APhA-ASP
AMERICAN PHARMACISTS ASSOCIATION
ACADEMY OF STUDENT PHARMACISTS

APhA

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Proposed Resolutions

R1.1

Proposing APhA-ASP Chapter: Albany College of Pharmacy and Health Sciences

Proposed Resolution Title/Topic: Amendment to Resolution 2019.2 - Amendment to APhA-ASP 2015.4 - Increased Access to Opioid Reversal Agents

Proposed wording:

1. APhA-ASP supports state and federal legislation to increase access to opioid reversal agents.
2. APhA-ASP encourages pharmacists and student pharmacists to provide public education about opioid reversal agents, including proper administration in situations of opioid-related drug overdose.
3. APhA-ASP encourages all schools and colleges of pharmacy to incorporate opioid reversal agent training as a requirement prior to completion of the pharmacy program. APhA-ASP recommends this training includes a live, hands-on component, identification of high-risk patients, and recognition of the stigma surrounding opioid use disorder.
4. APhA-ASP encourages Administrative regulation requiring equal representation of opioid antagonist products in Medicare and Medicaid formularies.
5. APhA-ASP supports increased Administrative oversight of pharmaceutical companies in the event of a Public Health Emergency, including blocking patent lawsuits that prevent generic manufacturing, patent revocation, and preventing unwarranted price increases.

Background Statement:

Overdose deaths involving the use of opioids has increased from 8,048 in 1999 to roughly 50,000 per year (both illegal and legal use).1The annual rate of opioid deaths has continued to rise an additional 30,000 people to 47,600 deaths per year in 2017.2 We have yet to see a decline in the severity of the opioid crisis. This amendment to proposal 2015.4 emphasizes the role that Administrative Departments can take to mitigate the crisis. Under the Administrative Procedures Act, governing bodies can implement regulations following a 60-day public comment period. These regulations could help to curb serious issues that have arisen since the adoption of the 2015 proposal.

When the Department of Health and Human Services (HHS) declared a public health emergency in 2017, two of their top five goals were to promote opioid antagonists and increase their accessibility. Since then, the Surgeon General has called for an increase in Naloxone prescribing (Apr 2018) and the FDA has called for the co-prescribing of Naloxone products with opioid prescriptions for high risk patients (Dec 2018).4 The current 2019 operating budget for the Center for Disease Control and Prevention (CDC) allots $5,000 for the Opioid Epidemic, $10,00 for educational campaigns to raise opioid awareness, and $475,579 towards overdose prevention.5 In total, this represents less than a quarter of what Purdue Pharmaceuticals spent marketing OxyContin in 2001 alone and roughly the cost of only 112 Evzio injection kits or 3,334 Narcan devices (based on Medicare coverage).6,7,8 Despite the increased focus by administrative bodies, the existence of questionable pharmaceutical business practices continue to limit access to opioid antagonist products.

The FDA fast-tracked the approval of two self-administrable Naloxone products: Evzio in 2013 (self-injectable; Kaleo) and Narcan in 2014 (nasal spray; Emergent Biosolutions). APhA-ASP supports a fast-tracked process in order to meet patient demand; however, there needs to be similar support for generic products, as there is currently limited competition helping to control prices. Four years passed before the first generic version of Narcan was FDA approved. Despite the emergence of possible future treatment options, it is unclear whether those products will make it to the market due to patent lawsuits. For example, Emergent Biosolutions has applied five separate patents it holds for Narcan towards two separate lawsuits against Teva pharmaceuticals and Perrigo following their ANDA submissions.11 One of these patents (U.S. Patent 9,211,253 B2) both promoted the need for OTC approval of a naloxone nasal spray device, while simultaneously providing language used in the aforementioned patent lawsuits to delay generic manufacturing. Portions of this specific patent has been ruled unpatentable by the US Patent and Trademark Office as of 8/27/2019; however, this still required over 15 petition filings from a combination of Teva and Nalox-1 Pharmaceuticals and further delayed generic manufacturing.12,13

While APhA-ASP acknowledges the need for a legal system that allows companies to settle their own disputes, there are actions that governing bodies can take to increase naloxone access that avoids lag associated with Congress' lawmaking abilities. Under the Administrative Procedures Act, the Food & Drug Administration (FDA) could create regulations permitting generic manufacturing while patent lawsuits proceed in the courts. The US Patent Office could also revoke patents claimed in the pending lawsuits or expedite rulings on petitions filed by generic manufacturers regarding drugs outlined by a Public Health Emergency. APhA-ASP should support increased administrative oversight of patents and patent lawsuits in order to improve access to critical life-saving drugs in the event of a declared Public Health Emergency. There have also been questionable drug pricing within the last five years. Specifically, regarding the opioid crisis, Kaleo strategically increased its price incrementally over a year while also working with healthcare providers to ensure it was deemed medically necessary by governing bodies. By the time the CDC had officially recommended the co-prescribing of opioids in 2016, the price of Evzio had been increased by 500%. There were no Kaleo press releases covering these price increases. In the event of a Public Health Emergency, the FDA could require documentation justifying a price increase for relevant drugs and retain the ability to reject the increase if reasons are insufficient. In extreme cases of unwarranted pricing for products that do not have alternatives, the FDA could implement regulations granting the ability to revoke a patent in order to spur development of generic alternatives that will aid the Public Health Emergency. Once more generic products are available, then encouraging legislation requiring an equal opportunity Medicare formulary should help mitigate unanticipated price surges by ensuring equal competition.

References:

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7. Narcan [Internet]. 2019 [cited Oct 08 2019]. Available from: https://www.goodrx.com/narcan/medicare-coveragehttps://s3-us-west-1.amazonaws.com/ptab-filings%2FIPR2019-00685%2F11
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11. Teva wins generic Narcan approval as FDA mulls bolder actions [Internet]. 2019 [cited Sep 29 2019]. Available from: https://www.biopharmadive.com/news/teva-narcan-generic-fda-approval-co-prescription/553148/.
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Are there any adopted resolutions currently on the books related to this Proposed Resolution? Yes ___ No_X_
If yes, please provide the number and title of the adopted resolution(s) as well as your rationale for the addition of this Proposed Resolution:

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R1.2

Proposing APhA-ASP Chapter: Binghamton University School of Pharmacy and Pharmaceutical Sciences

Proposed Resolution Title/Topic: Pharmacist's Right to Patient Information in Antibiotic Prescribing

Proposed wording:
APhA-ASP encourages the inclusion of pertinent patient information which includes, but is not limited to, weight of the patient and the condition being treated with the antibiotic on a prescription, so that pharmacists can ensure proper dose and optimal antibiotic choice.

Background Statement:

Due to the growth of patients becoming resistant to antibiotics, pharmacists have the ability to make a key intervention by having the weight and condition being treated included on the prescription when sent to a pharmacy. The reason for this resistance is in part due to both the overprescribing and inaccurate dosing of these important medications.

The United States Centers for Disease Control and Prevention has reported that up to 50 percent of antibiotics prescribed for treatment of healthcare-acquired infections in acute care hospitals in the US were either inappropriate or unnecessary. This can cause resistance in antibiotics, as well as expose patients to unnecessary harmful adverse events. In a study done by clinical pharmacists on team-based enablement interventions to improve antibiotic prescribing prescribers, pharmacists, and nursing staff were educated on the proper prescribing of antibiotics for UTIs. At the start of the study, 23% of antibiotic regimens treating UTIs were inappropriate. After undergoing an antibiotic stewardship live-training program, there were no cases of inappropriate antibiotic regimens for UTIs. 1 This study showed that not only does proper education of the prescribing of antibiotics make a difference in proper prescribing, but inter-professional communication between prescribers, pharmacists, and nurses can also lead to fewer medication errors.

