PROPOSED RESOLUTION FORM

Region #: 4

Proposing APhA-ASP Chapter: Butler University

Proposed Resolution Title/Topic:
Implementation of e-cigarette/vaping education into the curriculum of accredited College of Pharmacies.

Proposed wording *(desired action(s)):*
APhA-ASP encourages College of Pharmacies programs to implement e-cigarette/vaping education as mandatory content in PharmD curriculums. It shall be the duty of the respective program to comply with this standard and create an action-plan.

Background Statement (list reasons for the action(s) / pros and cons / references or resources):

They have several titles and users know them as 'e-cigs,' 'mods,' 'vape pens,' or 'e-hookahs.' They're marketed to youth and adults through schemes that portray them as attractive, cheap, usable in non-smoking areas, and as effective aids in smoking cessation.[1,2,3,4] Often, users even think of them as 'safe' alternatives to traditional cigarettes.[5] What healthcare providers know them as: the culprits of one of the 'biggest public-health crises facing the country.'[6]

Every year, the National Institute of Health (NIH) conducts a survey to report changes in usage of various substances of abuse. The most recent survey conducted in 2018 and analyzed the change in e-cigarette/vaping use between the years 2017 and 2018; it revealed that in 2018 e-cigarette-past-month-use was double the figure of that in 2017.[7] The NIH states 'this jump is among the greatest one-year increase seen for any substance in the history (forty-four years) of this survey.'[7] Another report goes on to explain this prevalence, stating that '40 percent of young adults who use e-cigarettes…were never smokers before trying e-cigarettes.'[5] Today, e-cigarettes are now the most commonly used form of tobacco among youth in the United States.[8]

It is reported that youth are more likely than adults to use e-cigarettes.[9] However, this does not mean that adults are not using them, too. In fact, most e-cigarette users aged forty-five years and older are current or former cigarette smokers who are now using e-cigarettes because they believe them to be harmless or a safer alternative to cigarettes.[1,2,3,4,5] The CDC has aimed to showcase the type of adults that are using these products; their 2015 data concluded that most users have some past exposure to conventional cigarettes. Per the results, it is estimated that, in adults utilizing e-cigarettes, 29.8% are former regular cigarette smokers, 58.8% are current cigarette smokers, and 11.4% have never smoked before.[9] Today, more than 2.8% of adults smoke e-cigarettes daily and that number is estimated to keep rising.[9] To blame for this epidemic—the grotesque marketing of these devices. More than $125 million was committed to e-cigarette advertising in 2014 alone, thus fueling the false marketing that deprives consumers of the truth: these toxic compounds are in fact not harmless, having caused seizures, lung injury and death.[10,11,12,13]

As of September 12th of this year, both the CDC and FDA have issued updates on the health issues related to vape usage.[8,9] As of the most recent reporting from the CDC, there are approximately 530 cases of vape-induced lung injury within 38 states and one U.S. territory. Greater so, six states have confirmed e-cigarette-related deaths.[9] As these agents continue to rise in popularity within the U.S., it is imperative that healthcare workers exercise their influence in fighting this epidemic. It is our role to educate patients on the imminent health risks associated with use of such products.

We believe that the implementation of e-cigarette/vaping education into PharmD curriculums

across the U.S. will not only benefit students, one of the largest age groups handling these products, but also future and current patients. By preparing students for rising health trends and resulting disease states/conditions in the academic setting, student pharmacists will be better equipped to help treat, guide, and support future patients. Pharmacists are oftentimes viewed as one of the most trusted and accessible healthcare workers in the field.[14] More so, as professionals who serve patients of all ages. Therefore, it is imperative that as first-line professionals, we have the accurate information to provide atients when they come seeking assistance and information.

For college students and younger patients, with nervous systems that are still developing, using vape pens or e-cigarettes threatens healthy development. The FDA most recently issued a statement describing the possible correlation between e-cigarette use in youth/young adults and seizure activity.[10] Beyond this, e-cigarettes have been attributed to nicotine addiction, brain risks, behavior risks, as well as increased risk for conventional cigarette use.[13] Through implementation of said curriculum, college-aged students are not only promoting the health of future patients but, more so, their own health.

As portrayed in the alarming statistics, this fad does not discriminate in terms of demographics. Adults and older patients are very much at risk when it comes to receiving accurate and reliable information regarding e-cigarettes. By incorporating materials on the usage of vape pens and other devices in current PharmD coursework, the benefit to older, adult patients will be multifaceted. First, these materials will accent smoking cessation coursework. Heavy curriculum emphasis is given to tobacco cessation and the importance of quitting in a safe and permanent matter. Despite false marketing from manufacturing companies, E-cigarettes are not a FDA-approved smoking cessation aid; therefore, it is beneficial to incorporate this material into tobacco-cessation curriculum.[15] We also believe that e-cigarette/vaping should now have its own coursework and practice dedicated to effective motivational interviewing/counseling on e-cigarette cessation. For those who are sole e-cigarette consumers, it is important that these patients, too, have appropriate education on safe and effective cessation.

We predict the role of the pharmacist on this subject will continue to grow. For now, no studies exist to support the concept that e-cigarettes might interact with medication metabolism; however, it is reasonable to assume that medication interactions will exist in individuals who vape. Conventional cigarette smoking is notorious for its effects on drug metabolism, most of which is due to the presence of polycyclic aromatic hydrocarbons (PAHs) in the generated smoke.[16] While present in smaller quantities, e-cigarettes have also been shown to possess PAHs.[17] Thus, it is quite likely that e-cigarettes will impact certain drug metabolic processes, and that the data to support this will soon be studied and elucidated. As this information is released, the role of the pharmacist in this setting will become more imperative. By incorporating e-cigarette/vaping education as mandatory content-matter in PharmD curriculums, APhA-ASP will be setting a precedent in healthcare—professionals who are proactive instead of reactive, to better serve our patients.

References:

1. Etter J-F (2010). Electronic cigarettes: a survey of users. BMC Public Health, 10(1), 1–7. doi: 10.1186/1471-2458-10-231
2. Etter JF, Bullen C. Electronic cigarette: users profile, utilization, satisfaction and perceived efficacy. Addiction. 2011;106(11):2017–2028. doi: 10.1111/j.1360-0443.2011.03505.x.
3. Cataldo JK, Petersen AB, Hunter M, et al. E-cigarette Marketing and Older Smokers: Road to Renormalization. Am J Health Behav. 2015;39(3):361-371. Doi:10.5993/AJHB.39.3.9.
4. Vickerman KA, Carpenter KM, Altman T, Nash CM, Zbikowski SM. Use of Electronic Cigarettes Among State Tobacco Cessation Quitline Callers. Nicotine Tob Res. 2013;15(10):1787–1791. doi: 10.1093/ntr/ntt061
5. E-cigarettes: Facts, stats and regulations. Truth Initiative Inspiring Tobacco-Free lives. https://truthinitiative.org/research-resources/emerging-tobacco-products/e-cigarettes-facts-stats-and-regulations. January 31, 2019. Accessed September 21, 2019.

