APhA
AMERICAN PHARMACISTS ASSOCIATION

2021 House of Delegates
Report of the New Business Review Committee

Committee Members

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

Item No. 1
Date received: 2/1/2021
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American Pharmacists Association
House of Delegates – March 15, 2021

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Michael A. Mone
(Name)

02.01.2021
Date

Former Speaker (On behalf of the Task Force)
(Organization)

Subject: Systemic Racism

Motion:

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.

Background:

Summer of 2020, already fraught with uncertainty from the global COVID-19 pandemic, brought with it a movement on issues of systemic racism to the mainstream conversation. Bringing light to issues of social justice has come with the opportunity to deepen dialogue and engage in discussion like never before, and the pharmacy community must be committed to engaging in and addressing the issue of how racism impacts our profession, our community, and our patients. Within the oath of the pharmacist, our professional responsibility and commitment to patient care comes with the responsibility for pharmacists to do our best to examine and address factors that negatively impact patient care. Racism in all its forms, ranging from interpersonal, implicit or explicit, to structural policies and programs that intentionally or unintentionally perpetuate racial disparities, contributes to the negative health impacts seen across communities, particularly among marginalized identities (i.e., Black, Indigenous, Persons of Color, gender identities, sexual orientation, etc.).

Structural Racism continues to negatively impact both patient outcomes as well as pharmacy professionals who identify as Black, Indigenous, and Persons of Color because of the obstacles posed to fulfill the basic human rights to survival, security, development, and social participation. Achieving equitable outcomes for all patients, especially Black, Indigenous, and Persons of Color patients and professionals, without first addressing structural racism within the profession is therefore antithetical to the oath of a pharmacist and APhA core values.

The APhA Task Force on Systemic Racism conducted a review of existing association policy related to the intersections of race, social determinants of health, health inequities, education, research, practice, and organizational policies and programs. The Task Force determined that existing policy is silent on these topics and this represents a "gap" in important areas of contemporary social, public and health policy.

The proposed policy statements reflect a commitment to denounce all forms of racism and bigotry within and outside of our profession, and to urge the entire pharmacy community to commit to dismantling racism. Each individual will be at a different point in their journey towards understanding and addressing racism from just scratching the surface and educating themselves, to being in positions of power and influence to shape organizational policies. Nonetheless, we urge our community to commit to doing the work incrementally to shape greater change, no matter where they are in this journey. We also recognize and hold accountable individuals in positions of leadership and those who have decision-making power to examine their agency for opportunities they may have to impact policies and initiatives/programs; we urge the community to further the work in dismantling racism by incentivizing and creating opportunities for more education, research, and practice to dismantle racism.

Current APhA Policy & Bylaws:

2017, 2012, 1989
Equal Rights and Opportunities for Pharmacy Personnel
APhA reafrms its unequivocal support of equal opportunities for employment and advancement, compensation, and organizational leadership positions. APhA opposes discrimination based on sex, gender identity or expression, race, color, religion, national origin, age, disability, genetic information, sexual orientation, or any other category protected by federal or state law.
(Am Pharm 29(7):464 July 1989) (Reviewed 2001) (Reviewed 2007)(JAPhA 52(4) 459 July/August 2012)(JAPhA 57(4): 441 July/August 2017)

2012, 1991
Recruitment of a Diverse Population into Pharmacy
1. APhA supports a vigorous long term program for the recruitment of a diverse population of student pharmacists into the pharmacy profession.
2. APhA encourages the development and regular updating of comprehensive recruitment materials, directed toward diversity and inclusion, that address such issues as pharmacy career opportunities, nancial aid, and educational prerequisites, and that highlight professional diverse role models.
3. APhA encourages national, state, and local association; schools; students; and industry to create a network of pharmacists who would serve as role models for a diverse population of student pharmacists.
4. APhA supports the development of guidelines that assist schools of pharmacy in implementing diversity and inclusion initiatives into student pharmacist recruitment programs.(Am Pharm 31(6):28 June 1991) (Reviewed 2001) (Reviewed 2007) (JAPhA 52(4) 459 July/August 2012)(Reviewed 2017)(Reviewed 2018

1979
Consideration of the Equal Rights Amendment
APhA supports efforts to assure equal rights of all persons.
(AmPharm 19(7):60 June 1979) (Reviewed 2009)(Reviewed 2014)(Reviewed 2018)

2009
Disparities in Healthcare
APhA supports elimination of disparities in health care delivery.
(JAPhA 49(4):493 July/August 2009)(Reviewed 2013)(Reviewed 2018)

2006
Cultural Health Beliefs and Medication Use
1. APhA supports culturally sensitive outreach efforts to increase mutual understanding of the risks and other issues of using prescription medications without a prescription order or using unapproved products.
2. APhA supports expanding culturally competent health care services in all communities.
(JAPhA 46(5):561 September/October 2006) (Reviewed 2009)(Reviewed 2014)(Reviewed 2019)

2005
Cultural Competence
1. Recognizing the diverse patient population served by our profession and the impact of cultural diversity on patient safety and medication use outcomes, APhA encourages pharmacists to continually strive to achieve and develop cultural awareness, sensitivity, and cultural competence.
2. APhA shall facilitate access to resources that assist pharmacists and student pharmacists in achieving and maintaining cultural competence relevant to their practice.
(JAPhA 45(5):554 September/October 2005) (Reviewed 2006)(Reviewed 2011)(Reviewed 2016)

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

New Business Items are due to the Speaker of the House by **February 10, 2021** (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.

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

Item No: 2
Date received: 2/8/2021
Time received: 1:56 PM

American Pharmacists Association
House of Delegates – March 15, 2021

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Aimee Dawson (APhA-APPM Delegate)

02-8-2021 **(Date)**

Delegation on behalf of the APhA-APPM Diabetes Management SIG **(Organization)**

Subject: People First Language

Motion: To adopt the following new policy statements:

APhA encourages the use of people first language in all written and oral forms of communication.

Background:

People first language, or person first language, was first adopted and embraced by organizations that support people with disabilities. In the healthcare setting, it has been recognized that person-first language should expand to all patients with any medical condition, not just conditions categorized as disabilities. People first language is a communication style that ensures appropriate and respectful language is used.[1] The language recognizes the person first, not their condition. For example, patients should be referred to as "a person with…." or "a person who has…". In the health-care setting, everyone should strive to use people-first language when speaking about patients. This is as simple as using the term "patients with diabetes" instead of "diabetic patients" or "a person living with HIV" instead of "an HIV patient". Language matters and this is an important tool to help efforts to limit discrimination, generalizations, and

stereotypes.[2] In 2017, we saw the expansion of this idea and its use in healthcare when the American Association of Diabetes Educators (AADE) and the American Diabetes Association (ADA) developed a joint task force to discuss language in diabetes care and education.[3] This task force published a report with their recommendations including the use of person first language.[3] APhA should stand with the CDC, AADE/ADA, and the numerous other organizations that support the use of people first language.[1-3]

Although it is usually best to use people first language when referring to another person, individuals may wish to use identity-first language when referring to themselves or ask others to use this language when speaking about them.[4,5] Identity-first language is when the disability or condition will come first. For example, a person with autism may choose to refer to themselves as "an autistic person." People that use identity-first language for themselves state that this is a choice of empowerment.[4,5] People or organizations who prefer identify first language often state that are proud of their disability or condition and would like to be identified as such.[4,5]

Overall, when referring to another person, people first language should always be used unless that person has indicated that they prefer identify-first language.