Pharmacists have this type of antibiotic stewardship education worked right into our curriculum to avoid the overuse and misuse of antibiotics. Infectious Disease and Skills Lab are just two of the important courses embedded in every PharmD curriculum that discusses when antibiotics are necessary, and how to properly counsel patients on antibiotic use. Pharmacists have the ability to aid prescribers through their expert advice. They exhibit expertise on the current formulary, resistance data, and are able to raise awareness of the importance of adhering to a medication, particularly the importance of adhering to antibiotics.

When pharmacists are provided with the appropriate information of their patient, they can more accurately determine if the medication, dose, and length of treatment is effective. This creates a checks and balances system and ultimately leads to better patient outcomes. By using a team approach, Pharmacists could work with prescribing practitioners and mitigate the ongoing problem of the ineffectiveness of antibiotics.

Are there any adopted resolutions currently on the books related to this Proposed Resolution? Yes _X__ No__

If yes, please provide the number and title of the adopted resolution(s) as well as your rationale for the addition of this Proposed Resolution:

1998.6 – Antibiotic Use and Adherence. APhA-ASP encourages development and implementation of educational programs on the importance of proper antibiotic use and adherence for patients and health care professionals.

Our proposal still emphasizes the idea that health care professionals should be well educated on proper antibiotic use, and participate in antibiotic stewardship programs. Our proposal is different on the terms that pharmacists will directly interact with doctors to prevent a medication error, providing a system of inter-professional communication and checks and balances.

2007.2 – Personal Health Records. APhA-ASP encourages collaboration between public and private healthcare organizations in the development and use of a standardized, secure, electronic, personal health record system to facilitate continuity of care across all practice settings. This record should include, but not be limited to, current diagnoses, allergies, medication history, laboratory data, and immunization history.

Our proposal is similar in that it addresses the lack of transparency between health care providers. Our proposal is different in that it addresses how more appropriate inter-professional communication can lead to improved prescribing of antibiotics.

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R1.3

Proposing APhA-ASP Chapter: D'Youville College School of Pharmacy

Proposed Resolution Title/Topic: Collaborative Practice Agreements, Emergency Refill

Proposed wording:

1. APhA-ASP recommends that all pharmacy practice settings to allow pharmacist's ability to write emergency refill prescriptions including but not limited to;
    a. the physician is unable to be reached
    b. the patient is traveling within two weeks
    c. when the prescribed drugs are under shortage
    d. drugs should have therapeutically equal effect
    e. drug is not controlled substance
2. APhA-ASP further invites American Pharmacists Association to create an educational course for physicians and other providers to encourage more CPAs to be established including but not limited to;
    a. Online courses like CEs
    b. Seminars
    c. Webinars
    d. Rx radio

Background Statement:

Currently, 48 states and Washington DC gave the authority for pharmacists to practice under collaborative practice. Out of that 48, only 8 states opened all practice settings to practice Collaborative Drug Therapy Management. Other states have limited practice scope and this situation The goal of the collaborative practice agreement (CPA) is to expand the pharmacist's knowledge and expertise of drug therapy, patient adherence, and cost barriers.1 Collaborative practice agreements can be used to create a formal relationship between a pharmacist and another health care provider to work towards more patient-oriented care services. CPAs allow pharmacists to work beyond their scope of practice.

The scope of CPA and the participating number of physicians or other prescribers has been low although 48 states have authority to practice. As CPAs allows pharmacists to work above and beyond their normal field of practice, the CPA should be more widely practiced. Especially when it comes to hospital settings, it is important to have interprofessional collaboration/conversation in order to provide personalized patient care. Although health professions may recognize other health professions, it is not always clear that they understand each other's roles. Not only do CPAs give pharmacists several opportunities to expand their practice, but it also optimizes the patient's care while saving the patient's own time.

Multiple studies have been done to measure the effectiveness of collaborative practice agreement since 1997 as the collaborative practice was first introduced in 1997. 1 A study was done in the Department of Obstetrics and Gynecology at Baystate Medical Center in Massachusetts and they were able to conclude the fact that collaborative practice was successful and collaborative practice will also be successful even if it gets implemented to different hospital settings and community settings 2

It is also ideal to allow pharmacists to provide therapeutically equivalent drugs if the drug that the physician prescribed is currently facing a shortage. Drug shortage is also another issue that pharmacists are battling. Drug shortage is defined as a supply deficiency which affects how the pharmacy prepares and dispenses a prescribed drug or influences patient care when prescribers must use an alternative agent.3 By allowing pharmacists to substitute prescribed medications that are under shortage with ones that have the same therapeutic effect, the pharmacist's role in healthcare will be expanded and prevent abrupt withdrawal of medications. Typically, if there is a drug shortage, it could be the result of one or multiple factors throughout the supply chain which includes raw materials, manufacturers, regulators, wholesalers/distributors, prime vendors, and group purchasing/healthcare organizations.

Due to these various issues surrounding the lack of emphasis regarding CPAs and drug shortages, it is fundamental to address these concerns and ensure pharmacists are practicing to their full potential while providing optimal care for their patients. Collaborative Practice Agreement has lots of potentials for us to have more room for growth in pharmacist's limits.

References

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2. Susan Dejoy, Ronald T. Burkman, Barbara W. Graves, et al. Making It Work: Successful Collaborative Practice. Obsterics & Gynecology, 2011;118(3):683-686.
3. Milena M. McLaughlin, Ellena Anagnostis, Jason Babby, et al. Drug Distribution and Control: Procurement – Guidelines. American Society of Health-System Pharmacists, Inc, 2018;101-109.

Are there any adopted resolutions currently on the books related to this Proposed Resolution? Yes _X__ No__

If yes, please provide the number and title of the adopted resolution(s) as well as your rationale for the addition of this Proposed Resolution:

2018.3 - Emergency Prescription Refill Protocol

1. APhA-ASP encourages state boards of pharmacy to develop a standardized protocol allowing pharmacists to provide refills, not-pursuant to a prescription, during a declared state of emergency, natural disaster, or man-made disaster.

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R1.4

Proposing APhA-ASP Chapter: Husson University School of Pharmacy

Proposed Resolution Title/Topic: Personalized Medicine

Proposed wording:
APhA-ASP supports the addition of Personalized Medicine into the pharmacy school curriculum. Personalized Medicine encompasses integrative -omics approaches of Pharmacogenetics (2014.1) and Pharmacomicrobiomics.

Background Statement:
In 2014, the APhA adopted resolution 2014.1 Pharmacogenomics. This resolution encouraged our profession to take leadership and ownership in this area of expertise by supporting the development of continuing education programs to train pharmacists how to utilize this clinically useful tool. A great amount of progress has been made over the past five years because of this initiative. Now is the time to integrate into the equation the growing area of pharmacomicrobiomics. The adoption of this initiative is the next natural step for pharmacists to continue to be at the forefront of personalized medicine. Scientists have accumulated much evidence to support that the gut microbiome plays a significant role in variable drug response. Pharmacogenomics (PGx) and pharmacomicrobiomics are the pillars to personalized medicine and fill the gap that classic PK/PD does not explain. Together they integrate human microbiome-gene-drug interaction.

For an individual drug, only 50-75% of the population will incur a response (either an increase in efficacy or toxicity) after its administration. Furthermore, it has been estimated that genes contribute to between 20 to 95% of drug responsiveness variability.1 Advances in pharmacogenomics tests have paved the way to personalized treatments making them one of the most powerful tools in clinical decision making. Data of drug-gene interactions is ever increasing. Currently there are 360 therapeutic products with drug labeling information about how genes affect them.2 This information is essential to avoid pharmacotherapy failure or potentially fatal ADRs. For example, in 2015 the FDA made major label revisions to codeine after child fatalities occurred in several instances. This also prompted clinical guidelines for CYP2D6 testing before prescribing codeine.3 PGx testing is invaluable for cancer treatment due to the highly variable response of anticancer agents.3 PGx testing maximizes therapeutic efficacy while minimizing risk of ADRs and allows treatment to start sooner. Yet, there are challenges pharmacogenomics faces including standardization of lab values, gene assays, electronic medical record system implementation, and concerns for privacy. There is no consensus on which genes and their variants should be considered for testing. Furthermore, interpretations of the lab results can vary between labs. Finally, there is limited support for PGx data in the electronic health record systems making it difficult to relay the results to the patient's prescriber.3 These challenges will be surmounted as much has already improved in the five years since the APhA adopted 2014.1 pharmacogenomics.

