3	160	84.21%	30	20	Consent Agenda

Process utilized for Poll Result Tabulation

The poll was sent to **363 registered delegates**. A quorum is defined as 182 of those delegates completing the poll. As of March 7, 2023, midnight Pacific Time, **210 delegates completed the poll**. Therefore, a quorum was established.

Votes 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. Delegates who select "Abstain" as their vote will be counted as abstention and removed from the denominator in each vote's final count.
3. 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.
4. The total number of "Approve" votes represents the numerator in the final count for that poll item.

APhA House of Delegates Policy Reference Committee Report
Phoenix, Arizona

Policy Reference Committee
Loren Kirk, Chair
Nicholas Capote
Dalton Fabian
Heather Free
Brooke Kulusich
Charlie Mollien
Frank North
Lucy West

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

Topic #1 – Workplace Conditions

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

Statement #1: APhA calls for employers to provide fair, realistic, and equitable workplace conditions for pharmacy personnel that promotes a safe, healthy, and sustainable working environment.

[Refer to Workplace Conditions Summary of Discussion Items 1–9]

The Policy Reference Committee noted that terms such as "fair", "realistic" and "sustainable" are defined and expanded on in the Policy Committee's summary of discussion.

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

Statement #2: APhA urges all entities that impact pharmacy personnel workplace conditions to adopt the ~~APhA/National Alliance of State Pharmacy Associations (NASPA)~~ Pharmacists Fundamental Responsibilities and Rights.

[Refer to Workplace Conditions Summary of Discussion Items 1–2, 10–12]

The Policy Reference Committee recommends the edit above, to properly capture the Pharmacists Fundamental Responsibilities and Rights. For added context on who constitutes a relevant "entity", delegates may refer to Summary of Discussion points 11 and 12 of the Workplace Conditions Section of the Policy Reference Committee Report.

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

Statement #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 ~~and facilitate improved focus~~ to minimize distractions.

[Refer to Workplace Conditions Summary of Discussion Items 1–2, 13–22]

The Policy Reference Committee recommends the edit above, to be more concise.

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

Statement #4: APhA advocates for employers to provide workplace onboarding and training for pharmacy personnel to ~~promote optimal~~ optimize employee performance and satisfaction.

[Refer to Workplace Conditions Summary of Discussion Items 1–2, 23–26]

The Policy Reference Committee recommends the edit above, to be more concise. The committee also reaffirms the intended meaning of this statement to encourage onboarding and training for employees as a method of increasing employee satisfaction and performance.

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

Statement #5: APhA encourages pharmacy personnel, starting with leaders, to model and ~~promote~~ facilitate individualized healthy working behaviors that improve well-being and to encourage and empower colleagues to do the same.

[Refer to Workplace Conditions Summary of Discussion Items 1–2, 23–26]

The Policy Reference Committee accepts the recommended edit above, noting that "facilitate" may be the more appropriate verb. The committee considered whether to expand this statement to address patient safety outcomes, however opted to narrow the overall scope of this policy topic to pharmacists' wellbeing.

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

Statement #6: APhA opposes the sole use of productivity and fiscal measures for employee performance evaluations.

[Refer to Workplace Conditions Summary of Discussion Items 1–2, 31–34]

The Policy Reference Committee considered a recommendation to include alternative performance measures in the statement besides "productivity and fiscal measures", however the committee determined further specificity is not warranted to achieve the intended meaning.

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

Statement #7: APhA calls for employers to take an active role in the development and use of behavioral performance competencies in performance evaluations.

[Refer to Workplace Conditions Summary of Discussion Items 31–34]

The Policy Reference Committee considered a recommendation to elaborate on behavioral competencies in the proposed statement, and determined this could potentially limit the intended meaning. Examples of behavioral competencies as noted in the summary of discussion, include empathy, active listening, effective communication, and personal responsibility.

Topic #2 – Just Culture Approach to Patient Safety

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

Statement #1: APhA calls for employers to adopt and implement just culture principles to improve patient safety and support pharmacy personnel.

[Refer to Just Culture Approach to Patient Safety Summary of Discussion Items 1–3]

The Policy and Policy Reference Committee broadly defined just culture as a system in which errors are not attributed to an individual's mistakes, but rather to the totality of a structured environment, system, and workflow. The committee considered a recommendation to elaborate on this definition within the proposed statements themselves, however deemed these principles as well-established component of just culture, and that covered in the statements. The committee also noted that second victim syndrome is captured by the call to "support pharmacy personnel", and thus no further revisions warranted.

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

Statement 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.

[Refer to Just Culture Approach to Patient Safety Summary of Discussion Items 1–2, 4–6]

The Policy Reference Committee considered a recommendation to specify that actions taken to promote continuous quality improvement are "non-punitive", however noted this may be redundant in the context of just culture principles. Furthermore, non-punitive mechanisms are already addressed in the following statement related to boards of pharmacy.

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

Statement 3: APhA urges the adoption of non-disciplinary and non-punitive mechanisms for use by boards of pharmacy to promote just culture when addressing people, systems, and processes involved in medication errors.

[Refer to Just Culture Approach to Patient Safety Summary of Discussion Items 1–2, 7–16]

The Policy Reference Committee recommended no further action or revisions of this proposed policy.

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

Statement 4: APhA encourages national and state associations to advocate for legislation ~~in all states~~ to provide protections to individuals utilizing error reporting systems to promote just culture.

[Refer to Just Culture Approach to Patient Safety Summary of Discussion Items 1–2, 12, 17–18]

The Policy Reference Committee reviewed a delegate comment, which expressed concern over implications of negligence by encouraging national and state associations to advocate for such legislation. The committee noted just culture principles are distinct from protecting negligence. The committee recommends to strike "in all state", to better capture intended meaning of individual stakeholder advocating for their respective legislation.

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

Statement 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.

[Refer to Just Culture Approach to Patient Safety Summary of Discussion Items 1–2, 19]

The Policy Reference Committee reviewed a recommendation received to model such mechanisms on existing national standards for medicine or nursing, and determined that no further action was warranted at this time, based on limited operational scope of policy.

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

Statement 6: APhA supports the development of just culture education and training in the curriculum of all schools and colleges of pharmacy, postgraduate training, and continuing professional development programs.

[Refer to Just Culture Approach to Patient Safety Summary of Discussion Items 1–2, 20]

The Policy Reference Committee noted a delegate comment, that there may be an opportunity to engage patient advocacy groups in discussions of just culture education and training.

Topic #3 – Site of Care Patient Steerage

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

Statement 1: APhA calls for the elimination of payer-driven medication administration policies and provisions that restrict access points, interfere with shared provider–patient decision-making, cause delays in care, or otherwise adversely impact the patient.

[Refer to Site of Care Patient Steerage Summary of Discussion Items 1–10]

The Policy Reference Committee outlined that this policy topic overall centers around two ideas: the elimination of payer-driven mandates for patients to certain sites of care and addressing a current gap in the involved business models. The committee emphasized that while these proposed policy statements have an origin connecting back to the 2022 Procurement Strategies and Patient Steerage policies, the issues around site of care steerage are broader and can stand alone as a separate policy topic within the APhA policy manual.

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

Statement 2: APhA asserts that care coordination services associated with provider-administered medications are essential to safe and effective medication use and calls for the development of broadly applicable compensation mechanisms for these essential services.

[Refer to Summary of Discussion Items 1–5, 9–17]

The Policy Reference Committee reviewed a delegate recommendation to consider the impacts that high-cost medications and limited insurance coverage have on patient steerage. However, the committee determined this was out of the scope of the specific focus here to site of care patient steerage.

Summary of Discussion – Workplace Conditions

1. The policy committee considered multiple titles such as "workplace expectations," "employment standards," or "workplace best practices" and agreed on the wording of "workplace conditions." "Conditions" fit best in the context of this topic, as APhA is not a standard-setting organization and there are many different sets of "best practices" for pharmacy depending on the practice setting or workplace. (1–6)
2. The committee reviewed the International Labour Organization's definition of "working conditions," recognizing that this concept could mean different things to different people. This definition describes that working conditions cover a broad range of topics and issues, from working time (e.g., hours of work, rest periods, and work schedules) to remuneration as well as the physical conditions and mental demands that exist in the workplace. (1)
3. The committee also noted that the word choice of "workplace conditions" represents the intent to convey policies related to the work environment as opposed to inadvertently suggesting these policies are adding expectations of individual employees. (1–6)
4. The committee discussed a need to not only advocate safe and healthy working environments in proposed policy, but to also advocate that these work environments are sustainable. The committee noted that this addition was important to maintain a realistic and optimal expectation for pharmacy personnel. (1)
5. The committee determined that "calls on" is the best and most appropriate verb choice to convey urgency and agency of the recommendation. Alternative options considered included demand, insist, expect, urge, etc. (1)
6. The committee discussed the expectation that workplace conditions be realistic and be considered from both the employer and employee perspectives. (1)
7. The committee recognized in their discussion that an ideal work environment differs from person to person but may broadly be defined as an environment in which one feels supported, engaged, and equipped with the tools necessary to best facilitate their work and career advancement. (1)

8. When thinking about working conditions, the committee considered demands, environment, and circumstances of a job that directly impact its employees' satisfaction and activity. (1)
9. The committee reviewed the following articles when discussing the use of the adjective "realistic" to describe recommended working conditions: (1)
    a. *Journal of General Internal Medicine* article: Porter J, Boyd C, Skandari MR, et al. Revisiting the time needed to provide adult primary care. J Gen Intern Med. 2022; [Epub ahead of print]. doi: https://doi.org/10.1007/s11606-022-07707-x
    b. *Forbes* article describing the journal study: Balasubramanian S. Physicians would need almost 27 hour a day to provide optimal patient care, per new study. Jersey City: Forbes Media. Available at: https://www.forbes.com/sites/saibala/2022/08/28/physicians-would-need-almost-27-hours-a-day-to-provide-optimal-patient-care-per-new-study/?sh=449de521582b. Accessed November 9, 2022.
10. The committee reviewed the APhA and NASPA Pharmacists Fundamental Responsibilities and Rights as approved by both organizations in June 2021 with the intent that broader implementation of these principles are important for improvement of workplace expectations. (2)
11. The committee noted that, although the APhA and NASPA Pharmacists Fundamental Responsibilities and Rights is already supported by 57 entities at the time this report was created—including national associations, state associations, schools/colleges of pharmacy, and others—it would be especially powerful for the general APhA membership to demonstrate support through adoption of proposed policy for further implementation and support across the profession. (2)
12. The committee initially considered explicitly naming key stakeholders such as payers, employers, accrediting organizations, and other stakeholders in the policy statement related to the adoption of the APhA/NASPA Pharmacists Fundamental Responsibilities and Rights. However, the committee opted to keep the statement broadly applicable by using the language of "all entities" at the beginning of the statement to instead include anyone who places expectations on pharmacists. (2)
13. The committee noted the close connection between individual capability and availability to provide safe and effective patient care services. Therefore, the committee advocated for an explicit statement to emphasize a need for adequate staffing, thoughtful workflow design, and productivity analysis. (3)
14. The committee emphasized a need to not only call for optimized working environments and technology, but to also call for empowerment of the actual people involved. This is especially pertinent in situations in which frontline pharmacists do not feel permitted to act in their best interest during particularly challenging and intense work situations, even when technically they have support mechanisms available. The committee noted that this lacking sense of empowerment to act on personal judgment in pressing situations is a recurring point seen by results from the Pharmacy Workplace and Well-Being Reporting (PWWR) survey. (3)

15. The committee considered the word choice of "autonomy" to convey the agency of all personnel to utilize these models; however the committee noted that "autonomy" has varying implications across all levels of personnel and leadership (pharmacists, technicians, pharmacy managers, district leaders, etc.). As a result, the committee opted to frame this statement through the lens of empowerment. (3)
16. The committee discussed the word choice of "practice management models" to describe implementation of workplace procedures, noting that this phrase may have varying connotations with different readers. Alternative language considered included "staffing models," and "practice models." (3)
17. The committee noted limitations that APhA policy has in terms of describing workplace policies and procedures that may conflict with state legislative and regulatory scopes of authority. For example, the committee considered including pharmacy hours of operation in the list of considerations but recognized that some states regulate this at the state board of pharmacy level or department of health level. (3)
18. When discussing the issue of pharmacists' hesitation to exercise flexible practice management models, the committee reviewed a relevant example complaint from the state of Vermont, in which a pharmacy was reported for numerous offenses, including unanticipated store closures and unsafe pharmacy working conditions. Similarly, the committee reviewed another relevant example from Virginia of pharmacy personnel reporting risks to patient safety caused by understaffing. (3)
    a. Walgreens complaints from Vermont: State of Vermont Secretary of State. Walgreens Specification of Charges. Atlanta: Gray Television, Inc. Available at: https://webpubcontent.gray.tv/wcax/docs/Walgreens%20Specification%20of%20Charges.pdf. Accessed November 10, 2022.
    b. Understaffing at some CVS pharmacies in Virginia has put patients at risk, former employees say: Masters K. Understaffing at some CVS pharmacies in Virginia has put patients at risk, former employees say. N.p.: The Virginia Mercury. Available at: https://www.virginiamercury.com/2021/10/11/understaffing-at-some-cvs-pharmacies-in-virginia-has-put-patients-at-risk-former-employees-say/. Accessed November 10, 2022.
19. The committee discussed the importance of good-faith collaborative decision-making efforts among both pharmacy personnel and their employers/managers to adjust offered programs and services to patients and potential impact on hours of operation, with appropriate notification to regulatory agencies, based on availability of pharmacist and pharmacy personnel. (3)
20. The committee discussed "workload balancing tools" such as automated or centralized pharmacy services, in contexts where pharmacists have limited personnel to help support pharmacy services. These examples were not included in the proposed statement to keep the statement broad and allow pharmacy personnel to consider multiple options for flexible working environments. (3)
21. Related to workload balancing tools, the committee discussed the variation across state board of pharmacy regulations and how this variable significantly influences pharmacy workflow and provision of pharmacy services. (3)