Sources:

1. Office of the Director, National Center on Birth Defects and Developmental Disabilities -CDC. Communicating With and About People with Disabilities. https://www.cdc.gov/ncbddd/disabilityandhealth/pdf/disabilityposter_photos.pdf Accessed: October 10, 2019.
2. Texas Council for Developmental Disabilities. People First Language. https://tcdd.texas.gov/resources/people-first-language/ Accessed: October 10, 2019.
3. Dickinson JK, Guzman SJ, Maryniuk MD, et al. The Use of Language in Diabetes Care and Education. Diabetes Care. 2017;40(12):1790-1799.
4. Molly Callahan. 'Autistic Person' or 'Person with Autism': Is there a right way to identify people? July 12, 2018. https://news.northeastern.edu/2018/07/12/unpacking-the-debate-over-person-first-vs-identity-first-language-in-the-autism-community/ Accessed: October 10, 2019.

5. The pitfalls of political correctness: euphemisms excoriated [article online]. Braille Monitor, March 2009. Available from https://nfb.org/images/nfb/publications/bm/bm09/bm0903/bm090308.htm. Accessed November 7, 2019.

Current APhA Policy & Bylaws:

No current existing APhA Policy statements or bylaws related to this topic.

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American Pharmacists Association
House of Delegates – March 15, 2021

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Item No. **3**
Date received: **2/9/2021**
Time received: **5:44 PM**

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: **Jimmi Hatton Kolpek, PharmD, FCCM, FCCP, FNAP**
(Name)

02/09/2021
(Date)

American College of Clinical Pharmacy
(Organization)

Subject: **Increasing Awareness and Accountability to End Harassment, Intimidation, Abuse of Power, Position or Authority in Pharmacy Practice**

Motion:

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

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

3) APhA urges all pharmacy organizations to require individuals considered for any award, leadership position (including voluntary positions), fellowship recognition, or editorial board position, to formally confirm that they have never been involved in any instances of harassment, intimidation, or abuse of power or abuse of authority.

4) APhA recommends that any individual who has been engaged in, or who falsely attests that they have never been involved in, any instances of harassment, intimidation or abuse be excluded from consideration for

any award, leadership position (including voluntary positions), fellowship recognition, editorial board position, faculty/preceptor, or postgraduate training faculty/director position.

5) APhA recommends all pharmacy organizations incorporate harassment, intimidation, and abuse training in their member professional development and education activities.

Background:

The issue of harassment within the pharmacy profession has been brought to light through numerous public and private communications. A group of women pharmacists, motivated by the overwhelming response and outpouring of personal stories from individuals affected by harassment, intimidation, and abuse, conducted an anonymous survey to empower those impacted and provide them with an outlet to have their stories heard. A vast number of accounts perpetuated by numerous alleged harassers were shared. Through this effort, it became evident that many organizational harassment policies are outdated and without efficient reporting mechanisms. Most organizational policies rely on local or institutional responsibility for recognition and reporting of episodes of harassment or other unprofessional conduct. This has become problematic in the current, collaborative professional/interprofessional environment in which multi-institutional relationships are increasingly common. Further, as students, residents, and new practitioners pursue postgraduate training and other professional opportunities, they often interact with preceptors, faculty, and program directors from multiple institutions. Contemporary communication platforms and social media reveal that episodes of harassment, intimidation, and abuse during these interactions are far too common.

To highlight these concerns to national organizations, a petition, "End Gender Inequality in Clinical Pharmacy," was posted to the website change.org:

> *Members of the Board and Organizational Leadership,*
>
> *We, the undersigned, are writing to alert pharmacy organizations about the ongoing, troubling sexism in our profession. In recent months, it has become increasingly apparent that awards, presentations, and provisions of leadership have been used to intimidate women in our profession unbeknownst to many. At present, over 45 self-identified victims of this behavior have come forward. This behavior is persistent and has begun to have a significant impact on our trainees, creating a legacy of silent trepidation.*
>
> *We wish to work within these organizations to develop systematic processes to monitor and/or gain a better understanding of the implications when these individuals are awarded recognition and elevated professional status by national organizations. There is a need to generate mechanisms to alert selection committees or other leadership bodies about individuals who use professional status to undermine, intimidate, and sexually harass our female students, trainees, and peers. We are further asking for supportive partnerships and actions that can become integrated into organizational processes in order to help those who have experienced bullying or harassment to feel supported by our organizations.*
>
> *Thank you in advance for your attention to this delicate matter.*

Several national organizations have released statements in support of the petition's principles, which to date has logged more than 3,750 signatures.

The ACCP Board of Regents released the following statement on September 7, 2020:

> ***ACCP Supports Authors of Gender Inequality Petition***
>
> *After learning on September 3 of the petition titled, End Gender Inequality in Clinical Pharmacy, the ACCP Board of Regents held an urgent discussion session regarding the petition on the morning of September 4. The board reviewed the petition and considered the concerns that fostered its development. After in-depth discussion, the board reached consensus regarding its support of the petition and made the following observations:*
>
> - *Unfortunately, our profession, like society as a whole, is not immune to the impact of sexual harassment, bullying, and similar unacceptable behaviors.*

- *Like other pharmacy organizations, ACCP is seeking ways to provide support and guidance to members of the profession who encounter harassment, predatory conduct, gender bias, or other threatening or intimidating behaviors.*
- *It is difficult for any organization to assess allegations related to misconduct outside of its official bounds without verifiable documentation or firsthand knowledge of those allegations. However, ACCP is committed to addressing matters that are adversely affecting members of our profession. This applies not only to incidents of sexual harassment/intimidation, but the broader issues that surround inclusion, diversity, racial/gender bias, and equity.*
- *If one is confronted with a specific case of disturbing behavior that affects him/her individually (or that impacts a colleague, student, trainee, or mentee), the individual should immediately consult a human resources representative within her/his workplace.*

In reflecting on the board's discussion, ACCP President Brian Erstad commented, "ACCP encourages education of all stakeholders regarding the implications, detection, and management of sexual harassment, bullying, and similar unacceptable behaviors. Only through diligent efforts to report, follow-up, and investigate instances of unacceptable behaviors will our profession be able to meaningfully address this issue."