In the same year that the APhA implemented its Pharmacogenetics proposal, "Pharmacomicrobiomics" was termed.1 Pharmacomicrobiomics tries to understand drug-human microbiome interactions. Drug-microbiome interactions can influence PK, PD, efficacy and toxicity comparable to gene-drug interactions. The first studied drug-microbe interaction was documented in the 1930's with the development of Prontosil.1 However, the gut microbiome has only recently received the attention it deserves as an "organ"

consisting of around the same number of cells as our own body makeup.1,4 We are now just starting to uncover the complexities of this ecosystem living inside us and its role in health, disease, and drug-microbe interaction.

However, we cannot undermine its importance in personalized treatment and we must act early because technology is advancing at ever increasing speeds. Oral and topical drugs have the potential to interact with the gut microbiota both directly and indirectly. An example of direct drug-microbiota interaction is seen with Digoxin. In 10% of patients, Digoxin is converted to inactive metabolites when it interacts with specific strains of E. lenta that carry a cardiac glycoside reductase (cgr) operon. Other drugs directly interact with bacteria creating active or toxic metabolites. Toxic metabolites can be a cause of drug side effects and ADRs. Indirect drug-microbiota interactions are those when the bacteria produce metabolic compounds which have an effect on the immune system or host metabolism thus altering a drug's bioavailability. An example of this would be bile acids synthesized by gut bacteria influencing intestinal absorption allowing for a greater bioavailability and increased plasma concentrations of simvastatin. There could also be functionality changes in the microbiome. Metformin for example can cause an increase of Akkermansia muciniphila a species of bacteria that increases glucose metabolism.1 Lastly, and more familiar to people, antibiotics can cause composition changes in the microbiome. The implications of this is that a person's drug response can change with a single course of antibiotics. In addition, a person's diet can influence the microbiota.4 Interspecies drug-microbiota pathways are less understood. Recent research has shed light on the interactions between carbidopa-levadopa and two species of bacteria that ultimately lead to variability of response.5 As technology advances, scientists hope to understand more complex relationships between drugs and the microbiome.

The APhA should adopt pharmacomicrobiomics with the same vigor as the 2014.1 pharmacogenetics policy. Both policies are integral to the future of personalized medicine. Personalized medicine is an incredibly powerful tool, arguably the best we have. I believe that pharmacists are in prime position to utilize this knowledge and clinically apply it. This will ultimately lead to fewer ADRs which in turn saves the health care system money and improves therapeutic outcomes.

References:

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2. Group TT. Table of Pharmacogenomic Biomarkers in Drug Labeling. 2019. https://www.fda.gov/drugs/science-research-drugs/table-pharmacogenomic-biomarkers-drug-labeling.
3. Gaedigk A. Pharmacogenetics : Chasing Perfection. 2019;106(2):265-270. doi:10.1002/cpt.1511
4. Doestzada M, Vila AV, Zhernakova A, Koonen DPY. Pharmacomicrobiomics : a novel route towards personalized medicine ? Protein Cell. 2018;9(5):432-445. doi:10.1007/s13238-018-0547-2
5. Rekdal VM, Bess EN, Bisanz JE, et al. Discovery and inhibition of an interspecies gut bacterial pathway for Levodopa metabolism Discovery and inhibition of an interspecies gut bacterial pathway for Levodopa metabolism. 2019;6323(June). doi:10.1126/science.aau6323

Are there any adopted resolutions currently on the books related to this Proposed Resolution? Yes _X__ No__

If yes, please provide the number and title of the adopted resolution(s) as well as your rationale for the addition of this Proposed Resolution:
2014.1 Pharmacogenomics.

Personal Medicine needs to be clearly defined as encompassing the -omics approaches (pharmacogenomics and pharmacomicrobiomics).

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R1.5

Proposing APhA-ASP Chapter: Long Island University Arnold & Marie Schwartz COP and HS

Proposed Resolution Title/Topic: Accessible Medication Disposal

Proposed wording:
APhA-ASP encourages the expansion and implementation of medication disposal programs and drop-off boxes by community pharmacies that dispense prescription medications.

Background Statement:

It's a common problem: a doctor prescribes medications and patients end up not using it or having extra medication stockpiled. Patients would then want to discard the extra prescription medications. This policy proposal's aim is to address the role that pharmacists in the community setting can play in the safe disposal of unused, expired or unwanted medications. Proper medication disposal drop-off boxes should be available for patients in pharmacies that have the ability to dispense prescription medications. Patients normally have to wait for the semi-annual National Prescription Drug Take Back Days to get rid of unused or expired medications lying around the house. The event is held twice a year: once in April and once in October. It is held by the federal Drug Enforcement Agency (DEA).1 In April 2018, the DEA received an unprecedented 475 tons of medications at collection sites around the country.2 Additional programs similar to the DEA's National Prescription Drug Take Back Days should be encouraged in pharmacies year-round. This can dramatically help the elderly who have higher pill burdens and have a harder time accessing disposal locations, especially if they are scarce.

Opioid prescriptions are issued for quantities well above what would be considered appropriate therapy for minor pain. Many opioid prescriptions are not finished by the patient and are stored in the household for future use, which makes it more readily accessible for abuse and diversion. The overall disposal amounts can be tracked to see patients' adherence and willingness to take medications. This can provide a nationwide data comparison between the number of prescribed opioids and the amount that is collected from the drug disposal programs. All New York hospitals and nursing homes are required by law to act as collection centers for used household sharps such as syringes and lancets, with no identification required. However, these facilities cannot take back prescription medications.

The National Association of Boards of Pharmacy (NABP) listed only 18 drug disposal locations in New York City. These lists also tend to be outdated. On the New York State Department of Health website, New York City is listed to have no permanent drop-off boxes available (the site was updated in January 2019). Walgreens started adding drug disposal units in 2016 and now has 600 units. It has collected more than 270 tons of medications since the program began. Dispose RX packets distributed in Walgreens pharmacies provide an alternative, but are only available in select locations. CVS Health is in the process of installing 750 kiosks to its stores. So far, CVS has collected nearly 158 tons of medications.2 The Food and Drug Administration (FDA) has a list of 50 flushable medications, but that makes up only a small portion of medications prescribed every year.3 These medications are deemed flushable because they are considered more harmful to keep around compared to flushing down the toilet. Therefore, with the expansion and implementation of medication drop-off programs and boxes in pharmacies, it can eliminate the need to flush medications down the toilet causing harm to the environment and potential risks for drug abuse from unused, expired or unwanted medications.

References:

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2. https://www.aarp.org/health/drugs-supplements/info-2018/drug-stores-medication-disposal.html
3. https://www.fda.gov/drugs/disposal-unused-medicines-what-you-should-know/drug-disposal-flush-potentially-dangerous-medicine#FlushList

Are there any adopted resolutions currently on the books related to this Proposed Resolution? Yes __X__ No__

If yes, please provide the number and title of the adopted resolution(s) as well as your rationale for the addition of this Proposed Resolution:

2007.4- Proper Medication Disposal
1. APhA-ASP encourages the profession of pharmacy, federal and state regulatory agencies, waste management authorities and other appropriate entities to develop and implement standardized guidelines for the proper disposal of unused or expired medications.
2. APhA-ASP encourages pharmacists and student pharmacists to serve as a source of information for the public on the proper disposal of unused or expired medications.