22. The committee considered the role and influence a pharmacist in charge (PIC) should have in creating the optimal work environments outlined by the proposed policy statements, noting that the PIC should have the ability to determine what is best for that work environment in a manner that helps safely achieve its employer's strategy and goals. (3)
23. The committee reviewed existing APhA policy regarding onboarding and training program recommendations and determined a gap in policy was present. Additionally, members of the committee cited anecdotal examples of new pharmacists or technicians having had limited training or onboarding for new roles, which negatively impacted their performance and satisfaction and contributed to patient safety errors. (4)
24. The committee pointed out that existing policy also does not capture the element of employee satisfaction in their roles as it relates to training and onboarding facilitated by employers. The committee debated the addition of "in their roles" as it relates to employee satisfaction, and ultimately chose to strike this language. (4)
25. The committee considered how best to comprehensively describe workplace onboarding and training, and what the intended goals should be for such training. Considerations included descriptions such as "adequate" or "sufficient" and verbs such as "promote" or "facilitate." The committee agreed to use the word "promote," as it seemed most actionable. (4)
26. The committee reviewed the APhA 2019 Pharmacist and Pharmacy Personnel Safety and Well-Being; 2019 Pharmacists Role in Mental Health Emotional Well-Being; and 2012, 2007, 1970 Employment Standards adopted policy statements to identify potential gaps needing to be addressed in relevant policy regarding wellness and training. (4–5)
27. The committee discussed healthy working behaviors, and the modeling of such behaviors by those in leadership roles (such as pharmacists in charge, managers, preceptors, etc.) as positive examples for enforcement. "Healthy working behaviors" refers to a variety of components which may be individualized depending on a staff person's needs. For example, the committee acknowledged that this may include, but is not limited to, the practice of taking meal breaks, designated time and space for exercise, opportunities to engage with meditation apps, etc. (5)
28. The committee opted to avoid overgeneralizations by specifying that healthy working behaviors may be "individualized," acknowledging that different wellness practices work for different individuals. (5)
29. The committee referenced an October 22, 2022, *Wall Street Journal* article when considering how to promote healthy working environments. (5)
    a. *Wall Street Journal* article: Ellis L. Toxic workplaces are bad for mental and physical health, Surgeon General says. N.p.: The Wall Street Journal. Available at: https://www.wsj.com/articles/toxic-workplaces-are-bad-for-mental-and-physical-health-surgeon-general-says-11666230714. Accessed November 11, 2022.
30. The committee referenced multiple recommendations from the 2019 Enhancing Well-being and Resilience Among the Pharmacist Workforce: A National Consensus Conference, that outlined how leadership should prioritize and model well-being and resilience for their workforce. (5)

a. 2019 Enhancing Well-being and Resilience Among the Pharmacist Workforce: A National Consensus Conference: APhA, Accreditation Council for Pharmacy Education, American Association of Colleges of Pharmacy, et al. Enhancing Well-being and Resilience Among the Pharmacist Workforce: A National Consensus Conference. Washington, DC: APhA. Available at: https://aphanet.pharmacist.com/sites/default/files/audience/APhA_Well_Being_Resilience_Report_%200719.pdf. Accessed November 11, 2022.

31. The committee discussed that in some settings, productivity/fiscal measures may be used as the only metrics for performance evaluations of pharmacy personnel; for example, if someone was working solely with prior authorizations, medication therapy management services, comprehensive medication reviews, immunizations, or number of prescriptions filled. (6)
32. The committee discussed implications of behavioral and quality performance metrics in pharmacy, emphasizing that productivity and fiscal measures should not be used as the only metrics for employee performance evaluation. (6–7)
33. The committee identified a need and value in separating the productivity/fiscal and behavioral outcomes for personnel performance competencies into two separate statements. (6–7)
34. The committee provided rationale for including "behavioral" performance metrics, where examples of behavioral competencies outlined by the committee include empathy, active listening, effective communication, and personal responsibility. (6–7)

Summary of Discussion – Just Culture Approach to Patient Safety

1. The policy committee broadly defined just culture as a system in which errors are not attributed to an individual's mistakes, but rather to the totality of a structured environment, system, and workflow. (1–6)
2. The committee recommended intentional ordering of these policy statements to follow a logical progression from outlined just culture principles to encouraged transparency to advocacy to education. (1–6)
3. The committee discussed what the best and most appropriate verb choice would be to convey urgency and agency of the recommendation. Options included "calls for," "demand," "insist," "expect," "urge," etc. The ultimate recommendation to strike this balance was "calls on." (1)
4. The committee discussed the importance of information-sharing between employees and employers following medication errors and near misses. In doing so, the committee recommended this information transfer be deidentified and intentionally included this word within the statement. (2)
5. The committee refers to "deidentified" medication error data as information which does not name the individual staff members involved in a case. This does not necessarily mean deidentified patient data. (2)

6. The committee advocated for explicit support for not only information-sharing of medication errors, but also of near-misses, as near-miss analyses lead to improvements in risk avoidance. (2)
7. The committee noted that implementation of medication error reports varies depending on pharmacy practice site. For example, health systems integrate medication error reporting and just culture approaches in a more centralized manner compared to other pharmacy settings. (3)
8. The committee defined the intent of medication reporting processes as achieving transparency, data-sharing, and overall accountability across pharmacy practice sites. (3,5)
9. The committee noted that, in addition to reporting medication errors, information must also be used to reflect on the root cause of an error and how to improve systems involved. (3, 5)
10. The committee considered combining the ideas of mandatory national reporting systems for deidentified medication errors and encouraged transparency across settings into one shared policy statement. However, they ultimately agreed these were two separate ideas that warrant their own statements within this proposed policy. (3, 5)
11. The committee expressed interest in an industrywide effort to engage in confidential and transparent sharing of learnings and root cause findings that are relevant to reducing risk of medication errors. (3)
12. The committee considered mandatory enforcement of a just culture approach in pharmacy and referenced the tremendous lessons and information that are lost without standardized medication reporting practices. However, the committee opted against making this mandatory, recognizing APhA's limited ability to implement such a mandate, and instead opted to recommend collaboration with other stakeholders such as Institute for Safe Medication Practices (ISMP). (3–5)
13. When considering whether to recommend mandatory reporting, the committee reviewed APhA's 2022, 2018 Proactive Immunization Assessment and Immunization Information Systems policy as an example, which calls for mandatory reporting by all immunization providers of pertinent immunization data into Immunization Information Systems (IIS). (3)
14. The committee noted potential hesitation or pushback against shared medication error information from certain employers, due to personal interests and preservation. (3)
15. The committee discussed the importance of a standardized national documentation and reporting process that is the same across all states, rather than varying from state to state, so that pharmacy personnel are not ultimately burdened with documenting the same error multiple times. (3)
16. The committee reviewed APhA's 2000 Medication Errors policy. In doing so, they noted that the 2000 policy focuses on error prevention, whereas the proposed 2023 policy is intended to address the handling of errors after they are made. (1–3)
17. When discussing the role that pharmacy associations play in advocating for legislation to promote just culture, the committee considered the question of whether boards of pharmacy have the authority to be included in this recommendation. However, it was ultimately

determined that they were not in the best position to do so compared to other stakeholders. (4)

18. The committee considered whether legislation is the only advocacy goal that may be called for in their proposed statement, but determined that legislation is the only true method of regulating medication error reporting practices and the boards of pharmacy involved. (4)
19. The committee raised the need to provide additional protection for professionals who do report their medication errors. Specifically, addressing fear from many health care professionals that the information they include when reporting errors could be used against them. (5)
20. The committee referenced and closely modeled language used in previously adopted policy by the APhA House of Delegates (see 2018 Efforts to Reduce the Stigma Associated with Mental Health Disorders or Diseases) when advocating the development of just culture education and training. (6)

Summary of Discussion – Site of Care Patient Steerage

1. The committee reflected on the existing APhA 2022 Procurement Strategies and Patient Steerage policy and the additional gaps that were unable to be addressed by the House of Delegates during the March 2022 House of Delegates meeting. The following items were identified as key areas discussed by the Committee: (1–2)
    a. The 2022 policy ultimately addresses medication choice, chain of custody considerations, and the integrity of drug.
    b. The 2022 policy addresses mandated procurement strategies which restrict patients' and providers' ability to choose treatment options and that compromise patient safety or quality of care.
    c. The 2022 policy calls for procurement strategies and care models that lower total costs, ensure continuity care, and do not restrict or delay care.
    d. The 2022 policy does not explicitly contemplate the effect that payer-driven mandates have on the specific site where care is delivered and administered. This may be regarded as another strategy to lower costs without clinical benefit.
2. The committee emphasized that while these proposed policy statements have an origin connecting back to the 2022 Procurement Strategies and Patient Steerage policies, the issues around site of care steerage are broader and can stand alone as a separate policy topic within the APhA policy manual. (1–2)
3. The committee discussed to whom and where this policy topic is intended to apply and agreed this referred to specific patient care sites, such as medication administration sites, in addition to the currently uncompensated coordination and business model that must exist to ensure safe, effective, and affordable medication use in these settings. (1–2)
4. The committee outlined that this policy topic overall centers around two ideas: firstly, the elimination of payer-driven mandates for patients to certain sites of care and, secondly, addressing a current gap in the involved business models. (1–2)
5. The committee reviewed the following existing APhA adopted policy in connection to site of care patient steerage: (1–2)
    a. 2020 Coordination of the Pharmacy and Medical Benefit

    b. 2004,1990 Freedom to Choose
6. The committee noted that, while language of APhA's 2020 Coordination of the Pharmacy and Medical Benefit policy addresses compensation of pharmacists for patient care services, there is an opportunity to outline additional members of the pharmacy team in the 2023 policy, such as technicians and other staff involved in billing and care coordination activities (patient financial assistance, prior authorization, appeals, etc.). (1)
7. The committee discussed the role that payers, pharmacy benefit managers (PBMs), and vertical integration play in the implementation of site of care mandates and considered this in the drafting of their policy. (1)
8. The committee discussed the word choice of "shared decision making" versus "provider-informed patient choice" and ultimately opted for "shared provider-patient decision making" to capture both patient agency and health care professionals' exercise of professional judgement. (1)
9. The committee outlined that one of the issues intended to be addressed in this policy topic is that payer-driven site of care patient mandates are often not made with medication safety or quality of care as a priority for the mandates. (1–2)
10. The committee discussed the connection between patients having informed choice in their site of care to the minimization of delays in care coordination. (1–2)
11. In addition to calling for the elimination of payer-driven medication administration policies/provisions restricting access points, the committee discussed a need for specific mention of payment mechanisms to support more functions than simply the medication administration. (2)
12. The committee reviewed the Home Infusion Per Diem HCPCS Code (S9338), which could serve as a model of comprehensive compensation models that covers and creates clarity around services provided and paid for outside of the medication procurement. (2)
    a. "HCPCS code S9338 for Home infusion therapy, immunotherapy, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem as maintained by CMS falls under Home Infusion Therapy"
13. The committee considered potential pushback or questions of timelessness of this proposed policy. The committee noted the potential to sunset or modify this policy in the future as-needed if one day payer-driven provisions no longer restrict patient access to care or lead to other negative implications. (2)
14. The committee noted that part of what this policy advocates for is the pharmacists' ability to bill for all clinical, administrative, and care coordination services. The committee noted there is a magnitude of resources and personnel involved in this work that are not currently compensated and especially not directly compensated. (2)
15. The committee deliberated on how to best capture the payment and billing mechanisms involved and agreed care coordination services for provider-administered medications, often driven or led by pharmacy personnel, are essential to safe and effective medication use. Furthermore, the committee desired to call for payment mechanisms that would include, but not be limited to, only pharmacy providers for these services and as such selected the language of "provider-administered." (2)

16. The committee outlined that, when incorporating payment mechanisms in this policy, the term “comprehensive” covers all health care professionals, including pharmacy personnel. (2)
17. The committee contemplated word choice of “payment mechanisms” versus “compensation mechanisms” in an effort to best capture the need for a billing infrastructure for related tasks. They ultimately opted for “applicable compensation mechanisms” in an effort to be most inclusive. (2)

Employment Standards & Pharmacist-Practice-Payer Responsibilities

Background paper prepared for the 2022-2023 APhA Policy Committee

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2022-2023 Executive Residents

American Pharmacists Association

Issue

The American Pharmacists Association (APhA) Board of Trustees has directed the 2022–2023 Policy Committee to recommend policy to the APhA House of Delegates related to employment standards and pharmacist-practice-payer responsibilities. The Board's guidance on this topic included, but was not limited to, the roles and standards for employees and employers of pharmacists, as well as the responsibilities of pharmacists, patients, prescribers, and payers in patient care.

