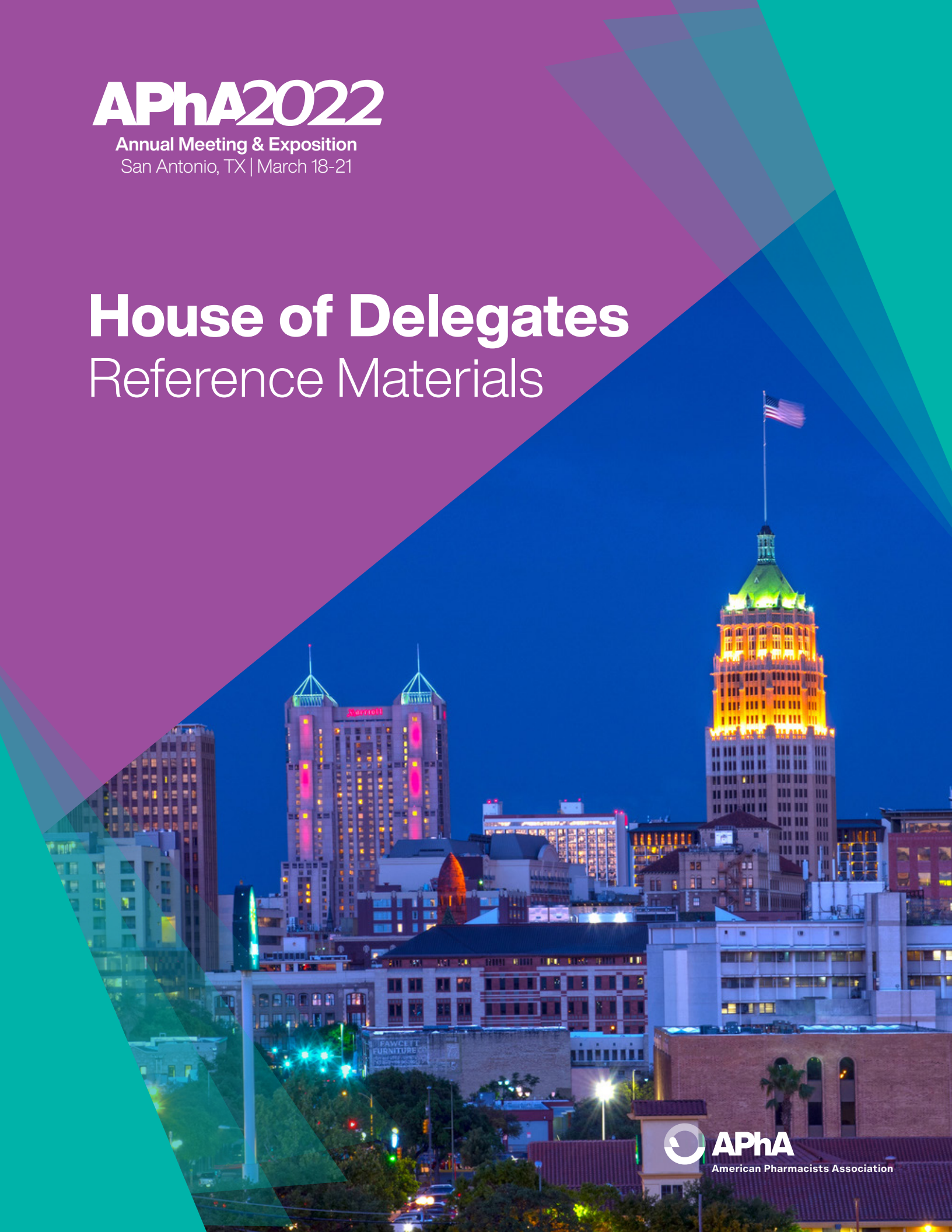
APhA2022

Annual Meeting & Exposition

San Antonio, TX | March 18-21

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;
- 2021-2022 APhA House Rules Review Committee Report;
- 2021-2022 APhA Policy Reference Committee Report; and
- 2021-2022 APhA Policy Committee Background Papers;
- 2021-2022 APhA New Business Items received.

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of the committee-related webinars, I encourage you to visit https://pharmacist.com/About/Leadership/HOD/Learn to view an archived version of the webinars conducted to date.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.

To provide an overview of the New Business Items to be discussed in this year's House, I will host two ***New Business Item Webinar*** **sessions** (one of which was held on February 23) the next is scheduled March 2 from 5:30-7:00pm . If you find that you are unable to participate in one of the live webinars, an archived version will be available online soon after. These webinars will aid you in learning more about the items submitted prior to the Annual Meeting and provides you an opportunity to prepare for the Open hearing and House discussions. You must register to participate in the webinars, register at https://pharmacist.com/About/Leadership/HOD/Learn.

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 – Hemisfair Ballroom Foyer

Registration for the First Session will open from **12:00pm-3:00pm on Friday**, **March 18, 2022.** Delegate registration will be located at the **Henry B. Gonzalez Convention Center** (900 E Market St, San Antonio, TX). Registration for the Final session will be available in the same location, from **11:00am-1:30pm on Monday, March 21, 2022**. 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 **Hemisfair Ballroom**. Please remember to bring your delegate reference materials and your name badge with you to registration. Please allocate sufficient time to check in prior to the start time of the House.

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

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

House of Delegates Office Hours

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

Planning for the 2023 House

It's never too early to plan ahead! In mid-April, APhA will begin the policy development process for 2023. 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 **March 30, 2022** 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 2022-2023 policy development process, I encourage you to complete the committee volunteer interest form **by April 18, 2022** at https://apha.secure-platform.com/a/solicitations/1587/home.

Thank you again for your interest and service to the 2022 House of Delegates! I look forward to seeing you in San Antonio! 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

Scott Knoer, PharmD, FASHP
Secretary, APhA House of Delegates
APhA Executive Vice President & Chief Executive Officer

Staff Liaisons:

Mitch Rothholz, Chief of Governance & State Affiliates and Executive Director, APhA Foundation (mrothholz@aphanet.org)
Brian Wall, Director, APhA Governance & Foundation Administration (bwall@aphanet.org)
Wendy Gaitwood, Project Manager, Executive Office & Governance (wgaitwood@aphanet.org)

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

APhA2022
Annual Meeting & Exposition
San Antonio, TX | March 18-21

HOUSE OF DELEGATES Schedule at a Glance

FRIDAY, MARCH 18		
12:00 pm – 2:45 pm	Hemisfair Ballroom Foyer	Delegate Registration
1:00 pm – 2:15 pm	Room 225C	APhA-APPM Delegate Caucus
1:00 pm – 2:15 pm	Room 225A	APhA-APRS Delegate Caucus
2:45 pm – 5:00 pm	Hemisfair Ballroom	House of Delegates – First Session (Be seated by 2:30 pm)

SATURDAY, MARCH 19		
1:00 pm – 2:30 pm	Room 217C	New Business Review Committee Open Hearing

SUNDAY, MARCH 20		
11:30 am - 12:30 pm	Room 217B	Pharmacist's Fundamental Responsibilities and Rights Year One – A Townhall Discussion
1:00 pm – 3:00 pm	Room 225B	Policy Reference Committee Open Hearing

MONDAY, MARCH 21		
9:00 am – 11:30 am	Room 225C	APhA-APPM Delegate Caucus
9:00 am – 11:30 am	Room 225B	APhA-APRS Delegate Caucus
11:00 am – 1:30 pm	Hemisfair Ballroom Foyer	Delegate Registration
1:30 pm – 4:30 pm	Hemisfair Ballroom	House of Delegates – Final Session (Be seated by 1:15 pm)

HOUSE OF DELEGATES OFFICE HOURS HEMISFAIR BALLROOM FOYER	
Thursday, March 17	3:00 pm – 6:00 pm
Friday, March 18	7:30 am – 3:00 pm
Saturday, March 19	8:00 am – 3:00 pm
Sunday, March 20	8:00 am – 3:00 pm
Monday, March 21	7:30 am – 1:00 pm

FRIDAY, MARCH 18 • House of Delegates – First Session

Agenda

1. Call to Order
2. Review of Voting Procedures
3. Credentials Report*
4. Adoption of Agenda and Rules*
5. Introduction of Head Table
6. Report of the Speaker, APhA House of Delegates
7. APhA House Rules Review Committee Report*
8. New Business Procedure
9. Report of the Committee on Nominations*
10. Speaker-elect Candidate Introductions
11. Unfinished/Referred Business Items
12. Policy Reference Committee Report - Consent Agenda*
13. Policy Reference 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 2022 APhA Board of Trustees Election
16. Discussion of New Business Items - If Time Allows
17. Housekeeping Announcements
18. Adjournment of the First House Session

MONDAY, MARCH 21 • 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. Policy Reference Committee Report*
6. Speaker-elect Candidate Speeches
7. Speaker-elect Election*
8. Consideration of New Business*
9. Announcement of Election Results
10. Installation of the 2022-2023 Speaker-elect
11. Installation of the APhA Board of Trustees
12. Installation of the 2022-2023 APhA President
13. Recommendations from APhA Members
14. Closing Announcements
15. Adjournment of the 2022 APhA House of Delegates

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

APhA House of Delegates

As of Date: 2/24/2022

AACP (*Delegates-2 Out of 2*)
Stuart Haines
Russell Melchert

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

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

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

ACCP (*Delegates-2 Out of 2*)
Katherine Pham
Leigh Ann Ross

ACCP (*Alt. Delegates*)
Michael Maddux

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

ACVP (*Alt. Delegates*)
Randy Carr

AIHP (*Delegates-2 Out of 2*)
Melissa Murer Corrigan
William Zellmer

AIHP (*Alt. Delegates*)
Gregory Higby

AIR FORCE (*Delegates-2 Out of 2*)
Ian Gaspar
Ann McManis

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

ALABAMA (*Alt. Delegates*)
Charles Thomas

ALASKA (*Delegates-2 Out of 2*)
Catherine Kowalski
Michelle Locke

AMCP (*Delegates-2 Out of 2*)
Vyishali Dharbhamalla
Paul Jeffrey

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

APC - Formerly IACP (*Alt. Delegates*)
Hali O'Malley

APhA Board (*Delegates-15 Out of 15*)
Melissa Duke
Gregory Fox
Andrew Gentles
Michael Hogue
Sean Jeffery
Scott Knoer
Sandra Leal
Randal McDonough
Wendy Mobley-Bukstein
David Nau
Juan Rodriguez
Magaly Rodriguez De Bittner
Alex Varkey
Wendy Weber
Theresa Wells-Tolle

APhA-APPM (*Delegates-27 Out of 28*)
Cara Acklin
Hillary Blackburn
Jeffrey Bratberg
Scott Brewster
Andrew Bzowyckyj
Denise Clayton
Sarah Cox
Nicholas Dorich
Patricia Fabel
Christopher Johnson
Amy Kennedy
Olivia Kinney
Laura Knockel
Catherine Kuhn
William Lee
Nicholas Lehman
Ashley Lorenzen
Jessica Marx
Cody Morcom
Sheena Patel
Traci Poole
Jordan Rowe
Myriam Shaw Ojeda
Brent Thompson
Jennifer Wilson
Bibi Wishart
Natalie Young

APhA-APPM (*Alt. Delegates*)
Javon Artis

APhA-APRS (*Delegates-28 Out of 28*)
Edward Bednarczyk
Deepak Bhatia
Brittany Bissell
Michelle Blakely
Antoinette Coe
Lawrence Cohen
M. Lynn Crismon
Karen Farris
Marc Fleming
Brandi Hamilton
Spencer Harpe
Tessa Hastings
Adriane Irwin
Roger Lander
Anandi Law
Yifei Liu
Meena Murugappan
Karen Nagel-Edwards
Julie Oestreich
Anthony Olson
Ana Quinones-Boex
Smita Rawal
Michael Smith
Karen Smith
Elliott Sogol
Terri Warholak
Andrew Wash
Henry Young

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

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

Sidrah Alam
Megan Byrne
Sonja Christensen
Madeline Clark
Zachary Coleman
Margaret Davis
Kennedy Erickson
Veronica Guastella
Madilyn Harris
Alexis Jones
Ji Yoon (Angie) Kim
Brooke Kulusich
Ronald Levinson
Shirly Ly
Constance Marker
Julia Miller
Neha Nadkarni
Mark Nagel
Stefanie Nguyen
Kate Noonan
Vanessa Rivera
Edgardo Rodriguez
Jessica Schowe
Dillon Solliday
Ashlyn Tedder
Olivia Waters
Jian Weng
Megan Wright

APhA-ASP (*Alt. Delegates*)

Olunife Akinmolayan
Shreya Asher
Martin Bailey
Maria Gonzalez
Audrey Wong

ARIZONA (*Delegates-3 Out of 4*)

Anthony Ball
Kelly Fine
Lorri Walmsley

ARKANSAS (*Delegates-2 Out of 2*)

Brenna Neumann
Lanita White

ARKANSAS (*Alt. Delegates*)

John Vinson

ARMY (*Delegates-2 Out of 2*)

Jonathan Bartlett
Seth Mayer

ARMY (*Alt. Delegates*)

Dana Bal
Diana Chung

ASCP (*Delegates-2 Out of 2*)

Hedva Barenholtz
Lisa Morris

ASCP (*Alt. Delegates*)

Kevin Fearon

ASHP (*Delegates-1 Out of 1*)

Georgia Luchen

ASPL (*Delegates-2 Out of 2*)

Gina Moore
Krystalyn Weaver

CALIFORNIA (*Delegates-9 Out of 9*)

Veronica Bandy
Kathleen Besinque
Jennifer Courtney
Richard Dang
Priyanka Dave
Steven Gray
Ethan Huynh
Elizabeth Johnson
George Yasutake

COLORADO (*Delegates-3 Out of 3*)

Randy Knutsen
Neda Leonard
Sara Wettergreen

COLORADO (*Alt. Delegates*)

Robert Willis

CONNECTICUT (*Delegates-3 Out of 3*)

Valentino Caruso
Karen Hoang
Philip Hritcko

CPNP (*Delegates-2 Out of 2*)

Julie Dopheide
Sarah Melton

DELAWARE (*Delegates-2 Out of 2*)

Kevin Musto
Kimberly Robbins

DELAWARE (*Alt. Delegates*)

Mark Freebery

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

Tamara Foreman
Michael Kim
Carolyn Rachel-Price

DISTRICT OF COLUMBIA (*Alt. Delegates*)

Juan Medrano

FLORIDA (*Delegates-5 Out of 5*)

Daniel Buffington
William Mincy
Carol Motycka
Katherine Petsos
Matthew Schneller

FLORIDA (*Alt. Delegates*)

Angela Garcia

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

Nancy Alvarez
Lowell Anderson
Maurice Bectel
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
Ronald Jordan
Gary Kadlec
Calvin Knowlton
Winnie Landis
Eugene Lutz
James Main
Thomas Menighan
Jacob Miller
Matthew Osterhaus
Robert Osterhaus
Marily Rhudy
Steven Simenson
Jenelle Sobotka
Lisa Tonrey
Timothy Vordenbaumen

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

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

GEORGIA (*Delegates-4 Out of 4*)

Liza Chapman
Mahlon Davidson
Johnathan Hamrick
Jonathan Sinyard

GEORGIA (*Alt. Delegates*)

David Carver

GUAM (*Delegates-0 Out of 2*)

HAWAII (*Delegates-2 Out of 2*)

Marcella Chock
Corrie Sanders

HOPA (*Delegates-2 Out of 2*)

Larry Buie
David Deremer

IDAHO (*Delegates-2 Out of 2*)

Jennifer Adams
Donald Smith

IDAHO (*Alt. Delegates*)

Elaine Ladd

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

ILLINOIS (*Delegates-5 Out of 5*)
Starlin Haydon-Greatting
Garth Reynolds
Jennifer Rosselli
J. Cody Sandusky
Emily Wetherholt

INDIANA (*Delegates-4 Out of 4*)
Stephanie Arnett
Chelsea Baker
Kathryn Marwitz
Veronica Vernon