2012.3- Proper Medication Disposal and Drug Take-Back Programs
1. APhA-ASP encourages the profession of pharmacy, federal and state regulatory agencies, law enforcement, waste management authorities, and other appropriate entities to develop and implement standardized guidelines for the proper disposal of unused or expired medications that help prevent drug abuse and reduce harm to the environment.
2. APhA-ASP supports state and federal regulations that allow pharmacies to take back unused or expired medications, including controlled substances, through a process that minimizes diversion, liability, and financial burden to all stakeholders.
3. APhA-ASP encourages pharmacists and student pharmacists to serve as a source of information for the public on the proper disposal of unused or expired medications.

These policies create guidelines/regulations and use pharmacists as the source of information on where to drop off unwanted medications, but does not directly purpose a method for pharmacists to help in the medication disposal process. By implementing more medication disposal drop of boxes, patients will have an easier and safer method of disposing expired, unused or unwanted medications and safe disposal. This proactive step can lead to the decreased opioid and other prescription medications from being accessed by the intended person.

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R1.6

Proposing APhA-ASP Chapter: MCPHS University Boston

Proposed Resolution Title/Topic: Implementation of Tech-Check-Tech Program

Proposed wording:

1. APhA-ASP supports the implementation of the Tech-Check-Tech (TCT) program to facilitate increased pharmacist-provided clinical services in all pharmacy practice settings and shall include specific requirements for pharmacy technician certification
2. APhA-ASP opposes the use of Tech-Check-Tech (TCT) programs to reduce essential pharmacist or pharmacy staff.

Background Statement:

Pharmacists, specifically community- based pharmacists- has long been viewed by other health care systems as "retailers". It is imperative that this perception is broken, and we create a new image in the mind of patients, payers and other health care provides that pharmacists are an integral part of the health care team with their knowledge and expertise in medication optimization services.

One strategy to do this is the implementation of the TCT program, i.e., the checking of a technician's order-filling accuracy by another technician rather than a pharmacist. TCT allows specially trained pharmacy technicians working in a practice situation to perform final verification on refill medications. Any pharmacist who has worked in a community setting will be able to say that most of the time is spent in verifying medications. An 18-month pilot project using TCT in 7 community pharmacies In Iowa showed that the majority of pharmacist's time was spent in dispensing. The study found that a sizeable portion of the pharmacists' time was spent in dispensing, with a 4.21:1 ratio of time in dispensing to time providing direct patient care 3. This gives the pharmacist very little time to focus on patient-centered care and to develop a plan to resolve the patient's problem. This issue is more pronounced in places where the workplace policies focus more on prescription volume rather than pharmacist's role as patient care providers. Even in a hospital setting, if a pharmacist focuses more on clinically oriented activities then there could be a reduction in medication errors and associated consequences such as increased length of stay, mortality and overall health care costs. One study reported a 51% decrease in medication errors when pharmacists accompanied a general medicine team on clinical rounds 1. Appropriately trained technicians with advanced responsibilities are complementing the evolving role of pharmacists as patient care providers by freeing up pharmacists from technical duties so they can spend more time providing patient care.

TCT program is basically providing a certified pharmacy technician with an opportunity to expand their roles by verifying the job of another technician. We recommend that the "checking technicians" must have worked 2000 hours as a pharmacy technician, 1000 of which are required to be on the site where the tech is currently working and also the technician must complete 6 hours of online instruction on prescription dispensing and the TCT process 3. It should be noted that the certified technician who would perform the final verification will be held responsible in the case of any error and that could lead to the technician potentially losing their license.

To prevent the misuse of this policy, it should be mandated that the policy should not lead to a reduction in a number of pharmacists working in a healthcare setting. This policy aims at expanding the role of technicians to have pharmacists perform the duties which he/she could not. The primary objective of this policy is to have expanded responsibilities like performing MTM, providing counseling and implementing more patient-centered care.

In response to the concerns for tech verifying, there have already been several types of research conducted which proves that there is no difference in verification accuracy. One of such study conducted in the University of Wisconsin Hospital and Clinics implemented a TCT program and found that technicians have a 99.8% accuracy in checking the medicine and the overall time for pharmacists spent on checking medication doses for cart fill was reduced from an average of 6 hours and 5 minutes per day to 20 minutes per day 6. Studies have also shown that most medication errors occur at the prescribing and administration phases and not at the dispensing phase which further focuses that pharmacists should be focused more on error-prone aspects of medication use.

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2. Annie U Shelton, Matt Wolf, Noah Franz, Philip W Brummond, Assessment of technician barcode scanning verification compared to pharmacist verification, *American Journal of Health-System Pharmacy*, Volume 76, Issue 3, 1 February 2019, Pages 148–152, https://doi.org/10.1093/ajhp/zxy018
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6. Michael Reed, Sylvia Thomley, Brad Ludwig, Steve Rough, Experience with a "tech-check-tech" program in an academic medical center, *American Journal of Health-System Pharmacy*, Volume 68, Issue 19, 1 October 2011, Pages 1820–1823, https://doi.org/10.2146/ajhp100578
7. Scarsi, Kimberly K., Michael A. Fotis, and Gary A. Noskin. "Pharmacist participation in medical rounds reduces medication errors." *American journal of health-system pharmacy 59*.21 (2002): 2089-2092.

Are there any adopted resolutions currently on the books related to this Proposed Resolution? Yes ___ No_X_

If yes, please provide the number and title of the adopted resolution(s) as well as your rationale for the addition of this Proposed Resolution:

Author of Proposed Resolution: Rohan Zaveri

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R1.7

Proposing APhA-ASP Chapter: MCPHS University - Worcester

Proposed Resolution Title/Topic: Mandatory Diagnosis Codes for Schedule II Prescriptions (CII)

Proposed wording:
APhA-ASP supports mandatory diagnosis codes be included with schedule 2 controlled substance (CII) prescriptions to ensure the safety, efficacy, and appropriateness of drug choice for the patient.

Background Statement:
According to the National Institute on Drug Abuse, about 21 to 29 percent of patients prescribed opioids for chronic pain misuse them. Subsequently, opioids alone were involved in 47,600 overdose deaths during 2017.

To prevent patients from being prescribed CII prescriptions unnecessarily, there should be a valid diagnosis to justify the prescription before dispensing.

Pharmacists need to be ensured that the Schedule II prescriptions that they are about to dispense are for the correct reasons and with an approved diagnosis.

Obtaining approved and proper diagnosis codes can open a discussion between the physician and the pharmacist. For example, if a prescriber lists back pain as the diagnosis, the pharmacist should know whether it is severe, chronic back pain versus a mild back ache. Diagnosis codes should be specific and descriptive so that the pharmacist can make the best judgment on appropriateness.

This will allow pharmacists to verify that the prescription efficiently and prevent adverse effects such as overdosing. This will also help pharmacists to prevent new patients from receiving opioid medications unnecessarily.

ICD codes are universally used in the hospital and the pharmacy which makes this change easier for providers.

References:

1. Vowles KE, McEntee ML, Julnes PS, Frohe T, Ney JP, van der Goes DN. Rates of opioid misuse, abuse, and addiction in chronic pain: a systematic review and data synthesis. Pain. 2015;156(4):569-576. doi:10.1097/01.j.pain.0000460357.01998.f1.
2. Drug Overdose Deaths; Drug Overdose; CDC Injury Center. Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/data/statedeaths.html. Accessed October 11, 2019.