6. Ducharme J. How Juul Hooked Kids and Ignited a Public Health Crisis. Time. https://time.com/5680988/juul-vaping-health-crisis/. September 19, 2019. Accessed September 21, 2019.
7. Drug and Alcohol Use in College-Age Adults in 2018. National Institute on Drug Abuse. https://www.drugabuse.gov/related-topics/trends-statistics/infographics/drug-alcohol-use-in-college-age-adults-in-2018. January 1, 2019. Accessed September 21, 2019.
8. Electronic Cigarettes (E-cigarettes). National Institute on Drug Abuse. https://www.drugabuse.gov/publications/drugfacts/electronic-cigarettes-e-cigarettes. June 6, 2018. Accessed September 21, 2019.
9. Outbreak of Lung Injury Associated with E-cigarette Use or Vaping. Centers for Disease Control and Prevention. https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html. September 19, 2019. Accessed September 21, 2019.
10. Some E-cigarette Users Are Having Seziures, Most Reports Involving Youth and Young Adults. Food and Drug Administration. https://www.fda.gov/tobacco-products/ctp-newsroom/some-e-cigarette-users-are-having-seizures-most-reports-involving-youth-and-young-adults. Arpi 10, 2019. Accessed September 21, 2019.
11. Layden JE, Ghinai I, Pray I, et al. Pulmonary Illness Related to E-Cigarette Use in Illinois and Wisconsin — Preliminary Report. N Engl J Med. 2019. DOI: 10.1056/NEJMoa1911614.
12. Vaping Illnesses: Consumers can Help Protect Themselves by Avoiding Tetrahydrocannabinol (THC)-Containing Vaping Products. Food and Drug Administration. https://www.fda.gov/consumers/consumer-updates/vaping-illnesses-consumers-can-help-proect-themselves-avoiding-tetrahydrocannabinol-thc-containing. September 6, 2019. Accessed September 21, 2019.
13. U.S. Department of Health and Human Services. E-Cigarette Use Among Youth and Young Adults. A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2016.
14. Kelly D.V., Young S., Phillips L., Clark D. Patient attitudes regarding the role of the pharmacist and interest in expanded pharmacist services. Can. Pharm. J. 2014;147:239–247. doi: 10.1177/1715163514535731.
15. What We Know about Electronic Cigarettes.smokefree.gov. https://smokefree.gov/quit-smoking/ecigs-menthol-dip/ecigs. Accessed September 21, 2019.
16. Elsherbiny M, Brocks DR. The ability of polycyclic aromatic hydrocarbons to alter physiological factors underlying drug disposition. Drug Metabolism Reviews. 2011;43(4):457-475. doi.org/10.3109/03602532.2011.596204.
17. Electronic Nicotine Delivery Systems. Pediatrics Nov 2015, 136 (5) 1018-1026; doi: 10.1542/peds.2015-3222.

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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PROPOSED RESOLUTION FORM

Region #: 4

Proposing APhA-ASP Chapter: APhA-ASP Cedarville University Chapter

Proposed Resolution Title/Topic:
Digital distribution of patient information leaflet.

Proposed wording *(desired action(s)):*
APhA-ASP supports digital distribution of the patient information leaflet to enhance patient experience and improve environmental sustainability in pharmacy.

Background Statement (list reasons for the action(s) / pros and cons / references or resources):

Per FDA regulations (21 CFR 201.56) it is mandatory that prescription drugs include a summary of the intended use, adverse effects, and other key counseling points in a non-misleading way to ensure the safe and effective use of medication.[1] Pharmacies are required to dispense this information, commonly known as patient information leaflet to patients. Most pharmacies have printed lengthy patient information leaflets on the minimum number of pages possible by reducing the font size and printing on double-sided paper all in an effort to not overwhelm the patient. Despite these efforts, patients often neglect to read the patient information leaflet. Additionally, pharmacists have increased patient counseling to ensure that patients understand how the drug should be used. However, with increasing workload, many pharmacists do not have the time to effectively go over all the salient points of the medication. These solutions have not been proven effective by both pharmacists and customer standards. According to the Institution of Medicine "an estimated 90 million adults in the United States have trouble understanding or following directions to medications."[6] As of 2016, a reported rate of 125,000 deaths per year equaling 100 to 300 billion dollars in healthcare costs have been a result of lowering patient adherence partly due to a disconnect in patient counseling. The World Health Organization (WHO) and the Institute of Medicine have recognized the problem and are studying technological intervention as a means of prevention.[7]

The prescribing information is often lengthy leaving patients confused and non-adherent to medications.[2] Pharmacists expect the leaflets to continue patient counseling outside of the pharmacy. On the contrary, pharmacists will often see a trend in which patients call asking for information that is provided in the patient information leaflet. While pharmacists tend to the role of these calls, it is a counterproductive process that can affect the pressure pharmacists feel with an increasing workload. The patient information leaflet does not tailor to varying levels of health literacy and while the information is available to patients it is not described as accessible. Accessibility, in this case, refers to the patient's ability and comfort to read and understand information. Information should be presented in a way such that the patient is able to use the teach-back method. With digital distribution of prescribed medications, there are multiple ways to increase the threshold of understood information. The use of technology is an innovative approach to traditional methods for delivering patient information. Digital distribution can occur on different technological devices including phones, tablets, smart watches, etc. It is a way of expanding communication to patients anytime and anywhere - on demand. Digital communication can include pictograms, videos, and enlarged size font to help patients comprehend medications.

The use of technology to deliver digital patient information has proven to increase patient experience. Recently a pharmacy in Marysville, Washington, adopted a program named MedsOnCue which gives patients the option to scan a quick response code on their cellular device to receive prescribed information.[3] The program allows patients

to have access to counseling beyond the pharmacy, anytime and anywhere the patient chooses. Additionally, it offers a step-by-step guide on how to use medications that need assistance, such as how to use an inhaler. Oftentimes in a community pharmacy setting patients do not retain information provided by the pharmacists due to the amount that is provided in a limited amount of time. The proposal for digital distribution of the patient information leaflet increases accessible patient counseling. The return on this investment could ultimately increase medication adherence and overall enhance the patient experience.

VUCA Health addresses the issue of decreased patient comprehension through the implementation of MedsOnCue software.[5] Since its launch in 2013, there are now 41 states that have adopted providing patients with the option to receive prescribing information via digital distribution. Having seen success, this proposal calls for the option of digital distribution of patient prescription information to be implemented nationwide. Both independent and retail pharmacies can impact patient demographics that need additional counseling.
Demographics that can benefit from this proposal include the elderly, hearing impaired, learning disabled, and patients who speak other languages. The use of digital distribution engages the patient as an active participant in improving their health, ultimately optimizing adherence.

With increased focus on environmental awareness, many pharmacies are strategizing on ways to reduce waste and become more eco-friendly. According to an article written by Rx Radio, it is estimated that within the United States pharmacies spend about 294 million dollars annually on paper. Not only is paper printing a financial burden, but the use of paper also comes at the cost of detrimental environmental impact. Deforestation is a build-up effect of the increasing use of pesticides, chemicals, and an imbalance in our ecosystems.[4]
As healthcare advocates, pharmacists should support the sustainability of our patients' health including physical, mental, and environmental well-being. The *Pharmaceutical Journal* states that pharmacists should both be knowledgeable and aware of the effects climate change will have on the health of our patients.[8] One way we can achieve environmental sustainability within pharmacy is to embrace digital distribution of the patient information leaflet. As pharmacists, this proposal is a call to action to enhance our patients' health and safety, both pharmacologically and environmentally, through digital technology.