INDIANA (*Alt. Delegates*)
Cory Holland

IOWA (*Delegates-3 Out of 3*)
Dalton Fabian
Robert Nichols
Diane Reist

IOWA (*Alt. Delegates*)
Steve Firman
Emmeline Paintsil

KANSAS (*Delegates-3 Out of 3*)
Amanda Applegate
Jessica Bates
Emily Prohaska

KENTUCKY (*Delegates-4 Out of 4*)
Kimberly Croley
Patricia Freeman
Catherine Hanna
Chris Harlow

KENTUCKY (*Alt. Delegates*)
Martika Martin

LOUISIANA (*Delegates-3 Out of 3*)
Nancy Caddigan
William Kirchain
Beverly Walker

LOUISIANA (*Alt. Delegates*)
Aurdie Bellard

MAINE (*Delegates-2 Out of 2*)
Frank McGrady
Daniel Mickool

MAINE (*Alt. Delegates*)
Peter McLean

MARYLAND (*Delegates-5 Out of 5*)
William Charles
James Dvorsky
Careen-Joan Franklin
Kinbo Lee
Salematou Traore

MARYLAND (*Alt. Delegates*)
Marci Strauss

MASSACHUSETTS (*Delegates-2 Out of 2*)
Trisha LaPointe
Rohan Zaveri

MICHIGAN (*Delegates-4 Out of 4*)
Heather Christensen
Farah Jalloul
Charles Mollien
Michelle Sahr

MICHIGAN (*Alt. Delegates*)
Augustine Bui

MINNESOTA (*Delegates-4 Out of 4*)
Michelle Aytay
Madeleine Davies
Riley Larson
Lauren Ostlund

MINNESOTA (*Alt. Delegates*)
Sarah Derr

MISSISSIPPI (*Delegates-3 Out of 3*)
Lauren Bloodworth
Peyton Herrington
Olivia Strain

MISSOURI (*Delegates-3 Out of 4*)
Abigail Charlier
Sarah Oprinovich
Roxane Took

MONTANA (*Delegates-2 Out of 2*)
Lyndee Fogel
Monica Orsborn

NAVY (*Delegates-2 Out of 2*)
Tanesia Maul
Sean Szad

NCPA (*Delegates-2 Out of 2*)
John Beckner
Hannah Fish

NEBRASKA (*Delegates-3 Out of 3*)
Ally Dering-Anderson
Edward DeSimone
Jennifer Tilleman

NEVADA (*Delegates-3 Out of 3*)
Mark Decerbo
Kenneth Kunke
Christina Quimby

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

NEW JERSEY (*Delegates-5 Out of 5*)
Elise Barry
Javier Rodriguez
Carmela Silvestri
Mark Taylor
Lucio Volino

NEW MEXICO (*Delegates-3 Out of 3*)
Jana Behrens
April Cross
Haniff Sealy

NEW YORK (*Delegates-6 Out of 6*)
Vibhuti Arya
Karl Fiebelkorn
Amanda Foster
Nasir Mahmood
Maria Mantione
Steven Moore

NEW YORK (*Alt. Delegates*)
Jessica Anderson

NORTH CAROLINA (*Delegates-5 Out of 5*)
David Catalano
Evan Colmenares
Christy Holland
Macary Marciniak
Katie Trotta

NORTH CAROLINA (*Alt. Delegates*)
Beth Mills

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

NPhA (*Delegates-2 Out of 2*)
Ryan Marable
Frank North

NPhA (*Alt. Delegates*)
Lakesha Butler

NRPhA (*Delegates-0 Out of 1*)

OHIO (*Delegates-6 Out of 6*)
Juanita Draime
Stacey Frede
Jessica Hinson
James Kirby
Jennifer Seifert
Jeff Steckman

OHIO (*Alt. Delegates*)
Andrea Brookhart
Mitchell Howard

OKLAHOMA (*Delegates-3 Out of 3*)
Krista Brooks
Eric Johnson
Katherine O'Neal

OREGON (*Delegates-2 Out of 3*)
Jill McClellan
Amanda Meeker

OREGON (*Alt. Delegates*)
Lincoln Alexander

PENNSYLVANIA (*Delegates-6 Out of 6*)
Howard Cook
John Dejames
Thomas Franko
Julie Gerhart-Rothholz
Sophia Herbert
Daniel Hussar

PHS (*Delegates-2 Out of 2*)
Matthew Kirchoff
Kristina Melia

PHS (*Alt. Delegates*)
Hillary Duvivier
Juliette Taylor

PUERTO RICO (*Delegates-2 Out of 3*)
Milagros Morales
Giselle Rivera

RHODE ISLAND (*Delegates-2 Out of 2*)
Christopher Federico
Matthew Lacroix

RHODE ISLAND (*Alt. Delegates*)
Jeffrey Bratberg

SOUTH CAROLINA (*Delegates-1 Out of 4*)
Cheryl Anderson

SOUTH CAROLINA (*Alt. Delegates*)
Alyssa Norwood

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

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

Kristen Tate

SOUTH DAKOTA (*Alt. Delegates*)

Amanda Bacon

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

Grace Baek
Cynthia Boyle
Bin Deng
Jason Gaines
Aliyah Horton
Nimit Jindal
Loren Kirk
Alison Knutson
Rawan Latif
Benjamin Lowry
Sara McElroy
Dallas Moore
Amy Reese
Daniel Robinson
Parth Shah
Rajan Vaidya
Ryan Waldschmidt
Lucianne West
Suzanne Wise

TENNESSEE (*Delegates-5 Out of 5*)

Cindy Fisher
R. Taylor Reed
Chelsea Renfro
Adam Welch
Casey White

TENNESSEE (*Alt. Delegates*)

Anthony Pudlo
Lucy Shell

TEXAS (*Delegates-7 Out of 7*)

Laura Beall
Mary Klein
Michael Muniz
Caroline Ngo
Carol Reagan
May Woo
Jessica Wooster

TEXAS (*Alt. Delegates*)

Carole Hardin-Oliver

USP (*Delegates-2 Out of 2*)

Carrie Harney
Sohail Mosaddegh

UTAH (*Delegates-0 Out of 2*)

VERMONT (*Delegates-2 Out of 2*)

Brittany Allen
Lauren Bode

VETERANS ADMIN (*Delegates-1 Out of 2*)

John Santell

VETERANS ADMIN (*Alt. Delegates*)

Anthony Morreale
Ronald Nosek
Heather Ourth

VIRGINIA (*Delegates-5 Out of 5*)

Sharon Gatewood
Farzana Kennedy
Robert Pritchard
Dominic Solimando
Adrian Wilson

WASHINGTON (*Delegates-3 Out of 3*)

Julie Akers
C A Leon Alzola
Collin Conway

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

Krista Capehart
Michael Lemasters
Karen Reed

WISCONSIN (*Delegates-2 Out of 3*)

Gina Besteman
Shilpa Khot

WYOMING (*Delegates-0 Out of 1*)

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

American Pharmacists Association House of Delegates
FIRST SESSION - Friday, March 18, 2022 - 2:45PM – 5:15PM

SEATING CHART

Speaker of the House

1	AL-4	AR-2	15	GA-4	GU-2	29	MD-5	43	NJ-5*	57	PA-3+	VT-2*
2	AK-2	AZ-4*	16	FL-5		30	KS-3	LA-3	44	NE-3+	RI-2	58	PA-3	OR-3
3	CA-6		17	ID-2	IA-3	31	MI-4+	ND-1	45	NC-5		59	SC-4*	
4	CA-3	DC-3*	18	IN-4	ME-2	32	MN-4*	MT-2	46	NY-6		60	TN-5+	
5	CT-3+	DE-2*	19	IL-5*		33	MO-4	NH-2	47	OH-6		61	PR-3*	TX-3
6	CO-3+	HI-2*	20	KY-4	MA-2	34	MS-3	NM-3	48	NV-3*	OK-3	62	SD-1	TX -4+
7	Speaker Appointed-5		21	Speaker Appointed-5		35	Speaker Appointed-5		49	Speaker Appointed-5		63	UT-1	VA-5
8	APhA-APPM-6		22	APhA-APRS-6		36	APhA-ASP-6		50	AACP, AAPS		64	WA-3	WV-3*
9	APhA-APPM-6		23	APhA-APRS-6		37	APhA-ASP-6		51	ACA, ACCP, ACVP		65	WI-3	WY-1
10	APhA-APPM-5		24	APhA-APRS-5		38	APhA-ASP-5		52	AIHP, AMCP		66	Vet Admin, PHS	
11	APhA-APPM-5		25	APhA-APRS-5		39	APhA-ASP-5		53	APC, ASCP, ASHP		67	Army, Air Force, Navy	
12	APhA-APPM-6		26	APhA-APRS-6		40	APhA-ASP-6		54	ASPL, CPNP		68	Board of Trustees-5	
13	Former Presidents-6		27	Former Speakers-5		41	Former Speakers-5		55	HOPA, NCPA		69	Board of Trustees-5	
14	Former Presidents-6		28	Former Presidents-5		42	Former Speakers-5		56	NPhA, NRPhA, USP		70	Board of Trustees-5	

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 18, 2022
2:45PM – 5:15PM

SEATING CHART BY DELEGATION NAME

Alabama – Table 1
Alaska – Table 2
Arizona – Table 2
Arkansas – Table 1
California – Tables 3 & 4
Colorado – Table 6
Connecticut – Table 5
Delaware – Table 5
District of Columbia – Table 4
Florida – Table 16
Georgia – Table 15
Guam – Table 15
Hawaii – Table 6
Idaho – Table 17
Illinois – Table 19
Indiana – Table 18
Iowa – Table 17
Kansas – Table 30
Kentucky – Table 20
Louisiana – Table 30
Maine – Table 18
Maryland – Table 29
Massachusetts – Table 20
Michigan – Table 31
Minnesota – Table 32
Mississippi – Table 34
Missouri – Table 33
Montana – Table 32
Nebraska – Table 44
Nevada – Table 48
New Hampshire – Table 33
New Jersey – Table 43
New Mexico – Table 34
New York – Table 46
North Carolina – Table 45
North Dakota – Table 31
Ohio – Table 47
Oklahoma – Table 48
Oregon – Table 58
Pennsylvania – Table 57 & 58
Puerto Rico – Table 61
Rhode Island – Table 44
South Carolina – Table 59
South Dakota – Table 62
Tennessee – Table 60
Texas – Tables 60 & 61
Utah – Table 63
Vermont – Table 57
Virginia – Table 63
Washington – Table 64
West Virginia - 64
Wisconsin – Table 65
Wyoming – Table 65
AAPS – Table 50
AACP – Table 50
ACA – Table 51
ACCP – Table 51
ACVP – Table 51
AIHP – Table 52
AMCP – Table 52
ASHP – Table 53
ASCP – Table 53
ASPL – Table 54
CPNP – Table 54
HOPA – Table 55
NCPA – Table 55
APC – Table 53
National Pharmaceutical Assn. – Table 56
National Pharmacists Assn. – Table 56
Air Force – Table 67
Army – Table 67
Navy – Table 67
PHS – Table 66
USP – Table 56
Veterans Administration – Table 66
APhA-APPM – Tables 8, 9, 10, 11, & 12
APhA-APRS – Tables 22, 23, 24, 25, & 26
APhA-ASP – Tables 36, 37, 38, 39, & 40
APhA Board of Trustee – Tables 68, 69, & 70
APhA Former Presidents –Tables 13, 14, & 28
APhA Former Speakers – Tables 27, 41, & 42
Speaker Appointed – Tables 7, 21, 35, & 49

American Pharmacists Association House of Delegates
FINAL SESSION - Monday, March 21, 2022 - 1:30PM – 4:30PM

SEATING CHART

Speaker of the House

1	CO-3+	HI-2*	15	KY-4	MA-2	29	MS-3	NM-3	43	NV-3*	OK-3	57	WI-3	WY-1
2	CT-3+	DE-2*	16	IL-5*		30	MO-4	NH-2	44	OH-6		58	WA-3	WV-3*
3	CA-3	DC-3*	17	IN-4	ME-2	31	MN-4*	MT-2	45	NY-6		59	UT-1	VA-5
4	CA-6		18	ID-2	IA-3	32	MI-4+	ND-1	46	NC-5		60	SD-1	TX-4+
5	AK-2	AZ-4*	19	FL-5		33	KS-3	LA-3	47	NE-3+	RI-2*	61	PR-3*	TX-3
6	AL-4	AR-2	20	GA-4	GU-2	34	MD-5		48	NJ-5*		62	TN-5+	
7	Speaker Appointed-5		21	Speaker Appointed-5		35	Speaker Appointed-5		49	Speaker Appointed-5		63	SC-4*	
8	APhA-APPM-6		22	APhA-APRS-6		36	APhA-ASP-6		50	AACP, AAPS		64	PA-3	OR-3
9	APhA-APPM-6		23	APhA-APRS-6		37	APhA-ASP-6		51	ACA, ACCP, ACVP		65	PA-3+	VT-2*
10	APhA-APPM-5		24	APhA-APRS-5		38	APhA-ASP-5		52	AIHP, AMCP		66	Vet Admin, PHS	
11	APhA-APPM-5		25	APhA-APRS-6		39	APhA-ASP-5		53	APC, ASCP, ASHP		67	Army, Air Force, Navy	
12	APhA-APPM-6		26	APhA-APRS-5		40	APhA-ASP-6		54	ASPL, CPNP		68	Board of Trustees-5	
13	Former Presidents-6		27	Former Speakers-5		41	Former Speakers-5		55	HOPA, NCPA		69	Board of Trustees-5	
14	Former Presidents-6		28	Former Presidents-5		42	Former Speakers-5		56	NPhA, NRPhA, USP		70	Board of Trustees-5	

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 21, 2022
1:30PM – 4:30PM

SEATING CHART BY DELEGATION NAME

Alabama – Table 6
Alaska – Table 5
Arizona – Table 5
Arkansas – Table 6
California – Tables 3 & 4
Colorado – Table 1
Connecticut – Table 2
Delaware – Table 2
District of Columbia – Table 3
Florida – Table 19
Georgia – Table 20
Guam – Table 20
Hawaii – Table 1
Idaho – Table 18
Illinois – Table 16
Indiana – Table 17
Iowa – Table 18
Kansas – Table 33
Kentucky – Table 15
Louisiana – Table 33
Maine – Table 17
Maryland – Table 34
Massachusetts – Table 15
Michigan – Table 32
Minnesota – Table 31
Mississippi – Table 29
Missouri – Table 30
Montana – Table 31
Nebraska – Table 47
Nevada – Table 43
New Hampshire – Table 30
New Jersey – Table 48
New Mexico – Table 29
New York – Table 45
North Carolina – Table 46
North Dakota – Table 32
Ohio – Table 44
Oklahoma – Table 43
Oregon – Table 64
Pennsylvania – Table 64 & 65
Puerto Rico – Table 61
Rhode Island – Table 47
South Carolina – Table 63
South Dakota – Table 60
Tennessee – Table 62
Texas – Tables 60 & 61
Utah – Table 59
Vermont – Table 65
Virginia – Table 59
Washington – Table 58
West Virginia - 58
Wisconsin – Table 57
Wyoming – Table 57
AAPS – Table 50
AACP – Table 50
ACA – Table 51
ACCP – Table 51
ACVP – Table 51
AIHP – Table 52
AMCP – Table 52
ASHP – Table 53
ASCP – Table 53
ASPL – Table 54
CPNP – Table 54
HOPA – Table 55
NCPA – Table 55
APC – Table 53
National Pharmaceutical Assn. – Table 56
National Pharmacists Assn. – Table 56
Air Force – Table 67
Army – Table 67
Navy – Table 67
PHS – Table 66
USP – Table 56
Veterans Administration – Table 66
APhA-APPM – Tables 8, 9, 10, 11, & 12
APhA-APRS – Tables 22, 23, 24, 25, & 26
APhA-ASP – Tables 36, 37, 38, 39, & 40
APhA Board of Trustee – Tables 68, 69, & 70
APhA Former Presidents –Tables 13, 14, & 28
APhA Former Speakers – Tables 27, 41, & 42
Speaker Appointed – Tables 7, 21, 35, & 49

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 November 5, 2021

The following information reflects the final language adopted by the APhA House of Delegates during its Fall Virtual House session on November 5, 2021.