Executive Summary

Pharmacists continue to demonstrate their essential role in the health care system. According to the CDC, most pharmacies are located within a five-mile radius of residential areas, which makes pharmacists the most accessible health care professionals[1]. Pharmacists, pharmacy technicians, interns, and clerks work vigorously to deliver high quality care and services for their patients. As an organization that leads the profession by example and promotes the evolving role and responsibility of pharmacists, it is vital that we develop recommendations for employment standards through our policy statements that can be implemented across all practice settings within pharmacy. Important components to consider in the policy development process include licensing, training, workplace safety, equal rights/opportunities, benefits, and enforcement of performance standards such as quotas and pharmacist-technician ratios. Recently, APhA has released documents to facilitate conversations between employers/employees on these topics, including the Pharmacists' Fundamental Workplace Responsibilities and Rights.

Definitions

Employment Standards: rules enacted by employers, as well as state and federal regulations, that outline how employers must treat, pay, and protect their employees.

Practice: the discipline of pharmacy, which involves developing the professional roles of pharmacists.[2]

Payer: entity that provides reimbursement to providers in exchange for healthcare services provided to patients.[3]

Pharmacy personnel: individuals working in a pharmacy setting, including pharmacists, pharmacy technicians, and student pharmacists.

Retaliation: an action taken by an employee in response to an action taken by an employer, such as termination or other adverse action.

Background

Employers play an integral role in creating the environment in which pharmacy personnel work through implementation of policies and procedures. This organizational framework has implications for pharmacy practice, and consequently patient safety and outcomes. Pharmacists' workplace environment is inextricably tied to patient safety, as lack of well-being can contribute to medication errors and patient harm. Employment standards within pharmacies have become a widely discussed topic amongst stakeholders in the patient care delivery process, including organizational leadership, individual pharmacy professionals, other healthcare professionals as well as patients. Recent changes to the federal regulatory landscape, including the *Dobbs v. Jackson* decision, have brought to the forefront discussions surrounding the pharmacist/employer relationship. It is important to distinguish that some pharmacists are employers themselves in their practices; for example, a pharmacist who owns an independent pharmacy. also take on the role of employer in their practices. Throughout the course of the COVID-19 pandemic, well-being and burnout in pharmacy professionals have been widely discussed as pharmacists have taken on additional patient care duties of vaccinations, antigen testing, and antibody testing.

Employment Standards

Licensing/Training

Pharmacists are licensed by the state, the District of Columbia, or a territory of the United States where they practice. To maintain state licensure and employment, pharmacists must adhere to their state's continuing education requirements.[4] While individual standards vary between states, all states require pharmacists to complete continuing education with each license renewal cycle.

Employment standards are defined at both the federal and state levels. Federally, the Fair Labor Standards Act (FLSA) establishes such standards as minimum wage and overtime pay.[5] The federal minimum wage is set at $7.25 per hour, though 32 states and territories have set the minimum wage at a higher level.[6] Current APhA policy does not address compensation levels for any pharmacy professional. At the state level, standards and requirements vary significantly.

Training for Employment

To adequately perform their roles, many pharmacists undergo periodic training in areas relevant to their practice. Examples of such training include those focused on upholding HIPAA guidelines, bloodborne pathogens, and cybersecurity. Community pharmacists engaging in certain patient care services may also complete training such as those on immunization, long-acting injectable and/or naloxone administration to perform certain services.

Employee Characteristics

These characteristics could be based upon the organization's mission or on duties required by the job. Examples of such prioritized characteristics include accountability, collaboration, interprofessional communication, time management, and critical thinking. There are also employee characteristics required of every pharmacist, as outlined in state and federal laws, company policies and procedures, and professional codes.

Code Of Ethics for Pharmacists[7]

Pharmacists are health professionals who assist individuals in making the best use of medications. This Code, prepared and supported by pharmacists, is intended to state publicly the principles that form the fundamental basis of the roles and responsibilities of pharmacists. These principles, based on moral obligations and virtues, are established to guide pharmacists in relationships with patients, health professionals, and society.

I. A pharmacist respects the covenantal relationship between the patient and pharmacist.

Considering the patient-pharmacists relationship as a covenant means that a pharmacist has moral obligations in response to the gift of trust received from society. In return for this gift, a pharmacist promises to help individuals achieve optimum benefit from their medications, to be committed to their welfare, and to maintain their trust.

II. A pharmacist promotes the good of every patient in a caring, compassionate, and confidential manner.

A pharmacist places concern for the well-being of the patient at the center of professional practice. In doing so, a pharmacist considers needs stated by the patient as well as those defined by health science. A pharmacist is dedicated to protecting the dignity of the patient. With a caring attitude and a compassionate spirit, a pharmacist focuses on serving the patient in a private and confidential manner.

III. A pharmacist respects the autonomy and dignity of each patient.

A pharmacist promotes the right of self-determination and recognizes individual self-worth by encouraging patients to participate in decisions about their health. A pharmacist communicated with patients in terms that are understandable. In all cases, a pharmacist respects personal and cultural differences among patients.

IV. A pharmacist acts with honesty and integrity in professional relationships.

A pharmacist has a duty to tell the truth and to act with conviction of conscience. A pharmacist avoids discriminatory practices, behavior or work conditions that impair professional judgement, and actions that compromise dedication to the best interests of patients.

V. A pharmacist maintains professional competence.

A pharmacist has a duty to maintain knowledge and abilities as new medications, devices, and technologies become available and as health information advances.

VI. A pharmacist respects the values and abilities of colleagues and other health professionals.

When appropriate, a pharmacist asks for the consultation of colleagues or other health professionals or refers the patient. A pharmacist acknowledges that colleagues and other health professionals may differ in the beliefs and values they apply to the care of the patient.

VII. A pharmacist serves individual, community, and societal needs.

The primary obligation of a pharmacist is to individual patients. However, the obligations of a pharmacist may at times extend beyond the individual to the community and society. In these situations, the pharmacist recognizes the responsibility that accompany these obligations and acts accordingly.

VIII. A pharmacist seeks justice in the distribution of health resources.

When health resources are allocated, a pharmacist is fair and equitable, balancing the needs of patients and society.

**adopted by the membership of the American Pharmacists Association October 27, 1994*

Pharmacists must abide by all laws, both federal and state, that are applicable to their area of practice. Violation of any laws, in addition to company policies and procedures, could constitute grounds for termination. The Pharmacist Code of Ethics, adopted in 1994 by APhA's membership, serves as a guide for pharmacists in their relationships with patients while engaging in the practice of pharmacy.[7] In addition, the APhA and NASPA Boards adopted "The Pharmacist's Fundamental Responsibilities and Rights" in 2021, which were developed as a tool to facilitate conversations between pharmacy staff and their employers.

The Pharmacist's Fundamental Responsibilities and Rights states that pharmacists have fundamental responsibilities, built on principles embodied by the Oath of a Pharmacist, and the Pharmacist Code of Ethics.[8]

- To practice with honesty and integrity
- To seek employment that aligns with their professional goals and personal values and needs
- To be lifelong learners to maintain professional competency and engage in the profession
- To educate their patients and the public to enhance public health
- To make decisions and seek resolutions regarding workplace concerns without fear of intimidation or retaliation from their employer or supervisors

To fulfill these responsibilities, the document asserts that pharmacists have the following fundamental rights:

- To practice pharmacy in the best interest of patient and community health and well-being
- To exercise professional judgment under the auspices of their license when delivering care to patients
- To be treated in a considerate, respectful, and professional manner by patients and supported by employers and supervisors
- To a workplace free of racism, discrimination, bullying, or harassment, as well as physical, verbal, or emotional abuse
- To a working environment where the necessary resources are allocated to provide both legally required patient care services, as well as any additional enhanced patient care services offered
- To reasonable working hours and conditions
- To have a voice in the development of metrics, and how those metrics are used as criteria for performance evaluations of all pharmacy staff

Ethical Behavior

Upon completion of their pharmacy degree program, newly graduated pharmacists recite the Oath of a Pharmacist, as updated in November 2021. The updated Oath incorporates themes of promoting diversity, equity, and inclusion throughout pharmacy practice.[9] Adherence to the Code of Ethics for Pharmacists as well as the Oath of a Pharmacist establishes pharmacists as trusted resources for patients and other health care providers alike.

Oath Of A Pharmacist

The revised Oath was adopted by the AACP Board of Directors and the APhA Board of Trustees in November 2021. AACP member institutions should plan to use the revised Oath of a Pharmacist during the 2021-22 academic year and with spring 2022 graduates.

"I promise to devote myself to a lifetime of service to others through the profession of pharmacy. In fulfilling this vow:

- I will consider the welfare of humanity and relief of suffering my primary concerns.
- I will promote inclusion, embrace diversity, and advocate for justice to advance health equity.
- I will apply my knowledge, experience, and skills to the best of my ability to assure optimal outcomes for all patients.
- I will respect and protect all personal and health information entrusted to me.
- I will accept the responsibility to improve my professional knowledge, expertise, and self-awareness.
- I will hold myself and my colleagues to the highest principles of our profession's moral, ethical and legal conduct.
- I will embrace and advocate changes that improve patient care.
- I will utilize my knowledge, skills, experiences, and values to prepare the next generation of pharmacists.

I take these vows voluntarily with the full realization of the responsibility with which I am entrusted by the public."

Workplace Safety

The safety of workplace environments is maintained through employer and employment standards integrated into policies and procedures. The Occupational Safety and Health Administration (OSHA) within the Department of Labor provides guidance to employers on standards that must be followed to keep employees safe.[10] In the case of pharmacy personnel, their safety directly translates to the safety of patients. Pharmacy personnel often work in environments with higher likelihood of occupational hazard exposure, including respiratory and bloodborne pathogens. Compliance to OSHA standards ensures that personnel can complete their respective duties safely while providing necessary patient care services.

Workplace Harassment

Employment standards not specific to health care professionals include those focused on harassment, discrimination, and retaliation. Among other federal entities, OSHA enforces several whistleblower laws that prohibit employers from retaliating against employees for engaging in protected activities. Retaliation can occur in the form of termination, demotion, or discipline.[4] Employees have the right to file a whistleblower complaint with OSHA if they believe their employer retaliated against them while exercising rights under the whistleblower protection laws. OSHA also provides resources for employers to create their own anti-retaliation programs within their workplaces.

Equal Rights and Opportunities

Employees are protected from harassment and discrimination through several federal laws. The Civil Rights Act of 1964 prohibits employment discrimination based on race, color, religion, sex, or national origin. The Americans with Disabilities Act of 1990 prohibits employment discrimination against individuals with disabilities. These laws cover all private employers, government employers, and education institutions that employ 15 or more individuals.[11] Employees who believe their employment rights have been violated may file a discrimination charge with the Equal Employment Opportunity Commission.[11]

Diversity, equity, and inclusion are also key elements to facilitate a welcoming environment for all patients and staff while combatting systemic prejudices. We as health care professionals take an oath to treat and provide care to everyone equally, irrespective of their age, gender identity, sexual orientation, and race. It is vital that we reinforce the concept of diversity, equity, and inclusion for employees and patients. Pharmacists must advocate for equal opportunity, accountability, and culture transparency amongst all individuals in their care.