Resources:

1. **https://www.fda.gov/media/72979/download**
2. **Ahmadi P, Badri SS, Zargarzadeh AH. An investigation on patient attitudes toward package inserts and their accessibility in Iran. *J Res Med Sci*. 2018;23:100. Published 2018 Nov 28. doi:10.4103/jrms.JRMS_67_18**
3. **Waithe R. Pharmacies, we have to talk... Your paper costs (and waste) are out of control. Medium. https://medium.com/rxradio/pharmacies-we-have-to-talk-your-paper-costs-and-waste-are-out-of-control-e849c8adcdaa. Published December 8, 2018. Accessed September 29, 2019.**
4. **Sustainability Roadmap for Hospitals. Paper Reduction and Sustainable Printing. http://www.sustainabilityroadmap.org/pims/18#.XZAgWy2ZNQI. Accessed September 29, 2019.**
5. **VUCA Health now has 43 States with Pharmacy State Boards Aligned with its Eco-friendly Digital Medication Information Delivery |. VUCA Health. http://www.vucahealth.com/vuca-health-now-43-states-pharmacy-state-boards-aligned-eco-friendly-digital-medication-information-delivery/. Published March 14, 2019. Accessed October 6, 2019.**
6. **Huff C. Prescription Drug Labels, Understand Directions - Health Discovery. AARP. https://www.aarp.org/health/drugs-supplements/info-01-2012/reading-prescription-drug-labels-health-discovery.html. Published January 20, 2012. Accessed October 6, 2019.**
7. **DiPersio LJ. Increasing Medication Adherence with Multi-Channel Communications. DTC Perspectives. http://www.dtcperspectives.com/increasing-medication-adherence-multi-channel-communications/. Published July 21, 2016. Accessed October 6, 2019.**
8. **Davidson I. Time to act: pharmacists must be prepared for environmental changes. Pharmaceutical Journal. https://www.pharmaceutical-journal.com/opinion/time-to-act-pharmacists-must-be-prepared-for-environmental-changes/11138390.article?firstPass=false. Published May 15, 2014. Accessed October 6, 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:

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APhA Academy of Student Pharmacists
Midyear Regional Meetings

APhA-ASP
AMERICAN PHARMACISTS ASSOCIATION
ACADEMY OF STUDENT PHARMACISTS

APhA

PROPOSED RESOLUTION FORM

Region #: 4

Proposing APhA-ASP Chapter:
Concordia University Wisconsin School of Pharmacy

Proposed Resolution Title/Topic:
Patient Care – Smoking Cessation

Proposed wording *(desired action(s)):*
APhA-ASP discourages pharmacists from supporting the use of electronic cigarettes or vaporizers for smoking cessation.

Background Statement (list reasons for the action(s) / pros and cons / references or resources):
There is no question that the market for electronic cigarettes and vaporizers has drastically grown. They have also become the focus of many health and legislative discussions. One such discussion is whether or not e-cigs and vaping should be utilized in smoking cessation.

Currently, there is no robust international scientific study to support the efficacy or safety of e-cigarettes for helping people to quit nicotine. However, we have a number of effective licensed nicotine replacement therapies (NRT) available. These products can help people to truly quit both tobacco and nicotine.

Those who support the use of e-cigs in smoking cessation often cite randomized controlled trial published in the *New England Journal of Medicine* from February 14, 2019. In this study, smokers who used e-cigarettes were twice as likely to remain smoke-free at 12 months, compared with those who used NRT. However, the rate of continuing e-cigarette use was high compared to NRT (80% to 9%). This suggests that there is no imperative to quit vaping. This can be seen as problematic if e-cigarette use for smoking cessation signals ongoing long-term use, which may pose as-yet-unknown health risks, especially concerning cardiovascular, respiratory, and gastrointestinal systems.[1,2]

Additionally, a main focus of the pro-vaping argument is relative safety in comparison with traditional tobacco products. Public Health England (PHE) has stated that electronic options are 95% safer. However, John Newton, chief knowledge officer at PHE, has stated that his percentage is not a precise scientific measure.[3]

Finally, the use of electronic cigarettes has shown potential correlation with cardiovascular and pulmonary illness. A study in *JAMA* showed increased oxidative stress in LDL and vasculature after e-cigarette use, as well as a shift in homeostasis toward sympathetic cardiovascular response.[4] A National Health Interview Survey of over 30,000 people showed increased risk of MI (OR=1.79) with daily e-cigarette use.[5] Lastly, a case series from the Wisconsin Department of Health Services and the Illinois Department of Public Health showed patients with similar presenting symptoms, such as shortness of breath (87%), cough (83%), and tachycardia (64%). Each of these patients reported electronic cigarette use in the last 90 days.[6] All of these relationships need additional research in the future.

As future pharmacists committed to science and public health, we shouldn't encourage the use of electronic cigarettes or vaporizers, especially with the absence of in-depth clinical research. With this in mind, APhA-ASP should discourage pharmacists from supporting the use of electronic cigarettes or vaporizers for smoking cessation.

References:

1. Hajek P, Phillips-Waller A, Przulj D *et al.* A randomized trial of e-cigarettes versus nicotine-replacement therapy. *N Engl J Med* 2019;380(7):629–637. doi: 10.1056/NEJMoa1808779

2. Stead LF, Perera R, Bullen C *et al.* Nicotine replacement therapy for smoking cessation. *Cochrane Database Syst Rev* 2012;11:CD000146. doi: 10.1002/14651858.CD000146.pub4

3. Mishra A, Chaturvedi P, Datta S *et al.* Harmful effects of nicotine. *Indian J Med Paediatr Oncol* 2015;36(1):24–31. doi: 10.4103/0971-5851.151771

4. Moheimani RS, Bhetraratana M, Yin F, et al. Increased cardiac sympathetic activity and oxidative stress in habitual electronic cigarette users: implications for cardiovascular risk. JAMA Cardiol. 2017;2(3):278– 284. https://doi.org/10.1001/jamacardio.2016.5303.

5. Alzahrani T, Pena I, Temesgen N, Glantz SA. Association Between Electronic Cigarette Use and Myocardial Infarction. Am J Prev Med. 2018;000:1-7. https://www.ajpmonline.org/article/S0749-3797(18)31871-3/pdf.

6. Layden JE, Ghinai I, Pray I, et al. Pulmonary Illness Related to E-Cigarette Use in Illinois and Wisconsin – Preliminary Report. NEJM. 2019; DOI: 10.1056/NEJMoa1911614 https://www.nejm.org/doi/pdf/10.1056/NEJMoa1911614?articleTools=true.

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:
N/A

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PROPOSED RESOLUTION FORM

Region #: 4
Proposing APhA-ASP Chapter: Ferris State University – College of Pharmacy

Proposed Resolution Title/Topic: Pharmacy Licensure *Multistate Compact*

Proposed wording *(desired action(s)):*
APhA-ASP supports the development and implementation of a multistate compact licensing process to improve portability and remove barriers from the pharmacist licensing process.

Background Statement (list reasons for the action(s) / pros and cons / references or resources):

With the everchanging role of pharmacists to a more patient care focus, numerous roles have expanded their care services, manufacturing, distribution, and prescription processes beyond state borders. Despite the great advancements amongst healthcare professionals who have the jurisdiction and scope to serve patients across the country, pharmacists are amongst very few professions required to pay for and take a different standardized law exam (MPJE) for each state in order to extend their care and services. Other healthcare professions such as nursing and medicine are not required to take a law exam at all as part of their licensing process yet are able to transfer their licensure and practice to multiple states. By having pharmacist take a law exam for each individual state, we are creating barriers and unneeded financial burdens. There also lacks evidence or studies to demonstrate that passing a standardized law exam leads to positive outcomes, retention of information, or understanding of state laws. APhA-ASP supports the development and implementation of a multistate compact allowing pharmacists to take one singular standardized law exam (MPJE) that is transferable to licensure in all 50 State and D.C.