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 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, retain, or amend all such existing policy, with limited debate, shall be in order. Items identified by the Policy Review Committee as needing amendment shall be reviewed by the Committee and Speaker of the House to determine that the amendment does not change the intent of the original policy and included in a separate section of the Policy Review Committee report provided to delegates. Any substantive amendments or those that change the intent of the original policy should be submitted by the Policy Review Committee to the New Business Review Committee for consideration.

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

Rule 15 Policy Reference Committee

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

Rule 16 Virtual House of Delegates

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

Rule 17 Unfinished and Referred Business Items

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

Upon confirmation of an "Unfinished Business Item", the Speaker must clearly identify within the "Actions of the House Report" how Unfinished Business Items will receive further action. Unless defined within a motion from a Delegate, the Speaker, in consultation with the Secretary of the House, has the authority to assign "Unfinished Business Items" to an appropriate House Committee, the Board of Trustees, or a future session of House business for further action.

An update on "Unfinished Business Items" or any "Referred Business Items" from any prior House session should be provided by the Speaker at future House sessions until action has been taken by the House or no further action is recommended on the item.

Parlimentary Procedures At A Glance

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

2020-21 House of Delegates

Report of the House Rules Review Committee

Committee Members

Cynthia Boyle, Chair
Susie Bartlemay
Lauren Bode
Matthew Lacroix
Ann McManis
Frank North
Rajan Vaidya

Ex Officio Members
Melissa Duke, Speaker of the House

2021-2022
APhA House Rules Review Committee Report

The 2021-2022 APhA House Rules Review Committee (HRRC) consists of the following APhA members and long-time Delegates:

Cynthia Boyle, Chair
Reisterstown, MD

Susie Bartlemay
Millington, TN

Lauren Bode
Saint Albans, VT

Matthew Lacroix
West Warwick, RI

Ann D. McManis
Tampa, FL

Frank North
Houston, TX

Rajan Vaidya
Sacramento, CA

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 November 29, 2021 and December 9, 2021 and made the following recommendations.

Recommendations to the APhA House of Delegates

After thorough consideration, and in conjunction with the feedback received from Delegates, members, leaders, and staff regarding the activities of the House of Delegates the HRRC unanimously supports the following recommendations for acceptance by the APhA House of Delegates.

- Review of Fall Virtual House
    - The Committee discussed the importance of conducting a Fall Virtual House session to complete "procedural" aspects of the House, allow Delegates to receive an interim update from the Speaker of the House outside of the annual update during the March House sessions, and allow for the opportunity to complete any unfinished or referred business from the March House sessions.
    - Additionally, the timing of the Fall Virtual House was reviewed, and the Committee acknowledged that it may be difficult for practicing pharmacists to take time from work to attend an afternoon session on a Friday afternoon. The Committee encourages APhA staff to consider a different day or a different time for future Virtual House Sessions.

- The Committee also noted one additional process to modify for Virtual House sessions regarding "calling the question". In order to mirror an in-person House session as closely as possible, the Speaker should identify the specific delegate that wishes to "call the question" if the name of this delegate is not otherwise visible to the rest of the delegates.

- Policy Review Committee
  - The Committee discussed the charges and scope of the Policy Review Committee at length throughout the year and specifically during both calls following the November 5, 2021, Virtual House session.
  - The Committee agreed that the Policy Review Committee should retain the ability to update and amend policies to ensure active policy does not become outdated and to provide a structured way to bring policies up to date outside of the existing New Business Item process.
  - Proposed modifications to Rule 6 and Rule 14 of the existing House Rules of Procedure are recommended by the Committee to achieve a balance of Committee authority to amend with oversight by Delegates.
  - The Committee agreed that the process of handling the majority of the report recommendations including retain, rescind, and archive should be maintained. This process would still allow any Delegate to pull out any of these items for individual debate and vote, as needed.
  - The Committee recommends that the Policy Review Committee presents any recommendation to amend a statement as a separate and individual motion. This is to ensure that these recommendations to amend are clear and Delegates know exactly what is being proposed. Transparency was a critical part of the Committee's discussion, and it should be very clear to Delegates as to what amendments to existing policy are up for debate and vote. This change will require a modification to Rule 14 of the existing APhA House Rules of Procedures and that modification is outlined within this report.
  - The Committee recommends additional modifications to Rule 6 and Rule 14 of the APhA House Rules of Procedures that will allow the Policy Review Committee to propose an amendment to existing policy that may go beyond the original intent of the policy. The Committee recommends this proposed change in tandem with additional guidance for development of the Policy Review Committee's report.
    - As noted earlier in this report the Committee recommends that any recommendation to amend is handled as a separate motion to allow for necessary review and debate by Delegates.
    - The Policy Review Committee will need to provide detailed background information to justify any change.
    - The Policy Review Committee will continue to host open forum webinars and will have the ability to change their recommendations following feedback received from these open forum webinars prior to debate of their report during a House session. This addition will mirror the process used by the Policy Reference Committee and the New Business Review Committee and ensure Delegates have the opportunity to provide

actionable feedback on the Policy Review Committee's report and recommendations.

- The Committee proposes these recommendations to allow for more transparency in the work of the Policy Review Committee, provide wider input from Delegates, and allow for more meaningful review and debate by Delegates prior to a vote within a House session.

- Use of a Poll to Accomplish House Business
  - The Committee noted their recommendations on the use of a ballot or poll were approved as presented within their November 5, 2021, Committee report. Furthermore, the Committee wishes to clarify that additional observation and collection of feedback on this process will be essential prior to drafting any formal proposed House Rules on this process.
  - The Committee had additional discussion around the name of the process to ensure it was clear that the action was not final and therefore has requested this be called a poll. APhA staff should provide clear instruction that the results of this poll lead into development of a consent agenda or a consent calendar that will have final action taken by the House during the March House session.
  - The Committee recommends a poll process to be used in preparation for the March 2022 House sessions. Content for this poll would only include the Policy Reference Committee's recommendations following the January open forum webinars on the proposed policy statements.
  - In future years, additional committee recommendations could be added into this polling process.

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 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 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~~, or amend~~ all such existing policy, with limited debate, shall be in order. Items identified by the Policy Review Committee as needing ~~amendment shall be reviewed by the Committee and Speaker of the House to determine that the amendment does not change the intent of the original policy and included in a separate section of the Policy Review Committee report provided to delegates.~~ any ~~substantive~~ amendments will be introduced as separate motions for consideration ~~or those that change the intent of the original policy should be submitted by the Policy Review Committee to the New Business Review Committee 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.

2021-2022 House of Delegates

Report of the Policy Reference Committee

- ❖ Standard of Care Regulatory Model for State Pharmacy Practice Acts
- ❖ Data Security in Pharmacy Practice
- ❖ Data Use and Access Rights in Pharmacy Practice

Committee Members

Alison Knutson, Chair
Dalton Fabian
Thomas Franko
Sara McElroy
Emily Prohaska
Daniel Robinson
Haniff Sealy

Ex Officio
Missy Skelton Duke, Speaker of the House

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

The APhA House of Delegates Policy Reference Committee reviewed feedback provided directly via email and from two open hearing webinars that took place on January 12, 2022 and January 19, 2022. The Committee then met on Wednesday, January 19, 2022, to develop the following recommendations. Note: proposed amendments are in red font and deletions are ~~**struck through**~~ and proposed additions are **underlined**.

Topic #1 – Standard of Care Regulatory Model for State Pharmacy Practice Acts

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

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

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

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

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

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

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

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

Topic #2 – Data Security in Pharmacy Practice

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

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.

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

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.

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

3. APhA calls on organizations to provide ongoing employee education and training regarding patient data protection, best practices, and cybersecurity standards.

Topic #3 – Data Use and Access Rights in Pharmacy Practice

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

1. APhA supports ~~an~~ organization~~'s~~ and patient care provider~~'s~~ 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.

Comments: Based on feedback during the open hearing webinars, the committee discussed the importance of including public health outcomes within this statement. Additionally, the Committee recommended amendments to streamline the language by removing the apostrophe and "s" from organization and provider.

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

2. APhA urges ongoing transparent, accessible, and comprehensible disclosure to patients by all HIPAA-covered and non-covered entities as to how personally identifiable information may be utilized.

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

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.

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

4. APhA supports the right of patients to have **full and** timely access to their personal health data from all entities.

Comments: The committee reviewed this suggested amendment from an open hearing webinar and agreed that the patient should have full access to their personal health data in addition to having timely access to this same data. The Committee agreed that this amendment enhances the original intent of the original policy statement.

Standard of Care Regulatory Model for State Pharmacy Practice Acts

Background paper prepared for the 2021-2022 APhA Policy Committee

Olivia C. Welter, PharmD
2021-2022 Executive Fellow
American Pharmacists Association Foundation

Issue

The American Pharmacists Association (APhA) Board of Trustees has directed the 2021–2022 Policy Committee to recommend policy to the APhA House of Delegates related to the regulation of pharmacist standard of care for state pharmacist practice acts. The Board's guidance on this topic included, but was not limited to, the current landscape of state practice acts, a newly implemented standard of care model in a state pharmacy practice act, and legislative considerations as pharmacists' standard of care evolves.

Summary of key concepts

- Pharmacy is among the most regulated of healthcare professions, with laws and rules pertaining to pharmacy practice having higher word counts, as compared to nursing and physicians.
- Pharmacy practice acts vary widely by state, with inconsistent definitions of pharmacy practice.
- Standards of care in pharmacy are continuously changing as research is constantly conducted.
- Most states require a change in law to carry out a change in pharmacy practice, while a "standard of care" model would allow professions to follow permissive rather than prescriptive regulations.
- Idaho implemented statewide pharmacist regulations following a standard of care model. The regulations took effect in July 2018.
- National Association of Boards of Pharmacy (NABP) convened a task force to develop regulations based on standards of care. The report was published in late 2018.
- Additional states are beginning to consider implementing rules which follow a "standard of care" model.

Definitions

Standard of care

NABP's Model State Pharmacy Act defines "standard of care" as "the degree of care a prudent and reasonable licensee or registrant with similar education, training, and experience will exercise under similar circumstances".[1]

"Standard of care" model

There is no formally recognized definition for "'standard of care' model". However, for the purpose of this background paper, "'standard of care' model" means a regulatory model that is permissive rather than prescriptive, and evolves over time, independent of laws/statutes.

Practice of pharmacy

The definition of "practice of pharmacy" is not consistent across state practice acts. NABP's *Model State Pharmacy Act* states: "The "Practice of Pharmacy" means, but is not limited to, the interpretation, evaluation, Dispensing, and/or implementation of Medical Orders, and the initiation and provision of Pharmacist Care Services. The Practice of Pharmacy also includes continually optimizing patient safety and quality of services through effective use of emerging technologies and competency-based training".[1]

Background

Members of the pharmacy profession widely agree that pharmacy is among the most regulated of health professions. This is evidenced by word counts within rules and code as well as by number of amendments that are made to pharmacist regulations. In fact, a 2019 article explored the regulatory burden of pharmacy professionals compared to medicine and nursing.[2] According to the analysis, the results showed that statutes and regulations related to pharmacy have 105.8% more words than those relating to medicine as well as 97.5% more words than nursing as they related to regulation of practice standards. Additionally, the study examined changes to regulations from 1996 to 2017 and found that nursing-related regulations decreased their total net word count by 28.7%, while those for pharmacy increased their word count by 36.6%. This shows that nursing, as a profession, has successfully been able to deregulate while pharmacy continues to become more regulated.

One state which provides a good example of how differently medicine and pharmacy are regulated within the state's code is Ohio. Ohio is recognized as one of the nation's most progressive states in pharmacy practice. However, Ohio Administrative Code visibly displays how much more of a regulatory burden to which pharmacy must adhere than medicine in general.[3] Chapter 4729 is titled "State Board of Pharmacy," and on the main webpage this chapter has an additional 11 sections. Each additional section has subsections, and each of those subsections additionally leads to several more subsets of code. For example, to read the code for pharmacist criteria for licensure by examination, one would click on Chapter 4729:1 ("Pharmacists"), then select 4729:1-2 ("Licensing of Pharmacists"), and finally 4729:1-2-01 ("Criteria for licensure by examination") to be brought to the actual code pertaining to that topic. In contrast, Chapter 4731 is titled "State Medical Board" and has no additional subsections displayed on the main webpage. To read the code related to eligibility for medical licenses, one would select Chapter 4731, then 4731-6 ("Medical or Osteopathic License"), and finally 4731-14 ("Eligibility for licensure"). Figure 1 serves as a visual representation of the main webpage for Ohio Administrative Code with chapters governing State Board of Pharmacy and State Medical Board visible. The structure that State Board of Pharmacy regulations follow in the image is similar to those of the Ohio Department of Commerce, Ohio Department of Natural Resources, and Ohio Development Services Agencies—all major components of the state government, whereas the State Board of Pharmacy is a relatively small entity in comparison.

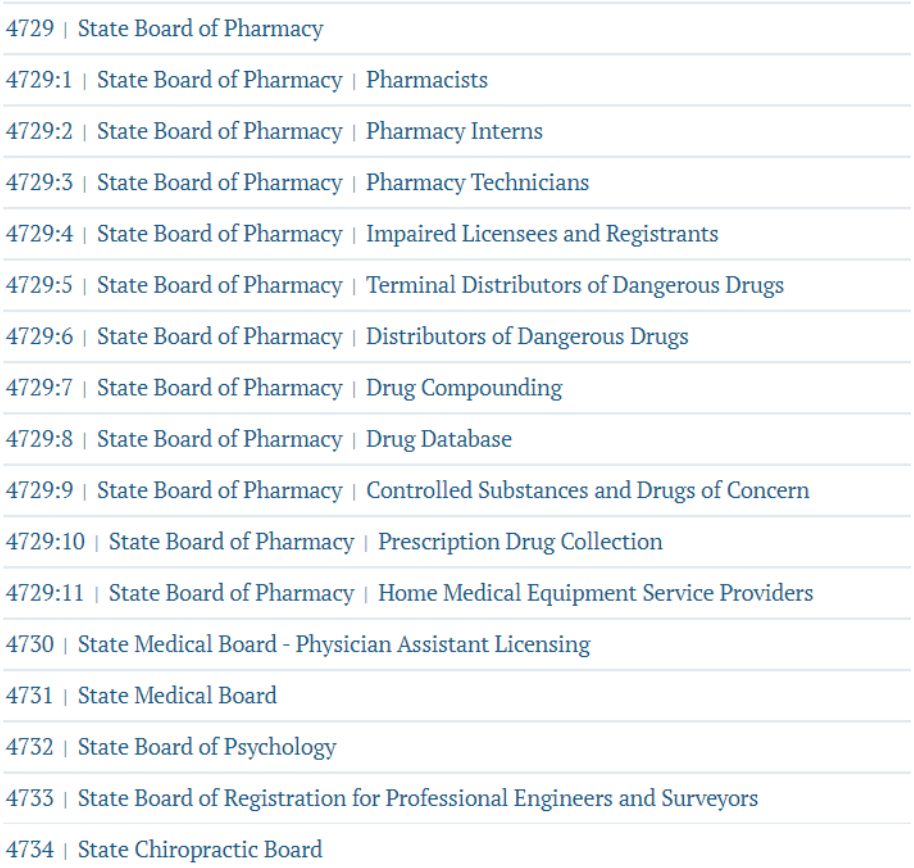


Figure 1. A screenshot showing Ohio Administrative Code's main webpage, showing pharmacy regulations (4729:1-11) versus medical regulations (4731).

The current landscape of pharmacy regulation is rooted in state pharmacy practice acts. Each act can have its own definition of the practice of pharmacy, which allows for individualized provisions regarding acts pharmacists are and are not allowed to perform. This is one reason why pharmacists must take a separate exam for each state in which they desire to be licensed; while in one state a pharmacist may have full ability to prescribe certain treatments to patients, in another jurisdiction the same type of prescribing by a pharmacist may be forbidden. Some jurisdictions, such as District of Columbia, have separate practice acts for pharmacies and for pharmacists,[4] which complicates the practice of pharmacy overall in these areas.