ASHP released the following statement on September 10, 2020:

ASHP Response to Petition to End Gender Inequality in Clinical Pharmacy

Recently, ASHP became aware of a petition to pharmacy organizations titled, End Gender Inequality in Clinical Pharmacy. In this petition it is stated that:

"In recent months, it has become increasingly apparent that awards, presentations, and provisions of leadership have been used to intimidate women in our profession unbeknownst to many. At present, over 45 self-identified victims of this behavior have come forward." It goes on to say that "there is a need to generate mechanisms to alert selection committees or other leadership bodies about individuals who use professional status to undermine, intimidate, and sexually harass our female students, trainees, and peers."

ASHP stands on values that include a culture that strongly supports equality, diversity, and inclusion. ASHP opposes and will not tolerate unprofessional behaviors that may undermine, intimidate, and harass others. Our values reside in helping and supporting all of our members and colleagues. This extends to support of gender equality, and ASHP is proud to be a longtime leader in national efforts to support women in pharmacy.

ASHP's Statement on Professionalism encourages pharmacy practitioners, administrators, faculty members, preceptors, residents, and students to advance patient care and strengthen the pharmacy profession by promoting professionalism in everyday practice. ASHP encourages pharmacists to serve as mentors to students, residents, and colleagues in a manner of high personal standards of personal integrity.

Further, our professional policy advocates that hospitals and health systems adopt zero-tolerance policies for intimidating or disruptive behaviors and encourages development and implementation of education and training programs to facilitate effective communication, set expectations for standards of conduct, and discourage intimidating or disruptive behaviors. ASHP encourages hospitals and health systems to implement processes for identification and reporting of intimidating or disruptive behaviors to evaluate and mitigate unacceptable behaviors in a timely and effective manner.

ASHP's policies and guiding principles are based on core tenets of professionalism, equality, diversity, and inclusion. It is with this same spirit that we, as a professional organization, actively support eliminating discrimination, exclusion, and injustices of all types directed at any individual or group of individuals.

The APhA Board of Trustees released the following statement on September 21, 2020:

Women in pharmacy face intolerable levels of harassment and intimidation

We want to make this clear right off the bat: APhA is steadfastly opposed to sexism, racism, discrimination, harassment, and intimidation – implicit or explicit – and we are committed to combatting behaviors that undermine any member of our profession.

A recent change.org petition called on national pharmacy organizations to address the ways women are silenced: Women risk leadership roles, awards, and opportunities to present their research if they speak out about sexism and sexual misconduct. The petition inspired a wave of women to share their own stories of abuse and harassment based on their gender. The petition also led to discussions about the unfairness of guilty parties receiving tenure-track promotions, positions of power, and professional awards and accolades with no consideration of their unprofessional and destructive treatment of their women peers.

This is a very real threat to pharmacy and the patients we serve. When women are sexually harassed, and when their achievements are subjugated and disregarded, we are deprived of valuable perspectives, ideas, and innovations that could propel us forward.

Every one of us, especially men, needs to take an honest inventory of how we think and act, and how we play a role in letting sexism endure. APhA members and staff must do so as well, not only as individuals but as an organization.

It's clear what we oppose, but what do we support? Well before the change.org petition resurfaced issues around gender discrimination and sexual harassment, the APhA Academy of Pharmaceutical Research and Science and the American Association of Colleges of Pharmacy convened a joint task force aimed at ensuring gender equity in careers in the sciences.

We are proud that three out of APhA's last five presidents are women, and that another woman will take the mantle in March. Our House of Delegates first took an unambiguous anti-sexist stance decades ago: In 1989, it adopted policy condemning gender discrimination and other bias-based discrimination. The policy was expanded in 2012 and 2017 to include gender identity and expression.

The change.org petition posted this month is upsetting to those who weren't clued into the problem already, but it's also a hopeful sign. It has motivated pharmacy groups, APhA and others, to reevaluate their actions to support women in the profession and recommit to living their principles, and it has amplified a conversation that must be ongoing.

We've got work to do. We call on all organizations and individuals to join us in fighting sexism, racism, discrimination, harassment, and intimidation. Let's get at it.

With the support of several national organizations, it is the hope of this group to create an efficient interorganizational stance against all levels of harassment within our profession with a focus on education and formal reporting mechanisms to attenuate the perpetuating environment of harassment within clinical pharmacy.

Current APhA Policy & Bylaws:

2004, 1994

Sexual Harassment in the Workplace

1. APhA supports the principle that all work environments and educational settings be free of sexual harassment.
2. APhA recommends all pharmacy practice environments and educational settings have a written policy on sexual harassment prevention and grievance procedures.
3. APhA recommends that every owner/employer in facilities where pharmacists work institute a sexual harassment awareness education and training program for all employees.
4. APhA supports the wide distribution of the model guidelines on "Sexual Harassment Prevention and Grievance Procedures".

(AmPharm 34(6):55 June 1994)(Reviewed 2001)(JAPhA 44(5):551 September/October 2004)(Reviewed 2010)(Reviewed 2015)

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

Item No. 4
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American Pharmacists Association
House of Delegates – March 15, 2021

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Rachel Barenie (APhA-APPM Delegate)
(Name)

February 9, 2021 — **(Date)**

APhA-APPM Delegation on behalf of the APhA-APPM Pain, Palliative Care and Addiction Special Interest Group (SIG) — **(Organization)**

Subject: Increasing Access to and Affordability of Naloxone

Motion: To adopt the following policy statements:

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

Background:

Deaths due to overdoses continue to claim the lives of tens of thousands American every year in the US, with more than half involving an opioid.[i] In response, federal, state, and local authorities have made curtailing the opioid overdose crisis a top priority and funneled tremendous resources into efforts to combat it.[ii] One key measure is ensuring access to naloxone, which is a life-saving medication that acts as an opioid antagonist and used in the event of opioid overdose. The Surgeon General of the United States has recommended that everyone, whether that is a person at-risk for overdose, emergency personnel, or a loved one, have access to naloxone.[iii,iv] Double-digit increases in

overall drug overdose fatalities were reported by the CDC between May 2019 and May 2020.[v] The number of overdose deaths recorded in this 12-month timespan, more than 81,000 overall, was the highest ever reported in one year, the majority of these deaths caused by illegal opioids.[5] The Health Advisory recommends several strategies to expand the provision and use of naloxone and overdose prevention education.[5]

In recent years, there have been prolific efforts advanced to achieve the Surgeon General's aim. From national guidelines and prescription drug labels that recommend practitioners to co-prescribe to widespread uptake of standing orders that allow pharmacists to co-dispense, naloxone remains a key harm reduction tool to combat the epidemic.[vi,vii] Prior APhA policies have been phrased to narrowly support specific initiatives, such as state and federal laws that permit pharmacists to furnish the drug; however, all states now have passed laws related to increasing naloxone access via pharmacists and pharmacy staff.[viii] Research has even shown that laws allowing pharmacists to dispense naloxone without a prescription is associated with significant increases in dispensing rates.[ix] Thus, it is important that future policies to broaden access go beyond mere regulatory changes, especially during a historic pandemic that continues to disproportionately affect those at the highest risk of fatal and nonfatal overdose and their caregivers. The solution is to make naloxone as accessible and affordable as possible. **Retire statement 4 of Controlled Substances and Other Medications with the Potential for Abuse and Use of Opioid Reversal Agents (*2014)*: 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. Support: APhA supports policies and practices that increase the availability and accessibility of naloxone.**

Access to naloxone is distinctly different from access to treatments for opioid use disorder (OUD). Evidence-based treatment for OUD includes medication sometimes in combination with psychosocial support. These medications are **life-sustaining** and include methadone, buprenorphine, and naltrexone. Since it is an "emergency-use" medication, ensuring access to naloxone is a life-saving effort, and the American Society of Addiction Medicine Guidelines recommend that all patients diagnosed with OUD receive naloxone. The FDA also recommends that people using methadone or buprenorphine also receive a naloxone prescription.[x] An emphasis should be placed not only on **life-sustaining** treatment for OUD as supported by previous policies passed by APhA but also **life-saving** measures to help prevent unnecessary loss of life and ensure that those managing OUD and their caregivers are able to get the help they need.