Employee Benefits

The Department of Labor also provides guidance on employee benefits. The Employee Retirement Income Security Act (ERISA) regulates employers who offer pension options to their employees. In addition to wage and overtime pay, the FLSA covers many other employee benefits. While federal law does not require meal breaks, most employers allow them for employees. Walgreens became the first national pharmacy chain to implement mandatory 30-minute lunch breaks for their pharmacy personnel in 2020, with CVS following suit in 2022.[12,13] In response to increasing reports of dangerous workplace environments, Illinois passed aggressive legislation in 2020 that required pharmacists take meal breaks to promote pharmacist and patient safety.[14]

Although it is not required by the law to pay extra for employees working nighttime, the FLSA does require that non-exempt workers be paid time and one-half of the employees' regular rate for overtime beyond 40 hours. Usually, extra pay for the night shift is dependent on the employer and the agreement they create with the employees. Some states have overtime laws, in this case, the employee must follow state and federal laws. Additionally, under the FLSA an employer is not required to make payments for time not worked such as vacations, holidays, and sick leave. However, some of the benefits may be an agreement between an employee and the employer.[15]

As per the Federal Law, for those seeking to balance professional and personal responsibilities, eligible full-time employees can take up to 12 weeks off within a 12-month period under Family Medical Leave Act (FMLA) for the following eligibility criteria outlined by the U.S. Department of Labor[16]:

- The birth of a child and to care for the newborn child within one year of birth
- The placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement
- To care for the employee's spouse, child, or parent who has a serious health condition
- A service health condition that makes the employee unable to perform the essential functions of his or her job
- Any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered miliary member on "covered active duty"

For nursing mothers, under the FLSA of 1938, employers are required to provide reasonable and adequate break time for the nursing mothers. However, the law does not require for the break time to be compensated.[17]

No employer can terminate employment under FMLA. This act applies to public agencies, public and private schools, and companies with 50 employees or more. The eligibility criteria for an employee to meet the standards for the FMLA, that one must have worked for the employer for

at least 12 months, should have 1,250 hours of service in the past 12 months and an employer must have at least 50 staff members within the 75-mile radius. If conflict occurs, an employee is eligible to file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may pursue a private lawsuit against an employer.[16]

Performance Standards

Pharmacy performance standards are often enforced to measure quality and function of pharmacies, pharmacist-provided services, and pharmacy-based services for continuous quality assessment and improvement. This may include quantifying prescription data and quotas, establishing procedures for handling patient complaints, enforcement of pharmacist-technician ratios, and more. There is often great utility in these standards, and the analysis of their resulting data. For example during the COVID-19 pandemic, as pharmacists' role and scope of practice was advanced through additional responsibilities such as Paxlovid test-to-treat, pharmacy personnel continued to work diligently to meet required quality metrics. The quantified outputs generated were then used to demonstrate the value of pharmacists, pharmacy staff, overall business revenue, and patient outcomes.[17]

However while performance measures may provide objective standards to assess and incentivize pharmacy performance, they may also yield unintended negative effects on pharmacy personnel, and even detract from patient safety. For example, chain pharmacies have been accused in recent years of holding their pharmacy personnel to unattainable quotas, leading to strained resources, burnt-out staff, and potential medication errors. In response to such practices, the California Pharmacists Association went as far as to co-sponsor a state law in 2021 to prohibit the practice of imposing certain quotas on pharmacists and pharmacy technicians' duties.[18] Other states such as Florida and Tennessee have deliberated pharmacist-technician ratios, and their effects on both patient safety and operational efficiency.[19] On the one hand, larger ratios provide more personnel support to the pharmacist. However on the other hand, this also means a greater challenge of oversight on the pharmacists' part. All these standards and more are critical to consider in the discussion of overall employment standards.

Conclusion

Pharmacists are the most trusted and accessible health care workers. It is imperative we take accountability and to not only consider clinical and financial outcomes, but to also create safe and ethical working conditions for pharmacy personnel. Ensuring the empowerment and well-being of pharmacists, pharmacy technicians, and pharmacy interns ultimately optimizes patient care. Setting standards for employment within the pharmacy profession will serve as a guide and set expectations for employers and employees. As a result, this could potentially improve pharmacy practice and optimize quality of care.

Related APhA Policy[20]

Current Adopted Policy Statements, 1963-2021

2021: Anti-Racism in Pharmacy

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: 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; July/August 2021)

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)

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 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 negatively affect patient safety.

(JAPhA. 58(4):355; July/August 2018) (Reviewed 2020) (Reviewed 2021)

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)

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)

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)

2011: Requiring Influenza Vaccination for All Pharmacy Personnel

APhA supports an annual influenza vaccination 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)

2001: Employee Benefits

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)(suppl1):S10; September/October 2001) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2019)

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)

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Just Culture Approach in Pharmacy

Background paper prepared for the 2022-2023 APhA Policy Committee

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Issue

The American Pharmacists Association (APhA) Board of Trustees has directed the 2022–2023 Policy Committee to recommend policy to the APhA House of Delegates related to the Just Culture Approach in Pharmacy. This policy recommendation comes almost five years after a fatal medication error committed by former nurse RaDonda Vaught in 2017 gained national infamy, and recently culminated to a jury conviction for criminally negligent homicide and impaired adult abuse, along with a sentence to three years of probation.

Summary of key concepts

- Medical errors are an inevitable aspect of health care delivery that adversely affects patients, health care practitioners, and institutions.
- Health care delivery is an intricate, multidisciplinary, and multifaceted process, making it challenging to entirely eliminate all opportunities for error.
- Despite the numerous efforts put in place to diminish errors, health care delivery continues to result in some medical errors that translate into adverse health care outcomes such as disease mismanagement and, in severe cases, preventable deaths.[1]
- Just culture entails a system of shared accountability, as opposed to individual blame.[2]
- To err is human; however, consistent coaching, corrective action, and remedial training can help to ensure accountability for error prevention.
- In 2000, Albert Wu coined the term, “second victim.” The second victim is the provider who is involved in a patient safety event/medical error who subsequently becomes traumatized by the event.[3]
- Health care employers should consider implementing a “second victim” support program

Definitions

Just culture

Just culture is “model of workplace justice intended to create fairness for providers and create better outcome for patients. It is about creating a common language to evaluate provider conduct.”[4]

Human error

When there is general agreement that the individual should have done other than what they did, and in the course of that conduct inadvertently causes or could cause an undesirable outcome, the individual is labeled as having committed an error.[5]

Medical error

An avoidable adverse outcome of medical care efforts with or without proof of harm to the patient.[6]

Negligence
Failure by an individual to exercise expected care, including a minimal demonstration of caution and awareness for substantial and unjustifiable risks.[5]

Recklessness
Conscious disregard of substantial and unjustifiable risk when conducting patient care.[5]

Background
Medical errors are a phenomenon that have always existed in health care delivery. Although, the way they have been handled in recent years have led to increased scrutiny. The verdict of the 2017 medication error case involving nurse, RaDonda Vaught, raised many concerns for health care workers all over. In this case, RaDonda Vaught, a nurse at Vanderbilt University Medical Center accidentally gave a dose of vecuronium, a powerful paralyzing medication, instead of Versed. The drug left RaDonda's patient brain dead. As disturbing as RaDonda's actions are, the details following the error created a myriad of issues that led to an intense and high-profile case.

A medical error is an avoidable adverse outcome of medical care efforts with or without proof of harm to the patient.[6] Some common medical errors experienced in the health care delivery process include misdiagnosis, improper transfusions, and incorrect medication administration. This can result in over and under treatment, wrongful surgeries, adverse drug events, and more.[6] Unfortunately, medical errors are impossible to eliminate entirely from health care delivery and can adversely affect patients, health care practitioners, and institutions. Understanding medical errors is, therefore, crucial in designing and developing care processes that ensure patients are safe from accidental harm through a holistically safe health care system.[7] Some systemic and structural barriers impeding optimal patient safety include the inability to admit and concede fallibility, financial limitations undermining care operations, harmful status quo, and professional norms of hierarchy and perfectionism.[8]

From a general outlook, just culture refers to an organizational practice in which staff members, and especially front-line operators, are exempted from punishment for decisions, actions, or omissions taken or committed by them. Instead, it is the organization as a whole that assumes responsibility, so long as willful violations or harm have been ruled out. Therefore, in an organization where a just culture is practiced, staff members may feel safer to admit and speak up about their own mistakes or omissions and those of others without fear of retaliation.[9] In this situation, employees are not named, shamed, and blamed for errors made without malice or intent during service delivery. Ultimately, just culture entails identifying systemic flaws and introducing solutions that promote patient safety while maintaining a practice that eliminates discriminatory and harsh punishments for individuals involved in medical errors.[2] This is because a method that punishes individuals who fall short during the patient care process often results in a practice where failures and mistakes go unreported, covered up, or ignored. In any patient safety event/medical error, the first victim is the patient. The "second victim" is the health care professional who is involved in a patient safety event/medical error who subsequently

becomes traumatized by the event.[3] Several studies have shown that second victims can experience significant emotional distress, including but not limited to anxiety, depression, guilt, sleep disturbances, loss of confidence in their practice, and decreased job satisfaction.[3] How do we provide support for the health care professionals involved in medical errors? How do we make sure that we are creating a healthy and safe work environment post medical errors? Studies have shown that the most effective management of second victims includes the support of health care professionals by peer colleagues from within their own specialty.[3] While support from friends, significant others and supervisors are important, most health care professionals prefer support from a trusted colleague, which has prompted several institutions to implement robust second victim response teams.[3] Receiving support from a colleague from within one's own specialty offers a sense of shared understanding about the complex nature of patient care. It also normalizes the situation for the affected professional. Peer support teams that are trained to provide emotional first aid are also incredibly beneficial.[3] Creating a strong support network can help to lessen the effects of Second Victim Syndrome.[3]

In a health care delivery context, just culture is thought to provide a framework that attempts to ensure optimal patient safety through a patient-centered system. A system that is thought to work towards better synchronization of workplace processes. Implementation of this system is done by developing and maintaining a professional work culture and ecosystem. An ecosystem that supports and encourages their staff members through a systemic understanding that leaves room for human error. However, it is imperative to note that while the idea of a just culture approach sounds good, a fine line remains between medical errors made due to legitimate versus illegitimate behaviors. When determining if legitimate or illegitimate behaviors contributed to a medical error persons must assess the organization's standard operating procedures as well as all other variables present during that time. Overall, accountability should remain at the forefront of everyone's mind when an error occurs. Accountability should be executed through consistent coaching, corrective action, and remedial training. Just culture should never excuse illegitimate behaviors under any circumstance. This raises the question, if a just culture approach pushes shared accountability and puts a spotlight on a flawed process will health care employees gain or lose accountability?

Behavioral Explanation: Human Errors (Rasmussen's Human Error Model)

Despite the simplicity of the phrase "human error," which might be understood merely as errors tied to healthcare professionals, it is imperative to acknowledge that the health care delivery process occurs within complex sociotechnical systems. Oftentimes this involves both technical and human components working harmoniously to achieve specific desired outcomes.[10] Rasmussen's Human Error Model is a theoretical model developed by Jens Rasmussen and is typically used in aviation to analyze system safety and the involved human factors. Also referred to as Rasmussen's SRK Model from the skill-rule-knowledge parameters that guide the model, this theoretical framework factors in and analyzes human behavior and decision-making within a man-machine ecosystem and the resulting errors.[11]

Rasmussen's model introduces a shift away from focusing on individuals' roles in human error, but rather a need to consider context of the processes involved.[12] Ultimately, this rationale poses the need to view errors as a difference between the desired state and an actual state.

Personal factors are one of the main issues tied to the involvement of human errors in health care delivery. Human factors in this context refer to how health care practitioners interact with devices, products, and gadgets in their daily professional environment. Health care professionals often encounter equipment or sophisticated work environments that result in compromised or less than optimal performance. Failure to consider human capacities, strengths, and limitations when designing products results in gadgets and devices that are inefficient, unsafe, confusing, and challenging to use.[13] As complicated and unfamiliar things easily disorient humans, the health care sector must work towards maintaining a standard in the production of goods by observing efficient specifications such as color codes and standard model designs. Design in stimuli on medical equipment, such as flashing lights and beeping tones, should be of appropriate intensity where necessary.[13]

Another factor centered on human behavior that constitutes a significant percentage of medical errors is communication difficulties among health care practitioners.[7] Studies in this field have also shown medical errors involving surgical procedures increase significantly where there are issues with communication, leadership, interpersonal relationships, information transmission, and conflicts. Therefore, to establish a patient-centered care model, it is imperative to address issues with communication. This will significantly help in the implementation of a just culture model.

While just culture is intended to cater to medical errors that inevitably and unintentionally arise from the interaction of various elements in the healthcare delivery process, sometime healthcare professionals might engage in practices that amount to violations. When health care practitioners knowingly engage in at-risk behavior that wrongly justifies a risk or fails to identify risk, such practices are considered violations. Negligent behavior that consciously fails to acknowledge risks resulting in a medical error is also regarded as a violation.

Variables Influencing Patient Safety and Medication Errors

A. State-level Pharmacy Practice

The health care sector in its entirety remains highly regulated. Pharmacy practice just as other professions is highly regulated at the state level, resulting in inconsistencies in various definitions of pharmacy practice. With standards of care continuously changing as more research is being undertaken towards optimizing the quality of patient care, most states still require changes in the law to affect changes in pharmacy practice. However, in an ideal healthcare system, a "standard of care" model would facilitate flexibility within the structures of pharmacy practice allowing pharmacists and other professionals within the practice to follow permissive and logical systems rather than rigid prescriptive regulations.[1] In October 2021, NABP Task Force met and agreed that board members and staff need to know how to distinguish errors that are due to human error, at-risk behavior, or reckless behavior and that

punitive discipline is acceptable in cases where reckless behavior affected patient safety.[14] They went on to say, boards should be encouraged to instruct licensees to adopt organization-wide improvement plans where all involved are engaged in evaluating and correcting medication error issues.[14] Ultimately, the NABP Task Force recommended the following:

1. NABP should explore the development of a medication safety training academy for board members, compliance officers, and NABP surveyors. Implementation would include the following:
    a. Allocating money/resources through the NABP Foundation
    b. Focusing on the need for culture change – making it a priority will allow for change
    c. Utilizing existing resources, such as interactive forums and the Annual and District Meetings, as educational tools to make an ongoing commitment to support an evolving process
    d. Identifying potential partners
    e. Develop expertise and serve as a resource for effective regulatory approaches and implementable tools, which include nonpunitive accountability actions such as corrective action plans developed from peer review and robust continuous quality improvement programs, third-party monitors, and apology letters. In addition, NABP should survey the states to obtain additional examples.
    f. Soliciting input from members of the Tri-Regulator Collaborative
2. NABP should compile relevant resources that can be provided to boards of pharmacy and licensees and use its communication vehicles to disseminate such resources. In addition, NABP should:
    a. Create a medium of exchange and encourage boards of pharmacy to contribute/publish examples of medication errors and corrective actions taken to highlight safety problems;
    b. Consider establishing a community pharmacy safety newsletter; and
    c. Consider providing ISMP Medication Safety Alert! newsletters to boards of pharmacy and others.