In order for pharmacists to gain the power to perform a new service for patients, a state's code must first be amended. This process is not conducive to changes that would address urgent patient care needs. The legislative process is often slow-moving, and it can take several legislative sessions for a bill to be passed. Each state has different time frames for legislative sessions, and they can be less than 2 months long; for example, Utah's 2021 legislative session lasted from January 19 to March 5, and Florida's 2021 session spanned only from March 2 to April 30.[5] This amount of time may not allow for pharmacy regulatory changes to be considered a priority, so it could take multiple years before pharmacy advocates are able to garner adequate attention from elected officials and their constituencies.

A “standard of care” approach to regulation of a given profession creates an opportunity that would allow professions to follow permissive rather than prescriptive regulations. By following practices which are generally accepted by others with similar education and practice experience, professionals can make informed decisions about which acts they can and cannot perform. This type of regulatory model would bypass the legislative process, as pharmacy practice acts would not need to be updated as often. “Standard of care” models would closely follow evidence-based guidelines and treatment algorithms, among other resources provided by nationally recognized entities.

Recent actions

State and national entities have taken recent actions related to the implementation of “standard of care” models to regulate the pharmacy profession at the state level.

Idaho model

Recently, Idaho’s Board of Pharmacy completely scrapped their rules in exchange for a more concise and permissive pharmacy practice act. Beginning in 2017, the Board took comments from the public on their proposed new rules, and discussion behind changes made to their draft rules are highlighted in the Board’s minutes.[5] An extensive review process involving many stakeholders continued from this point. Then, in March 2018, Idaho Board of Pharmacy reported via its newsletter that the Idaho legislature had approved the repeal of all Board of Pharmacy rules and had subsequently approved a new, 6-chapter set of rules, which took effect in July 2018.[6,7] The new chapters are:

1. General Provisions
2. Rules Governing Licensing and Registration
3. Rules Governing Pharmacy Practice
4. Rules Governing Pharmacist Prescriptive Authority
5. Rules Governing Drug Compounding
6. Rules Governing Durable Medical Equipment (DME), Manufacturing, and Distribution

Essentially, this new set of rules applies the idea that a pharmacist’s scope of practice is everything except that which is expressly prohibited by law as long as the licensee’s training, education, and/or practice experience is consistent with the act in question. In addition, if the accepted standard of care includes performance of an action, it is generally a pharmacist is generally to perform it.

Rule 100 within the chapter titled “General Provisions” defines pharmacy practice for the state of Idaho:[9]

> **100. PRACTICE OF PHARMACY: GENERAL APPROACH.**
> To evaluate whether a specific act is within the scope of pharmacy practice in or into Idaho, or whether an act can be delegated to other individuals under their supervision, a licensee or registrant of the Board must independently determine whether:
> **01. Express Prohibition**. The act is expressly prohibited by:

a. The Idaho Pharmacy Act, Title 54, Chapter 17, Idaho Code;
b. The Uniform Controlled Substances Act, Title 37, Chapter 27, Idaho Code;
c. The rules of the Idaho State Board of Pharmacy; or
d. Any other applicable state or federal laws or regulations.

02. Education, Training, and Experience. The act is consistent with licensee or registrant's education, training, and experience.

03. Standard of Care. Performance of the act is within the accepted standard of care that would be provided in a similar setting by a reasonable and prudent licensee or registrant with similar education, training[,] and experience.

The language for "03. Standard of Care" was based on Idaho Board of Medicine and Board of Nursing language.[6]

What this means for pharmacy practice in Idaho is that their rules will no longer need to be amended or updated for pharmacists to begin performing new services within their standard of care. Pharmacist roles in Idaho will be able to evolve as new research is conducted and accepted by the profession, as the model is more evergreen in nature and flexible depending on the current landscape of the pharmacy profession. This allows for pharmacists to start implementing new approaches to patient care quickly, bypassing the wait time that is almost guaranteed when going through the legislative process.

An article published in *JAPhA* in July 2020 examined Idaho's innovative approach to pharmacy regulation and its impacts on the profession.[10] It noted that the rules, as they are currently written, allow for pharmacists to delegate tasks to pharmacy technicians if they determine the tasks are within the scope of the technician's education and training; therefore, many pharmacists have been delegating technicians to perform final product verification. In addition, the new rules leave room for pharmacists to perform prescription adaptation. With this added ability, pharmacists can perform acts—such as extending a prescription for an additional 30 days' supply for a maintenance therapy so as not to disrupt the treatment—as well as using professional judgment to independently transition a patient from one statin to a different statin, as an example.

The *JAPhA* article also offers an analysis of the portion of the new rules that focuses on facility standards. The author stated that the Board was pursuing 2 goals in changing language related to facilities: make the regulations practice- and technology-agnostic, and enable decentralization of pharmacy functions to offsite locations. Removing the existing granular language intended to provide discipline in cases of medication errors and/or theft or loss of controlled substances did not change the fact that the Board can take disciplinary action due to already existing rules on unprofessional conduct.

Overall, Idaho was able to reduce its word count related to professional practice standards by 47.9%, and its word count related to facility standards by 68.4%.[10]

NABP resolution & Task Force

At the May 2018 NABP Annual Meeting, Resolution 114-4-18: Task Force to Develop Regulations Based on Standards of Care was passed, resolving "that NABP convene an interdisciplinary task force to explore considerations for transitioning from strictly prescriptive rule-based regulations to a model that includes a standard of care process, and discuss the necessary tools (eg [sic], peer review committees, enforcement approaches) for boards of pharmacy to make this transition".[11] There were several points included within the resolution as to why it was being prioritized:

- The practice of pharmacy continues to evolve toward direct patient care.
- In some settings, pharmacists are currently prescribing drugs and devices, ordering and interpreting drug therapy-related tests, and administering drugs.
- Technology continues to develop and lead to advancements within the pharmacy profession.
- Medical and nursing regulations include standards of care that have allowed flexibility in their professional scope of practice while preserving the ability of their respective regulatory boards to maintain patient safety

In response to this resolution, NABP convened a task force, which met in October 2018. Their report outlined 5 recommendations to NABP:[12]

- **Recommendation 1:** NABP should encourage state boards of pharmacy to review their practice acts and regulations, consistent with public safety, to determine what regulations are no longer applicable or may need to be revised or eliminated while recognizing evolving pharmacy practice.
- **Recommendation 2:** NABP should encourage state boards of pharmacy to consider regulatory alternatives for clinical care services that require pharmacy professionals to meet the standard of care.
- **Recommendation 3:** NABP should collaborate with states that may adopt standards of care-based regulations to identify, monitor, and disseminate outcomes.
- **Recommendation 4:** NABP should develop a definition of "standards of care" based in evidence to be included in the *Model Act*.
- **Recommendation 5:** NABP should monitor the adoption of the standards of care-based regulation model by the states and, if and when appropriate, consolidate and share information and tools obtained from professional regulatory groups and relevant stakeholders for regulating standards of care-based practice.

In the report, it was noted that some members of the task force were apprehensive to the idea of "permissionless innovation," citing the need for maintaining patient safety. However, they also recognized that pharmacy professionals should be allowed to practice at the top of their licenses. It was suggested that boards of pharmacy collaborate closely with boards of medicine and nursing in order to identify tools that can be used to enforce regulations and provide accountability. In further discussions, the task force determined that, if states implement standards of care–based regulation and it is found to maintain patient safety, NABP should be involved in developing a path forward for state boards interested in following suit. The task force

did acknowledge the timeline for this path forward could be long due to need for metrics-based data to determine safety.

NABP has been able to accomplish Recommendation 4 from the task force report. In August of 2020, NABP published their most recently refreshed version of the *Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy*.[1] In this version, NABP successfully included a definition of "standards of care": "the degree of care a prudent and reasonable licensee or registrant with similar education, training, and experience will exercise under similar circumstances."

State-level actions

Following Idaho, other state pharmacy organizations are beginning to consider modernized practice acts as a regulatory priority. Specifically, Iowa Pharmacy Association (IPA) has begun their process of modernizing their state practice act to potentially reflect a "standard of care" model. Their 2019 House of Delegates passed policy resolution 19-U2: Revisions to the Iowa Pharmacy Practice Act,[13] indicating that IPA members were supportive of the creation of a task force to evaluate a need for modernization, with representatives from both the Iowa Board of Pharmacy and IPA. Additionally, the membership supported thorough consensus-building as a strategy to ensure stakeholders could provide input to a rewrite of the state practice act. The group determined that modernizing the act was necessary for reasons such as the act having last been completely updated in 1986 and the need for several major revisions that reflect Iowa pharmacy professionals' ability to participate in new services, including immunizations and technician product verification.

Throughout the final half of 2021, IPA is hosting town halls to garner member feedback on their task force's draft of a practice of pharmacy definition. Notably, the definition references following the "standard of care" related to prescribing of drugs, drug categories, and devices.

Conclusion

Pharmacy is a profession that carries a heavy regulatory burden, especially in comparison to other health professions. A "standard of care" approach to regulatory models could be a potential way for pharmacist roles to evolve as standards of care change so that pharmacists are able to continuously practice at the top of their licenses.

Related APhA Policy

- **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)

- **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 the following: (a) adequate resources; (b) independent authority, including autonomy from other agencies; and (c) assistance in meeting their mission to protect the public health and safety of consumers.

  3. APhA 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)

- **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)

References

1. Model Pharmacy Act/Rules. nabp.pharmacy. Published August 27, 2021. Accessed November 9, 2021. https://nabp.pharmacy/resources/model-pharmacy-act/
2. Adams AJ. Transitioning pharmacy to "standard of care" regulation: Analyzing how pharmacy regulates relative to medicine and nursing. *Res Social Adm Pharm.* 2019 Oct;15(10):1230-1235. doi: 10.1016/j.sapharm.2018.10.008
3. Ohio Administrative Code. codes.ohio.gov. Accessed November 9, 2021. https://codes.ohio.gov/ohio-administrative-code
4. Pharmacy Laws and Regulations. dchealth.dc.gov. Accessed November 9, 2021. https://dchealth.dc.gov/service/pharmacy-laws-and-regulations
5. 2021 State Legislative Session Calendar. National Conference of State Legislatures. Last updated November 9, 2021. Accessed November 9, 2021. https://www.ncsl.org/research/about-state-legislatures/2021-state-legislative-session-calendar.aspx
6. Minutes of the Idaho State Board of Pharmacy. bop.idaho.gov. Pages 5-6. Published October 25, 2017. Accessed November 9, 2021. https://bop.idaho.gov/wp-content/uploads/sites/99/board_meeting/2017_Board-Meeting-Minutes_All.pdf
7. Idaho State Board of Pharmacy News. nabp.pharmacy. Published March 2018. Accessed November 9, 2021. https://nabp.pharmacy/wp-content/uploads/2016/06/Idaho-Newsletter-March-2018.pdf
8. Idaho State Board of Pharmacy News. nabp.pharmacy. Published June 2018. Accessed November 9, 2021.https://nabp.pharmacy/wp-content/uploads/2018/06/Idaho-Newsletter-June-2018.pdf
9. IDAPA 27 – Idaho Board of Pharmacy. bop.idaho.gov. Published March 20, 2020. Accessed November 9, 2021. https://bop.idaho.gov/wp-content/uploads/sites/99/2020/07/2020-Rule-Changes.pdf
10. Adams AJ, Chopski NL. Rethinking pharmacy regulation: Core elements of Idaho's transition to a "Standard of Care" approach. *J Am Pharm Assoc.* Nov-Dec 2020;60(6):e109-e112. doi: 10.1016/j.japh.2020.07.013.
11. Task Force to Develop Regulations Based on Standards of Care (Resolution 114-4-18). nabp.pharmacy. Published May 18, 2018. Accessed November 9, 2021. https://nabp.pharmacy/news/news-releases/task-force-to-develop-regulations-based-on-standards-of-care/
12. Report of the Task Force to Develop Regulations Based on Standard of Care. nabp.pharmacy. Published October 2018. Accessed November 9, 2021. https://nabp.pharmacy/wp-content/uploads/2018/12/Task-Force-to-Develop-Regulations-Based-on-Standards-of-Care-December-2018-1.pdf).
13. 2019 House of Delegates: Policies Adopted. *J Iowa Pharm Assoc.* Page 13. Published November 7, 2019. Accessed November 9, 2021. https://issuu.com/iowapharmacyassociation/docs/2019q3_journal

Data Security, Data Use, and Data Access Rights in Pharmacy Practice

Background paper prepared for the 2021-2022 APhA Policy Committee

Aiya Almogaber, PharmD and Brittany Botescu, PharmD
2021-2022 Executive Residents
American Pharmacists Association

Issue

The American Pharmacists Association (APhA) Board of Trustees has directed the 2021–2022 Policy Committee to recommend policy to the APhA House of Delegates related to data ownership role of pharmacies and pharmacy practices to secure data. The Board's guidance on this topic included, but was not limited to, the current landscape of state practice acts, a newly implemented standard of care model in a state pharmacy practice act, and legislative considerations as pharmacists' standard of care evolves.

Introduction

The Information Age has facilitated a variety of technological advancements and innovations that make knowledge more accessible than ever. With the click of a button, virtually everyone in the United States has access to any person or source of information they can imagine—and never was this so apparent than during the COVID-19 pandemic. Americans were not only dependent on technology for COVID-19 updates, interpersonal connections, and work-from-home opportunities; they were also dependent on technology for health care access. Local pharmacies remained open to help bridge the gap in clinical services such as maintenance vaccinations; however, there was still an emphasis on technology for primary care visits. While there is never an ideal time for a global pandemic to occur, the technology available in the twenty-first century certainly made it more manageable compared to other eras in history. Telemedicine practices rose thanks to platforms like Zoom and Microsoft Teams. The scientific community was able to communicate internationally about COVID-19 data trends and treatments. Outdoor clinics events and health services were created using portable technologies.

However, despite all the positives of technology during this time, a different problem—cybercrime—increased and was exploited in the background. According to an article in *Forbes*, hacking incidents have increased for the fifth consecutive year in 2020, with attacks on health care being particularly brutal.[1] Hackers seemed to take advantage of the vulnerabilities in health systems as they pivoted to accommodate virtual work and telehealth demands. This, in addition to the general fatigue and confusion among health care workers, presented opportunities for those with ill intentions to send targeted attacks, malware, phishing attempts, and more.[1] As a result, the need to investigate and resolve the threats of cybersecurity has increased, especially in the field of health care.

Key terms

Cybersecurity: The protection of networks, devices, and data from unauthorized access or criminal use and the practice of ensuring confidentiality, integrity, and availability of information.[2]

Cybercrime: Criminal activity which either targets or uses a computer, computer network, or networked technological device.

Ransomware: Malware designed to encrypt files on a device, rendering these files and systems useless.[3]

Telehealth: The use of electronic information and telecommunication technologies to provide care when you and the practitioner are not in the same physical place at the same time. Telehealth may also be commonly referred to as telemedicine.[4]

Medical Device: An instrument, apparatus, implement, machine, contrivance, implant, or other similar product intended for the use in diagnosis of disease, or the cure, mitigation, treatment, or prevention of disease. Alternatively, it may be intended to affect specific body structures or functions.[5]

Virtual Private Network: An internet network which helps to establish a protected network connection when using public networks.[6]

Background

The Centers for Medicare and Medicaid Services estimate health care spending in the U.S. accounts for almost 18% of the nation's gross domestic product.[7] Undoubtedly, this makes the health care industry an enticing target for cybercrime. Experienced hackers are taking advantage of outdated Information Technology (IT) systems, fewer cybersecurity protocols, and valuable patient data that can be a dozen times more valuable on the black market. Unfortunately for health care professionals, cyberattacks often have complications beyond financial loss and privacy breaches. These attacks seem to have regulatory compliance and legal impacts which could result in medical malpractice.. As health care organizations struggle to maintain balance between improving patient care and minimizing costs, they must shift their focus to improving technology and keeping patients and staff safe.

Rapidly arising issues in cybersecurity warrant an immediate need to update and design health care systems that protect patient data. Currently, there are several professional roles that function to address core competencies in this area. Data security analysts should be privy to various system vulnerabilities in order to combat potential threats and investigate incidents as they arise. IT security employees are also often tasked with developing a culture of risk awareness by educating staff and motivating senior leadership to ensure network safety.