The Food and Drug Administration has approved naloxone in multiple, prescription-only formulations, such as Narcan (nasal spray) and Evzio (intramuscular autoinjector) most recently.[xi] Its onset of action is rapid, although dependent upon the route of administration, with the intravenous (IV) and intranasal routes demonstrating its effect within minutes to reverse potentially fatal effects of respiratory depression.[xii,xiii] The drug can be administered by both laypersons and medical professionals, and it does not cause physical or psychological dependence.[xiv,xv] This medication is extraordinarily safe, with no serious side effects associated with its use. Administering naloxone to an individual who is not suffering from an opioid overdose will not cause any harm. While the medication is not a treatment for opioid use disorder, it certainly is a key component of a set of harm reduction interventions for people who use drugs.[xvi,xvii]

In recent years, there have been numerous initiatives to minimize barriers and improve access to naloxone.[xviii] States have passed laws regarding authorized dispensing methods; immunity (civil, criminal, and/or disciplinary immunity for the prescriber/dispenser); and training (certification/education requirements). A majority of states permit third-party prescribing in a potential opioid overdose situation, in order to bypass the general prescriber-patient relationship requirement for prescribing medications to a patient, naloxone to be prescribed to a third-party patient (parent, caregiver, friend), so they can administer it to another person at-risk of an overdose

risk.[xix] Several states have even promulgated laws allowing standing orders for naloxone administration and dispensing. Such orders may include a collaborative pharmacy practice agreement between the prescriber and a pharmacist, and a minority of states have enacted laws that permit some or all pharmacists to prescribe naloxone on their own authority.

States have also opted to pass "Good Samaritan Law" to help increase access to naloxone.[xx] Witnesses of opioid overdoses are frequently afraid to get involved and report the situation, fearing their own arrest for a drug-related crime. To urge witnesses to call for emergency help, the majority of states modified laws to offer protection from prosecution and arrest against minor drug possessions for the person placing such emergency calls in good faith. Most of these laws provide a person who calls for emergency responders in good faith protection from prosecution for minor drug possessions. Almost all of those laws offer the same protection to the victim of the overdose as well. Some laws even expand protection to shield individuals from probation/ parole violations or even other drug-related crimes.[xxi]

Recent research, however, suggests that only a fraction of patients who need the medication may actually be dispensed it. For example, recent claims database analyses suggest that merely 0.5% to upwards of 2% of patients who were at high-risk for an opioid-related overdose were dispensed the medication.[xxii,xxiii] While this does not account for paying cash for the medication or obtaining it through a government sponsored distribution program, it does signal that access remains difficult to access for numerous reasons, such as cost, stigma, staffing shortages (lack of personnel with time to educate about need), regulatory issues, patient-related problems (discomfort with the program setting), patient preferences (some at-risk patients did not want an overdose kit) and legal concerns (patients' concerns that having the kits would result in legal problems).[xxiv] An effective policy intervention to increase naloxone co-prescribing and co-dispensing are state laws requiring naloxone prescriptions for patients receiving higher dose opioids, opioid-benzodiazepine combinations, those with an OUD diagnosis, and people who have a history of overdose.[xxv] **APhA supports policies and practices that increase the availability of naloxone.**

State and federal governments recognize this medication is of premier public health importance. For example, in 2019, the FDA even developed over-the-counter labeling for naloxone.[xxvi,xxvii] Yet, no manufacturer to-date has stepped up to manufacture it. More recently, the FDA added co-prescribing naloxone to the drug labeling on opioids and medications for opioid use disorder.[xxviii] Making naloxone available as a non-prescription drug could substantially minimize the stigma patients may face when asking for naloxone at their pharmacy or having a claim billed to their insurance for it. This would offer patients an alternative means to access the medication. **APhA supports the availability of naloxone as both a prescription and non-prescription medication.**

With improved access must come improved affordability because the cost of naloxone may be one reason persons who need it do not have it. Recent research shows that the cost of naloxone—even when patients have insurance—is expensive, especially the brand-name formulation Evzio.[xxix,xxx] If naloxone becomes available as a non-prescription medication, it will be important that it not only remains reasonably priced, but also is part of the optional coverage by insurers as a non-prescription medication.[xxxi] Just as expanding Medicaid coverage is associated with a reduction in county-level opioid overdose deaths, it's likely that maintaining coverage of naloxone by payers as a non-prescription drug will sustain this outcome trend.[xxxii] **APhA encourages pharmacists and payers to ensure equitable access to and affordability of at least one naloxone formulation regardless of prescription status.**

In addition to access and affordability, fair reimbursement must also be supported for the dispenser of naloxone. A recently published article regarding pharmacy reimbursement found that pharmacies observed increases in generic drug prices by 50% or more during a recent two-year period, but the health plan and pharmacy benefit reimbursement did not parallel increasing

prices.[xxxiii] More specifically, reimbursement only kept up with the rising prices 16% of the time.[33] These findings underscore the fact that pharmacies are often positioned to make difficult decisions when their costs increase without adequate reimbursement, which has likely contributed to an ongoing number of closures among retail pharmacies around the U.S. in recent years.[33,xxxiv,xxxv] These closures are more likely to occur in communities with characteristics that are associated with higher drug overdose prevalence, thus further diminishing the impact of pharmacy-based naloxone.[xxxvi] **APhA encourages payers to provide fair reimbursement to dispensers of naloxone.**

Current Related APhA Policy & Bylaws:

2011 **Potential Conflicts of Interest in Pharmacy Practice**

1. APhA reaffirms that as health care professionals, pharmacists are expected to act in the best interest of patients when making clinical recommendations.

2. APhA supports pharmacists using evidence-based practices to guide decisions that lead to the delivery of optimal patient care.

3. APhA supports pharmacist development, adoption, and use of policies and procedures to manage potential conflicts of interest in practice.

4. APhA should develop core principles that guide pharmacists in developing and using policies and procedures for identifying and managing potential conflicts of interest.