B. Demanding Workload

Studies indicate that the workload assigned to a health care professional is directly associated with the quantity and frequency of medical errors incurred in the course of health care delivery.[15] Understaffing in health care facilities means a heavier workload for health care professionals, which ultimately endangers patient safety due to increased medical errors.[16] Research on this issue indicates that inadequate staffing ratios result in burnout and fatigue from challenges such as insufficient equipment preparation, poor patient supervision, and inefficient nursing and medical care documentation. All these challenges contribute to increased medical errors. Inadequate provision of effective feedback channels also results in medical errors.

C. Values & Expectations

While it is imperative to correctly identify and remedy the involvement of individual health care practitioners in the occurrence of medical errors, there is a growing acknowledgment that some of the mistakes made in the course of health care delivery are out of their control.[1] The values and expectations bestowed upon health care practitioners within their institutions also determine

the occurrence and frequency of medical errors. Values that tolerate staff abuse and misuse within health care organizations often result in medical errors as these factors undermine their performance. Similarly, values that fail to advocate for ethical practices in all facets of health care delivery, including the pharmacy sector, often result in medical errors. Ultimately, health care organizational cultures that do not expect healthcare professionals to strive towards patient-centered care through patient advocacy and satisfaction significantly contribute to medical errors. Poor health care management commitment, absence of standard treatment reference materials or protocols, and poor orientation of new staff play a role in perpetuating a culture of medical errors.

While a just culture approach attempts to minimize medical errors without pointing blame to individuals, it is crucial to recognize that this approach should not condone conscious and reckless disregard of obvious risks to patient safety or gross misconduct. Some of these violations include falsifying records and performing duties outside of protocol.[13] Organizations should outline zero tolerance for toxic and inefficient work cultures and unethical practices that undermine patient safety and cause patient dissatisfaction. If an organization fails to take accountability, and merely punishes individual practitioners instead, the error's root cause may fail to be identified.[16] Organizational curiosity and investigations into root causes for error are important to ensure zero tolerance for repeated medical errors due to reckless and/or negligent behavior in the future. In RaDonda's case, she had willingly come forth about her mistake to the hospital when it occurred. However, the organization decided to attribute the patient's death to natural causes until a whistleblower came forth. The error was not reported to state or federal officials, as required by law, or The Joint Commission, an accrediting agency that recommends but does not require reporting.[17] These are all actions that the hospital administration would be responsible to follow through on in a just culture.

D. Legislation and Medical Error Reporting

In any efforts towards implementing a just culture model in pharmacy practice, well-crafted legislation is capable of playing a major role in facilitating patient safety by establishing a framework and structure for evidence-based interventions, learning, and change implementation at system and organizational levels.[8] Legislation cannot function alone without good leadership. This is because effective leaders ensure that regulations are interpreted appropriately and entrenched into the organizational culture. Whether or not a just culture approach model is implemented in pharmacy, organizations must be able to ensure accountability when an error is made.[8] Policies should provide a framework that promotes healthy information sharing and open discussions. They should also encourage disclosure of incidents to patients and their families or care providers. Lastly, the policies must promote trust within the practice through transparency and enable objective analysis of, and learning from, incidents.[8] Essentially, the goal of the policies should focus on outlining clear expectations for handling patient safety incidents.

Some of the potential types of patient safety legislation that may be implemented within pharmacy practice include: mandatory reporting which involves engaging third parties when patient safety incidents occur, mandatory disclosure which ensures affected patients and their families are aware of a medical error, apology protection which provides that an apology is not

equivalent to admission of fault or liability, and quality assurance which makes quality assurance information inadmissible in legal proceedings.[8]

Implementing Just Culture in the Pharmacy Sector

The World Health Organization (WHO) defines patient safety as mitigation of risk of unnecessary harm or the absence of preventable harm inflicted upon a patient during health care.[9] Patient safety entails efforts aimed at minimizing any form of harm that the patient might experience during treatment.[9] Health care is a multi-faceted system that involves various processes and is not one hundred percent error proof. Medication safety, a major aspect of patient safety that is often led by pharmacy, involves efforts to prevent medication-related harm and medication errors. This translates into optimizing the safe use of medication at every stage of the patient's medication use process and notably at the points of care transition. Ensuring proper medication procedures is an intricate process often involving multiple organizations and individuals from different disciplines. This is because medication therapy requires input from other stages and areas of healthcare delivery, such as diagnostics and testing. The pharmacy is the critical link between the patient and medication, which makes it imperative to develop an optimal patient safety culture as a pillar of the pharmacy sector.

While the just culture model is a fairly new approach in healthcare, this concept has been in practice in fields such as aviation for a long time. Since the 1970's, the aviation industry has fashioned an almost standard practice where in the event of an error or an adverse event, the focus lies on the circumstances under which the error was made and not necessarily on identifying the individual who made the error.[7] Can this be effectively replicated in the pharmacy sector?

Conclusion

The just culture model depicts a system of shared accountability, as opposed to individual blame.[5] Under this model, errors and adverse events are not merely issues that need fixing but opportunities that need to be exploited to better the processes involved. However, does the just culture approach effectively ensure that employees are held responsible for reckless and negligent behavior? Where do we draw the line between legitimate versus illegitimate behaviors that lead to medical errors? How do we factor in personal and environmental variables? All of these questions deserve to be addressed to improve the practice of pharmacy.

Related APhA Policy

- **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 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. 2020;60(5):e10)

- **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. 128

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 nonpunitive 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)

- **2012 Medication Verification**
  1. 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)

- **2001 Administrative Contributions to Medication Errors**
  1. APhA encourages implementation of a standard 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 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 preadjudication 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 online 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)

- **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)

- **2000 Medication Errors**
  1. APhA, as the national professional society of pharmacists, will work to ensure that 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 nonpunitive 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)

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Site of Care Patient Steerage Related to Bagging Practices

Background Paper
2022-2023 APhA Policy Committee

Issue

The American Pharmacists Association (APhA) Board of Trustees has directed the 2022–2023 Policy Committee to recommend policy to the APhA House of Delegates surrounding site of care patient steerage related to bagging practices. This subject comes as an extension of NBI #4 of the 2022 APhA House of Delegates raised by the Health System Strategy Council (HSSC), which discussed policy on procurement strategies and patient steerage related to practices such as brown bagging, white bagging, and clear bagging. Two of the three proposed policy statements were amended and adopted, leaving one proposed policy statement and topic to be referred to the 2023 cycle.

Executive Summary

Increasingly more health systems are affected by bagging policies, in which payers have vertically integrated with pharmacy benefit managers (PBMs) so that pertinent medications may be filled by a PBM-owned specialty pharmacy. Whereas the policy statements adopted policy in the March 2022 House of Delegates largely addressed subjects of patient steerage of medication therapies and clinician procurement strategies, the 2023 Policy Committee is charged with addressing the additional nuance of patient steerage of site of care, or site of administration. In other words, the committee will dive into the nuanced impact that bagging practice may have on patients' choice of where their medications may be given.

As part of payer bagging policies, patients are often limited to where certain medications that need to be injected or administered can be dispensed and in which setting the medication can then be administered. These policies raise concerns of patients' timely access to medications, maintenance of integrity of the drug chain of custody, and autonomy for patients and pharmacists.

Background Cited Directly From 2022 New Business Item #4 – Received 2/15/22

Over the past years, many health systems have been affected by payer healthcare coverage policies, also referred to as 'bagging.' Several payers have vertically integrated with pharmacy benefit managers (PBMs) and specialty pharmacies which may incentivize payers to steer patients to fill clinician-administered-medications at a PBM-owned specialty pharmacy. This model is different from traditional buy-and-sell models of medication billing, in which a single provider may be responsible for the purchase, storage, and administration of a medication, and then compensated for both the product and service accordingly. In bagging models, these responsibilities are split among a greater chain of players – including providers, specialty pharmacies, and health care systems involved in medication administration. For example, once the medications are filled by one party, they are shipped either to the patient (brown bagging) or directly to the patient's health system (white bagging) where the medication will be administered. Medications utilized in bagging policies are often intravenous drugs, requiring support by the provider for administration, wherein the provider is left with only the professional component of reimbursement.

The chain of custody for how medications are filled, transported, and administered differentiate the different bagging terms:

- **Brown bagging:** The patient picks up a prescription at a pharmacy and takes the medication to the provider's office for administration. (Figure 1)
- **White bagging:** A specialty pharmacy, predominantly at the discretion of the provider, ships the patient's medication directly to the provider, which holds the product until the patient arrives for treatment. (Figure 2)
- **Clear bagging:** A provider's internal specialty pharmacy (e.g. Health-system-owned specialty pharmacy) dispenses the patient's medication and transports the product to the location of drug administration. (Figure 3)
- **Gold bagging:** Refers to a proposed gold standard model, incorporating a transparent patient-centered clear bagging approach while also recognizing the key role and steps of the pharmacy process.

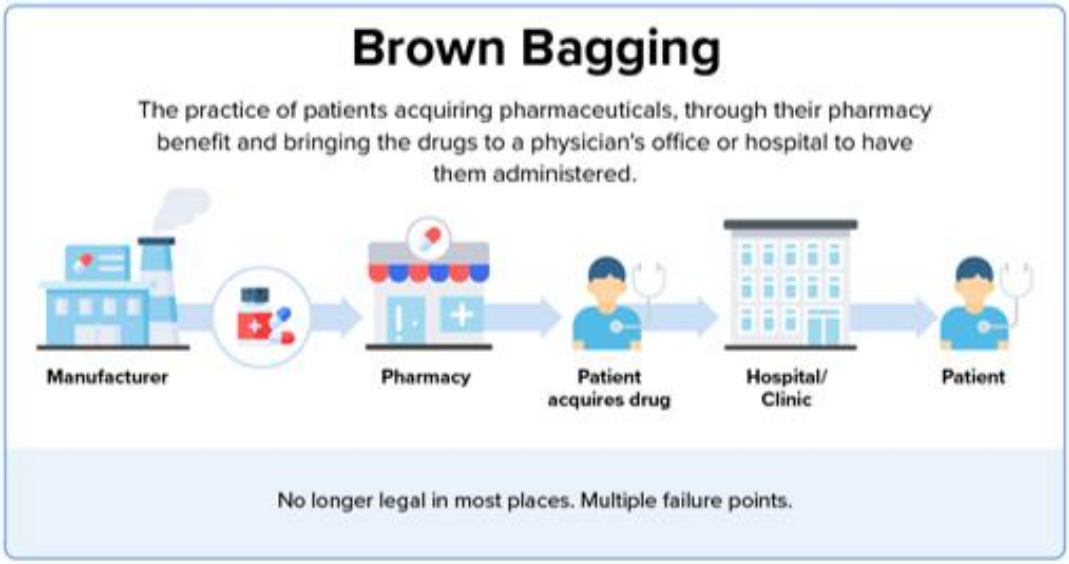

Figure 1, *Emerging Pharm Trends.* Health System Owned Specialty Pharmacy Alliance. May 2021.

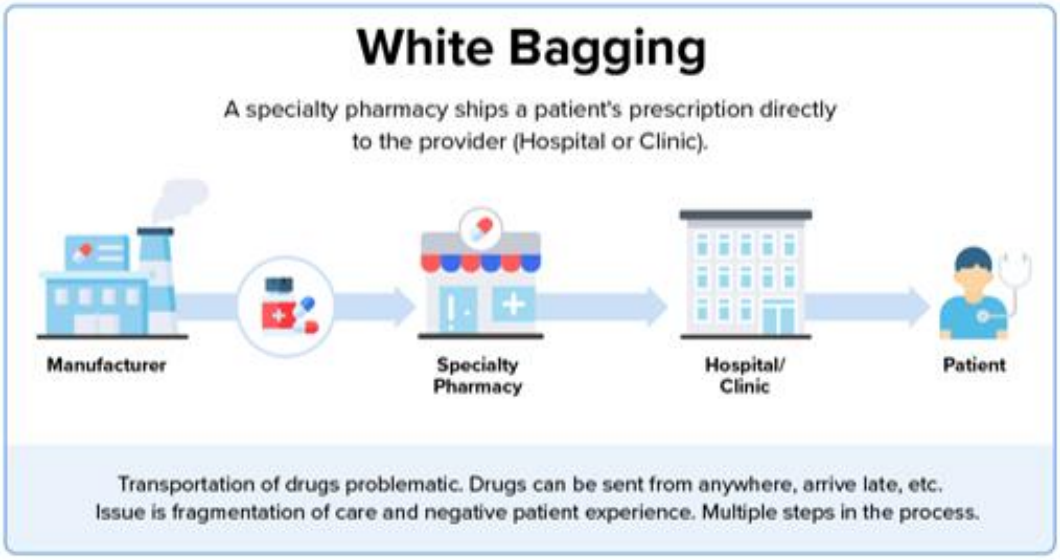

Figure 2, *Emerging Pharm Trends.* Health System Owned Specialty Pharmacy Alliance. May 2021.