Types of health system cybercrimes

Cybercrimes are unique due to their immaterial and virtual nature, which allows threats to occur while the attacker is in another part of the world. While the health care industry has become a target for many different types of cyberattacks, there are 6 major categories of concern.

The first is ransomware, or a type of malware that infects systems and files rendering them inaccessible until a certain amount of ransom is paid. Ransomware is especially prevalent within hospitals, as hackers are more likely to use this type of attack to seize critical processes and slow down internet access. In 2020, at least 92 U.S. health care organizations suffered ransomware attacks, resulting in an average ransom demand of $169,446 and netting cybercriminals an estimated $15.6 million in ransoms demanded from the U.S. health care sector.[8] To avoid dealing with substantial damage, health care organizations must ensure the use of protected networks by continuously updating their defense system.

A data breach is a “loss or theft of, or other unauthorized access to, sensitive personally identifiable information that could result in the potential compromise of the confidentiality or integrity of data.”[9] Data breaches may appear as credential-stealing malware that aim to steal protected health information and sell it or use it for other malicious purposes. Medical devices that store sensitive health care data—such as pacemakers or implanted cardioverter defibrillators, insulin pumps, and biosensors—have become particularly valuable to cybercriminals and should have adequate protection against potential cyberattacks.

Distributed denial of service attacks (DDoS attacks) are used by cybercriminals to overwhelm a network so that it loses function. It is extremely difficult to detect DDoS attacks, but it is relatively simple for cybercriminals to attack a specific network. Motives for these attacks range from opportunism to personal or political power to financial gain. DDoS attacks are often a precursor to larger attacks, such as those using ransomware. The health care sector should take measures to develop and improve protection software and provide training for all staff to avoid DDoS attack ramifications such as extended internet loss causing financial loss and inconvenience for patients.

Another major risk within health care systems is the risk of exploitation by insiders also known as insider threats. Since insiders hold legitimate access to the system, they typically also know its weaknesses. The 2 most common forms of insider attacks are carried out by a malicious insider or from an inadvertent insider.

Computer fraud is one of the oldest and most frequent forms of cybercrime. Direct computer fraud is defined as deceitfulness of the person—using a computer system as a medium—, while indirect computer fraud refers to a hacker deceiving the computer system. The most recurrent type of computer fraud is carried out via email, in which a hacker will request data about one’s bank account, social security number, or other personal data. Unfortunately, hackers can develop a very lucrative business for themselves via this avenue, since statistically one in 10,000 people reply with the requested data.

Though it may seem futuristic, hackers can also commit cybercrimes that affect the human body though implanted medical devices (IMD). Human malware refers to the ability of a hacker to access an IMD and cause physical harm by inputting a virus that stops the device from running properly.

Incidence

In March 2021, the Federal Bureau of Investigation (FBI) released the 2020 edition of its annual Internet Crime Report, which analyzes almost 800,000 complaints of suspected internet crime.[10] This number marked an increase of over 300,000 complaints from the year before in 2019. [10] The top 3 cybercrimes listed included phishing scams, nonpayment/non delivery scams, and extortion. The report also found that many of the internet crime during 2020 exploited the COVID-19 pandemic, with over 28,500 of the reported complaints related to COVID-19.

In their report, the FBI breaks down cybercrime in the United States during 2020 by state and category.[11]

State	Number of healthcare-related cybersecurity victims	Financial loss per healthcare-related cybersecurity victim
Alabama	8	$24,260
Alaska	88	$2,700
Arizona	23	$286,188
Arkansas	1	$72
California	153	$2,161,635
Colorado	365	$1,449
Connecticut	17	$51,850
Delaware	3	$712
District of Columbia	2	$60
Florida	81	$3,956,724
Georgia	59	$1,766,256
Hawaii	4	$4,582
Idaho	3	$51
Illinois	31	$3,312,941
Indiana	11	$5,620
Iowa	3	$2,432,320
Kansas	4	$219
Kentucky	11	$462
Louisiana	6	$571
Maine	2	$0
Maryland	24	$142,394
Massachusetts	16	$13,561
Michigan	43	$33,500
Minnesota	13	$843

Mississippi	6	$254
Missouri	25	$986,647
Montana	2	$26
Nebraska	7	$513
Nevada	8	$3,583
New Hampshire	3	$94
New Jersey	38	$3,510,750
New Mexico	14	$17,045
New York	104	$1,998,102
North Carolina	26	$53,247
North Dakota	0	$0
Ohio	27	$173,784
Oklahoma	6	$699
Oregon	9	$2,038
Pennsylvania	213	$312,664
Rhode Island	4	$834,728
South Carolina	3	$311
South Dakota	2	$1,118
Tennessee	15	$3,645
Texas	68	$1,665,912
Utah	5	$17,260
Vermont	0	$0
Virginia	29	$33,047
Washington	18	$89,579
West Virginia	3	$720
Wisconsin	13	$25,581
Wyoming	2	$4,209

In terms of global data, according to the 2021 Cyber Attack Trends Mid-Year Report, there was a 29% increase in cyberattacks globally during 2021, as well as a 93% increase in global ransomware attacks.[12]

2021 Mid-Year Report	Average Attacks Per Week	Percent Change from Year Prior
United States of America Organizations	443	+17%
Europe, Middle East & Africa (EMEA) Organizations	777	+36%
Asia, Pacific (APAC) Organizations	1338	+13%

Although the number of attacks in the United States is not the highest rank among these groups, that is not to say that these attacks have been mild. In early July 2021, approximately 200 U.S. businesses were affected by a single "colossal" supply-chain ransomware attack against Florida-based IT company Kaseya, causing the U.S. Department of Cybersecurity and Infrastructure Security Agency to release a statement of action.[13] This same attack also affected hundreds of businesses outside of the United States, including one grocery chain in Sweden which was forced to temporarily close at least 800 stores as a result.[14]

Earlier in February 2021, the American grocery store chain Kroger Co. announced that both employee and customer information was stolen in a cyberattack against one of their third-party vendors.[15] Although less than 1% of Kroger customers are believed to have been affected, the attack was naturally a great concern for all 2,750 grocery retail stores and 2,200 pharmacies within the Kroger network nationwide. Vulnerable information to this hack included[15]

- Patient names
- Email addresses
- Phone numbers
- Home addresses
- Dates of birth
- Social security numbers
- Health insurance information
- Prescriptions
- Medical history

Outcomes

According to the 2020 FBI Internet Crime Report, cybercrimes resulted in $4.2 billion in losses overall. Victims lost money most commonly via business email compromise scams, romance and confidence schemes, and investment fraud.[10]

Methods to protect against and combat cyberattacks

National/federal government level

President Biden established cybersecurity as one of the top Department of Homeland Security priorities during his administration. As a result, DHS has dedicated different time ranges in the form of "sprints" to important subtopics of cybersecurity.[16]

- Ransomware Sprint: April 2021–May 2021
- Cybersecurity Workforce Sprint: May 2021–June 2021
- Industrial Control Systems Sprint: July 2021–August 2021
- Cybersecurity and Transportation Sprint: September 2021–October 2021
- Election Security Sprint: November 2021–December 2021
- International Cybersecurity Sprint: January 2022–February 2022

Internationally, cybersecurity was also a topic of the 47th G7 summit of world leaders in Great Britain in June 2021. During the summit, President Biden publicly outlined 16 U.S. Departments not to be hacked.[17] U.S. Congress established cybersecurity as a priority via the recent National

Defense Authorization Act (NDAA), which provides authorities for Cybersecurity and Infrastructure Security Agency (CISA) to seek out cyberthreats in federal agency networks as well as issue directives for other federal agencies to participate in programs intended to identify cybersecurity vulnerabilities.[18]

Local/institution level

On the more local level, businesses and organizations across the country are employing their own methods to protect against cyberthreats. This includes IT safety training programs, virus protection software, employee safe blocks, and internal reporting procedures for potential cyberthreats.

Related APhA policy

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 upon 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)

1996 Confidentiality of Patient Data

APhA supports the establishment of uniform national privacy protection standards for personally identifiable health information. These standards should:

a) include provisions for patients to access and request modification of their health information, and disclosure of who will have access to the information;

b) establish broad privacy protections for the individual patient without compromising patient care or creating an excessive administrative burden for health care providers; and

c) make a distinction between the clinical information required for communication among health care professionals, and the administrative or financial information required by others (e.g., claims processors and payers).

(JAPhA NS36(6):396 June 1996) (Reviewed 2005) (Reviewed 2009) (Reviewed 2010)

1994 Confidentiality of Computer-generated Patient Records

APhA, in cooperation with the National Council of Prescription Drug Programs, Inc. (NCPDP), 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)

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)

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)

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)

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)

References

1. Culbertson N. Cyberattacks on healthcare institutions shows the need for greater cybersecurity. *Forbes*. 2021. https://www.forbes.com/sites/forbestechcouncil/2021/06/07/increased-cyberattacks-on-healthcare-institutions-shows-the-need-for-greater-cybersecurity.
2. United States Cybersecurity & Infrastructure Security Agency. Security tip (ST04-001): What is cybersecurity? Cybersecurity & Infrastructure Security Agency. 2019. https://us-cert.cisa.gov/ncas/tips/ST04-001.
3. Certified Information Systems Auditor. Stop Ransom Ware. 2021. https://www.cisa.gov/stopransomware.
4. United States Department of Health & Human Services. What is telehealth? 2021. https://telehealth.hhs.gov/patients/understanding-telehealth/.
5. United States Food & Drug Administration. How to determine if your product is a medical device. 2019. https://www.fda.gov/medical-devices/classify-your-medical-device/how-determine-if-your-product-medical-device.
6. Cisco. What is a VPN? Cisco. https://www.cisco.com/c/en/us/products/security/vpn-endpoint-security-clients/what-is-vpn.html.
7. California Health Care Foundation. 2020 Edition—Health care costs 101. California Health Care Foundation. 2020. https://www.chcf.org/publication/2020-edition-health-care-costs-101/.
8. Peden S, Rezek M. Clinical treatment of ransomware in healthcare. *Security*. 2021. https://www.securitymagazine.com/articles/95381-clinical-treatment-of-ransomware-in-healthcare.
9. Princeton University. What to do in the event of theft, loss, or unauthorized use of confidential research data. Princeton University. N.d. https://ria.princeton.edu/human-research-protection/data/what-should-i-do-in-the-e.
10. United States Federal Bureau of Investigation. FBI releases the Internet Crime Complaint Center 2020 internet crime report, including COVID-10 scam statistics. FBI: Federal Bureau of Investigation. 2021. https://www.fbi.gov/news/pressrel/press-releases/fbi-releases-the-internet-crime-complaint-center-2020-internet-crime-report-including-covid-19-scam-statistics.
11. United States Federal Bureau of Investigation. FBI 2020 State Annual Report. IC3. 2021. https://www.ic3.gov/Media/PDF/AnnualReport/2020State/StateReport.aspx#?s=1.
12. Check Point Research. Cyber attack trends: Mid year report 2021. https://securitydelta.nl/media/com_hsd/report/443/document/cyber-attack-trends-report-mid-year-2021.pdf.
13. Cybersecurity and Infrastructure Security Agency. Kaseya VSA supply-chain ransomware attack. 2021. https://us-cert.cisa.gov/ncas/current-activity/2021/07/02/kaseya-vsa-supply-chain-ransomware-attack.
14. De Vynck G, Lerman R. Widespread ransomware attack likely hit 'thousands' of companies on eve of long weekend. *The Washington Post*. 2021. https://www.washingtonpost.com/technology/2021/07/02/kaseya-ransomware-attack/.
15. Bajak F. Kroger: Some pharmacy customer data impacted in vendor hack. AP. https://apnews.com/article/hacking-data-privacy-8b5dbb610754ba28c7346d15ef201a4e.

16. Department of Homeland Security. Cybersecurity. Homeland Security. https://www.dhs.gov/topic/cybersecurity.
17. Sanger DE, Perlroth N. Biden weighs a response to ransomware attacks. *The New York Times*. 2021. https://www.nytimes.com/2021/07/07/us/politics/biden-ransomware-russia.html.
18. National Defense Authorization Act for Fiscal Year 2021, S.4049, 116th Cong (2020). https://www.congress.gov/bill/116th-congress/senate-bill/4049.

American Pharmacists Association

For Every Pharmacist. For All of Pharmacy.

2022 House of Delegates

Report of the New Business Review Committee

Committee Members

Mary Klein, Chair
Christopher Harlow
Nimit Jindal
Amy Kennedy
Amy Reese
Parth Shah
Lucy West
Rohan Zaveri

Ex Officio
Melissa Skelton Duke, Speaker of the House

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. 1
Date received: 2/14/2022
Time received: 7:30 PM

American Pharmacists Association
House of Delegates – March 18-21, 2022

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Ashley Pugh, APhA-APPM Delegate
(Name)

February 14, 2022 (Date)

APhA-APPM Delegation on behalf of the Immunizing Pharmacists Special Interest Group (SIG) (Organization)

Subject: Integration of a National Immunization Information System (IIS)

Motion: To amend existing policy: 2018 Proactive Immunization Assessment and Immunization Information Systems, Statement #3

3. APhA calls for a National Immunization Information Systems (IIS) database to report all immunization data among all state registries ~~APhA supports nationwide integration of Immunization Information Systems (IIS) that incorporates federal, state, and local databases~~ for the purpose of providing pharmacists and other health care professionals with accurate and timely information to assist in clinical decision making related to immunization services.

Background:

Currently, there is no national database or organization that maintains vaccine records, which leads to states having their respective Immunization Information Systems (IIS) to keep record of vaccines for both children and adults.[1] Immunization Information Systems are computerized information systems that gather immunization data from different healthcare providers in a given area, assisting healthcare providers to record and review a patient's vaccine needs and coverage.[3] However, not all states have immunization registries to maintain vaccine records, and those that do may not have all healthcare providers take part and engage in these registries.[4] This leads to fractured and inconsistent vaccine records, especially as individuals relocate or travel. If updated records of immunizations aren't provided as proof that patients received certain vaccines, some may need to get vaccinated with additional doses.[1] A national, standardized IIS allows for all pharmacists and other healthcare providers to correctly determine which vaccine to administer and when, in addition to avoiding vaccine waste and promoting better interprofessional patient care.[2]

Current APhA Policy & Bylaws:

2018 Proactive Immunization Assessment and Immunization Information Systems

1. APhA supports mandatory requirements for ALL immunization providers to report pertinent immunization data into Immunization Information Systems (IIS).
2. APhA calls for government entities to fund enrollment and engagement of all immunization providers in Immunization Information Systems (IIS). This engagement should support lifetime tracking of immunizations for patients.
3. APhA supports nationwide integration of Immunization Information Systems (IIS) that incorporate federal, state, and local databases for the purpose of providing health care professionals with accurate and timely information to assist in clinical decision making related to immunization services.
4. APhA advocates that all appropriate health care personnel involved in the patient care process have timely access to Immunization Information Systems (IIS) and other pertinent data sources to support proactive patient assessment and delivery of immunization services while maintaining confidentiality.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the bidirectional exchange of data with Immunization Information Systems (IIS).

(JAPhA. 58(4):355 July/August 2018)

References:

1. Cdc.gov. 2021. *Locating and Tracking Adult Vaccine Records | CDC*. [online] Available at: <https://www.cdc.gov/vaccines/adults/vaccination-records.html> [Accessed 27 September 2021].
2. Hhs.gov. 2021. *Vaccine National Strategic Plan*.| HHS. [online] Available at: <https://www.hhs.gov/sites/default/files/HHS-Vaccines-Report.pdf> [Accessed 27 September 2021].
3. Cdc.gov. 2021. *ACIP Vaccination Records Guidelines for Immunization | CDC*. [online] Available at: <https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/records.html> [Accessed 27 September 2021].
4. Immunize.org. 2021. *Ask the Experts: Documenting Vaccination*. [online] Available at: <https://www.immunize.org/askexperts/documenting-vaccination.asp> [Accessed 27 September 2021].

****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 **February 16, 2022** (30 days prior to the start of the first House session). Consideration of urgent items can be presented with a suspension of the House Rules at the session where New Business will be acted upon. Please submit New Business Items to the Speaker of the House via email at hod@aphanet.org.