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

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

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

2. To reduce the consequences of stigma associated with injection drug use, APhA supports the expansion of interprofessional harm reduction education in the curriculum of schools and colleges of pharmacy, postgraduate training, and continuing professional development programs.

3. APhA encourages pharmacists to initiate, sustain, and integrate evidence-based harm reduction principles and programs into their practice to optimize the health of people who inject non-medically sanctioned psychotropic or psychoactive substances.

4. APhA supports pharmacists' roles to provide and promote consistent, unrestricted, and immediate access to evidence-based, mortality- and morbidity-reducing interventions to enhance the health of people who inject nonmedically sanctioned psychotropic or psychoactive substances and their communities, including: sterile syringes, needles, and other safe injection equipment, syringe disposal, fentanyl test strips, immunizations, condoms, wound care supplies, pre- and post-exposure prophylaxis medications for human immunodeficiency virus (HIV), point-of-care testing for HIV and hepatitis C virus (HCV), opioid overdose reversal medications, and medications for opioid use disorder.

5. APhA urges pharmacists to refer people who inject non-medically sanctioned psychotropic or psychoactive substances to specialists in mental health, infectious diseases, and addiction treatment; to housing, vocational, harm reduction, and recovery support services; and to overdose prevention sites and syringe service programs.

(JAPhA 59(4):e17July/August 2019)

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)

2011 **The Role and Contributions of the Pharmacist in Public Health**

In concert with the American Public Health Association's (APHA) 2006 policy statement, "The Role of the Pharmacist in Public Health," APhA encourages collaboration with APHA and other public health organizations to increase pharmacists' participation in initiatives designed to meet global, national, regional, state, local, and community health goals.

(JAPhA NS51(4) 482;July/August 2011)(Reviewed 2012)(Reviewed 2016) (Reviewed 2020)

1983 **Stocking a Complete Inventory of Pharmaceutical Product**

APhA supports the rights and responsibilities of individual pharmacists to determine their inventory and dispensing practices based on patient need, practice economics, practice security, and professional judgment.

(Am Pharm NS23(6):52 June 1983) (Reviewed 2004) (Reviewed 2010) (Reviewed 2015)

2005,1977 **Government-Financed Reimbursement**

1. APhA supports only those government-operated or -financed, third-party prescription programs which ensures that participating pharmacists receive individualized, equitable compensation for professional services and reimbursement for products provided under the program.

2. APhA regards equitable compensation under any government-operated or -financed, third party prescription programs as requiring payments equivalent to a participating pharmacist's prevailing charges to the self-paying public for comparable services and products, plus additional, documented, direct and indirect costs which are generated by participation in the program.

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

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

2005,1981 **Third-party Reimbursement Legislation**

APhA supports enactment of legislation requiring that third-party program reimbursement to pharmacists be at least equal to the pharmacists prevailing charges to the self-paying public for comparable services and products, plus additional documented direct and indirect costs, which are generated by participating in the program.

(Am Pharm NS21(5):40 May 1981) (Reviewed 2005) (Reviewed 2009)(Reviewed 2014)(Reviewed 2019)

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2016 **Opioid Overdose Prevention**

1. APhA supports access to third-party (non-patient recipient) prescriptions for opioid reversal agents that are furnished by pharmacists.

2. APhA affirms that third-party (non-patient recipient) prescriptions should be reimbursed by public and private payers.

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

2019,2016 **Substance Use Disorder**

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

2. APhA supports consumer sales limits of nonprescription drug products, such as methamphetamine precursors, that may be illegally converted into drugs for illicit use.

3. APhA encourages education of all personnel involved in the distribution chain of nonprescription products so they understand the potential for certain products, such as methamphetamine precursors, to be illegally converted into drugs for illicit use. APhA supports comprehensive substance use disorder education, prevention, treatment, and recovery programs.

4. APhA supports public and private initiatives to fund treatment and prevention of substance use disorders.

5. APhA supports stringent enforcement of criminal laws against individuals who engage in drug trafficking.

(JAPhA 56(4); 369 July/August 2016)(JAPhA 59(4) e28 July/August 2019)

2019 **Referral System for the Pharmacy Profession**

1. APhA supports referrals of patients to pharmacists, among pharmacists, or between pharmacists and other health care providers to promote optimal patient outcomes.

2. APhA supports referrals to and by pharmacists that ensure timely patient access to quality services and promote patient freedom of choice.

3. APhA advocates for pharmacists' engagement in referral systems that are aligned with those of other health care providers and facilitate collaboration and information sharing to assure continuity of care.

4. APhA supports attribution and equitable payment to pharmacists providing patient care services as a result of a referral.

5. APhA promotes the pharmacist's professional responsibility to uphold ethical and legal standards of care in referral practices.

6. APhA reaffirms its support of development, adoption, and use of policies and procedures by pharmacists to manage potential conflicts of interest in practice, including in referral systems.

(JAPhA 59(4):e16 July/August 2019)

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

1. APhA supports education for pharmacists and student pharmacists to address issues of pain management, palliative care, appropriate use of opioid reversal agents in overdose, drug diversion, and substance-related and addictive disorders.

2. APhA supports recognition of pharmacists as the health care providers who must exercise professional judgment in the assessment of a patient's conditions to fulfill corresponding responsibility for the use of controlled substances and other medications with the potential for misuse, abuse, and/or diversion.

3. APhA supports pharmacists' access to and use of prescription monitoring programs to identify and prevent drug misuse, abuse, and/or diversion.

4. APhA supports the development and implementation of state and federal laws and regulations that permit pharmacists to furnish opioid reversal agents to prevent opioid-related deaths due to overdose.

5. APhA supports the pharmacist's role in selecting appropriate therapy and dosing and initiating and providing education about the proper use of opioid reversal agents to prevent opioid-related deaths due to overdose.

(JAPhA 54(4) July/August 2014)(Reviewed 2015)(Reviewed 2018)

1993 **Pharmacists' Services**

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

2. APhA believes that appropriate incentives for the pharmacist providing care should be part of any payment system.

(Am Pharm NS33(7):53 July 1993) (Reviewed 2005) (Reviewed 2007) (Reviewed 2009) (Reviewed 2010)(Reviewed 2011)(Reviewed 2012)(Reviewed 2017)

2018 **Direct and Indirect Remuneration Fees**

APhA opposes retroactive direct and indirect remuneration (DIR) fees and supports initiatives to prohibit such fees on pharmacies.

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

2018 **Pharmacist Workplace Environment and Patient Safety**

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

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

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

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

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

6. APhA opposes retaliation against pharmacy staff for reporting workplace issues that may negatively impact patient safety.

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

2018,2013 **Revisions to the Medication Classification System**

1. APhA supports the Food and Drug Administration's (FDA's) efforts to revise the drug and medical device classification paradigms for prescription and nonprescription medications and medical devices to allow greater access to certain medications and medical devices under conditions of safe use while maintaining patients' relationships with their pharmacists and other health care providers.

2. APhA supports the implementation or modification of state laws and regulations to facilitate pharmacists' implementation and provision of services related to a revised drug and medical device classification system.