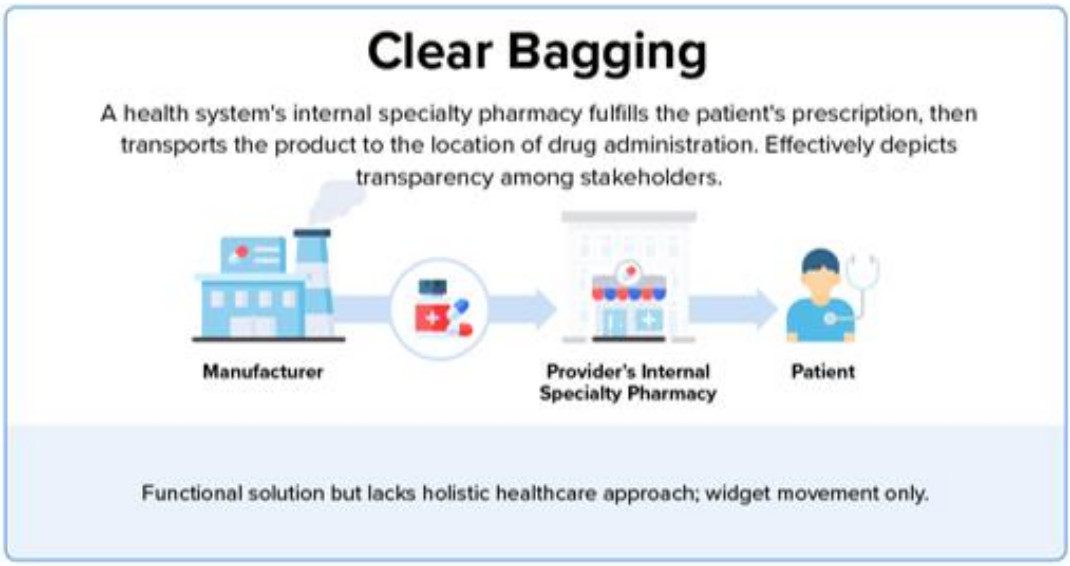

Figure 3, *Emerging Pharm Trends.* Health System Owned Specialty Pharmacy Alliance. May 2021.

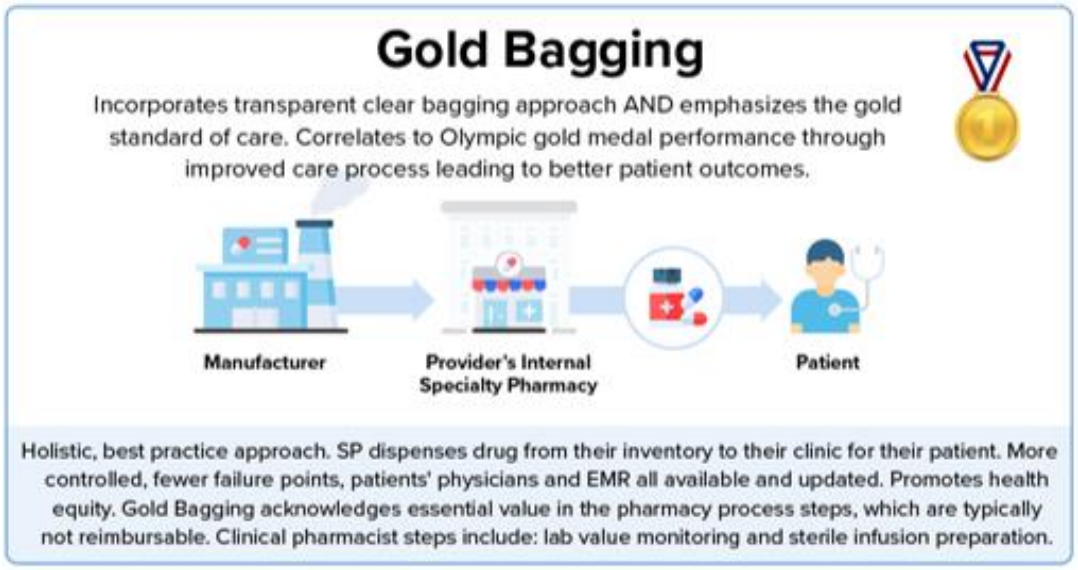

Figure 4, *Emerging Pharm Trends.* Health System Owned Specialty Pharmacy Alliance. May 2021.

Bagging policies ultimately impact the patients being treated. Common issues arising from bagging policies include:

- The most tangible provider opposition to bagging is grounded in lost revenue and reduced profit from the loss of margin from drug buy-and-bill. While supplemental to the professional component of reimbursement, it is often seen as covering the order, dose and sterile room preparation of infused therapies, the last of which has a significant fixed cost of facility.
- Outside of these reimbursement considerations bagging policies do not mitigate, and may increase, handling costs associated with the drug. Providers incur costs for handling and storage in separate, patient-specific, inventory of product and associated assurance that the product is available and accessible (ex. associated disposable medical equipment (DME)), when the patient arrives for treatment.
- Beyond financial considerations, the below logistical aspects have called into question the viability of bagging policies and have been used to ground consensus in opposition across provider and patient stakeholders:
    - Therapeutics are patient-specific, wherein treatment regimen changes that exclude or minimize its use or in situations where the entire vial is not used, the medication must be discarded. The provider and patient (copay) bear the burden, similar to picking up a prescription which is then not used. Disposal may require costly special handling at the expense of the provider.
    - Not only is storage still required but must be separate from buy-and-bill drugs as they are patient specific. Even among hospital pharmacies, white bagging can be a storage and logistics issue.
    - As these drugs are processed a patient-specific medication, they often do not go through the checks and balances of the order-entry system. Thus, pharmacy errors, from dosage to strength, may be more difficult to catch.
    - As with any mail-order service, drugs are not always delivered to the right place or in-time for the patient's appointment. This can leave providers racing

to institute alternative treatment plans, which may involve pulling from their own inventory of product to ensure the patient is treated on time. A point seized upon by legislators, as detailed below, this contrasts with buy-and-bill where the pharmacy has the drugs or ensures the distributor delivers the drugs in time.

- Additional handling costs may be incurred to comply with track-and-trace and drug pedigree laws, including the Drug Supply Chain Security Act, and other state laws

Site of Care Patient Steerage

Among the many implications of bagging policies as listed above, one of the most personal to patients is the maintenance of their autonomy – both in their medication therapy and the sites involved in obtaining them. While bagging practices are often framed as "savings enhancing", they often force health systems to shift away from the traditional buy-and-bill models of obtaining patient-specific medications in favor of directing patients to associated specialty pharmacies. Such bagging practices may introduce the need to coordinate with multiple pharmacy and health-system settings for the purchase, storage, administration, and claim adjudication of the patients' medication.

Surveys have found that patients may experience unnecessary anxiety of when and where they will receive timely and appropriate care, as they track the status of their medication along the multi-step bagging chain of possession. A certain level of this uneasiness may be attributed to patient steerage, directing patients away from their usual preferred pharmacies in favor of PBM-owned specialty pharmacies. These alternate locations may be less preferable to the patients for any number of reasons, including preferred proximity to their home or workplace, preferred health care personnel, or more.

Advocacy Efforts Related to Drug Supply Chain Integrity

To date, multiple national associations have been involved in advocacy efforts to prohibit health plans and pharmacy benefit managers from requiring white bagging of clinical-administered drugs – including APhA. In addition to advocating on behalf of provider and patient interests, these associations have also appealed to the interests of regulatory agencies by highlighting the patient safety and drug supply chain concerns of white bagging. For example, from a Drug Supply Chain Security Act (DSCSA) perspective, bagging practices entail an extensive track-and-trace system to enforce optimal safety and quality of care. The inherent shared responsibility among all parties involved in bagging practices raises questions of liability and enforceability – especially as it relates to mandated sites of care.

From a state perspective, an increasing number of states have moved to regulate white and/or brown bagging practices, such as California, Georgia, Indiana, Louisiana, Massachusetts, New Jersey, Texas, and Wisconsin. These may present in action of the state Board of Pharmacy or Department of Health level, bills to amend state insurance codes, and even bills to ban payors from mandating white bagging of specialty medications.

Existing Policy

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)

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 mergers and acquisition 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)

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)

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):441; July/August 2017) (Reviewed 2019) (Reviewed 2020)

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)

1978 Postmarketing Requirements (Restricted Distribution)

1. APhA opposes any legislation 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)

References:

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APhA House of Delegates New Business Review Committee Report
Phoenix, Arizona

New Business Review Committee
Matthew Lacroix, Chair
Ally Dering-Anderson
Sarah Derr
Shane Garrettson
Mary Gurney
Brian Hose
Matthew Kirchoff
John Pieper
Traci Poole

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

NBI #1 – Development of veterinary pharmacy curricula in schools and colleges of pharmacy and pharmacy technology

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

1. APhA encourages schools and colleges of pharmacy and pharmacy technology to develop ~~curriculums~~ curricular opportunities for student pharmacists ~~that educate pharmacists, student pharmacists, and pharmacy technicians~~ to attain competencies in the principles of veterinary pharmacotherapy.

The committee recommends amendment of the proposed policy statement, noting that the development of "curricula" in principles of veterinary pharmacology may be more prescriptive and restrictive than intended. "Curricular opportunities" reflect the overall intent and principles for this policy.

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

2. APhA encourages training of pharmacists and pharmacy technicians in the principles of veterinary pharmacotherapy.

The committee recommends addition of a second statement, to capture experiential education and training for pharmacy personnel in the principles of veterinary pharmacy.

NBI #2 – Uncompensated Care Mandates in Pharmacy

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

1. APhA ~~expects~~ calls for appropriate payment ~~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 all mandated pharmacist and pharmacy-provided services.

The committee recommends amendment of the proposed policy statement to maintain brevity, while also capturing the original intent to target payment for mandated pharmacist services. The committee also notes that "calls on" may be a stronger verb for this subject and intended audience.

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

2. APhA calls for ~~expects that all government entities, manufacturers, and~~ payors ~~incorporate~~ to be transparent and perform comprehensive cost analyses ~~associated~~ with the implementation of new programs ~~in establishing reimbursements for~~ requiring pharmacist-provided patient care services.~~, medical products and supplies, and related administrative services~~.

The committee recommends amendment in the interest of brevity, while still capturing the original intent of advocating for cost analyses to determine appropriate payment for pharmacist services.

NBI #3 – Access to Reproductive Health Care Services

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

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, and permanent contraception.

The committee recommends "permanent contraception", to utilize most current reproductive health care terminology. The feedback to incorporate such language was raised by delegates during webinars.

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

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.

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

3. APhA supports evidence-based legislation that ensures patient access to comprehensive reproductive health care services.

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

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.

The committee recommends integrating the statement originally presented via New Business Item #4 Statement #1, as an additional statement #4 to New Business Item #3, per delegate feedback during the Open Forums on APhA2023 New Business Items. This recommendation comes in consultation with the original New Business Item authors, to simplify the presentation of these policy statements relating to similar content. Additionally, based on feedback from open forums, the committee recommends the addition of "or information regarding", to capture the full of scope of reproductive health care services which are within pharmacists' scope of practice.

NBI #4 – Pharmacist Protection Related to Reproductive Health Care Services

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

~~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.~~

The committee recommends integrating the statement originally presented via New Business Item #4 Statement #1, as an additional statement #4 to New Business Item #3, per delegate feedback during the Open Forums on APhA2023 New Business Items. Therefore, in order to execute this recommendation to integrate the statement to New Business Item #3, the committee must reject New Business Item #4 as a standalone motion. This recommendation comes in consultation with the original New Business Item authors, to simplify the presentation of these policy statements relating to similar content.

NBI #5 – Employer Responsibilities Related to Reproductive Health Care Access

The APhA New Business Review Committee recommends adoption of New Business Item #5 Whole Numbered Statement #1 as written.

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

The APhA New Business Review Committee recommends adoption of New Business Item #5 Whole Numbered Statement #2 as written.

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.

NBI #6 – Pharmacist Representation on Medical Staff

The APhA New Business Review Committee recommends adoption of New Business Item #6 Whole Numbered Statement #1 as amended.

1. APhA advocates for pharmacists to be included as members of ~~the~~ medical staffs and ~~to be~~ eligible to vote on the bylaws, standards, rules, regulations, and policies that govern ~~the~~ those institutions' medical staffs.

The committee recommends amendment, with the intent to maintain broad language that captures medical staff across all practice settings.

The APhA New Business Review Committee recommends adoption of New Business Item #6 Whole Numbered Statement #2 as amended.

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.

The committee recommends amendment to remove "that", from a grammatic perspective.