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

American Pharmacists Association
House of Delegates – March 18-21, 2022

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

Item No. 2
Date received: 2/14/2022
Time received: 7:30 PM

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Christopher Johnson, APhA-APPM Delegate
(Name)

February 14 , 2022 — **(Date)**

APHA-APPM Delegattion on behalf of Diabetes Management Special Interest (SIG) — **(Organization)**

Subject: Reimbursement for Diabetes Education Services

Motion:

1. **APhA supports the expansion of patient access to diabetes self-management education and support.**
2. **APhA calls upon public and private payers to recognize and reimburse pharmacists as providers of diabetes self-management education and support regardless of practice setting.**
3. **APhA supports the development of a guide for pharmacists seeking appropriate reimbursement from payors for diabetes self-management education and support.**

Background:

The intent of this policy statement would be to expand the existing CMS billing options to include reimbursement for diabetes self-management education and support (DSMES) that may be structured differently than formally accredited programs to support the provision of these services in a community pharmacy setting.

It is estimated that half of the US adults with diagnosed diabetes are not controlled, as defined by the American Diabetes Association (ADA) non-pregnant clinical goals.[1] A major factor contributing to the ability to achieve this goal is the self-management capabilities of a person with diabetes. The purpose of DSMES is to "is to give people with diabetes the knowledge, skills, and confidence to accept responsibility for their self-management."[2] Patient engagement in DSMES has demonstrable benefit in patient clinical outcomes, and the American Diabetes Association (ADA) guidelines recommends referral to DSMES at several key points in the care of a patient with diabetes.[3] However, given significant barriers to billing, which impact the sustainability of these programs, many patients lack ready access to these resources. The reimbursable benefit by Medicare for DSMES is termed diabetes self-management training and is reimbursed through the "G codes" (G0108 and G0109).[4] These codes have strict requirements for use, including a costly accreditation by the American Diabetes Association (ADA) or American Diabetes Care and Education Specialists (ADCES), patient referral from a Medicare qualifying provider, and enrollment with Medicare Part B.[5] Furthermore, services provided under these codes must rigidly adhere to the outlined DSMES process, which while beneficial, may not be the only modality for care that can provide

benefit to patients. In recognition of this, some private payers have created billing codes for group education and training for patient self-management (e.g. 998960-98962) to provide reimbursement outside of formally recognized DSMES programs.[6] However, these codes are not universally available due to payer-to-payer variation. Providers may also attempt to use evaluation and management (E/M) codes (e.g. 99211-99215) for payment for these services.[6,7]

Pharmacists face even more barriers for reimbursement for diabetes education services. Currently, pharmacies can seek Medicare reimbursement for DSMES programs using the G codes. However, in the community setting, obtaining referrals and operating within the constraints of an ADA/ACDES-accredited program may be unnecessary, impractical, or impossible. For other options such as E/M codes or the group education codes mentioned above, pharmacist use is contingent on being able to bill "incident to," which also has barriers including the inability to bill the same day as the provider.

Despite the barriers, many pharmacists are already conducting formalized DSMES, and increasing numbers of pharmacists are seeking additional training and certification in this area including the APhA Pharmacist and Patient-Centered Diabetes Care Certificate Training Program and as Certified Diabetes Care and Education Specialists (CDCES, formerly CDE). Pharmacists inarguably have the skills, knowledge, and training to provide self-management education to patients with diabetes and should be empowered to utilize these skills to improve patient outcomes. Examples of the positive impact of pharmacist-provided DSMES is demonstrated in various studies including the Diabetes Ten City Challenge[8], the EMPOWER study[9], and the Asheville Project where the mean participants' A1c reduced by –1.1 ±1.9% (mean ±SD, $p < 0.0001$) from baseline after 6 months.[10] The National Community Pharmacists' Association (NCPA) supports expanding diabetes care services, and APhA should also actively support the recognition and reimbursement of pharmacists in expanded settings as providers for DSMES.[7]

References:

1. Centers for Disease Control and Prevention. National Diabetes Statistics Report, 2020. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Dept of Health and Human Services; 2020.
2. Powers MA, Bardsley JK, Cypress M, Funnell MM, Harms D, Hess-Fischl A, Hooks B, Isaacs D, Mandel ED, Maryniuk MD, Norton A, Rinker J, Siminerio LM, Uelmen S. Diabetes Self-management Education and Support in Adults With Type 2 Diabetes: A Consensus Report of the American Diabetes Association, the Association of Diabetes Care & Education Specialists, the Academy of Nutrition and Dietetics, the American Academy of Family Physicians, the American Academy of PAs, the American Association of Nurse Practitioners, and the American Pharmacists Association. Diabetes Care. 2020 Jul;43(7):1636-1649. doi: 10.2337/dci20-0023. Epub 2020 Jun 8. PMID: 32513817.Standards of Medical Care in Diabetes-2021. Diabetes Care: 44 (Supplement 1). Diabetes Care. 2021;44(Supplement 1).
3. Condon JE, Eichorst B. Medicare Billing for DSME and MNT Services. http://healthyinteractions.com/assets/files/Medicare-Billing-for-DSME-and-MNT-Services.pdf Accessed: January 3, 2019.
4. Rassmussen CA. Utah Diabetes Telehealth Series. 2011 Sep 21. Available at: http://choosehealth.utah.gov/healthcare/continuing-education/diabetes-webinar-series/archives/presentations-2011/October_DSMEinPCP_rasmussen.pdf
5. Coding for Group Visits. AAFP: https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/group-visits.html
6. Kliethermes MA, Parrott AM, Sachdev G, Singh RF, Weber ZA. Pharmacist Billing for Ambulatory Pharmacy Patient Care Services in a Physician-Based Clinic and Other Non-Hospital-Based Environments – FAQ. https://www.ashp.org/-/media/assets/ambulatory-care-practitioner/docs/sacp-pharmacist-billing-for-ambulatory-pharmacy-patient-care-services.pdf Accessed: January 3, 2019.
7. Expanding Diabetes Care Services. https://www.ncpanet.org/innovation-center/diversified-revenue-opportunities/expanding-diabetes-care-services Accessed: January 3, 2019.
8. Fera T, Bluml BM, Ellis WM. Diabetes Ten City Challenge: final economic and clinical results. J Am Pharm Assoc (2003). 2009 May-Jun;49(3):383-91. doi: 10.1331/JAPhA.2009.09015. PMID: 19357068.
9. Kraemer DF, Kradjan WA, Bianco TM, Low JA. A randomized study to assess the impact of pharmacist counseling of employer-based health plan beneficiaries with diabetes: the EMPOWER study. J Pharm Pract. 2012 Apr;25(2):169-79. doi: 10.1177/0897190011418513. Epub 2011 Oct 10. PMID: 21987530.

10. Cranor CW, Bunting BA, Christensen DB. The Asheville Project: long-term clinical and economic outcomes of a community pharmacy diabetes care program. J Am Pharm Assoc (Wash). 2003 Mar-Apr;43(2):173-84. doi: 10.1331/108658003321480713. PMID: 12688435.

Current APhA Policy & Bylaws:

To our knowledge, currently there are no existing APhA Policy statements or bylaws related to this topic.

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)

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.

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 re-act 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.

****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 **February 16, 2022** (30 days prior to the start of the first House session).
Consideration of urgent items can be presented with a suspension of the House Rules at the session where New Business will be acted upon.
Please submit New Business Items to the Speaker of the House via email at hod@aphanet.org.

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

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

Item No. 3
Date received: 2/16/2022
Time received: 7:30 PM

American Pharmacists Association
House of Delegates – March 18-21, 2022

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Myriam E. Shaw (APhA-APPM Delegate)
(Name)

February 14, 2022 (Date)

APhA-APPM Delegation on behalf of the Public Health Special Interest Group (SIG) (Organization)

Subject: Data to Advance Health Equity

Motion:

1. **APhA urges pharmacists to use evidence-based data to address health disparities, equitably distribute resources, and drive decision-making in advocacy and practice.**
2. **APhA supports the collection, analysis, reporting, and exchange of disaggregated data regarding race, ethnicity, language, sexual orientation, gender identity, and social determinants of health in partnership with the impacted communities.**
3. **APhA urges schools and colleges of pharmacy to prioritize and incentivize the collection and analysis of disaggregated data as part of institutional research efforts towards health equity.**

Background:

COVID-19 has brought to light the importance of collecting disaggregated data to understand populations' access to testing, healthcare, and insurance, as well as infection, hospitalization, death, and vaccination rates. Data disaggregation means breaking down large data categories into more specific sub-categories. When data are broken down and disaggregated by ethnic groups, they can show the unique differences among groups and reveal significant disparities. For example, "in New Mexico, American Indian and Alaska Natives have accounted for nearly 40 percent of COVID-19 cases, even though Native peoples make up only 9 percent of the population. But because detailed, tribal level data are not available, there is no way of knowing which tribes are most impacted within the 40 percent infection rates across tribal nations. This prevents decision-makers from determining where and how best to intervene" (APIAHF, Advocating for Data Disaggregation by Race and Ethnicity).

As our nation becomes increasingly diverse in terms of race, ethnicity, and gender, advancing health equity requires an understanding of how health and health disparities are experienced across distinct communities. When information is collected about race and ethnicity, it is often done using federal categories guided by the Office of Management and Budget's (OMB) minimal standards. Broad categories such as "Asian American" or "Latino" lump together communities with unique cultures, lived experiences, strengths, and challenges (APIAHF, Advocating for Data Disaggregation by Race and Ethnicity). Furthermore, many surveys, programs, tools, and data collection instruments do not capture even the most basic OMB categories. When this data is collected within healthcare

settings, there are often challenges exchanging information with external providers or agencies due to a lack of interoperable systems. “These flaws in data collection and reporting render populations invisible, mask unique needs, and hide strengths and assets. It means that decisions are being made that impact people’s lives and well-being without complete information” (APIAHF, Advocating for Data Disaggregation by Race and Ethnicity).

To better see and serve diverse communities, the pharmacy profession must commit to collecting meaningful patient data that can be used to address disparities and drive decision-making. Only with accurate data can we ensure that resources and interventions are laser focused to help address widening health, economic, and social disparities. This requires collecting, analyzing, reporting, and exchanging disaggregated data regarding demographics and social determinants of health. Demographic information are characteristics of a given population and may include factors such as age, race, ethnicity, sex, gender, and geographic area. Social determinants of health, according to the Centers for Disease Control and Prevention, are “conditions in the environments in which people are born, live, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks” (CDC, Healthy People). Health People 2030 focuses on five domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. Discrimination, for example, would be a social determinant of health. Prioritizing and incentivizing these practices within academic institutions is also required to address disparities. It also requires prioritizing and incentivizing these practices within academic institutions. As such, the APhA-APPM Public Health SIG proposes these policy statements to underscore our profession’s role in collecting data such as race, ethnicity, language, and sexual & gender identity, and social determinants of health as a means of advancing health equity. Through these policy statements, we will improve our understanding of communities and our ability to identify solutions that provide more equitable care.

Resources:

- https://northsoundach.org/wp-content/uploads/2019/11/Counting_a_Diverse_Nation_08_15_18_sized.pdf
- https://www.pharmacist.com/APhA-Press-Releases/apha-physicians-and-nurses-urge-bolstered-collection-of-race-and-ethnicity-data-during-covid-19-vaccinations
- https://www.aha.org/ahahret-guides/2011-03-01-improving-health-equity-through-data-collection-and-use-guide-hospital
- https://www.ama-assn.org/delivering-care/health-equity/role-data-collection-covid-19-pandemic
- https://www.apiahf.org/wp-content/uploads/2021/05/FINAL-REL-DataDisaggregationMessage-Guide-December-2020.pdf
- https://www.searac.org/wp-content/uploads/2019/03/2019.02-DataDisagg_UpdatedFactsheet_general_final.pdf
- https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Current APhA Policy & Bylaws:

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.

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.

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.

****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 February 16, 2022 (30 days prior to the start of the first House session). Consideration of urgent items can be presented with a suspension of the House Rules at the session where New Business will be acted upon. Please submit New Business Items to the Speaker of the House via email at hod@aphanet.org.

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

American Pharmacists Association
House of Delegates – March 18-21, 2022

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

Item No. 4
Date received: 2/15/2022
Time received: 4:04 PM

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Javon Artis (APhA-APPM Delegate)
(Name)

2-15-2022
(Date)

APhA-APPM Delegation
(Organization)

Subject: Procurement Strategies and Patient Steerage

Motion:

1. APhA supports medication procurement strategies that meet chain of custody standards for pharmaceutical products moving from one entity to another; ensuring the exchanges are accurate, timely, and follow best practices prior to administering the product to the patient; and preserve the economic viability of pharmacy practices.
2. APhA opposes required procurement strategies (e.g., site of care steerage, brown bagging, and white bagging) that restrict the patient's and providers' ability to choose treatment options that may lead to or result in fragmented care between the patient, pharmacist and other healthcare providers.
3. APhA calls for the creation of operational efficiencies that allow the patient's choice of pharmacy and site of care; do not restrict or delay care; and ensure continuity of care through collaborative efforts between providers that leads to optimal patient health outcomes.

Background:

Over the past years, more and more health systems have been affected by payer healthcare coverage policies, also referred to as 'bagging.' Payers have vertically integrated with pharmacy benefit managers (PBMs) and specialty pharmacies to be filled by a PBM-owned specialty pharmacy. Once the medications are filled, they are shipped either to the patient or directly to the patient's health system. 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 it to the provider's office for administration.
- White bagging: A specialty pharmacy, predominantly at the discretion of the provider, ships the patient's prescription directly to the provider, which holds the product until the patient arrives for treatment.
- Clear bagging: A provider's internal specialty pharmacy (e.g. Hospital-owned specialty pharmacy) dispenses the patient's prescription and transports the product to the location of drug administration.

Bagging policies ultimately impact the patients being treated. Common issues causing issues from bagging 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 latter which has a significant fixed cost of facility. Outside of these financial considerations, white and other bagging does 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 logistical aspects have called into question the viability of white bagging and has been a point 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 as the patient's-specific medication, they 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. 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 state laws; track-and-trace and drug pedigree laws, including the Drug Supply Chain Security Act, and other state laws

References:

1. Drug Supply Chain Security Act; Drug Supply Chain Security Act; https://www.govinfo.gov/content/pkg/PLAW-113publ54/pdf/PLAW-113publ54.pdf Accessed 12/6/2021.
2. "ASHP Stands Opposed to Payer Mandated White Bagging" Accessed 3/18/2021
3. "White and Brown Bagging Emerging Practices, Emerging Regulation" NABP White Paper 4/2018.
4. Medication "Brown Bagging" CMS Report on the Council of Medical Service 2015.

Current APhA Policy & Bylaws:

2019: Consolidation Within Health Care
2017: Patient Access to Pharmacist-Prescribed Medications
2019: Referral System for the Pharmacy Profession
2004,1990: Freedom to Choose
1989: Impact of Drug Distribution Systems on Integrity and Stability of Drugs
1978: Post-Marketing Requirements

****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 **February 16, 2022** (30 days prior to the start of the first House session). Consideration of urgent items can be presented with a suspension of the House Rules at the session where New Business will be acted upon. Please submit New Business Items to the Speaker of the House via email at hod@aphanet.org.

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

American Pharmacists Association
House of Delegates – March 18-21, 2022

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

Item No. 5
Date received: 2/14/2022
Time received: 3:16 PM

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Hillary Duvivier
(Name)

14 February 2022 **(Date)**

United States Public Health Service **(Organization)**

Subject: Pharmacists Prescribing Authority and Increasing Access to Medications for Substance Use Disorders

Motion: To adopt the following policy statement listed below:

APhA supports expanding access to medication-assisted treatments (MAT) by permitting pharmacists' prescriptive authority for the management of substance use disorders.

Background:

APhA recognizes the role pharmacists can play in the management of chronic diseases, including substance use disorders. In 2015, the APhA Institute on Substance Use Disorders was developed following the termination of a program after 63 years at the University of Utah. Pharmacists and student pharmacists were able to learn about the recovery process and participate in this Utah School on Alcoholism and Other Drug Dependencies starting in 1983. Pharmacists across the country wanted to continue this phenomenal experience and the movement led to the development of the Institute. The goal was to continue to guide the most accessible community health care providers dealing with drug abuse and more specifically the opioid epidemic every day.