Are there any adopted resolutions currently on the books related to this Proposed Resolution? Yes ___ No_X_

If yes, please provide the number and title of the adopted resolution(s) as well as your rationale for the addition of this Proposed Resolution:

Author of Proposed Resolution: Deborah Cho

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R1.8

Proposing APhA-ASP Chapter: Northeastern University School of Pharmacy

Proposed Resolution Title/Topic: Pharmacist Dispensing of Emergency Post-Exposure Prophylaxis (PEP)

Proposed wording:
APhA-ASP supports allowing pharmacists to dispense emergency Post-Exposure Prophylaxis (PEP) without a prescription in the event of possible exposure to HIV. The core of the proposal revolves around decreasing the time between exposure and rescue (PEP).

As unlimited dispensing of PEP may encourage abuse among patients, we propose a limit of one dispense every three months, with the added requirement that the patient participate in a public health event/seminar on HIV education & prevention. Fulfilling the education requirement would allow the patient to become eligible again for PEP in the following quarter. Victims of sexual assault would be exempt from this clause.

Background Statement:
Post-exposure prophylaxis (PEP) refers to the administration of antiviral therapy following probable exposure to HIV. The window to administer PEP is very important as it is quite small. The CDC recommends starting PEP no later 72 hours following a possible exposure incident, and the sooner the better. However, for most patients, the only way to get the PEP is to talk to their health care provider or an emergency room doctor (1). Both of those routes adds lag time to the initiation of PEP and can decrease the success of the prophylaxis. By allowing pharmacists to dispense PEP without a prescription, we can reduce that lag-time to starting treatment and help prevent the spread of HIV. As one of the most accessible health care professionals, it makes sense to have pharmacists be able to dispense such an important tool in stopping the spread of HIV. This also decreases the burden on other health care professionals, especially emergency room doctors. Patients can follow up with their primary care providers after initiating the treatment to discuss testing and further lifestyle changes if necessary.

Although we have come a long way in controlling the HIV epidemic, the fight is far from over. In 2017, there were approximately 38,739 new cases of HIV, and that's just the ones that were reported/diagnosed (2). Preventing the spread of the virus is a vital aspect in our efforts against HIV. PEP is an important tool that can supplement the traditional methods of decreasing the spread of the virus, namely safe sex practices and not sharing blades, needles, and other instruments that can transfer bodily fluids between individuals. It is especially important in those cases that we do not have control over, such as in sexual assault or barrier breakage. Also, with the rise in opioid abuse, there is a possibility of increased transmission through the sharing of injection needles (3).

One might argue that by allowing PEP to be more accessible, we are encouraging more risky behaviors, as a prophylaxis is available. However, this can be remedied by limiting the amount of PEP treatments a patient can get at a reduced cost in a certain time period, such as allowing only 1 treatment covered in a 3month period. We can also implement rebate initiatives for completing an online module or going to a seminar on safe practices to help control the costs of treatments.

References:
1. PEP | HIV Basics | HIV/AIDS | CDC. https://www.cdc.gov/hiv/basics/pep.html (accessed Sep 27, 2019).
2. Published: Mar 25, 2019. The HIV/AIDS Epidemic in the United States: The Basics. https://www.kff.org/hivaids/fact-sheet/the-hivaids-epidemic-in-the-united-states-the-basics/ (accessed Sep 27, 2019).
3. Sullivan, L. E.; Metzger, D. S.; Fudala, P. J.; Fiellin, D. A. Decreasing International HIV Transmission: the Role of Expanding Access to Opioid Agonist Therapies for Injection Drug Users. Addiction 2005, 100 (2), 150–158.

Are there any adopted resolutions currently on the books related to this Proposed Resolution? Yes _X__ No__

If yes, please provide the number and title of the adopted resolution(s) as well as your rationale for the addition of this Proposed Resolution:

2014.2 - Dispensing and Administering Medications in Life-Threatening Situations
1. APhA-ASP supports pharmacists' authority to dispense and administer medications, including but not limited to, naloxone, epinephrine auto-injectors, and albuterol inhalers, without a prescription in a life-threatening situation prior to the arrival of emergency medical services.
2. APhA-ASP supports protection from civil and criminal prosecution of medically trained personnel, including pharmacists, for actions taken in the best interest of the patient during a life-threatening situation.

2014.2 Rationale:
Although not immediately life-threatening, HIV can have detrimental, long-term effects on a patient's life. The physical health detriments are further compounded by social stigma and the effects on their mental and emotional well-being. Thus, HIV exposure should be seen as a life threatening situation, as it has the potential to cause major upheaval in multiple aspects of a patient's life. Preventing the initial infection from taking hold is critical to halting disease progression. The timing of the PEP application is critical to this preventative effort, as the efficacy can drastically decrease after the 72 hour post-exposure mark. Thus, the short window of opportunity justifies the expedience that pharmacy based administration of emergency PEP would provide.

2001.5 - Pharmacists' Voluntary Involvement with the Provision of Emergency Contraceptives
1. APhA-ASP supports the voluntary involvement of pharmacists, in collaboration with other health care providers, in emergency contraception programs that include patient evaluation, patient education, and direct provision of emergency contraception medications.

2001.5 Rationale:
Although not directly related, there are parallels between emergency PEP and emergency contraceptives. Both agents are time sensitive, and both affect the patient's long-term quality of life. Both the resolution and proposal support safe sex practices, and also support to victims of sexual assault.

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R1.9

Proposing APhA-ASP Chapter: St. John Fisher College Wegman's School of Pharmacy

Proposed Resolution Title/Topic: Providing LGBT+-Inclusive Care and Pharmacy Services

Proposed wording:
APhA-ASP supports the provision of LGBT+-inclusive care and pharmacy services by adopting a universal practice that includes preferred name and preferred pronoun on pharmacy forms for all patients.

Background Statement:
Disparities in healthcare are a national issue and patients that are part of the LGBT+ community are no exception. As the number of LGBT+ patients deciding to make a gender transition grows, the likelihood that pharmacists and student pharmacists will have the opportunity to be a part of their care team is increasing as well. At the pharmacy, names can be triggering to individuals who do not associate with the name under their prescription information. This unpleasant occurrence has negative effects on patients' overall experience and can lead to poorer relationships between patients and pharmacy staff. According to an analysis of 3,486 transgender patients, almost 31% said that they delayed or failed to pursue needed health care due to discrimination alone. This is a highly vulnerable population with respect to both physical and mental health and therefore, it is important that they feel comfortable seeking care from healthcare professionals without fear of discrimination.

By implementing preferred patient names and preferred patient pronouns in practice, pharmacists and pharmacy students can develop trusted relationships with their patients and add value to their health experiences. This policy is intended to create a comfortable environment and enhance pharmacy experiences for the LGBT+ community, in order to provide effective, communicable, patient-based care.

References:

1. Bonner L. Pharmacists can be accessible, trusted providers for transgender patients. Pharmacy Today [Internet]. 2016 [cited 2019Sep25];22(3):57. Available from: https://www.pharmacytoday.org/article/S1042-0991(16)00356-X/pdf
2. Parkhill AL, Gainsburg J, Fearing S, Mathews JL. The Need for Transgender Health Content in the Pharmacy Curriculum. INNOVATIONS in pharmacy [Internet]. 2011 [cited 2019Sep25];2(4). Available from: https://pdfs.semanticscholar.org/006f/bd6b5197edf44b182861c108444d3f3494a2.pdf
3. Redfern, Jan & Jann, Michael. (2019). The Evolving Role of Pharmacists in Transgender Health Care. Transgender Health. 4. 118-130. 10.1089/trgh.2018.0038.

Are there any adopted resolutions currently on the books related to this Proposed Resolution? Yes _X__ No___

If yes, please provide the number and title of the adopted resolution(s) as well as your rationale for the addition of this Proposed Resolution:

2018.1—Education on Lesbian, Gay, Bisexual, Transgender, and Other Identities

1. APhA–ASP encourages the advancement of optimal patient care for Lesbian, Gay, Bisexual, Transgender, and Other (LGBT+) patients through the implementation of the following measures:
    a. Development of continuing education programs with a focus on unique health disparities, specialized pharmacotherapeutic considerations, and advancement of cultural competencies, and;
    b. Inclusion of education on topics related to diverse gender and sexual identities in the curriculum of schools and colleges of pharmacy.