NBI #7 – Greenhouse Gases

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

1. APhA urges ~~stakeholders within the pharmaceutical supply chain to reduce their greenhouse gas emissions~~ implementation of strategies throughout the pharmaceutical product lifecycle (e.g., research, development, manufacturing, marketing, distribution, dispensing, use, and disposal) to achieve net zero emissions by 2050.

The committee recommends amendment, to broaden the scope of gas emissions beyond greenhouse gases, while also providing a target reduction for stakeholders to strive for. This comes as a result of delegate questions and feedback during the webinar sessions.

NBI #8 – Access to Essential Medicines

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

1. APhA ~~encourages~~ advocates regulation, policies and legislation that recognize access to quality and affordable essential medicines as a fundamental human right.

The committee recommends an amendment to the proposed policy statement, to strengthen the intended purpose of the proposed policy, and clarify the relevant stakeholders.

NBI #9 – Antidiscrimination

The APhA New Business Review Committee recommends adoption of New Business Item #9 Whole Numbered Statement #1 as amended.

1. APhA ~~affirms its support of~~ advocates for patients ~~obtaining~~ to obtain medications from pharmacies, free from discrimination.

The committee recommends condensing the two originally proposed policy statements into one, so as not to be repetitive nor dilute the overall intent. Based on feedback from open forums, the committee also recommends "advocates for", as a stronger verb choice.

The APhA New Business Review Committee recommends rejection of New Business Item #9 Whole Numbered Statement #2 as written.

2. ~~APhA opposes discrimination on the basis of disability, pregnancy or related conditions~~.

The committee recommends condensing the two originally proposed policy statements into one, so as not to dilute the overall intent; thus, a second statement is not needed after the first statement.

NBI #10 – Pharmacy Shortage Areas

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

1. APhA recognizes geographic proximity and transportation to pharmacies as key determinants in equitable access to medications, vaccines, and patient care services.

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

2. APhA calls for laws, regulations, and policies that reduce pharmacy shortage areas and ensure equitable access to essential services.

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

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.

NBI #11 – Legalization or Decriminalization of Illicit Drugs

The APhA New Business Review Committee recommends adoption of New Business Item #11 Statement #2 as written within the *2016, 1990 Legalization or Decriminalization of Illicit Drugs* Policy.

2. APhA supports decriminalization of the possession or use of illicit drug substances or paraphernalia.

The APhA New Business Review Committee recommends adoption of New Business Item #11 Statement #3 as written within the *2016, 1990 Legalization or Decriminalization of Illicit Drugs* Policy.

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.

APhA New Business Review Committee recommends adoption of New Business Item #11 Statement #4 as written within the *2016, 1990 Legalization or Decriminalization of Illicit Drugs* Policy.

~~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.~~

APhA New Business Review Committee recommends adoption of New Business Item #11 Statement #5 as amended within the *2016, 1990 Legalization or Decriminalization of Illicit Drugs* Policy.

~~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.~~

The author(s) of New Business Item #11 proposed amendments to the existing *2016, 1990 Legalization of Decriminalization of Illicit Drugs* APhA policy, with the rationale to reflect modern language and practices in the fields of drug criminalization and illicit drugs. These recommendations include retainment of the original statement #1, addition of new statements #2 and #3 as shown above, removal of statement #4 as shown above, and amendment to language already included in existing policy shown above as Statement #5. The committee recommends adoption of the New Business Item authors' recommendations for Statements #2, #3, and #4 as shown above (indicated in black text). However rather than accepting the proposed edits to Statement #5 by the NBI authors, the committee recommends removing this statement altogether (as indicated in red text).

NBI #12 – Transgender and Nonbinary Health Care

The APhA New Business Review Committee recommends adoption of New Business Item #12 Whole Numbered Statement #1 as amended.

1. APhA supports the enactment by state and federal legislatures to establish laws and policies to end discriminatory practices that limit access to care for transgender and nonbinary ~~(TNB)~~ people.

The committee recommends amendment of all three statements of New Business Item #12 to remove acronyms so that each individual policy statement may stand alone.

The APhA New Business Review Committee recommends adoption of New Business Item #12 Whole Numbered Statement #2 as amended.

2. APhA advocates for intentional recruitment ~~inclusion~~ of ~~the~~ transgender and nonbinary ~~TNB~~ ~~community~~ individuals in clinical research.

The committee recommends amendment of all three statements of New Business Item #12 to remove acronyms so that each individual policy statement may stand alone. The committee recommends "recruitment" over inclusion, to more accurately convey the intent of seeking transgender and nonbinary individual representation in studies.

The APhA New Business Review Committee recommends adoption of New Business Item #12 Whole Numbered Statement #3 as amended.

3. APhA encourages equity in care for transgender and nonbinary ~~TNB~~ individuals through:
    a) ~~Offering accredited~~ Continuing education on the pharmacist's role in transgender care, gender-affirming therapy, and health disparities in transgender and nonbinary ~~TNB~~ 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.

The committee recommends amendment of all three statements of New Business Item #12 to remove acronyms so that each individual policy statement may stand alone.

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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, Gigi Davidson, and Natalie Young
(Name)

Jan 22, 2023 **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

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Item No.: 2
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Time received: 12:01PM

NEW BUSINESS

(To be submitted and introduced by Delegates only)

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

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

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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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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.: 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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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.: 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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House of Delegates – March 24-27, 2023

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

Item No.: 8
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: Access to Essential Medicines as a Fundamental Human Right

Motion: To adopt the following policy statement:

1. 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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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
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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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House of Delegates – March 24-27, 2023

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

Item No.: 10
Date received: 1/23/2023
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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.

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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.

****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.

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.: 11
Date received: 1/23/2023
Time received: 5:49PM

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Adrienne Simmons
(Name)

January 23, 2023 **APhA-APPM**
(Date) **(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.

References:

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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.**

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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.: 12
Date received: 1/23/2023
Time received: 6:18 PM

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

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Ronald Levinson
(Name)

01/20/2023
(Date)

APhA-ASP Delegation
(Organization)

Subject:
Transgender and Nonbinary Health Care

Motion:

1. APhA supports the enactment by state and federal legislatures to establish laws and policies to end discriminatory practices that limit access to care for transgender and nonbinary (TNB) people.
2. APhA advocates for intentional inclusion of the TNB community in clinical research.
3. APhA encourages equity in care for TNB individuals through:
    a. Offering accredited continuing education on the pharmacist's role in transgender care, gender-affirming therapy, and health disparities in TNB 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.

Background

A growing number of state legislators are trying to criminalize, ban, and limit access to Gender-Affirming Therapy (GAT). These actions prevent pharmacists from following the vows pharmacists take to advocate for justice in advancing health equity and to consider the welfare of others above all. However, pharmacy organizations have not published any policy statements on the role of pharmacists in caring for transgender and non-binary (TNB) populations. Strong

evidence shows that GAT improves health outcomes and quality of life for TNB populations.[1.] One prospective cohort study found gender-affirming care for TNB youths was associated with 60% lower odds of moderate or severe depression and 73% lower odds of suicidality over a 12-month follow-up. Additionally, a survey of internal medicine and family medicine physicians practicing in a Midwest health system found that only 50% of respondents were willing to continue administering hormone therapy to TNB populations.[2.] With evidence that access to GAT improves physical and mental health, continuing to provide care to TNB populations is incredibly important. Many aspects of GAT include hormone therapy medications and as such, pharmacists must uphold their oaths and strive to protect and advance access to GAT.

In the first three weeks of 2023, over 90 anti-LGBTQ+ bills have been introduced nationally with over two dozen targeting gender-affirming health care have been introduced across eleven states.[3.] State bans and policies are estimated to result in over 58,000 transgender youth losing access to life-saving health care.[4.] It is imperative that action is taken now to protect patients' ability to access to GAT. One such example of increased access to care is Virginia House Bill 1429, which was passed in 2020. This bill prohibits insurers from denying or limiting coverage of services to TNB individuals. The Human Rights Campaign Foundation's 2021 State Equality Index report also shows that 44 pro-equality bills were passed in state legislatures, however, 27 anti-equality bills were also signed into law. This anti-equality legislation included bills filed to prevent TNB youth from receiving medically necessary, gender-affirming health care, and bills creating religious exemptions allowing medical care providers to refuse to serve TNB populations were passed in South Dakota, Montana, and Ohio. Though some progress has been made, further legal protections are needed to prevent discrimination and ensure access to care for TNB populations.

Statement two pertains to the dearth of representation for TNB populations in clinical research. Data collection in the binary gender paradigm prevents the TNB population from being represented. TNB people now constitute 1.6% of U.S. adults and 5% of young adults, or over 1.6 million individuals, according to recent surveys however it is assumed that this number is much higher due to the lack of appropriately obtaining this data.[5,6] The FDA released statements addressing the importance of the inclusion of TNB participants in clinical research in 2014 and again in 2020, yet of 115,057 clinical trials reported between July 2018 and February 2022, only 78 (0.06%) reported the participation of transgender patients.[7] Of these trials, the majority centered on HIV or sexually transmitted infections, displaying the pervasive stigma of the TNB population permeating our research. Focusing exclusively on this health care realm minimizes the TNB population's individuality, ignoring the humanity and the need for more representative research in other areas like cardiovascular health, neurology, or orthopedics.

A team of researchers working in the HIV and public health sphere who are transgender raise a pointed question in their petition for equitable research published in 2022: "Who is the research for: the researchers or the study population?"[8] For centuries, investigative health care fell into two categories: benefiting the white-male model of health or catering to researcher curiosity. The modest advancement in the equitable representation of women and minorities seen in more contemporary trials has been an incremental result of societal and cultural pressure reaching various peaks and valleys over the years.[9,10,11]

Additionally, from the limited data that are available, there is evidence to suggest that the CYP enzymes, specifically CYP1A2 activity, may be altered in transgender patients receiving estrogen therapy. It was noted that the CYP1A2 enzyme's metabolic activity may be lower, which would affect many commonly prescribed medications including tizanidine, duloxetine, and fluvoxamine.[12]. Given this, it is possible that other metabolizing enzymes or transporters could be affected in the TNB population undergoing hormone treatment. There is a deficiency in pharmacology-related information in this patient population that requires additional research to accurately address pharmacodynamic needs beyond the conduction of simple drug–drug interaction reviews.[13] Clinical research that continues to omit this growing population is harmful and ignores a basic need for equitable health care.

There is undeniably a need for pharmacists as well as all health care professionals to become better equipped to care for the TNB population, and their unique health needs and disparities. A survey of more than 6,000 TNB participants in the United States indicated that 50% of participants were subject to frequent discrimination in the form of refusal of care or verbal harassment by health care providers. These barriers can be attributed to the inadequate education health providers have regarding care for the TNB population.[14,15] A cross-sectional survey of community pharmacy residents shows that most residents believe transgender health education should be integrated into continuing professional education (CE) programs and curricula. However, in that same study, approximately 71% of residents stated they were not educated about transgender patient issues in pharmacy school.[16] Interventions made to educate pharmacists on transgender health appear to have benefits. A pre-test/post-test study design was used to measure the impact of a 3-hour CPE course on the knowledge of pharmacists on transgender care. Participants in the study demonstrated an average percent improvement in knowledge by 20%, showing at least a positive effect on the short-term impact of introducing pharmacists to the topic.[17] While further research is necessary to assess the long-term impact of these courses, the studies indicated a need for more education on the topic and the promising benefits of including this topic in CPE/curricula.

In addition to continuous health care provider education, many health systems still lack the integration and utilization of gender-affirming language and health information within their electronic health record (EHR). Using affirmed names and pronouns for patients greatly improves outcomes in patient care. In a study published by the Centers for Disease Control, over 50% of patients felt they had to educate their providers on understanding transgender health care and using gender-affirming language.[18] In addition to using gender-affirming language, EHRs should also include integrating and utilizing an anatomical inventory through collaboration with regulating bodies, such as the Joint Commission and Health Information Exchanges. Many patients within the TNB community undergo medical and surgical interventions to affirm their gender identity. These interventions may include gender-affirming hormone therapy, hysterectomy, chest reconstruction, and genital surgeries.[19] However, there are patients within the TNB community who also elect not to have any interventions, thus creating a need for implementing an anatomical inventory within an EHR. A simple checklist within a patient's EHR can accommodate an atomical inventory by reporting the presence or absence of organs.

Resources and training related to gender-expansive care should include all employed within a health care setting. When the patient approaches the front desk to check in for their

appointment, the staff should be comfortable using gender-affirming language, and so should their pharmacist. Medical education and lack of cultural competence are some of the many barriers transgender patients face when visiting a health care provider.[20] In one study, 92.4% of health care providers reported that training would increase their competence and thus improve health care outcomes for transgender patients.[21] Providing employees with gender-expansive care training and resources will greatly increase the TNB patient population's health care experience and achieve optimal health care outcomes.