Opioid use disorders have led to significant morbidity and mortality resulting in the national opioid epidemic that has taken over 500,000 American lives between 1999 and 2020. In 2020, 91,799 drug overdose deaths occurred at a rate of 28.3 per 100,000 which was 31% higher than in 2019[1]. Additionally, alcoholism has been a well-documented public health concern that has significant health consequences. Buprenorphine has been proven to be safe and effective in the management of both opioid-use and alcohol-use disorders, which are treatable chronic diseases. Pharmacists are often the most accessible health care providers, making them strategically placed to offer acute and chronic health services throughout the country in this time of crisis. Many are directly involved in management of chronic pain with opioids, participating in state prescription monitoring programs, evaluating and referring patients to substance abuse treatment, and prescribing naloxone to prevent opioid overdose deaths.

Pharmacists have varying levels of prescriptive authority based on state licensure and restrictions based on individual collaborative practice agreements, not national regulations. Certain pharmacists manage chronic pain with opioid prescribing under authority of a DEA license, however, there is no legal avenue to allow these same pharmacists to treat opioid use disorder with buprenorphine. Pharmacists throughout various practice settings that have been on the frontlines of this epidemic spearheading novel approaches to curtail negative impact on their communities and are passionate about obtaining the privilege to help their patients.

Opioid prescribing is subject to not only the Controlled Substances Act, but the Children's Health Act, Drug Addiction Treatment Act (DATA) of 2000, the Comprehensive Addiction and Recovery Act (CARA) of 2016, and most recently the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018. The DATA created the buprenorphine waiver, commonly referred to as the DATA waiver or X-waiver, permitting only physicians to treat opioid use disorder with narcotic medications including buprenorphine. This substantially increased access to opioid use disorder treatment as it removed barriers of the Narcotic Addiction Treatment Act of 1974 that continues to restrict methadone prescribing by certified Opioid Treatment Programs. The CARA Act increased access by relaxing prescriber restrictions from 30 to

100 patients maximum. The SUPPORT Act further increased access to buprenorphine by extended prescriptive privileges to include Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, and Certified Nurse-Midwifes, but not pharmacists, through 2023. In 2021, buprenorphine restrictions were relaxed further to remove barriers during the COVID-19 pandemic. Currently, patients are not required to be in psychosocial treatment, while prescribers are not required to complete the DATA mandated training if they manage 30 patients or less.[2]

Pharmacists would like to continue to impact patient's lives and desire to have the ability to manage all chronic diseases. Pharmacists support removing stigma surrounding substance abuse, including requiring post-graduate training to fulfill a gap in pharmacy school curriculum currently and historically. Pharmacists support further expansion of access to life-saving medication-assisted treatments and the authority to manage substance use disorders.

Citation:

1) Hedegaard H, Miniño AM, Spencer MR, Warner M. Drug overdose deaths in the United States, 1999–2020. NCHS Data Brief, no 428. Hyattsville, MD: National Center for Health Statistics. 2021. DOI: https://dx.doi.org/10.15620/cdc:112340.
2) Buprenorphine. Substance Abuse and Mental Health Services Administration. 2022. DOI: https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/buprenorphine.

Current APhA Policy & Bylaws:

Current policy statements on the pharmacist's prescribing authority are part of several sections (i.e., Dispensing Authority p.27, Drug Product Selection p. 40, Interprofessional Relations p. 71, Pharmacy Practice p.98, 100, Prescribing Authority p. 117, and Prescriptions and Prescription Orders p. 119). We recommend that the new policy statement be added to Section:

PRESCRIBING AUTHORITY

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)

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)

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)

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)

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)

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)

2016

Medication-Assisted Treatment

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)

****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 **February 16, 2022** (30 days prior to the start of the first House session). Consideration of urgent items can be presented with a suspension of the House Rules at the session where New Business will be acted upon. Please submit New Business Items to the Speaker of the House via email at hod@aphanet.org.

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

American Pharmacists Association
House of Delegates – March 18-21, 2022

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

Item No. 6
Date received: 2/14/2022
Time received: 3:16 PM

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Matt Kirchoff, USPHS Delegate; Juliette Taylor, USPHS Alternate Delegate
(Name)

Feb. 4, 2022
Date

United States Public Health Service Commissioned Corps
(Organization)

Subject: Supporting the Integration of Pharmacists into the Clinical Research Workforce

Motion: Adopt the following two policy statements:

1. APhA supports the integration of pharmacists as clinical research team members in all forms of clinical research, including but not limited to healthcare outcomes research, pre-marketing clinical trials, and post-marketing studies.
2. APhA encourages pharmacists and student pharmacists to build clinical research enterprise knowledge and specialized skills.

Background:

Clinical trials for new medicines and devices regulated by the US Food and Drug Administration (FDA) or other regional regulatory bodies involve rigorous and highly regulated processes to provide adequate safety and efficacy data for regulatory approval and post-marketing monitoring. It is estimated that over 34,000 clinical trials are being conducted at any given time in the United States.[1] The execution of these trials requires a highly trained workforce with a variety of skills in addition to a general healthcare background.

While the American Pharmacists Association Academy Of Pharmaceutical Research And Science provides an avenue to support pharmacist researchers, there does not appear to be an existing community for pharmacists engaged in the broader clinical research enterprise. Traditionally, many jobs within the clinical research enterprise have often recruited for and been filled by nurses. Examples of these jobs include clinical research coordinators, clinical research associates, operations managers, logistics managers, compliance managers, regulatory managers, and a variety of other related and similar positions. These jobs include many entry-level positions which provide additional skills development, opportunities for advancement, an interesting and varied career, and the opportunity to travel both domestically and internationally. Settings for these positions include academic institutions, hospitals, clinics, dedicated study sites, clinical research organizations, life science companies, government entities such as National Institutes of Health or Centers for Disease Control and Prevention, Food and Drug Administration, and others. The current policy statement urges the sponsors of drug research to permit pharmacists to serve as principal investigators; however, there are many other roles that pharmacists may be well-suited to serve.

Over the past decade business cost-saving practices, technological advancements, regulatory changes, and increased patient access to remote or mail-order pharmacy has generally reduced the number of pharmacist job openings relative to the overall new pharmacist graduation rate. Clinical research professionals have steadily increased during this time, with a recent report finding a 9.3% compound annual growth in monthly job postings across all clinical research positions from 2016 to 2019.[1] The average salary for clinical trial specialists was reported to be $100,224.[1]

References:

1. Association of Clinical Research Professionals (ACRP). *An Assessment of the Adequacy of the Clinical Research Workforce*. 2020.

Current APhA Policy & Bylaws:
In the current policy handbook, sections that pertain to this motion include: Internships/Externships and Residencies p 49, Pharmaceutical Care p 91, Facility Design and Face-to-Face Communication p. 106, Research p 148, 149.

2013, 2008
Pharmacy Practice-Based Research Networks

1. APhA supports establishment of pharmacy practice-based research networks (PBRNs) to strengthen the evidence base in support of pharmacists' patient care services.
2. APhA encourages collaborations among stakeholders to determine the minimal infrastructure and resources needed to develop and implement local, regional, and nationwide networks for performing pharmacy practice-based research.
3. APhA encourages pharmacy residency programs to actively participate in pharmacy practice-based research network (PBRNs).

(JAPhA. NS48(4):471; July/August 2008) (JAPhA. 53(4):366; July/August 2013) (Reviewed 2018)

1989

Pharmacists as Principal Investigators in Clinical Drug Research

1. APhA urges the sponsors of drug research to permit pharmacists to serve as principal investigators.
2. APhA encourages state and federal agencies to eliminate regulatory and policy obstacles that prohibit pharmacists from being investigators, including principal investigators, in drug research or sponsors of Investigational New Drug Applications, Investigational Device Evaluations, and Animal Investigational New Drug Applications.

(Am Pharm. NS29(7):465; July 1989) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

****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 **February 16, 2022** (30 days prior to the start of the first House session). Consideration of urgent items can be presented with a suspension of the House Rules at the session where New Business will be acted upon. Please submit New Business Items to the Speaker of the House via email at hod@aphanet.org.

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

American Pharmacists Association
House of Delegates – March 18-21, 2022

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

Item No. **7**
Date received: **2/14/2022**
Time received: **3:16 PM**

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Kristina Melia, USPHS Delegate
(Name)

Feb. 7,2022
(Date)

United States Public Health Service Commissioned Corps
(Organization)

Subject: Pharmacist and Pharmacy Technician Roles in Type 2 Diabetes Prevention

Motion: Adopt the following three policy statements:

1. APhA advocates for the recognition and utilization of pharmacists, student pharmacists, and pharmacy technicians to address diabetes prevention, such as through Centers for Disease Control and Prevention's (CDC) National Diabetes Prevention Program's (National DPP) lifestyle change program.
2. APhA advocates for campaigns focused on increased community wellness awareness and health benefits knowledge in areas such as healthy eating and physical exercise for diabetes prevention and diabetes self-management education and support (DSMES). APhA recommends expanding the pharmacist's role and pharmacy services, and building on the competencies noted in "EDUCATION, CURRICULUM AND COMPETENCE FOR PHARMACISTS, Pharmacist Training in Nutrition" to leverage pharmacists and pharmacies as a means of increasing patient education on nutrition and physical exercise in relation to diabetes prevention and DSMES.
3. APhA encourages the development of pharmacy curricula and continuing education on the topics of diabetes prevention and health promotion through improvements in modifiable risk factors.

Background:

We know that more than 30 million people have diabetes, but that's only the tip of the iceberg. An estimated 96 million American adults have prediabetes. This hidden health threat means that approximately 1 in 3 adults in this country have a substantially higher risk of developing type 2 diabetes, heart disease, and stroke. Even worse, 90% of them don't know they have this condition, so they may not be taking the right steps to prevent or delay the onset of type 2 diabetes.

The National Diabetes Prevention Program (National DPP), established and managed by Centers for Diseases Control and Prevention (CDC), is a partnership of public and private organizations working together to build the infrastructure for nationwide delivery of an evidence-based lifestyle change program for adults with prediabetes to prevent or delay onset of type 2 diabetes. Pharmacists can play a key role in this partnership because of their proximity to people with prediabetes and the community's trust in them.

The National DPP lifestyle change program is based on the science of the Diabetes Prevention Program research trial, and subsequent translation studies, which showed that making modest behavior changes helped people with prediabetes lose 5% to 7% of their body weight and reduce their risk of developing type 2 diabetes by 58% (71% for people over 60 years old). The National DPP's lifestyle change program is a proven model that effectively helps those with prediabetes take the steps necessary to prevent their progression to type 2 diabetes. The pharmacy workforce is well-positioned to play a significant role in promoting and delivering the National DPP lifestyle change program in their communities.

The National DPP has four overarching strategic goals:

1) Increase the supply of quality programs across the U.S.
2) Increase awareness and demand for the program among high-risk adults.
3) Increase public and private coverage for the program to ensure long-term sustainability.
4) Increase health care provider referrals of people with prediabetes to CDC-recognized organizations offering the program.

The pharmacy community can be a part of all these goals.

At the close of 2021, there were 162 pharmacies across 42 states and Washington D.C. that are CDC-recognized National DPP delivery organizations.

CDC released a resource guide titled: Rx for the National Diabetes Prevention Program Action Guide for Community Pharmacists (cdc.gov) "Rx for the National Diabetes Prevention Program: An Action Guide for Pharmacists." It outlines the specific ways in which pharmacists, pharmacy residents, students, and technicians can participate in the National DPP.

The pharmacy resource guide came about through collaboration between CDC's Division of Diabetes Translation and several national pharmacy stakeholders. The stakeholder group consisted of Duquesne University, *NASPA, NACDS, NCPA, CPESN, AACP, ASHP, APhA, and Kroger. During stakeholder meetings, these organizations shared that they needed a resource with information specific to pharmacies on the National DPP; they also detailed various barriers to entry as well as key opportunities for engagement.

The pharmacy guide was framed around the concept of "three tiers of engagement," and pharmacies can pick and choose which tiers to engage in based on their own resources and capacity. The three tiers are:

1) Promoting awareness of prediabetes and the National DPP.

2) Screening, testing, and referring eligible patients to a local or online CDC-recognized lifestyle change program.

3) Becoming a CDC-recognized organization and delivering the 12-month lifestyle change program in the pharmacy practice site.

Millions of Americans have the National DPP lifestyle change program as a covered benefit. In March 2016, the Centers for Medicare & Medicaid Services (CMS) certified the expansion of the National DPP lifestyle change program into Medicare on the basis of results from a model test conducted by the Center for Medicare & Medicaid Innovation (CMMI) with the Y-USA. Beginning in April 2018, the National DPP lifestyle change program became a covered preventive service for eligible Medicare beneficiaries through the Medicare Diabetes Prevention Program (MDPP)—the first preventive service model tested by CMMI to be expanded into Medicare and a landmark for public health. Program delivery organizations with CDC preliminary or full recognition are eligible to apply as

MDPP suppliers. Additionally, 17 states have approved Medicaid coverage for the National DPP lifestyle change program and many employers and commercial health plans also include the program as a covered health benefit (see Participating Payers and Employers - National DPP).

APhA and NCPA are currently partnering directly with CDC on activities that are expanding the pharmacy infrastructure and actively promoting the National DPP lifestyle change program in pharmacies nationwide.

So, why should pharmacists get involved in the National DPP? Pharmacists can be valuable partners in the effort to expand the National DPP for the following reasons:

1) Pharmacists know preventive care: Pharmacists deliver preventive health care services (administering vaccinations, assisting with smoking cessation and blood pressure control, delivering diabetes self-management education and support, etc.). The National DPP lifestyle change program aligns well with this service delivery model.

2) Pharmacists have frequent patient encounters: Pharmacists are likely to have daily encounters with patients who have prediabetes and are unaware of their condition or the risks involved. They also may be key in reaching populations who are underserved or providing services in areas where gaps exist due to a lack of clinical or community resources.

3) Pharmacies are an essential part of today's health care system. Pharmacies are expanding their portfolio of patient care services and ultimately seek to achieve better health outcomes for their patients.

4) Pharmacists can play a significant role in addressing social determinants of health (SDOH): Pharmacies are a hub for trusted community resources. Pharmacists can identify the social factors that affect a patient's ability to achieve and maintain wellness to impact individuals across the health care continuum.

* National Alliance of State Pharmacy Associations (NASPA), National Association of Chain Drug Stores (NACDS), National Community Pharmacists Association (NCPA), Community Pharmacy Enhanced Services Network (CPESN), American Association of Colleges of Pharmacy, American Society of Health-System Pharmacists (ASHP), American Pharmacists Association (APhA).

Citation:

Centers for Disease Control and Prevention. (2022, January 18). *National Diabetes Statistics Report*. Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/diabetes/data/statistics-report/index.html

Current APhA Policy & Bylaws:

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)

2020

Community-Based Pharmacists as Providers of Care

1. 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.
2. APhA advocates for laws and regulations that allow pharmacists to identify and manage medical conditions treated by community-based pharmacists.
3. 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.
4. APhA supports research to examine the outcomes of services that focus on medical conditions treated by community-based pharmacists.

(JAPhA. 60(5):e10; September/October 2020)

2013

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)

****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 **February 16, 2022** (30 days prior to the start of the first House session). Consideration of urgent items can be presented with a suspension of the House Rules at the session where New Business will be acted upon. Please submit New Business Items to the Speaker of the House via email at hod@aphanet.org.

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

American Pharmacists Association
House of Delegates – March 18-21, 2022

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

Item No. 8
Date received: 2/15/2022
Time received: 11:21 PM

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Andrew Bzowyckyj, Grace Baek, Gigi Davidson
(Name)

2/15/2022
(Date)

APhA Policy Review Committee
(Organization)

Subject: 2007 PHARMACY PERSONNEL IMMUNIZATION RATES

Motion: To amend the following policy statement as shown:

2007 Pharmacy Personnel Immunization Rates

3. APhA encourages federal, state, and local public health officials to recognize pharmacists, student pharmacists, pharmacy technicians, and pharmacy support staff among the highest priority groups as essential healthcare workers ~~as first responders (e.g. physicians, nurses, police, etc.) and prioritize pharmacists~~ to receive medications and immunizations during pandemics and/or other disaster preparedness and emergency response situations.