Author of Proposed Resolution: Abigail Bornstein & Alicia Kessler

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R1.10

Proposing APhA-ASP Chapter: St. John's University College of Pharmacy & Allied Health Sciences

Proposed Resolution Title/Topic: Engaging with Community Leaders to Prevent Assumption Based Student Service Projects

Proposed wording:
APhA-ASP encourages student pharmacists to identify specific health-related needs of communities by actively engaging with community stakeholders to design service projects/outreach events that target those needs.

Background Statement:
Service is at the core of pharmacy practice. Student pharmacists embrace this quality early on in their careers through participating in and creating various community service projects. The scope of patients receiving healthcare information through student-pharmacist-organized community service projects is not to be underestimated. According to APhA-ASP, in the 2015-16 academic year, Operation Diabetes educated over 3 million patients through public relations initiatives; Operation Immunization also educated over 3 million patients and Operation Heart, over 4 million patients. However, what we do not know is whether patients benefited from the education provided through these outreach events. In the age of technology, our patients have easy access to multiple sources of healthcare information. We do not have guidance as to what healthcare knowledge our patients already have and what information they need before we organize community outreach events. Because we lack that information about the communities we serve, we base our service on assumptions. By making assumptions on a community's health literacy, we not only provide suboptimal care to those we are trying to serve, but we also hurt our credibility as healthcare professionals by not providing relevant information.

According to the NYC Department of Health and Mental Hygiene's Community Engagement Framework, stakeholders are defined as individuals, communities, institutions/organizations and their representatives that are invested in and are affected by the intervention or program. Engagement with stakeholders is a way of communicating and building a relationship with a community. Engagement starts with consulting and can lead to involvement/collaboration overtime. Consulting considers input from community members and solicits feedback through various methods including surveys, questionnaires, interviews, facilitated discussions, social media engagement, email blasts, community input sessions, advisory boards, etc. With time, investment, and trust between student pharmacists and community stakeholders, the stakeholders can have a shared responsibility in implementing the focused projects which can lead to larger and more consistent community member involvement.

Through engaging and partnering with community stakeholders, student pharmacists can create service projects that address the health-related disparities of the community they are serving. Researching the health-related needs of a community requires additional time within the planning process. Nonetheless, once relationships are established, determining those gaps in care and information becomes easier. By creating these meaningful relationships, the people being served can see the value in pharmacy and support movements towards advancement of the profession.

Are there any adopted resolutions currently on the books related to this Proposed Resolution? Yes ___ No__X_

If yes, please provide the number and title of the adopted resolution(s) as well as your rationale for the addition of this Proposed Resolution:

Author of Proposed Resolution: Saara Nasruddin

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R1.11

Proposing APhA-ASP Chapter: The University of Rhode Island College of Pharmacy

Proposed Resolution Title/Topic: Pharmacist Prescribed of Hormonal Contraceptives

Proposed wording:
APhA-ASP supports state and federal legislation that allows pharmacists to prescribe, dispense, and administer hormonal contraceptives and provide related clinical services in order to increase patient access to care and screen for indications requiring care follow-up, referral, or therapy adjustment. Hormonal contraceptives and related clinical services such as subsequent referral, counseling and/or other interventions may include, but not be limited to, hormonal contraceptive patches, self-administered oral hormonal contraceptives, and injectable hormonal contraceptives.

Background Statement:
In the United States, approximately 1 in every 2 pregnancies are unplanned. Hormonal contraceptives are one of the most safe and effective methods of birth control available, but not all female patient populations have access to them. Pharmacists are trained on both medications and patient interviewing skills. No lab testing is required to help a patient select a proper form of hormonal contraceptive; therefore, the process of a pharmacist interviewing a female patient with a risk assessment tool, completing a blood pressure screening, and selecting a proper form of hormonal contraceptive can be performed in a community pharmacy setting. The true purpose of the practice of pharmacy is to improve patient health and wellbeing. This can be accomplished by allowing pharmacists to prescribe hormonal contraception for patients without a clinic visit. Although increasing access to contraception is effective at reducing unintended pregnancy, there are many obstacles to its consistent use. Barriers to receiving a hormonal contraception script at a doctor's office include long appointment waits, high co-pays, inconvenient clinic hours, and desire to avoid a pelvic exam It is estimated that by providing hormonal contraceptives over the counter, unintended pregnancy could be reduced up to 25%. With the current health care environment, pharmacist prescribed contraception is the best alternative. There is existing evidence that pharmacist prescriptive authority of hormonal contraceptives has been successful with the prevention of 50 unintended pregnancies and a taxpayer cost savings of $1.6 million in just 2 years in a single state. Unintended pregnancies are more likely to result in health complications for both the child and mother, ultimately costing both the patient and healthcare system more money. Additionally, patients are not disadvantaged by having a women's health clinic visit every three years rather than annually. The CDC recommends that women between the ages 21-65 receive a pap testing every three years.

References:
1. https://www.pharmacist.com/article/osu-study-allowing-pharmacists-prescribe-birth-control-expands-access
2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5014441/
3. https://www.ncbi.nlm.nih.gov/pubmed/26760409
4. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2835625/
5. https://www.cdc.gov/cancer/gynecologic/provider-education/cervical/recommendations.htm
6. https://www.womenshealth.gov/pregnancy/you-get-pregnant/unplanned-pregnancy

Are there any adopted resolutions currently on the books related to this Proposed Resolution? Yes ___ No_X__

If yes, please provide the number and title of the adopted resolution(s) as well as your rationale for the addition of this Proposed Resolution:

Author of Proposed Resolution: Erinn Mangona, Emilie Carroll, Melissa Menditto

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R1.12

Proposing APhA-ASP Chapter: University at Buffalo The State University of New York SOP

Proposed Resolution Title/Topic: Regulation of Temperature-Sensitive Medication Delivery through Mail-Order Services

Proposed wording:
APhA-ASP supports regulation of temperature-sensitive medication delivery through mail order pharmacy services to ensure medication quality, safety, and efficacy.

Background Statement:

Mail-order pharmacy services have recently begun to reshape the pharmaceutical industry, representing a $131 billion dollar industry within the last year.[1] Mail-order services regularly involve the shipment and delivery of numerous temperature-sensitive medications, such as insulin and biologics. The U.S. Food and Drug Administration (FDA) requires that all prescription drugs are to be stored at appropriate temperatures and conditions that have been set in the product labeling.[2] Temperatures in packing and shipping containers, however, are subject to change under environmental influences such as extreme temperatures. In 2005, researchers studying the effects of extreme weather on medications found that formoterol capsules in original blister packaging experienced aggregation of capsule contents, changes in weight, and decreased formoterol delivery after 3 hours in temperatures that mimicked mailboxes in Arizona, ranging from 104-158° F. Decreases in drug efficacy were also observed in formoterol capsules that where placed in the same environmental conditions after a shorter time span of thirty minutes.[3] Although temperatures of extreme heat are often the focal point of studies such as the one above, colder temperatures can also pose the risk of freezing for many products as well, which could also alter drug integrity. OptumRx reports having shipping solutions that protects medications in the 32°- 0° F temperature range, which can cover all but the coldest times of year, where temperatures may be well below 0° F due to wind chill.[4] This poses a risk of freezing for products such as insulin, which require storage at temperatures between 36°F to 46°F and are warned against use by the FDA after having been frozen due to decreased efficacy.[5]

Presently, seven out of ten products require temperature controlled shipping, where a change of temperature as little as 2 degrees can alter the integrity of some pharmaceuticals. The cold-chain packaging and temperature regulating technologies that are currently utilized for the purpose of drug delivery have limited parameters for effective temperature regulation beyond a demonstrated time period, meaning that the gap in time between drug delivery and patient reception and placement into appropriate storage conditions very widely and can result in significant ramifications on drug stability, integrity, and efficacy. Consequently, alterations to drug integrity may have inadvertent effects on clinical outcomes for patients receiving their medications from mail-order pharmacies.[6] Without assurance that a medication can be maintained at the appropriate temperatures indicated after delivery, stricter regulations may need to be considered regarding limitations on mail-order services of such pharmaceuticals.