3. APhA supports a patient care delivery model built on coordination and communication between pharmacists and other health care team members in the evaluation and management of care delivery.

4. APhA affirms that pharmacists are qualified to provide clinical interventions on medications and medical devices under FDA's approved conditions of safe use.

5. APhA urges manufacturers, FDA, and other stakeholders to include pharmacists' input in the development and adoption of technology and standardized processes for services related to medications and medical devices under FDA's defined conditions of safe use.

6. APhA supports the utilization of best practices, treatment algorithms, and clinical judgment of pharmacists and other health care providers to guide the evaluation and management of care delivery related to medications and medical devices under FDA's approved conditions of safe use.

7. APhA encourages the inclusion of medications, medical devices, and their associated services provided under FDA's defined conditions of safe use within health benefit coverage.

8. APhA supports compensation of pharmacists and other health care professionals for the provision of services related to FDA's defined conditions of safe use programs.

(JAPhA 53(4): 365 July/August 2013)(JAPhA 58(4):356 July/August 2018)

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:

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***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 10, 2021** (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.

APhA House of Delegates

American Pharmacists Association
House of Delegates – March 15, 2021

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

Item No. **5**
Date received: **2/9/2021**
Time received: **11:25 PM**

NEW BUSINESS

(To be submitted and introduced by Delegates only)

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

2/9/2021
(Date)

Pennsylvania Pharmacists Association
(Submitted as an individual delegate)

Subject: Unity and Strength of the National Pharmacy Practitioner Organizations

Motion: APhA should initiate discussions/negotiations with other national pharmacy practitioner organizations (to include but not be limited to ASHP, NCPA, ASCP, ACCP and ACA) for the purpose of considering mergers, acquisitions, and/or the establishment of a collaborative/federated organizational structure to represent and promote the interests of pharmacy practitioners and the profession of pharmacy.

Background: The challenges facing pharmacy practitioners and the profession of pharmacy are unprecedented and threatening. The profession of pharmacy does not presently have an organizational structure with sufficient unity and strength to most effectively represent the profession in responding to these challenges. In some situations, the programs and actions of the national pharmacy organizations are more competitive than collaborative, with the result that advocacy for the profession is compromised.

A merged and unified national organizational structure to represent pharmacy should be established as a goal, but may not be attainable in the near future. The important and urgent need to quickly address certain of the challenges facing the profession requires attention to strategies that may be less than optimal but may be easier for the national pharmacy organizations to consider on a timely basis. One such concept is that of a collaborative/federated structure that will include the current national pharmacy practitioner organizations. Because the American Pharmacists Association is the largest national pharmacy organization with the most diversified membership and widely-recognized name, the name of the proposed organizational structure should be the American Pharmacists Association. Other current national pharmacy practitioner organizations that would be participants in the proposed structure would *retain* their current names, autonomy, policies, budgets, leadership, employees, programs, buildings/real estate, and anything else they value as individual organizations. An action-oriented, policy-making body would be developed for the new structure, with representation of the individual organizations based on their membership and resources. This would facilitate approval and

implementation of policies and actions on behalf of the profession of pharmacy, rather than representing views of a coalition of individual and separate pharmacy organizations.

The proposed strategy is cumbersome and inefficient, but may offer the most realistic and timely hope for a more unified and stronger organizational structure to which the profession of pharmacy can commit its efforts. With time, changes in leadership, and creative ideas, the initial structure may become more consolidated and unified in a manner that would result in efficiencies (e.g., buildings/offices, computer/communication systems, consolidation of duplicative programs/services) that would provide greatly increased resources that can be devoted to the profession's highest priorities.

Current APhA Policy & Bylaws: N/A

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APhA House of Delegates

American Pharmacists Association
House of Delegates – March 15, 2021

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

Item No. **6**
Date received: **2/10/2021**
Time received: **9:15 AM**

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

Introduced by: **Brenda Jensen, Gigi Davidson**
(Name)

2/10/2021 American College of Veterinary Pharmacists
(Date) **(Organization)**

Subject: **Definition of patient**

Motion: **Adopt the following policy statement,**

APhA calls for the adoption, by pharmacy organizations and regulatory and professional entities, of the expanded definition for patient to include human or non-human species.

Background: In two independent surveys[1,2], 77% of pharmacists responding reported that they routinely filled prescriptions for animals. The Current APhA Policy Manual discusses veterinary drugs and Animal Investigational New Drug Applications but does not acknowledge animals as patients. Both NABP and the American Veterinary Medical Association have expressed resolutions emphasizing the need for pharmacist education in veterinary pharmacotherapy. To include non-human species in APhA's definition for patients would provide a platform for future APhA policy and initiatives that could broaden pharmacy impact in areas including but not limited to One Health Medicine and providing pharmaceutical care for animals.

1. Sorah, E. and Davidson, G., 2015, June. Royal K. Dispensing errors for non-human patients in the community pharmacy setting: A survey of pharmacists and veterinarians. In Poster presented at: Society of Veterinary Hospital Pharmacists, 34th Annual Meeting.

2. Mingura, M., 2017, June. Community pharmacists and veterinary prescriptions: An analysis of prevalence, type, training, and knowledge retention. In Poster presented at: Society of Veterinary Hospital Pharmacists 36th Annual Meeting.

Current APhA Policy & Bylaws:

2004, 1988 **Pharmacists' Relationship to Veterinarians**

APhA encourages pharmacists and student pharmacists to become more knowledgeable about veterinary drugs and their usage.

(Am Pharm NS28(6):395 June 1988) (JAPhA NS44(5):551 September/October 2004) (Reviewed 2010) (Reviewed 2015)

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.**

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

Item No. **7**
Date received: **2/10/2021**
Time received: **12:31 PM**

American Pharmacists Association
House of Delegates – March 15, 2021

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: **E. Michael Murphy**
(Name)

2/10/2021
(Date)

Submitting on behalf of himself (Delegate from Ohio)
(Organization)

Subject: Social Determinants of Health

Motion: Adopt the following policy statements,

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.

Background:

Social determinants of health are the non-clinical factors that affect health outcomes, such as the places where people live, learn, work, and play.[1] They include aspects of the social environment (e.g., racism, income, education), the physical environment (e.g., housing, transit) and health services (e.g., insurance status). An analysis shows that health outcomes are shaped 40% by social and economic factors, while only 20% are shaped by clinical care.[2] Social determinants of health also have an important influence on health inequities.[3] Thus, to address health inequities, we must understand and address factors beyond clinical care.

Pharmacists, student pharmacists and pharmacy technicians are uniquely positioned to play an important role in addressing social determinants of health. While our profession often addresses social determinants of health as integral members of our communities, there are opportunities to enhance the role that we play.[4] A review of existing association policy confirmed that such policy does not address social determinants of health. The proposed policy statements, developed with input from the APhA-APPM Public Health SIG Policy Committee, recognize our profession's role in identifying and addressing social determinants of health. The statements also reflect a commitment to meaningfully engage communities and improve population health.