According to the National Council of State Nursing Board (NCSBN), nurses have a multistate compact that consists of over 29 states. Currently, there are an additional four states that are pending this jurisdiction and three who await implementation of this multistate compact. The NCBSN is continuously working on progressing to a national state exam, moving away from individual state exams, allowing nurses to transfer licensure and practice in all states. In addition, the portability of licensure allows for nurses to improve access to care for patients and removes unneeded barriers when taking on a role or position within another state. Nursing serves as one of many health professions that do not require a law exam for licensure. Others include: physicians, dentists, psychiatrists and chiropractors.

Another major barrier is financial burden on gradating student pharmacists. According to the American Association of College of Pharmacy (AACP) the average student loan debt for pharmacy students in 2019 was $172,329. The 2019 NABP NAPLEX/MPJE Candidate Application Bulletin states the MPJE application fee is $100 per jurisdiction and examination fee of $150 per jurisdiction. In comparison the NAPLEX application fee is $100 per jurisdiction and examination fee of $475 per jurisdiction. The 2018 NABP Survey of Law demonstrates that the average cost

of initial licensure ranges from $25-$455 with an average fee of approximately $150 per state. Taking these numbers and averages into account, if a pharmacist were to apply for licensure in three states, this would cost around $1,100 for the law exam and application fees alone. For a pharmacist (who works in a distribution facility) that may need to be licensed in all 50 states and D.C., the approximate cost for the law exam requirements would total $20,400, nearing the average yearly salary of some pharmacy technicians. Development of a multistate compact, will help to alleviate some of the financial burden placed on student pharmacists and pharmacists.

The American Pharmacy Association states that, "The goal of Pharmaceutical Care is to optimize the patient's health-related quality of life, and achieve positive clinical outcomes,… to achieve this goal, the following must be accomplished: The pharmacist assures that the patient has all supplies, information, and knowledge necessary to carry out the drug therapy plan." Limited law licensure acts as a barrier to this possibility of achieving maximal access and outcomes in patient care if the if the patients' needs extends beyond state borders. Varying organizations extend care through specialty pharmacy care in multiple states requiring pharmacists to take exams in those individual state even if the laws differ by meniscal aspects. According to many state regulations, without this multistate compact, if a pharmacy is to obtain a medication from a state, other than its own, the operational pharmacist(s) may be required to obtain that state's license, even if it is purely for distribution. Being the first line of access to many patients through the multistate compact this could provide greater accessibility to care. It would also expand roles and remove barriers for pharmacists who travel between states to provide care, or greater accessibility to manufacturing and distribution for companies with pharmacies in multiple states. Pharmacist could also expand care into multi-states with the notion of still being held responsible for their duties through transferring licensure via the Board of Pharmacy in those states.

The implementation of a multistate compact may seem feasible in theory; however, some may question the differences in legality amongst individual states and how this can promote uniformity in professional exams across state lines. To this, the response would be to highlight the NAPLEX examination. While there are variations in therapeutics recommendations, guidelines, and scenarios, the purpose of the licensure exam is to test minimal competency. Based on the scenario, pharmacists are to use their professional judgement and clinical knowledge, but the NAPLEX exam does not account for all possible various. Content on the NAPLEX also does not encompass every scenario, disease state, or possibility. Similarly, while state laws may differ, pharmacists are expected to stay up to date with laws and exercise professional judgement based on scenarios. Although each state has variances in laws, many states abide by similar, if not the same laws. There are numerous occasions in which pharmacists who live one state have patients come in from its neighboring states in which case the strictest law is to be followed according to the state of practice. Lastly, many companies and organizations often enact internal policies to ensure risk mitigation. Many organizations will have varying policies that often times may be stricter than law to ensure lawsuits, or harm are minimized. This can act as another opportunity to ensure safe or best practices are followed. Lastly, we pose a few questions for the audience to consider: 1) what studies are there to demonstrate that passing a law exam leads to pharmacists following or knowing the law? 2) what studies or evidence are there to show that a law exam in each state leads to less lawsuits or legal burden on pharmacists? 3) what evidence is there to demonstrate that passing a law exam reduces the number of legal errors during a pharmacist's career?

In conclusion, pharmacy is one of the very few (if any) health professions required to take a law exam. In order to ease the burden financially, increase access to care, and expand our capabilities, pharmacists must move towards more efficient licensure standards. Pharmacists play a crucial role in patient care yet are faced with a higher burden of taking multiple law exams compared to any other profession. Adopting a multistate compact would allow pharmacists to further serve patients, increase opportunities for care, and remove red tape burden from licensure.

Resources

https://www.pharmacist.com/principles-practice-pharmaceutical-care?is_sso_called=1
https://www.aacp.org/sites/default/files/2019-07/2019-gss-national-summary-report_0.pdf
https://nabp.pharmacy/wp-content/uploads/2019/03/NAPLEX-MPJE-Bulletin-Sept-2019.pdf
https://nabp.pharmacy/publications-reports/publications/survey-of-pharmacy-law/
https://www.ncsbn.org/nurse-licensure-compact.htm
https://www.nursinglicensure.org/articles/nurse-practitioner-license.html
http://www.ncbex.org/exams/mbe/

Are there any adopted resolutions currently on the books related to this Proposed Resolution? NO

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APhA Academy of Student Pharmacists
Midyear Regional Meetings

PROPOSED RESOLUTION FORM

Region #: 4

Proposing APhA-ASP Chapter: Manchester University College of Pharmacy, Natural & Health Sciences

Proposed Resolution Title/Topic: 2017.3 - Efforts to Reduce Mental Health Stigma

Proposed wording *(desired action(s)):*
APhA-ASP supports standardized and comprehensive training for pharmacist and student pharmacist on suicide ideation as a medication side effect, appropriate counseling interventions and prevention strategies.

Background Statement (list reasons for the action(s) / pros and cons / references or resources):

As pharmacists pioneer the public health fight tackling each challenge with utmost accessibility and evidence-based approaches, it is crucial to meet those standards for mental health as well. Suicide rates have increased in the last 10 years from 10.8 to 13.9 per 100,000 persons. As suicide rates continue to rise in the United States, the current situation demands the accessible pharmacist's intervention. Mental health conditions are debilitating in nature, creating a barrier to the already challenging treatment procedure of seeing a therapist or psychiatrist. Wait time for appointments can last from several weeks to months, and insurance coverage greatly varies on mental health visits. Additionally, many medications and drug interactions can lead to suicidal ideation creating a situation where treatment plans focusing on behavioral therapy are left missing an essential component that is the pharmacology of psychiatry and non-psychiatry drugs. This problem describes a situation where pharmacists are well positioned to help patients whether at-risk or not, to identify preventative strategies and prioritize mental health wellbeing.

A comprehensive study focusing on suicide prevention training for pharmacists and physicians found promising results supporting increased education. After a 1.5-hour training for California pharmacists showed a significant increase in their ability to distinguish important suicide risk categories and awareness. The highest participation of pharmacist in this training was from the community pharmacy field. This specific finding highlights two important points:

1. Community pharmacist are eager to help their patients improve their mental health due to the strong relations with the community as a result of the continuity of care nature.
2. There is a well-established platform for the successful promotion of suicide prevention in the community pharmacy model.