References:

1. Kaiser Family Foundation. Mail Order Sales of Prescriptions Drugs by Payer. Available from: https://www.kff.org/health-costs/state-indicator/mail-order-sales-of-prescriptions-drugs-by-payer/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
2. U.S. Food and Drug Administration. CFR - Code of Federal Regulations Title 21. Available from: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?fr=205.50
3. Robbins RA1, Thomas AR, Proctor LM, Hoyt JC, Hayden JM. Chest. Heat decreases formoterol delivery. 2005 Dec;128(6):4036-40. https://www.ncbi.nlm.nih.gov/pubmed/16354878
4. Optum. Six cool thoughts about shipping sensitive medications. Available on: https://www.optum.com/resources/library/cool-thoughts-shipping-sensitive-medications.html
5. U.S. Food and Drug Administration. Information Regarding Insulin Storage and Switching Between Products in an Emergency. Available from: https://www.fda.gov/drugs/emergency-preparedness-drugs/information-regarding-insulin-storage-and-switching-between-products-emergency
6. ABCO Transportation, Inc. THE RULES FOR SHIPPING PHARMACEUTICALS YOU NEED TO KNOW. Available on: https://www.shipabco.com/the-rules-for-shipping-pharmaceuticals-you-need-to-know/

Are there any adopted resolutions currently on the books related to this Proposed Resolution? Yes ___ No_X_

If yes, please provide the number and title of the adopted resolution(s) as well as your rationale for the addition of this Proposed Resolution:

Author of Proposed Resolution: Caroline Irwin, Rachel Mesina, Marissa Polino

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R1.13

Proposing APhA-ASP Chapter: University of Connecticut School of Pharmacy

Proposed Resolution Title/Topic: Accessibility of Language Assistance Resources

Proposed wording:
APhA-ASP encourages standardized implementation of language assistance resources in the pharmacy.

Background Statement:
Approximately 61.6 million individuals, foreign and U.S. born, spoke a language other than English at home and about 41 percent (25.1 million) of those individuals considered themselves Limited English Proficient (LEP)[1]. Despite recent technological developments in language support and recognition of language-related disparities, a majority of pharmacies do not have specific protocols and procedures to address patients' language barriers. Studies have shown that more than 80% of pharmacies lack systematic approaches for identifying and documenting linguistic needs as well as informing patients of the pharmacy's translation capabilities. [2] This inadequate implementation leads to poor patient outcomes and disparities among groups with limited English proficiency.

Addressing this problem starts with assessment of current policy and regulations concerning language support accessibility. One example of success in this area was the vast improvement of New York City chain pharmacies' provision of pharmacy language services due to changes in New York State legislation. These state regulations included mandatory language support training for all pharmacy staff, required signage at the pharmacy indicating rights to language assistance services, accessibility of language support services, and penalties for pharmacies not directly adhering to the legislation. [3]

Taking New York State as an exemplar for the proposed standardization, there is a clear opportunity for the establishment of specific regulations regarding language support services on a national scale. Adopted guidelines would promote proper education of all pharmacy staff on language assistance services and technology, as well as stress the requirements of linguistic service advertisements at the pharmacy counter. Every pharmacy nationwide should be able to provide a patient with medication labels, warning labels, drug information sheets, and oral interpretation services in the patient's primary language, so long as the additional costs are not overly burdensome given a community's need for such services. A pharmacy can achieve this through their own resources or a third-party provider. It can be noted that there is also a potential for healthcare cost savings through promotion of these measures due to an increased patient understanding of their medications and thus increase medication adherence and decreased trips to the Emergency Department.

To be exempt from providing the language support services described above, a pharmacy would have to apply for a waiver and prove the need for language support services in their locality is not significant enough to warrant the extra costs. All pharmacies that are found to be non-compliant with these measures would receive penalties to ensure a national standard of quality care. Through the actualization of these policies on a federal level, pharmacies can work towards a goal of increased comprehension of health information and improved health outcomes among patients of limited English proficiency

References:

1. The Limited English Proficient Population in the United States, https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states
2. Assessing the Impact of Language Access Regulations on the Provision of Pharmacy Services, https://doi.org/10.1007/s11524-018-0240-z
3. The Laws of New York: Title 8, Article 137, Section 6829, https://www.nysenate.gov/legislation/laws/EDN/6829

Are there any adopted resolutions currently on the books related to this Proposed Resolution? Yes _X_ No__

If yes, please provide the number and title of the adopted resolution(s) as well as your rationale for the addition of this Proposed Resolution:

1997.8 - Use of Alternative Communication Resources

Original Wording: "APhA-ASP supports the development and use of alternative communication resources (e.g., pictograms, TDD, patient's native language, large print materials) to facilitate patient comprehension."

APhA-ASP has previously encouraged the use of communication resources, including patient's native language, to enhance the patient's understanding, but we propose a standardized application of these resources to promote impactful interactions at the pharmacy. Our proposed amendment to the previous resolution would state, "APhA-ASP supports the standardization and implementation of alternative communication resources (e.g., pictograms, TDD, patient's native language, large print materials) as well as mandatory linguistic service training of pharmacy personnel to facilitate patient comprehension".

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R1.14

Proposing APhA-ASP Chapter: University of New England College of Pharmacy

Proposed Resolution Title/Topic: Educate Pharmacists on the Associated Risks of E-cigarettes and Vaping-related Products

Proposed wording:
APhA-ASP supports the placement of federal warnings on e-cigarettes and other vape products.

Background Statement:

E-cigarette's original purpose was to serve as a safer smoking alternative to those trying to quit smoking cigarettes. Over the past decade there has been an increasingly popular trend associated with e-cigarette and vaping devices. This trend has mainly targeted young adults and adolescents; many of whom had never smoked cigarettes beforehand. The long term effects of these vaporizing devices is unknown. It is the responsibility, as a healthcare professional, to educate patients on the risks and uncertainties of these devices. E-cigarettes work by heating a liquid into aerosol form through electric heat. The liquid usually contains nicotine and additive chemicals and flavorings but marijuana and other drugs can also be vaporized through e-cigarettes. The content of this "vape juice" or commonly known "pods" is relatively unknown by most users. Two-thirds of JUUL users aged 15-24 do not know that JUUL contains nicotine. In addition, JUUL pods have extremely high levels of nicotine. One individual JUUL pod contains as much nicotine as an entire pack of 20 cigarettes.1 With four pods sold in a pack, which is the most common way to buy JUUL pods; each pack of pods amounts to the same nicotine content as four full packs of cigarettes. Not only is the aerosol content people are inhaling unsafe and unknown, it is also being widely distributed to young teens and adolescents. The Center for Disease Control and Prevention have found that 38% of high school teens and 13% of middle school students have tried vaping.2 In addition, they also reported that over two-million high school and middle school students have vaped within the past month. This number includes 11.3% of high school students and 4.3% of middle school students.2 These statistics show that adolescents may be vaping regularly; the American youth is using e-cigarettes at a higher rate than adults are.2 This early exposure to nicotine can be detrimental to the young, developing brain. Using nicotine in adolescence may increase the risk of future addiction to other illicit drugs, it may also harm the parts of the brain that control attention, learning, mood and impulse control.1 Nicotine also changes the way synapses are formed in the brain, as well as the rate they are formed.1 There are many misconceptions with these e-cigarette devices and the liquids that are being heated and inhaled. The long-term effects of these products is completely unknown. The CDC reported that 450 cases of vaping-related lung illnesses have been reported in over 33 states and five people have died.3 They stated that these respiratory illnesses are most likely caused by a chemical exposure.3 Since more and more vaping related illnesses and deaths are reported, this has become a public health epidemic that needs to be addressed. Pharmacists can help patients by advocating against vaping-related devices being sold in their stores or by having educational pamphlets or signs posted around the pharmacy to raise awareness on the danger of these products.