Background:

The full existing policy 2007 Pharmacy Personnel Immunization Rate is provided here for reference. This new business item is only intended to amend statement 3 as outlined in the motion above, while leaving the other two statements as they are currently written. The original language of statement 3 can also be found within the following existing policy.

2007 Pharmacy Personnel Immunization Rates – (CURRENT/ACTIVE POLICY BEING AMENDED IN THIS PROPOSAL)

1. APhA supports efforts to increase immunization rates of healthcare 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 public health officials to recognize pharmacists as first responders (e.g. physicians, nurses, police, etc.) and prioritize pharmacists to receive medications and immunizations.

(JAPhA NS45(5):580 September/October 2007) (Reviewed 2009)(Reviewed 2014)(Reviewed 2019)

This policy was referred to the 2021-22 APhA Policy Review Committee for review as a result of the 2021 APhA House of Delegates passing the policy statement "2021 Continuity of Care and the Role of Pharmacists During Public Health and Other Emergencies". The committee discussed this policy (originally passed in 2007) through the context of the ongoing COVID-19 pandemic and identified a need to contemporize the language within statement 3 for the following 4 reasons (described below). The work of drafting the actual amendment was taken on by a subset of committee members, although all committee members had an opportunity to comment throughout the process. Please bear in mind that all three of these policy statements are currently active APhA policy that was passed in 2007 and subsequently reviewed in 2009, 2014, 2019, and 2021. We are not recommending any amendments to the first two statements; rather, they are included in this amendment simply for context. If this amendment does not pass, the original wording of the policy "2007 Pharmacy Personnel Immunization Rates" will remain as active APhA Policy.

1. Broadening the policy's scope to also include student pharmacists, pharmacy technicians, and pharmacy support staff:
    a. As previously written, the policy only advocated for pharmacists to be prioritized for receiving medications and immunizations in emergency situations such as a pandemic. However, as we all witnessed during the COVID-19 pandemic, the pharmacy cannot function without all of the team members being in good health and working together. It is not possible to care for all of the patients relying on us for care (regardless of setting) if only pharmacists are protected and authorized to work in the pharmacy.
2. Emphasizing our roles as "essential healthcare workers"
    a. During the COVID-19 pandemic, the National Academies of Science, Engineering, and Medicine advised a four-phased allocation framework for the vaccine – with Phase 1a covering front-line health workers,

workers who provide healthcare-facility services…who also risk exposure to bodily fluids or aerosols, and first responders.[1] Note how "first responders" is listed entirely separately from the other two health-related groups, including front-line and behind-the-scenes healthcare workers. The term "first responder" is often used by states as a term specifically designated for fire/emergency medical services or law enforcement, not pharmacists or healthcare personnel.[2-5]

b. The Advisory Committee on Immunization Practices (ACIP) defined health care personnel as "paid and unpaid persons serving in health care settings who have the potential for direct or indirect exposure to patients or infectious materials."[6] ACIP goes on further to state "Health care personnel comprise clinical staff members, including nursing or medical assistants and support staff members (e.g., those who work in food, environmental, and administrative services). Jurisdictions might consider first offering vaccine to health care personnel whose duties require proximity (within 6 feet) to other persons. If vaccine supply remains constrained, additional factors might be considered for subprioritization."[6]

c. For all of the work our profession has done to advocate for pharmacists as healthcare providers and the pharmacy as a patient care setting, it seems counterproductive to have this policy continue to depict us as anything other than essential healthcare workers. There is also an abundance of other active APhA Policies describing the important role of pharmacists in emergency preparedness, emergency response, national defense, health mobilization, and public health emergencies (referenced below), so the committee felt the reference to "first responders" here was not essential for maintaining that sentiment in active APhA policy.

3. Contextualizing the policy statement
    a. As previously written, the policy was vague regarding the context to which it should be applied. Therefore, the committee added the clause "during pandemics and/or other disaster preparedness and emergency response situations" at the end of the policy statement to clarify the context.
4. Prioritization of pharmacy personnel
    a. There are many essential healthcare workers who are deserving of medications and immunizations in these situations. This proposed broader wording advocates for pharmacy personnel to be "among the highest priority groups" which includes more contemporary

language than the original wording of "prioritize pharmacists". As we saw with COVID-19, a lot of people were prioritized as "Phase 1" for vaccines, but even within that prioritization, came the sub-prioritization of Phases 1-4 (or sometimes more!).[1]

Sources:

1. First responders, front-line healthcare workers will get COVID-19 vaccine first. US Pharmacist. October 14, 2020. https://www.uspharmacist.com/article/first-responders-frontline-healthcare-workers-will-get-covid19-vaccine-first
2. New Hampshire Department of Safety. First-responder COVID19 vaccine prioritization overview. https://prd.blogs.nh.gov/dos/hsem/?page_id=10850
3. Texas Department of Insurance. First responder FAQ. https://www.tdi.texas.gov/wc/employee/firstresp.html
4. Florida Statute. Chapter 112, Section 1815. https://m.flsenate.gov/statutes/112.1815
5. California Government Code. Chapter 68, Section 8562. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB1945
6. Dooling K, McClung N, Chamberland M, et al. The Advisory Commuttee on Immunization Practices' Interim Recommendation for Allocating Initial Supplies of COVID-19 Vaccine – United States, 2020. MMWR. 2020;69(49)1857-1859. https://www.cdc.gov/mmwr/volumes/69/wr/mm6949e1.htm

Current APhA Policy & Bylaws:

2007 Pharmacy Personnel Immunization Rates – (CURRENT/ACTIVE POLICY BEING AMENDED IN THIS PROPOSAL)
1. APhA supports efforts to increase immunization rates of healthcare 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 public health officials to recognize pharmacists as first responders (e.g. physicians, nurses, police, etc.) and prioritize pharmacists to receive medications and immunizations.
(JAPhA NS45(5):580 September/October 2007) (Reviewed 2009)(Reviewed 2014)(Reviewed 2019)

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)]; 26
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)

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)

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. In view of these responsibilities, it shall be the policy of APhA,

1. To cooperate with all responsible agencies and departments of the federal government.
2. To 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. To 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. To 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.
5. To 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)

2005,2002 Emergency Preparedness
APhA supports the continuing efforts of the Joint Commission of Pharmacy Practitioners working group on emergency preparedness and response to network with the Office of Homeland Security and with any other relevant governmental and/or military agency. *(JAPhA NS42(5): Suppl. 1:S61 September/October 2002)(JAPhA NS45(5):559 September/October 2005)(Reviewed 2006)(Reviewed 2009)(Reviewed 2014)*

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, which 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)

****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 **February 16, 2022** (30 days prior to the start of the first House session). Consideration of urgent items can be presented with a suspension of the House Rules at the session where New Business will be acted upon. Please submit New Business Items to the Speaker of the House via email at hod@aphanet.org.

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

American Pharmacists Association
House of Delegates – March 18-21, 2022

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

Item No. 9
Date received: 2/16/2022
Time received: 7:05 PM

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

Introduced by: Lauren Ostlund (MN), Madeleine Davies (MN), Riley Larson (MN), Lorri Walmsley (AZ), Jennifer Adams (ID)
(Name)

2/16/2022 **Arizona, Idaho, Minnesota Delegations**
(Date) **(Organization)**

Subject: Pharmacists' application of professional judgment

Motion: Adopt the new proposed policy regarding pharmacists' application of professional judgment

Pharmacist's application of professional judgment:
1) APhA supports pharmacists, as licensed health care professionals, in their unrestricted 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 the creation of state and federal laws that negate a pharmacist's right to exercise professional judgment in the best interest of patients' clinical outcomes.
4) APhA calls for civil, criminal, and legal liability protections for pharmacists and pharmacies if the right to use professional judgment is limited by state and federal laws.

Background:

There has been an emerging trend with recently proposed state legislation across the country that is potentially limiting or prohibiting a pharmacist's use of professional judgment regarding medications they deem clinically inappropriate.[1-24] While the intent of much of the legislation targets off-label dispensing during the pandemic, several versions are more expansive and would apply to pharmacy practice beyond the pandemic. If passed, these bills create a dangerous precedent undermining a pharmacist's application of professional judgment. The pharmacists' role in medication review and patient safety is imperative within the health care team to protect patients from potential harm. These pieces of legislation are in direct conflict with many state and federal laws[25, 26] requiring

pharmacists to conduct drug utilization reviews and to assess medication safety in the course of prescription dispensing.

Several versions of state legislation have liability protections for pharmacies and pharmacists, but many do not. Regardless of civil and criminal liability protections, these potential laws may still create internal conflicts for pharmacists from an ethical and moral responsibility. Limiting the professional judgment to refuse to fill a prescription with a clinical conflict that cannot be resolved, and may cause harm to a patient, places the pharmacist in an ethical dilemma to either knowingly break the law or potentially harm a patient. Further, some third party plans have policies limiting the payment for off-label uses, which may result in third party chargebacks causing additional financial liabilities and harm to pharmacies. Most significantly, these pieces of legislation may result in harm to patients by limiting the pharmacists' application of professional judgment.

When reviewing existing APhA policies, we contemplated if the current policy was sufficient, if a modification was needed or if a new policy item would be most appropriate. The following policies were considered for potential modification during our process: Pharmacist Conscience Clause, Code of Ethics for Pharmacists, Mission of Pharmacy, Potential Conflicts of Interest in Pharmacy Practice, Pharmacy Practice: Professional Judgement, Non-FDA-Approved Drugs and Patient Safety, Regulatory Infringements on Professional Practice, and Controlled Substances and Other Medications with the Potential for Abuse and Use of Opioid Reversal Agents. While there were policies that partially fit the authors' intent, there was not a policy that was all-inclusive and would be suitable to defend pharmacists' judgment against this type of legislative attack. Therefore, a new policy statement from APhA is imperative to support pharmacists' right to use professional judgment when reviewing medications for safety and efficacy. Furthermore, this policy is paramount to protect public safety and to prevent potential reputational harm to the profession.

References

1. H.B. 237, 2022 Biennium, 2022 Reg. Sess. (Alaska 2022). http://www.akleg.gov/basis/Bill/Text/32?Hsid=HB0237A.
2. S.B. 1413, 2022 Biennium, 2022 Reg. Sess. (Ariz. 2022). https://www.azleg.gov/legtext/55leg/2R/bills/SB1413P.pdf.
3. S.B. 1016, 2022 Biennium, 2022 Reg. Sess. (Ariz. 2022). https://www.azleg.gov/legtext/55leg/2R/bills/SB1016P.pdf.
4. H.B. 613, 2022 Biennium, 2022 Reg. Sess. (Idaho 2022). https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2022/legislation/H0613.pdf.
5. H.F. 2265, 2022 Biennium, 2022 Reg. Sess. (Iowa 2022). https://www.legis.iowa.gov/docs/publications/LGI/89/HF2265.pdf.
6. H.B. 2280, 2022 Biennium, 2022 Reg. Sess. (Kan. 2022). http://www.kslegislature.org/li/b2021_22/measures/documents/hb2280_00_0000.pdf.
7. S.B. 381, 2022 Biennium, 2022 Reg. Sess. (Kan. 2022). http://www.kslegislature.org/li/b2021_22/measures/documents/sb381_00_0000.pdf.
8. H.B. 352, 2022 Biennium, 2022 Reg. Sess. (Ky. 2022). https://apps.legislature.ky.gov/recorddocuments/bill/22RS/hb352/orig_bill.pdf.
9. H.F. 2902, 2022 Biennium, 2022 Reg. Sess. (Minn. 2022). http://wdoc.house.leg.state.mn.us/leg/LS92/HF2902.0.pdf.
10. S.B. 1133, 2022 Biennium, 2022 Reg. Sess. (Mo. 2022). https://www.senate.mo.gov/22info/BTS_Web/Bill.aspx?SessionType=R&BillID=75553529.
11. S.B. 1525, 2022 Biennium, 2022 Reg. Sess. (Okla. 2022). http://webserver1.lsb.state.ok.us/cf_pdf/2021-22%20INT/SB/SB1525%20INT.PDF.
12. S.B. 1639, 2022 Biennium, 2022 Reg. Sess. (Okla. 2022). http://webserver1.lsb.state.ok.us/cf_pdf/2021-22%20INT/SB/SB1639%20INT.PDF.
13. S.B. 1638, 2022 Biennium, 2022 Reg. Sess. (Okla. 2022). http://webserver1.lsb.state.ok.us/cf_pdf/2021-22%20INT/SB/SB1638%20INT.PDF.
14. H.B. 1741, 2021 Biennium, 2021 Reg. Sess. (Pen. 2021). https://www.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=HTM&sessYr=2021&sessInd=0&billBody=H&billTyp=B&billNbr=1741&pn=1972.
15. H.B. 1870, 2022 Biennium, 2022 Reg. Sess. (Tenn. 2022). https://www.capitol.tn.gov/Bills/112/Bill/HB1870.pdf.
16. H.B. 2744, 2022 Biennium, 2022 Reg. Sess. (Tenn. 2022). https://www.capitol.tn.gov/Bills/112/Bill/HB2744.pdf.
17. H.B. 2506, 2022 Biennium, 2022 Reg. Sess. (Tenn. 2022). https://www.capitol.tn.gov/Bills/112/Bill/HB2506.pdf.
18. S.B. 1880, 2022 Biennium, 2022 Reg. Sess. (Tenn. 2022). https://www.capitol.tn.gov/Bills/112/Bill/SB1880.pdf.
19. S.B. 2630, 2022 Biennium, 2022 Reg. Sess. (Tenn. 2022). https://www.capitol.tn.gov/Bills/112/Bill/SB2630.pdf.
20. S.B. 2621, 2022 Biennium, 2022 Reg. Sess. (Tenn. 2022). https://www.capitol.tn.gov/Bills/112/Bill/SB2621.pdf.
21. S.B. 711, 2022 Biennium, 2022 Sess. (Va. 2022). https://lis.virginia.gov/cgi-bin/legp604.exe?221+ful+SB711.
22. H.B. 102, 2022 Biennium, 2022 Sess. (Va. 2022). https://lis.virginia.gov/cgi-bin/legp604.exe?221+ful+HB102H1.
23. H.B. 976, 2022 Biennium, 2022 Sess. (Va. 2022). https://lis.virginia.gov/cgi-bin/legp604.exe?221+ful+HB976.

24. H.B. 4309, 2022 Biennium, 2022 Reg. Sess. (W. Va. 2022). https://www.wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=HB4309%20INTR.htm&yr=2022&sesstype=RS&i=4309.
25. H.R. 5835 – 101st Congress: Omnibus Budget Reconciliation Act of 1990, IV U.S.C. § 1927 (1990). https://www.congress.gov/bill/101st-congress/house-bill/5835/text
26. Code of Federal Regulations, 21 U.S.C. § 1306.04(a) (1971). https://www.ecfr.gov/current/title-21/chapter-II/part-1306/subject-group-ECFR1eb5bb3a23fddd0/section-1306.04

Current APhA Policy & Bylaws:

Pharmacist Conscience Clause (1998, 2004)

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)

Code of Ethics for Pharmacists (1994)

Preamble: 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 covenant relationship between the patient and pharmacist. Considering the patient-pharmacist 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 communicates 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 judgment, 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 responsibilities 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 October 27, 1994)

Mission of Pharmacy (1991)
APhA affirms that the mission of pharmacy is to serve society as the profession responsible for the appropriate use of medications, devices, and services to achieve optimal therapeutic outcomes.
(Am Pharm. NS31(6):29; June 1991) (Reviewed 2004) (Reviewed 2010) (Reviewed 2015) (Reviewed 2018)

Potential Conflicts of Interest in Pharmacy Practice (2011)
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)

Non-FDA-Approved Drugs and Patient Safety (2009)
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)

Regulatory Infringements on Professional Practice (2001, 1990)
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)

Controlled Substances and Other Medications with the Potential for Abuse and Use of Opioid Reversal Agents (2014)
1. 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.
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)

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.
JAPhA. 2020; 60(5): e9

Pharmacy Practice: Professional Judgment (2004, 1977)

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)

****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 **February 16, 2022** (30 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.