However, the study findings also indicated that there was a noticeable decrease in the respondent's confidence in identifying signs of suicide if they had previously known someone close to them who ended his/her life. Another finding showed overall significant increase in further training for suicide prevention related education.

Overall, there is an urgent need for mental health and suicide prevention training for pharmacist and student pharmacist to be well equipped public health champions. Additionally, this training must be comprehensive, recurring in nature, and considerate of different cultural beliefs and values. Several programs that meet these some of these requirements are already available to the public but seems to circulate solely in the field of academia. A great example of those training programs is the Mental Health First Aid program. The program helps trainees identify signs of different suicide stages and provides evidence-based approaches to improve mental health as a preventive measure. Manchester's APhA-ASP chapter is in favor of more information and education on the topic of mental health and for pharmacists and student pharmacists to be educated on screening and strategies for suicide prevention.

References / Resources

1. World Health Organization. Preventing suicide: a global imperative. World Health Organization, Luxembourg; 2014. p 89.

2. Health Status - Suicide Rates - OECD Data." TheOECD, data.oecd.org/healthstat/suicide-rates.htm.

3. Gable, Kelly N. "Starting the Conversation about Depression and Suicide Prevention." Pharmacy Today, vol. 25, no. 2, 1 Feb. 2019, pp. 44–53., doi:10.1016/j.ptdy.2019.01.022.

4. Pharmacist training in suicide prevention. Painter, Nathan A. et al. Journal of the American Pharmacists Association, Volume 58, Issue 2, 199 - 204.e2

5. San Diego County. Suicide Prevention Council Report to the Community 2015. Available at: http://www.sdchip.org/wp-content/uploads/2015/12/ SPC-2015-Report-Card-Final-HHSA-9-15-15.pdf.

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:

2017.3 - Efforts to Reduce Mental Health Stigma

This amendment aims to add a fourth point to the aforementioned adopted resolution with the following title:

APhA-ASP supports standardized and comprehensive training for pharmacist and student pharmacist on suicide ideation, appropriate counseling interventions and prevention strategies.

Although there is an adopted resolution that aims to increase mental health education, we believe that suicide attempts or ideation is a more urgent and pinpointed concern that should be addressed in the pharmacy. Although, a specialized health professional would be more qualified to discuss suicide prevention, obstacles to receiving adequate mental health are on the rise whether due to the debilitating nature of mental health conditions along with the stigma and barriers to care. This situation places the pharmacist at a unique position to discuss suicidal ideation as a side effect of different medications and the different strategies to cope with said ideations before talking to the appropriate therapists/provider. A standardized education tool such as Mental Health First Aid can be an incredible asset for staff and student pharmacists to be adequately comfortable and prepared to tackle suicide ideation and prevention. Due to the urgency and increasing problem with suicide, we believe that suicide prevention education should be addressed separately and with appropriate attention as a different statement within the 2017.3 adopted resolution.

Author of Proposed Resolution: **Mark Botros, Eric Beard, and Arman Harutyunyan**

Author Phone Number: **317-727-6541**

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APhA Academy of Student Pharmacists
Midyear Regional Meetings

PROPOSED RESOLUTION FORM

Region #: 4

Proposing APhA-ASP Chapter: Midwestern University

Proposed Resolution Title/Topic: Drug Abuse Screening

Proposed wording *(desired action(s)):*

APhA-ASP recommends the use of surveys and questionnaires as a part of a routine drug screening effort in adult patients.

Background Statement (list reasons for the action(s) / pros and cons / references or resources):

As a pharmacist, it is crucial to be aware of any and all medications a person takes. This necessity stems from the need to evaluate whether the medication in question interacts with either illicit drugs or drugs that have been filled at other pharmacies. Without all information about the patient's habits, including but not limited to drug use, misuse, or abuse, the pharmacist is not able to help the patient come to a fully informed decision regarding the risks of any new medication being dispensed.

Recently, the U.S. Preventive Services Task Force has issued a draft recommendation regarding the use of screening patients for illicit drug use in adults age 18 years or older. While this recommendation is aimed towards providers, the implications of the recommendation reach into the pharmacy. Information given to a pharmacist by a provider regarding a patient's illicit drug use can prompt better conversations about the medication and its risks and benefits either with the provider themselves or with the patient.

Are there any adopted resolutions currently on the books related to this Proposed Resolution? Yes___ 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:

Author of Proposed Resolution: Aaron Graham

Author Phone Number: 630-441-0799

Author Email Address: agraham28@midwestern.edu

APhA Academy of Student Pharmacists
Midyear Regional Meetings

PROPOSED RESOLUTION FORM

Region #: 4

Proposing APhA-ASP Chapter: Northeast Ohio Medical University

Proposed Resolution Title/Topic: Point-of-Care Testing

Proposed wording *(desired action(s)):*

APhA-ASP supports legislative and regulatory changes that would allow pharmacists to provide rapid flu tests to patients and administer the appropriate treatment based on specific protocol results.

Background Statement (list reasons for the action(s) / pros and cons / references or resources):

A couple of states throughout the country already have a bill or law passed that allows pharmacists to provide these services, and as future pharmacists we want to support this idea to become a national policy that will also provide more services for pharmacists and overall provide more job opportunities throughout all setting of pharmacies.

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: Timothy Huskey

Author Phone Number: 440-812-8323

Author Email Address: thuskey@neomed.edu

APhA-ASP
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PROPOSED RESOLUTION FORM

Region #: 4

Proposing APhA-ASP Chapter: Ohio Northern University Raabe College of Pharmacy

Proposed Resolution Title/Topic: Staffing to ensure counseling

Proposed wording:

APhA-ASP encourages pharmacy managers and owners to increase staffing to allow for proper counseling of patients.

Background Statement:

In the last few months, we have seen a drastic cut in pharmacy hours in the community setting. This is causing some pharmacies to operate drastically understaffed, which is causing pharmacists to focus more of their time away from the patients. Patients who experienced medication review, patient counseling and followups were associated with a lower rate of adverse drug events after the first 30 days of hospital discharge.[1] We find that over the last 14 years counseling rates have dropped for patients receiving prescriptions from their regular community pharmacy.[2] This could be attributed to many things including time pressures pharmacist age, job satisfaction, and skill. Another such study sited that 45% of pharmacists that were interviewed (n=440) said that they did not have enough time to counsel patients on certain medications.[3] If we if optimize the community setting to allow for more time for counseling we can overall increase patient outcomes.

References:

1. Schnipper JL, Kirwin JL, Cotugno MC, Wahlstrom SA, Brown BA, Tarvin E, Kachalia A, Horng M, Roy CL, McKean SC, Bates DW. Role of pharmacist counseling in preventing adverse drug events after hospitalization. Archives of internal medicine. 2006 Mar 13;166(5):565-71.
2. Flynn EA, Kenneth NB, Berger BA, Lloyd KB, Brackett PD. Dispensing errors and counseling quality in 100 pharmacies. Journal of the American Pharmacists Association. 2009 Mar 1;49(2):171-82.
3. Smith SRm Golin CE, Reif S. Influence of time stress and other variables on counseling by pharmacists about antiretroviral medications. Am J Health Syst Pharm. 2004;61:1120–9.