References:

1. Center for Disease Control and Prevention. Quick Facts on the Risks of E-cigarettes for Kids, Teens, and Young Adults. Accessed September 2019. https://www.cdc.gov/tobacco/basic_information/e-cigarettes/Quick-Facts-on-the-Risks-of-E-cigarettes-for-Kids-Teens-and-Young-Adults.html
2. Facts and Statistics. Vaping Statistics. Published November 30, 2018. Accessed September 2019. https://www.factstatistics.com/health/vaping-statistics/
3. NPR. CDC Says Number of Possible Cases of Vaping-Related Lung Illness has Doubled. Published September 6, 2019. Accessed September 2019. https://www.npr.org/sections/health-shots/2019/09/06/758337583/cdc-says-number-of-possible-cases-of-vaping-related-lung-illness-has-doubled

Are there any adopted resolutions currently on the books related to this Proposed Resolution? Yes _X__ No__

If yes, please provide the number and title of the adopted resolution(s) as well as your rationale for the addition of this Proposed Resolution:

"The Use of Electronic Cigarettes (e-cigarettes)" 2014.
In sight of the increase in vaping-related illnesses and deaths.

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R1.15

Proposing APhA-ASP Chapter: University of Saint Joseph School of Pharmacy

Proposed Resolution Title/Topic: Reducing Therapeutic Lapse During Medication Shortages and Recalls

Proposed wording:
APhA-ASP encourages pharmacists and student pharmacists to make efforts to contact prescribers to solicit new prescriptions for therapeutic alternatives in patients taking medications that are unavailable due to shortage or recall.

Background Statement:
Drug shortages and recalls have become more relevant to pharmacy practice in recent years, as the number of shortages continues to rise since they began being monitored in 2001. Patients regularly receiving a medication may be unaware of what to do when that medication becomes unavailable. Pharmacists soliciting new prescriptions for these patients can reduce therapy lapses. Lapses in therapy may lead to poor patient outcomes, especially in patients taking higher doses of maintenance medications. Clinically, many documented deaths have occurred due to medication shortages. Furthermore, shortages and recalls strain relationships in community pharmacy. Many patients may blame their pharmacy for the unavailability of medications, causing a breakdown of the pharmacist-patient relationship. Procuring an alternative prescription increases patient's trust in the pharmacist as a health resource.

References:
1. Ventola, C. Lee. "The drug shortage crisis in the United States: causes, impact, and management strategies." Pharmacy and Therapeutics 36.11 (2011): 740.
2. McLaughlin, Milena, et al. "Effects on patient care caused by drug shortages: a survey." Journal of Managed Care Pharmacy 19.9 (2013): 783-788.
3. Fox, Erin R., Burgunda V. Sweet, and Valerie Jensen. "Drug shortages: a complex health care crisis." Mayo Clinic Proceedings. Vol. 89. No. 3. Elsevier, 2014.

Are there any adopted resolutions currently on the books related to this Proposed Resolution? Yes __ No_X__

If yes, please provide the number and title of the adopted resolution(s) as well as your rationale for the addition of this Proposed Resolution:

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R1.16

Proposing APhA-ASP Chapter: Western New England University College of Pharmacy

Proposed Resolution Title/Topic: Amendment to Resolution 2019.2 - Amendment to APhA-ASP 2015.4 - Increased Access to Opioid Reversal Agents

Proposed wording:

1. APhA-ASP supports state and federal legislation to increase access to opioid reversal agents.
2. APhA-ASP encourages pharmacists and student pharmacists to provide public education about opioid reversal agents, including proper administration in situations of opioid-related drug overdose.
3. APhA-ASP encourages all schools and colleges of pharmacy to incorporate opioid reversal agent training as a requirement prior to completion of the pharmacy program. APhA-ASP recommends this training includes a live, hands-on component, identification of high-risk patients, and recognition of the stigma surrounding opioid use disorder.
4. APhA-ASP encourages college campuses to provide opioid reversal agent administration training to resident assistants and to ensure each dormitory on campus has opioid reversal agents readily available for resident assistants to use in the event of a possible on-campus opioid overdose.

Background Statement:
The age adjusted rate of drug poisoning deaths involving opioid analgesics and heroin have been rising since 20101. When explored more closely, the use of prescription opioids in people ages 18-25 has been decreasing since 2012, but the use of heroin in this age group has been steadily increasing since 20092. From 2010 to 2013, the rate of heroin-related death in people ages 18-24 has increased almost 130%1. Heroin is commonly injected, so along with the danger of overdose comes the possibility of contracting HIV, hepatitis B, hepatitis C, or another blood-borne disease. Opioid abuse has negative effects on the healthcare system, the criminal justice system, communities, and the loved ones of abusers3.

During college, most students are exposed to tobacco, alcohol, marijuana, stimulants, and/or prescription opiates. One study revealed, that over 40% of college students have had the opportunity to use prescription opiates and heroin either in college or in the 4 years after college, and almost 25% have used those drugs4. Due to the availability and prevalence of opioids on college campuses, it is reasonable to train resident assistants in opioid reversal agent administration in case of an overdose in a dormitory. Resident assistants serve as leaders in a campus community and are authority figures in dormitories. They would be quicker to respond than any emergency response team or campus police, because they live in dormitories with the rest of the student body. Death from an overdose normally occurs within 1-3 hour of symptom onset, so it is vital to successfully reverse an overdose with an opioid reversal agent to respond quickly. A study showed that the outcome of naloxone use by a bystander compared to the outcome of use by a trained administrator is similar, but those who are trained are better able to recognize and manage an overdose5.

APhA-ASP 2019.2 supports legislation to increase access to opioid reversal agents, encourages pharmacists and student pharmacists providing education about opioid reversal agents, and encourages pharmacy schools to incorporate opioid reversal agent training into mandatory curriculums. The proposed

amendment addresses a population that has a steadily increasing risk of opioid overdose and a possible way to help decrease the number of deaths due to them. It will expand the previously adopted resolution's positive impact on this high-risk population and increase education on overdose and opioid reversal.

References:

1. Hedegaard H, Chen L, Warner M. Drug-poisoning deaths involving heroin: United States, 2000-2013. NCHS Data Brief. 2015 Mar;190.
2. Martins SS, Segura LE, Santaella-Tenorio J, et al. Prescription opioid use disorder and heroin use among youth nonmedical prescription opioid users from 2002 to 2014. Addict Behav. 2017 Feb;65:236-241.
3. Daniels-Witt Q, Thompson A, Glassman T, et al. The case for implementing the levels of prevention model: opiate abuse on American college campuses. J Of ACH. 2017 Oct 1;65(7):518-524.
4. Allen HK, Caldeira KM, Bugbee BA, et al. Drug involvement during and after college: estimates of opportunity and use given opportunity. Drug Alcohol Depend. 2017 May 1;174:150-157.
5. Giglio RE, Li G, DiMaggio CJ. Effectiveness of bystander naloxone administration and overdose education programs: a meta-analysis. Inj Epidemiol. 2015 May 22. 2(10).

Are there any adopted resolutions currently on the books related to this Proposed Resolution? Yes _X_ No___

If yes, please provide the number and title of the adopted resolution(s) as well as your rationale for the addition of this Proposed Resolution:

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