For our profession to play a more visible and impactful role in improving patient outcomes, we must prioritize and incentivize addressing social determinants of health across practice, education and research. One novel example of the way in which we may address social determinants of health is the use of pharmacy technicians as community health workers. In addition to improving transitions of care, community health workers help address social and economic factors that perpetuate health inequities.[5] In drafting these statements, the authors discussed the ongoing need for payment reform for pharmacy services to better align incentives for patient care, including services related to addressing social determinants of health. The authors reaffirm existing APhA policies that seek to align financial incentives for patient care services, including those related to addressing social determinants of health.

Current APhA Policy & Bylaws:

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[5] Bailey JE, Surbhi S, Bell PC, Jones AM, Rashed S, Ugwueke MO. SafeMed: Using pharmacy technicians in a novel role as community health workers to improve transitions of care. *J Am Pharm Assoc (2003)*. 2016;56(1):73-81. doi:10.1016/j.japh.2015.11.011.

2020 **Providing Affordable and Comprehensive Pharmacy Services to the Underserved**

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

(JAPhA 2020 60(5) e11)

2019,1990 **Federal Funding to Evaluate the Impact of Health Care Policies**

1. APhA supports the study of economic, scientific, and social issues related to health care, particularly pharmaceutical services.
2. APhA urges the federal government to establish funding mechanisms for objective research to assess the impact of public policy on the health care system, particularly pharmaceutical services.
3. APhA urges that all federally-funded research addressing public policy pertaining to pharmaceutical services incorporate input from the pharmacy profession.

(Am Pharm NS30(6):46 June 1990) (Reviewed 2005) (Reviewed 2009)(Reviewed 2014)(JAPhA 59(4) e28 July/August 2019)

2016, 2011 **Pharmacists as Providers Under the Social Security Act**

APhA supports changes to the Social Security Act to allow pharmacists to be recognized and paid as providers of patient care services.

(JAPhA NS51(4) 482;July/August 2011)(JAPhA 56(4); 379 July/August 2016)

2014 **Care Transitions**

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

(JAPhA 54(4) 357 July/August 2014)(Reviewed 2019)

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

Item No. **8**
Date received: **2/10/2021**
Time received: **8:20 PM**

American Pharmacists Association
House of Delegates – March 15, 2021

NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: **APhA-ASP National Policy Standing Committee**
(Name)

2/10/2021 **(Date)**

APhA Academy of Student Pharmacists **(Organization)**

Subject: Promoting Financial Preparedness for Student Pharmacists, Applicants, and Recent Graduates

Motion: Adopt the following policy statement:

APhA encourages schools and colleges of pharmacy to provide financial literacy resources for student pharmacists and applicants to assess the potential financial burden associated with pursuing a PharmD and entry into the profession by:

1. Offering instruction on financial literacy (including but not limited to personal finance and loan repayment) as part of a required course or elective in their curriculum; and
2. Providing student pharmacists and potential applicants the comprehensive costs of pursuing a pharmacy education at their respective institutions along with financial aid costs and options; and
3. Providing student pharmacists and potential applicants with initial and periodic updates of the professional employment outlook.

Background: The primary objective of this item is to address the concerning trend in tuition increases, debt load, job reduction, and salary stagnation by creating opportunities for new practitioners to take an

active approach in maneuvering through their financial decisions. Four items will be discussed that are important for the implementation of this measure. First are the trends causing students to leave pharmacy schools with a record-high loan totals and little improvement in job prospects. Second, the negative impact of debt in the innovation, attitudes, and career decisions of new practitioners, as well as the future of our profession. Third, how to implement financial literacy and the electives that have already been established in the pharmacy's curriculum. Finally, how these courses can change students' approaches to their personal finance and their behavior towards student loan debt.

According to the American Association of Colleges of Pharmacy (AACP), 86% of pharmacy school graduates receive loans to pay for pharmacy school in 2020. Since 2015, the average student loan debt taken by student pharmacists has grown by nearly 20%, from $149,320 to $179,514.[1] However, according to Drug Channels, a site that works with the US Department of Labor Bureau of Labor Statistics to compile annual salary reports, the average salary for student pharmacists has not changed in proportion to the change in student loan debt. Drug Channels breaks down pharmacist salaries into three categories: pharmacists in outpatient settings, pharmacists at hospitals, and pharmacists at physician offices. From 2015-2019, pharmacists working in outpatient settings have seen a net increase in salary of approximately 4.2%. Pharmacists working in hospital settings have seen a net increase of approximately 7.2% from 2015-2019 and pharmacist working in physician offices have had an increase of approximately 0.5%.[2] These salary changes are not consistent with the changes in the debt load of new practitioners. According to the Bureau of Labor Statistics, the projected change in employment from 2019 to 2029 for pharmacists in any setting is -3%, with a loss of over 10,000 job.[3] Again, this change is not consistent with the rising number of pharmacists graduating with a significant student loan debt.

With a pattern in significant student loan and debt increase, it is important to evaluate how this can negatively impact the career of pharmacy. Student loan debt should not be viewed as just money owed, but as a form of capital investment. Students invest time and money into their education, forsaking the quicker entry into the workforce, for a greater long-term return or financial payoff. Postgraduate training extends that investment on time, seen in lower pay than new practitioners who directly enter the workforce upon graduation. The lower return on investment and the rising in tuition can potentially affect postgraduate opportunities that new practitioners can pursue. It has been shown that pharmacists who pursue a postgraduate training have lower career earnings than those who directly enter the

workforce after graduation.[4] Further complicating postgraduate career decisions is the raising student debt load. From 2004 to 2014, student loan debt has increased 154% from around $42,000 dollars to approximately $108,000.[5] A study performed by Hagemeier et al in the *American Journal of Pharmaceutical Education* surveyed pharmacy students on their perception of debt, how much debt they had, and where they intended to practice post-graduation. They found that students' perception of debt load and debt pressure had a greater influence than their actual debt.[5] This is confirmed in other studies that found the amount of debt did not influence a student pharmacist's career intentions.[6] This increased perception of debt load was positively correlated with choosing a career in chain community pharmacy and entering the workforce directly, as opposed to pursuing postgraduate training.[5] Hagemeier et al also noted that interventions can be made by schools and colleges of pharmacy to potentially decrease the perceived stress of their debt load, and teach student pharmacists how manage their debt.[5] If student pharmacists are able to better manage their debt by increasing their financial literacy, this may alleviate the pressure felt to immediately enter the workforce to begin paying off their debt.