Are there any adopted resolutions currently on the books related to this Proposed Resolution? Yes___ 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:

Author of Proposed Resolution: **Alexander Nixon**

Author Phone Number:

Author Email Address: **a-nixon@onu.edu**

APhA Academy of Student Pharmacists
Midyear Regional Meetings

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PROPOSED RESOLUTION FORM

Region #: 4

Proposing APhA-ASP Chapter: The Ohio State University Chapter of APhA-ASP

Proposed Resolution Title/Topic: Translation Services

Proposed wording *(desired action(s)):* APhA-ASP encourages that pharmacists, student pharmacists and all other pharmacy staff actively advertise and incorporate the use of translation services in patient care interactions for all patients who have a preferred language other than English. In addition, these language preferences should be requested, documented, and updated when a patient profile is created.

Background Statement (list reasons for the action(s) / pros and cons / references or resources):
Many pharmacies have translating services that are under-utilized. This could be that they are not well advertised in care settings as well as staff is not asking patients if they need translating services. The pro of this resolution is that patients who receive counseling in their primary language will have a better understanding and will be able to actively participate in their health care conversation. This considers historically marginalized patients whose adherence is affected by speaking with someone who literally speaks their language as noted by an article from Pharmacy Times[1]. This has been attributed to issues with medication adherence and, although multifaceted, is a clear area of improvement that could not only provide well for our patients but save money for the overall health care system. According to an article posted by the CDC in November of 2017, medication nonadherence costs the health care system approximately $100–$300 billion of U.S. health care dollars spent annually. As a part of the strategies, CDC noted that on top of considering health literacy, cultural competency and preferred language should be taken into account when crafting communication and education for patients[2]. Many pharmacies have these translating services already available so this would not require an investment.

A potential con is accessibility to these translating services to smaller pharmacies that are not able to afford these services. If the pharmacy is not well staffed, this could cause a back-up in workflow. With that being said, as we move to a more patient centered rather than dispensing model, this coincides with the capabilities available through provider status legislation. There may be issues if certain languages are not provided at the respective stores. Some may perceive this as a continued marginalization of the population. However, considering the top languages per the last U.S. Census and those being offered, this likely will not be an issue[3].

Although there are notes that indicate a patient may speak another language other than English, this is not consistently recorded on electronic health record systems. This would make it easier for a pharmacist or student pharmacist to prepare a counseling session with a patient with translating services available and potential medication handouts available in that specified language.

The pro of this act is that the relevant parties would be able to anticipate needing to request translating services and which line to choose from.

The con is that this section may not be readily available on electronic health record keeping systems, either requiring that the pharmacy staff include another alert (issue with alert fatigue) or requesting new sections on their electronic record system which will take time.

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

Author of Proposed Resolution: Natalie Hagy
Author Phone Number: 614-582-7363
Author Email Address: hagy.361@osu.edu

References

1. https://contemporaryclinic.pharmacytimes.com/chronic-care/medication-adherence-for-diabetes-less-likely-among-latinos-with-limited-english
2. https://www.cdc.gov/mmwr/volumes/66/wr/mm6645a2.htm
3. https://www2.census.gov/library/publications/2013/acs/acs-22/acs-22.pdf

PROPOSED RESOLUTION FORM

Region #: 4

Proposing APhA-ASP Chapter: Purdue University

Proposed Resolution Title/Topic: *Students with Substance Use Disorder (APhA-ASP Resolution 2020.1)*

Proposed wording *(desired action(s)):*

APhA-ASP encourages schools and colleges of pharmacy to:

1. Provide confidential avenues to treatment within the community for students struggling with Substance Use Disorder.
2. Protect students who willingly seek treatment from punitive measures.
3. Support students in continuing their education while seeking and receiving treatment.
4. Cultivate a healthy environment for students in recovery by breaking stigmas and barriers surrounding Substance Use Disorder and mental health.

Background Statement (list reasons for the action(s) / pros and cons / references or resources):

In 2013 the American Psychological Association changed the name of the diagnosis from "substance abuse or dependence" to Substance Use Disorder (SUD) which encompasses the appropriate medical term for addiction that is both physical and mental. It is important to utilize appropriate and inclusive language because many patients suffering from SUD experience heavy stigma and judgment.

Students and pharmacists are both populations at risk for substance use disorder because of their increased access to drugs and because of the stressful environments that surround them. According to the American Pharmacists Association, pharmacists experience SUD at an estimated rate very similar to the general population at 11-15%. Pharmacists and pharmacy students are not immune to addiction or other risk factors contributing to SUD. Common substances include alcohol, opioids, and amphetamines.

Barriers to seeking treatment may seem even more impossible because of what is at stake for students. The threat of students being removed from school is the main factor that prevents students from asking for help. While students should not be exempt from legal consequences of any actions, especially ones that put patients at risk, schools should provide avenues to treatment earlier in their journey rather than waiting until it is too late to manage. Maintaining enrollment and licensure is a primary concern for students.

The war on drugs in the 1970s promoted incarcerating and punishing people who used which only lead to more people in jails. This is not an effective way to lower consumption and creates

a harmful attitude. Ultimately, the goal is to lower overdoses, lower patient risk, and increase access to treatment sooner.

References:

American Pharmacists Association. “Addiction and substance abuse in the pharmacy professions: From discovery to recovery.” ://elearning.pharmacist.com/portal/Files/LearningProducts/7b5709cbae3642dabdeefd05c4c507b3/assets/CEaugust_Updated.pdf

Addiction Center. “Addiction vs Dependence”

https://www.addictioncenter.com/addiction/addiction-vs-dependence/

American Progress. “Criminal https://www.americanprogress.org/issues/criminal-justice/reports/2018/06/27/452786/ending-war-drugs/

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:

1991.2 - Chemical Dependency

1. APhA-ASP encourages each school and college of pharmacy, in conjunction with the pharmacy recovery program in the state, to develop and implement a program to ensure awareness about and provide assistance to student pharmacists whose ability to perform has been compromised due to chemical dependency or other causes.

2. APhA-ASP recommends that such programs include, but not be limited to, education, an evaluation process ensuring confidentiality, a mechanism for enrolling student pharmacists in the state pharmacist recovery program, and an appropriate mechanism for assisting in the re-entry process.

This adopted resolution is decades old and does not focus on protecting students and remaining in school. Chemical dependency is an outdated term and not all encompassing.

Author of Proposed Resolution: **Amanda Huntsman**

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Author Email Address: **arhuntsm@purdue.edu**

APhA Academy of Student Pharmacists
Midyear Regional Meetings

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PROPOSED RESOLUTION FORM

Region #: 4

Proposing APhA-ASP Chapter: Rosalind Franklin University of Medicine and Science

Proposed Resolution Title/Topic:
Improving vaccination rates by allowing mature minors to consent to their own vaccinations.

Proposed wording *(desired action(s)):*
APhA-ASP supports state and federal legislation to allow minors from 12-18 years of age to consent to immunizations without parental notification.