The TNB population has endured years of legislative barriers and prosecution at the hands of state government officials attempting to stop health care access. The discrimination has escalated in magnitude in many states that have introduced legislation to persecute TNB individuals. There is a dire need for more states to offer legal protection for gender-affirming therapy and for the members of this marginalized population. The role of the pharmacist as a bastion for equitable health care arises from the *Oath of a Pharmacist*, published and updated by the American Pharmacists Association. The first stanza vows to prioritize "the welfare of humanity and relief of suffering," establishing the pharmacist as the underpinning of holistic and compassionate health care. The alleviation of suffering should be any health care provider's primary directive. The second and most pertinent stanza is a vow to "promote inclusion, embrace diversity, and advocate for justice to advance health equity."[22] In a discussion of health care equity, it's critical to ensure an understanding of the existing systemic disparities that lead to poor outcomes. Gender-affirming therapy is lifesaving and medically necessary. Policies that limit access are discriminatory and threaten the safety of an already-marginalized population. Data have continued to demonstrate the benefits of GAT.[23,24,25] Therefore GAT should be included in the data-driven education and experience of pharmacists, however, advocating for the rights of TNB individuals transcends the pharmacist's inclination for evidence-based health care. Simply recognizing the evidence is insufficient. A stance must be taken to withstand the onslaught. Pharmacists should advocate against discriminatory policies or practices and will always strive for equitable health care. Alleviating suffering is not just a vow of health care providers; it's the foundation of empathetic humans.

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Current APhA Policy & Bylaws:

- Consideration of the Equal Rights Amendment – 1979
- Use of Representative Populations in Clinical Studies - 1990, 2005, 2019
- Data to Advance Health Equity – 2022
- People First Language - 2021
- Social Determinants of Health – 2021
- Disparities in Health Care – 2009

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and federal levels is push back from organized medicine, including the American Medical Association. A primary reason that AMA consistently opposes state and federal efforts to expand pharmacist scope of practice is because AMA has ten-year old House of Delegates policy that specifically "opposes federal and state legislation allowing pharmacists to independently prescribe or dispense." There have been several attempts to discuss this with AMA leadership – to no avail.
AMA 2012 policy is as follows:

> **Evaluation of the Expanding Scope of Pharmacists' Practice D-35.987**
> Our AMA: (1) will re-evaluate the expanding scope of practice of pharmacists in America and develop additional policy to address the proposed new services provided by pharmacists that may constitute the practice of Medicine; (2) will continue to collect and disseminate state specific information in collaboration with state medical societies regarding the current scope of practice for pharmacists in each state; studying if and how each state is addressing these expansions of practice; (3) will develop model state legislation to address the expansion of **pharmacist** scope of practice that is found to be inappropriate or constitutes the practice of medicine, including but not limited to the issue of interpretations or usage of independent practice arrangements without appropriate physician supervision and work with interested states and specialties to advance such legislation; (4) opposes federal and state legislation allowing pharmacists to independently prescribe or dispense prescription medication without a valid order by, or under the supervision of, a licensed doctor of medicine, osteopathy, dentistry or podiatry; (5) opposes federal and state legislation allowing pharmacists to dispense medication beyond the expiration of the original prescription; and (6) opposes the inclusion of Doctors of Pharmacy (PharmD) among those health professionals designated as a "Physician" by the Centers for Medicare & Medicaid Services.

The AMA has repeatedly issued stances against any forms of expanded scopes of practice to non-physicians, which have time and time again proven to be out of touch with what patients actually demand and need. For example, in the 2022 State of the Union, President Joe Biden announced new efforts to allow for rapid public access to both COVID-19 tests and treatments. Under the plan, pharmacy-based clinics, community health centers, long-term care facilities, and US Department of Veterans Affairs facilities will be able to test patients for COVID-19 and immediately prescribe oral medications to those who test positive. Shortly after, the AMA raised concerns about the "Test to Treat" initiative, saying pharmacy-based clinics might not know a patients' full medical history like a physician would. AMA president Gerald E. Harmon, MD stated that while the AMA is "pleased" that the Biden administration is ramping up supply of antivirals, establishing pharmacy-based clinics as one stop shopping for COVID-19 testing and treatments is "extremely ris.ky" Up to this point in the pandemic, the AMA has lobbied against pharmacist-provided COVID-19 testing and has questioned pharmacist-provided COVID vaccinations – both of which have proven to be essential and impactful to the national COVID-19 pandemic response. Under the provisions granted by the Public Readiness and Emergency Preparedness (PREP) Act, pharmacists have contributed to improved outcomes for patients. However, for over 30 years, the AMA's state and federal advocacy efforts have opposed nonphysician professional attempts to expand their scope for the sake of preserving their own scopes of practice.

In 2019, the AMA established the Center for Health Equity and subsequently issued a strategic plan to advance health equity across the country. They have devoted significant resources to this effort and created tools to support physicians embedding health equity into their practices. The AMA's repeated opposition to granting pharmacists appropriate and needed scope of practice authorities for patient care, despite pharmacists' demonstrated value and impact, is a direct contradiction to their health equity initiatives. Pharmacists consistently demonstrate their valuable impact within their communities, especially when it comes to bridging

gaps in patient care among medically underserved areas. If the AMA is as committed to the promotion of healthy equity as they claim, they should support solutions that would help to bridge gaps in patient care. Pharmacists are well equipped and willing to fill those gaps, for optimal patient care and equitable access.

Not only are pharmacists making positive impacts towards patient access, but they are also actively promoting issues of health inequities. APhA is committed to promoting diversity, equity, and inclusion in health care personnel and services delivered to diverse patient populations. This is conveyed in both AMA and APhA's strategic plans through initiatives that increase diversity of membership and leadership. For example, APhA has created a Diversity, Equity, and Inclusion Committee that aims to increase competencies, strategies, tactics, and partnerships that engage staff in discussions and activism related to social determinants of health, including those related to systemic racism. APhA also has an actively engaged Task Force to Address Structural Racism in Pharmacy to step up efforts to dismantle racial injustice facing patients, communities, and the profession.

Current APhA Policy & Bylaws:

Contemporary Pharmacy Practice
2017,
2012

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.

Patient Access to Pharmacist-Prescribed Medications

2017

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.

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

Independent Practice of Pharmacists

2013,
2009

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 and rules pertaining to the independent practice of pharmacists when those laws 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 and regulations 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.

Accountability of Pharmacists

2020

1. APhA affirms pharmacists' professional accountability within their role in all practice settings.

2. APhA advocates that pharmacists be granted and accept authority, autonomy, and accountability for patient-centric actions to improve health and medication outcomes, in coordination with other health professionals, as appropriate.

3. APhA reaffirms 2017 Pharmacists' Role Within Value-based Payment Models and supports continued expansion of interprofessional patient care models that leverage pharmacists as accountable members of the health care team.

4. APhA advocates for sustainable payment and attribution models to support pharmacists as accountable patient care providers.

5. APhA supports continued expansion of resources and health information infrastructures that empower pharmacists as accountable health care providers.

6. APhA supports the enhancement of comprehensive and affordable professional liability insurance coverage that aligns with evolving pharmacist accountability and responsibility.

Medication Selection by Pharmacists

2013,
1980

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.

The Pharmacist's Role in Therapeutic Outcomes

2003,
1992

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.

Dispensing and/or Administration of Legend Drugs in Emergency Situations (applicable to AMA's policy on refill extension)

1979

1. APhA supports making insect sting kits and other, life-saving, emergency, treatment kits available for lawful dispensing by pharmacists without a prescription order, based on the pharmacist's professional judgment.

2. APhA supports permitting pharmacists to lawfully dispense and administer legend drugs in emergency situations, without an order from a licensed prescriber, provided that: (a) there is an assessment on the part of the pharmacist and the patient that the drug is needed immediately to preserve the well-being of the patient; and (b) the normal legal means for obtaining authorization to dispense the drug must not be immediately available, such as in cases where the patient's physician is not available; and (c) the quantity of the drug, that can be dispensed in an emergency situation, is enough so that the emergency situation can subside, and the patient can be sustained for the immediate emergency, as determined by the pharmacist's professional judgment.

3. APhA supports expansion of state Good Samaritan Acts to provide pharmacists immunity from professional liability for dispensing in emergency situations without order from a licensed prescriber.

4. APhA supports permitting pharmacists to lawfully dispense and/or administer legend drugs without an order from a licensed prescriber during disaster situations.

Social Determinants of Health

2021

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.

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

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. **Urgent New Business Item, #1**
Date received **2/28/23**
Time received **2:33pm**

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: **Daniel A. Hussar**
(Name)

February 28, 2023 Pennsylvania Pharmacists Association (on behalf of himself)
(Date) **(Organization)**

Subject: Protection of Patients, Pharmacists, and Pharmacies

Motion:

1. APhA supports the right of patients to obtain approved nonprescription and legally prescribed medications in pharmacies.

2. APhA supports the professional role and responsibility of pharmacists in dispensing and providing medication administration services for approved nonprescription and legally prescribed medications.

3. In situations in which a pharmacist exercises conscientious refusal in declining to dispense an approved nonprescription or legally prescribed medication, APhA urges owners/employers of pharmacists to identify arrangements through which patients will have access to these medications.

4. APhA opposes disciplinary action against a pharmacist who for reason of conscientious refusal declines to dispense an approved nonprescription or legally prescribed medication.

5. In policy statements and communications regarding issues that may result in some pharmacists exercising conscientious refusal, APhA and its House of Delegates should consider including a statement that recognizes a pharmacist's right to exercise conscientious refusal.

Background:

In 1998, the APhA House of Delegates adopted the Pharmacist Conscience Clause Policy noted below:

"APhA recognizes the individual pharmacist's right to exercise conscientious refusal and supports the establishment of systems to ensure patient access to legally prescribed therapy without compromising the pharmacist's right of conscientious refusal."

The adoption of the conscience clause policy resulted in large part from the concerns of some pharmacists that hormonal contraceptive products, particularly when used in higher dosages, had a potential to cause what they considered to be an abortifacient action. These concerns increased when the FDA approved levonorgestrel (Plan B) in a higher dosage as an emergency contraceptive. Although the product was initially available only on prescription, it is now available (Plan B One-Step) on a nonprescription basis without any age restrictions. Although the number of pharmacists who declined to stock and/or dispense emergency contraception was very small, the allegations directed against these pharmacists were very critical and extensively publicized. In recent years there has been very little discussion about the availability of these products, strongly suggesting that very few pharmacists decline to provide these products, and that there is not an access problem for those who wish to purchase them.

The APhA's conscience clause policy has provided the appropriate rights and balance for those with differing opinions, and has served patients, pharmacists, and the APhA well. The need for this policy and increased awareness of it are greatly increased by several recent decisions and prescribing practices. Most important is the FDA's announcement on January 3, 2023 that it is making modifications to the Risk Evaluation and Mitigation Strategy (REMS) for mifepristone (for the medical termination of intrauterine pregnancy through 70 days gestation) that will enable certified pharmacies to dispense the products to patients who provide a prescription from a certified prescriber. CVS and Walgreens have announced that they will pursue certification of their pharmacies to dispense prescriptions for mifepristone, and it is anticipated that some other chain and independent pharmacies will also do so.

Many pharmacists employed in pharmacies that are certified to dispense mifepristone will exercise conscientious refusal and decline to do so because of their concerns that they are enabling the termination of a life. There are at least two current situations in which nurse practitioners employed in CVS clinics have been terminated because they have declined to prescribe mifepristone because of their religious beliefs. These nurses have filed lawsuits against CVS that allege religious discrimination. It should be anticipated that some employers will terminate its pharmacists who exercise conscientious refusal, and it is increasingly important that the rights of these pharmacists be respected and protected. It is also noteworthy that some consider the FDA restrictions on the availability of mifepristone to be excessive, and are advocating for the removal of restrictions (e.g., REMS, certification). A smaller number are recommending nonprescription availability.

APhA has voiced strong support for Diversity, Equity, Inclusion, and Belonging (DEIB), and the inclusion of pharmacists who exercise conscientious refusal is essential for the credibility of this position.

This new business item is NOT intended to restrict or limit the role of pharmacists, or APhA's support for any responsibilities and medications that are within the scope of the practice of pharmacy. It is important that our profession avoid division because of differences of opinion, as has occurred in the political arena and society in general.

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)

2002, 1991, 1977 **Pharmacist/Patient Communication**

1. APhA acknowledges the following:
   (a) Patients have the right to be informed participants in decisions related to their personal health care.
   (b) Pharmacists have a professional obligation to contribute to the education of patients to help achieve optimal drug therapy.
   (c) Pharmacists should provide drug-related information to their patients (or patients' agent) by face-to-face oral consultation, supplemented by written or printed material, or any other means or combination of means that is best suited to an individual patient's needs for specific information.
2. APhA acknowledges that the pharmacist is responsible for initiating pharmacist/patient dialogue and assessing the patient's ability to comprehend and communicate so as to optimize the patient's understanding of and compliance with drug therapy.
3. APhA encourages the research and development of ancillary communication aids and techniques to maximize patient understanding of medication and its proper use.

(JAPhA. NS17:464; July 1977) (Am Pharm. NS3(16):28; June 1991) (JAPhA. NS2(5)(suppl 1):563; September/October 2002) (Reviewed 2006) (Reviewed 2010) (Reviewed 2015) (Reviewed 2019)

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)

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 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)

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)

****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.