While a course in financial management has not been widely implemented at schools and colleges of pharmacy, the following schools have offered a course with personal finance education: Midwestern University College of Pharmacy-Glendale (PPRAG 1348: Personal Finance for the Health Care Professional), University of Hawaii at Hilo Daniel K. Inouye College of Pharmacy (PHFF 557: Personal Finance), University of Arkansas for Medical Sciences (PhPr 5702: Personal Finance), South Carolina College of Pharmacy (SCCP 764: Personal Finance), and Northeast Ohio Medical University College of Pharmacy (Personal Finance for the Student Pharmacist).[7] Midwestern University College of Pharmacy discussed in the American Journal of Pharmaceutical Education its implementation of an elective course that meets a total of 15 hours which focuses on financial literacy. Course PPRA 648: Personal Finance for the Health Care Professional provided student pharmacists with the knowledge and skills to create personal budgets, analyzing credits, understanding stocks, bonds, mutual funds, and many objectives for planning and achieving financial goals. Participation was crucial in the course, including small discussion groups and individualized assignments, to provide practical tools in customizing the students' personal financial goals. Overall, students were highly satisfied with the course and agreed that it helped prepare them for their financial future. One student commented that "….I was forced to sit down and look at my car insurance (which I ended up changing) and my profit-sharing portfolio (which I also ended up changing)." The students' financial literacy was measured by Jump$tart Financial Literacy Survey

to assess the successfulness of the program.[8] In 2018, Northeastern University provided online modules and resources for student pharmacists to increase their knowledge of financial literacy. Pre-course and post-course surveys were given to compare students' confidence after completing the online modules. The modules included basic domains of income, credit, investing, and budgeting. As expected, the results from the survey were found to show that financial literacy training helped students feel more prepared for managing financial responsibilities.[9] Even a short module of basic financial domains could help increase students' knowledge of this topic.

Several schools and organizations have already included financial management information on their school pages. One can turn these available resources into a teachable course in the PharmD curriculum. For example, Bill Gatton College of Pharmacy has "Financial Literacy" as part of their financial aid page. Financial Literary includes education on Budgeting Basics, The Impact of Interest and Fees, Credit-Debt, and Understanding Repayment.[10] The American Pharmacists Association provides resources on managing student debt, loan refinancing, investing, among many other financial resources on www.pharmacists.com. Some of these resources include "5 Common Financial Mistakes You Should Always Avoid", "Determining Your Student Loan Payoff Strategy", "Making the Financial Transition to New Practitioner Life", "Creating a Spending Plan for Financial Success" and more.[11, 12, 13, 14] Midwestern University's PPRA 648 financial elective courses, as previously mentioned, includes 10 course topics which were found most beneficial and meaningful to students: (1) Setting Financial Goals (2) Reducing Spending and Banking (3) Credit Cards and Debt Consolidation (4) Buying a House (5) Getting a Mortgage (6) Income Taxes (7) Home, Car, Health, Disability, and Life Insurance (8) Retirement Plans (9) The Stock Market and General Investing (10) Picking the Right Job.[8]

After graduation, student pharmacists will quickly transition from low-income financial situations to situations involving significantly higher income, debt, and increased financial responsibility. Midwestern University's financial literacy elective course discussed previously used Jump$tart Financial Literacy Survey to assess students' financial literacy at the beginning and end of the course. Students scored a mean baseline score of 18 at the beginning of the course. At the post-assessment, students scored a mean of 27, showing significant improvement ($p<0.001$).[8] Financial literacy courses provide student pharmacists with information necessary for a successful financial transition post-graduation, including student loan repayment and managing an increased income. However, topics and activities covered in these courses may cause student pharmacists to

re-evaluate their current financial situation. This can lead to students creating a more efficient budget, reevaluating credit card use, or even changing insurance plans to a plan that is more appropriate for the student's lifestyle. In turn, this can reduce the debt taken on by student pharmacists during pharmacy school. Providing financial literacy courses allows student pharmacists to consider more options post-graduation, including postgraduate training or a wider range of employment opportunities. As the financial literacy of student pharmacists increases, student debt management will improve, freeing up more income for student pharmacists to re-invest into their schools as alumni, pursue careers in innovative areas of pharmacy, and will allow for more freedom and confidence in their financial situations as student pharmacists make career and life decisions post-graduation.

Resources

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2. Pharmacists : Occupational Outlook Handbook. U.S. Bureau of Labor Statistics. https://www.bls.gov/ooh/healthcare/pharmacists.htm. Published October 13, 2020. Accessed November 22, 2020.
3. Chisholm-Burns, M. A., Gatwood, J., & Spivey, C. A. (2015). Economic Analysis of Obtaining a PharmD Degree and Career as a Pharmacist. *American journal of pharmaceutical education*, *79*(8), 117. https://doi.org/10.5688/ajpe798117
4. Hagemeier, N. E., Gentry, C. K., Byrd, D. C., Cross, L. B., Rose, D., Ansari, N., Subedi, P., & Branham, T. (2019). Student Pharmacists' Personal Finance Perceptions, Projected Indebtedness Upon Graduation, and Career Decision-making. *American journal of pharmaceutical education*, *83*(4), 6722. https://doi.org/10.5688/ajpe6722
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7. Chui MA. An Elective Course in Personal Finance for Health Care Professionals. *American Journal of Pharmaceutical Education*. 2009;73(1). doi:10.5688/aj730106.
8. Kang A, Kim Y, Ma K, Tam J, Woolley A. Utilization of Online Modules to Improve Financial Literacy in Pharmacy Students. https://www.northeastern.edu/rise/presentations/utilization-of-online-modules-to-improve-financial-literacy-in-pharmacy-students/. Published April 27, 2020. Accessed November 22, 2020.
9. Financial Literacy. ETSU Bill Gatton College of Pharmacy. https://www.etsu.edu/pharmacy/administration/financial_aid/financial_literacy.php. Published July 13, 2020. Accessed November 22, 2020.
10. Ulbrich T. 5 Common Financial Mistakes You Should Always Avoid. American Pharmacists Association. https://www.pharmacist.com/5-common-financial-mistakes-you-should-always-avoid. Accessed November 22, 2020.
11. Ulbrich T. Determining YOUR Student Loan Payoff Strategy. American Pharmacists Association. https://www.pharmacist.com/determining-your-student-loan-payoff-strategy. Accessed November 22, 2020.
12. Ulbrich T. Making the Financial Transition to New Practitioner Life. American Pharmacists Association. https://www.pharmacist.com/making-financial-transition-new-practitioner-life. Accessed November 22, 2020.
13. Ulbrich T. Creating a Spending Plan for Financial Success. American Pharmacists Association. https://www.pharmacist.com/creating-spending-plan-financial-success. Accessed November 22, 2020.

Current Related APhA Policy & Bylaws:

1991 **Doctor of Pharmacy Attainment through Non-traditional Mechanisms**

1. APhA encourages schools and colleges of pharmacy to consider, in their strategic planning process, offering non-traditional, post-baccalaureate, Doctor of Pharmacy degree programs. Issues to be considered in such planning should include at least the following: (a) entry requirements; (b) educational and financial resources; and (c) competency evaluation for course credit.
2. APhA recommends that non-traditional, Doctor of Pharmacy degree programs have competency outcomes for graduates equal to those in traditional programs.

(Am Pharm NS31(6):28 June 1991) (Reviewed 2003) (Reviewed 2006)(Reviewed 2011)(Reviewed 2016)

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