Background Statement (list reasons for the action(s) / pros and cons / references or resources):

Outbreaks of vaccine-preventable diseases continue to occur, especially in children and adolescents, despite efforts made to improve vaccination rates across the country. Currently, there are over 1,200 reported cases of measles in the United States so far in 2019.[1] This is more than three times the number of cases in 2018 (372). This can be largely attributed to the anti-vaccination movement, which stokes the fear that vaccines are unsafe, despite sufficient scientific evidence that demonstrates their safety.[2]

The CDC currently recommends the following vaccines for all persons 12-18 years of age without a contraindication: hepatitis A, hepatitis B, measles, mumps, and rubella (MMR), varicella, and human papillomavirus (HPV). These vaccines are indicated at various ages, but all fall within the range covered by this resolution. There is sufficient evidence that suggests that adolescents are capable of informed consent for low-risk medical procedures, including vaccinations, despite the wishes of their parents. This is not the first time the subject has been suggested.[3] Currently, 18 states allow "mature minors" to consent to vaccines. While the definition varies by state, it is generally based on a healthcare provider's assessment of the individual's age, understanding, and intellectual ability.[4] These policies have demonstrated the potential for success when minors are entrusted to take control of their own vaccination choices.

It is important to balance the benefit of allowing minors to consent to vaccinations with potential risks that may be involved with this decision. One of the concerns with vaccinations is the potential of adverse effects, however, serious adverse events from vaccinations are rare. For example, hepatitis A and B vaccines (both individually and in combination forms) list no serious adverse events except for the always-present possibility of anaphylaxis.[5,6] The same is true for the HPV vaccine.[7]

While live attenuated vaccines predictably have more adverse event rates, even these vaccines are accepted to be safe by the CDC and FDA. For example, the MMR vaccine by Merck has been linked to febrile seizures, fever, gastroenteritis, and bronchitis.[8] Only 1 out of 16 subjects who reported serious adverse effects was found to have symptoms that were actually caused by the vaccine, and all patients recovered fully. The varicella vaccine, including the MMRV combination vaccine, reports similar outcomes as the MMR vaccine.[9] Other side effects include injection site low-grade fever, fatigue, reaction, rash, muscle pain - all adverse effects deemed to be minor with appropriate care and counseling. In regards to anti-vaccine groups making claims that vaccines can be dangerous and cause conditions such as autism have all been thoroughly rejected by scientific consensus.(reference)

Given the evidence, the benefits of widespread vaccination strongly outweigh the risks of adverse effects. Minors in certain states can provide informed consent for vaccinations, as well as other medically related decisions such as birth control. For this resolution, the definition of mature minors can be based foremost on age, 12-18, with verbiage about using the healthcare professional's clinical judgement on ensuring the patient is able to provide informed consent. Allowing mature minors to legally consent to indicated vaccinations would strengthen herd immunity, reduce outbreaks of preventable diseases, and ultimately reduce cost, morbidity, and mortality associated with the disease burden.

References:

1. Measles (rubeola). cdc.gov. https://www.cdc.gov/measles/index.html. Updated June 18, 2019. Accessed September 26, 2019.

2. AHC Media. Antivaccination movement fuels return of measles. *Hosp Employee Health*. 2019;38(5):60.

3. Whelan AM. Lowering the age of consent: pushing back against the anti-vaccine movement. *J Law Med Ethics*. 2016;44:462-73. doi:10.1177/1073110516667942.

4. Vaidyanathan V. Can minors get vaccinated without parental consent?. ibtimes.com. https://www.ibtimes.com/can-minors-get-vaccinated-without-parental-consent-2763119. Published February 13, 2019. Accessed September 26, 2019.

5. VAQTA [package insert]. Whitehouse Station, NJ: Merck & Co, Inc; 2018.

6. Recombivax [package insert]. Whitehouse Station, NJ: Merck & Co, Inc; 2018.

7. Gardasil [package insert]. Whitehouse Station, NJ: Merck & Co, Inc; 2011.

8. Kuter BJ, Brown M, Wiedmann RT, Hartzel J, Musey L. Safety and immunogenicity of M-M-RII (combination measles, mumps, rubella vaccine) in clinical trials of healthy children conducted between 1988 and 2009. *Pediatr Infect Dis J*. 2016;35(9):1011-20.

9. Chaves SS, Haber P, Walton K, et al. Safety of varicella vaccine after licensure in the United States: experience from reports to the vaccine adverse event reporting system, 1995-2005. *J Infect Dis*. 2008;197:s170-7.

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: **Justin Bladecki**

Author Phone Number: **(219) 608-8313**

Author Email Address: **justin.bladecki@my.rfums.org**

APhA Academy of Student Pharmacists
Midyear Regional Meetings

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PROPOSED RESOLUTION FORM

Region #: 4

Proposing APhA-ASP Chapter: Roosevelt University College of Pharmacy

Proposed Resolution: *2019-* Pharmacists' Role in Medication Reconciliation ***(APhA-ASP Resolution 2019)***

Proposal Statement: APhA-ASP urges that medication reconciliations be done by pharmacists as they are the medication experts versus other healthcare professionals.

Background Statement:

Pharmacists are the medication experts and their knowledge needs to be utilized in medication reconciliation to prevent errors, reduce hospital readmission rates and emergency room visits[1]. Pharmacy as a field is currently experiencing regulatory alterations that aim to change a pharmacist's status from professionals to providers to achieve optimal patient care. Pharmacists' accessibility is a major key that contributes to their role in making an impact on patient care which is a strong indication of why pharmacists should be the health care professionals that provide medical reconciliation in comparison to other health care personnel.

A possible concern is the cost of compensation of a pharmacist compared to other health professionals, however, the reduction in emergency room visits, hospital remissions and medication errors will ultimately result in financial savings to those institutions employing a pharmacist for medication reconcilliation[2]. In addition, student Pharmacists can be trained and utilized in patient medication reconciliation. A pharmacist's involvement in medication reconciliation will improve patient adherence, compliance and continuation of therapy[3].

1. Pharmacist- versus physician-obtained medication histories. *Reeder TA, Mutnick A, Am J Health Syst Pharm. 2008 May 1; 65(9):857-60. (accessed 09/25/2019)*

2. Postdischarge pharmacist medication reconciliation: impact on readmission rates and financial savings. *Kilcup M, Schultz D, Carlson J, Wilson B. J Am Pharm Assoc (2003). 2013 Jan-Feb; 53(1):78-84. (accessed 09/25/2019)*

3. Impact of pharmacy-led medication reconciliation on admission to internal medicine service: experience in two tertiary care teaching hospitals*. Karaoui LR, Chamoun N, Fakhir J, Abi Ghanem W, Droubi S, Diab Marzouk AR, Droubi N, Masri H, Ramia E.BMC Health Serv Res. 2019 Jul 16; 19(1):493. Epub 2019 Jul 16. (accessed 09/26/2019)*

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:

Previous adopted resolution: 2007.1 - Medication Reconciliation

APhA-ASP recommends changing the approved proposal of 2007.1 from simply supporting pharmacists' involvement in medication reconciliation to having them exclusively responsible for medication reconciliation.

Author of Proposed Resolution: Shams Azzawi

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APhA Academy of Student Pharmacists
Midyear Regional Meetings

PROPOSED RESOLUTION FORM

Region #: 4

Proposing APhA-ASP Chapter: Southern Illinois University Edwardsville School of Pharmacy

Proposed Resolution Title/Topic:
Pharmacy Benefit Manager State Licensure (APhA-ASP Resolution 2019.1)

Proposed wording *(desired action(s)):*
APhA-ASP would like to encourage the change in legislature to mandate that Pharmacy Benefit Managers (PBMs) must acquire licensure provided by individual state governments in order to operate within that state.

Background Statement (list reasons for the action(s) / pros and cons / references or resources):

Pharmacy Benefit Managers (PBMs) were created with the idea of helping the consumer get the best deal possible. In theory, PBMs were a remarkable resource that would provide a life-changing opportunity to help everyday people with their pharmaceutical needs. After several years, PBMS were not as practical and helpful as they were originally thought to be. With virtually no transparency, PBMs are one of the main contributors to the consistent rise in prescription drug prices [1]. This is the main reason that patients are having a difficult time getting the medications that are essential for their well-being. With the lack of transparency within PBMs, some states are deciding that they need to be subject to regulation. Several states have already made it a requirement to have state licensure. This makes it easier for states to regulate the actions of PBMs. Within the licensure, some states have been able to ban the gag clause that prevents pharmacists from telling their patients about lower-cost options. Some states have also decided to put limits on patient cost-sharing [2]. In 2018, ten more states passed legislation that will help with the regulation of PMBs; a total of fourteen bills have been passed. More states are looking to follow in these footsteps as they see the benefits of state regulation but have yet to make any official moves. Twenty-seven states have considered bills but again have yet to act on the idea [3]. With a total of twenty-one states already on board with the required licensure, more are looking to follow. Connecticut is leading the way of regulating PBMs. The state is giving power to an insurance commissioner. The commissioner has the ability to investigate licensed PBMs and revoke their license if they find that the PMB is breaking the law [4].

Since their beginning, PBMs have caused severe problems for pharmacies across the nation. Several states are now taking charge by requiring PBM state licensure to regulate their actions. As future pharmacists, we should be encouraging each state to require PBMs to have a license, so they can be held accountable for their deceiving practices.

1. http://www.ncpa.co/pdf/applied-policy-issue-brief.pdf
2. https://nashp.org/comparison-state-pharmacy-benefit-managers-laws/
3. http://sourceonhealthcare.org/spotlight-on-2018-state-drug-legislation-part-6-pharmacy-benefit-manager-regulation/
4. https://www.cga.ct.gov/2018/rpt/pdf/2018-R-0083.pdf

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: 2012.4
We want to change the focus to an individual state level to combat the unfair business practices of PBMs.

Author of Proposed Resolution: Alina Viteri

Author Phone Number: 618-975-9260

APhA Academy of Student Pharmacists
Midyear Regional Meetings

PROPOSED RESOLUTION FORM

Region #: 4

Proposing APhA-ASP Chapter: University of Cincinnati James L. Winkle College of Pharmacy

Proposed Resolution Title/Topic: Easing Access to Care for Transgender/Gender Nonconforming Persons
For example: Health Literacy (APhA-ASP Resolution 2008.2)

Proposed wording *(desired action(s)):*
For example: APhA-ASP encourages pharmacists and student pharmacists to actively incorporate health literacy assessment into the development and implementation of each patient care plan.

APhA-ASP supports the inclusion of better patient demographic information regarding transgender status and preferred pronouns in healthcare systems that is uncoupled to past medical history and current anatomical inventory to increase access to care.

Background Statement (list reasons for the action(s) / pros and cons / references or resources):

The transgender and gender nonconforming communities are experiencing some of the highest rates of healthcare disparities in the US. They are at an increased risk for homelessness, poverty, psychological distress, HIV and suicidal ideation then their cisgender counterparts.[1] It can also be found that transgendered persons are at a decreased chance to have an up-to -date cancer screening when studied against a similar cisgender population.[2] These health disparities can be linked to the negative experiences relating to their gender identity that 33% of the respondents, in a survey done by James et. al, said that they had experienced within just the last year. The World Professional Association for Transgender Health has given an outline for simple additions to any EHR systems to make them more suited for treating transgender patients:

- The system should include preferred name, gender identity, and preferred pronouns in demographic data.
- Provide a way to document a patient's medical history and current anatomy inventory, which is uncoupled from the demographic information about gender identity, assigned sex or pronouns.
- The process of transitioning from one name, anatomic inventory, and/or sex should be smooth.
- The EHR should include an easily recognizable alert to notify users of a patient's proper name and pronouns.

In conclusion, this policy is a simple and cheap option to help discontinue discrimination of transgender people in the healthcare community. This hopefully will lead to better trust in the healthcare field and better outcomes.

1. Hayon, Ronni, and Kristin Stevenson. "Hormonal, Medical, and Nonsurgical Aspects of Gender Affirmation." *Facial Plastic Surgery Clinics of North America*, vol. 27, no. 2, 2019, pp. 179–190., doi:10.1016/j.fsc.2018.12.001.
2. James SE, Herman JL, Rankin S, et al. The report of the 2015 U.S. transgender survey 2016. Available at: http://transequality.org/sites/default/files/docs/usts/usts-full-report-Dec17.pdf Accessed September 20, 2019
3. Deutsch MB, Green J, Keatley J, et al. Electronic medical records and the transgender patient: recommendations from the World Professional Association for Transgender Health EMR Working Group. J Am Med Inform Assoc 2013;20(4):700-3

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: **Daniel Duda**

Author Phone Number: **513-939-5726**

Author Email Address: **dudadl@mail.uc.edu**

Please use only one form for each proposed resolution. Forms must be submitted by the Chapter via email to the APhA-ASP Regional Delegate 4 weeks prior to the start of the Midyear Regional Meeting.

APhA Academy of Student Pharmacists
Midyear Regional Meetings

PROPOSED RESOLUTION FORM

Region #: 4

Proposing APhA-ASP Chapter: University of Findlay

Proposed Resolution Title/Topic:

Community Pharmacy Naloxone Access

Proposed wording *(desired action(s)):*

APhA-ASP encourages pharmacists and student pharmacists to support legislation for proper reimbursement of all community pharmacies (both chain and independent) for carrying and dispensing naloxone.

Background Statement (list reasons for the action(s) / pros and cons / references or resources):

Currently, not all states require third-party reimbursement of naloxone (including Ohio). Given this lack of reimbursement, many community pharmacies do not provide this necessary service for their patients. This is especially prevalent in independent pharmacies and could be viewed as a disservice to their patient population. Proper reimbursement would enable all pharmacies to properly supply and dispense naloxone to combat the opioid epidemic facing our country. While some see this as enabling the abuser, pharmacists should recognize the rule of beneficence and having every patient's best interests in mind.

Even at prescribed doses there is always a risk of developing side effects that can lead to slowed breathing, and eventually an emergency. Although some worry that patients use naloxone as a safety net for misusing drugs, this is not supported by any evidence. Lucas Hill, PharmD, BCPS, BCACP, is clinical assistant professor at University of Texas at Austin (UT Austin) College of Pharmacy and clinical pharmacist at CommUnityCare Federally Qualified Health Centers. He states that however, "several analyses have demonstrated that increasing naloxone access leads to fewer overdose deaths and promotes entry into addiction treatment programs."

This recognition has not been made across all states and awareness should be made that all pharmacists should have access to naloxone for free to handout to patients who may need it. Michigan participates in an inspiring event where they have a day every year specified to pharmacies to handout naloxone for free to anyone who comes in the pharmacy. The naloxone is provided by Michigan Department of Health and Human Services and many pharmacies can participate in the distribution. Michigan partakes in this day to help combat the opioid epidemic and allow both pharmacies and patients to have easier access to naloxone and receive the proper counseling they need.

Overall, there are plenty of improvements that can be made nationwide to help combat the opioid epidemic, and one way to start moving in appositive direction is by receiving the proper legislation to reimburse all pharmacies for carrying and dispensing naloxone.

http://www.pharmacist.com/article/patients-can-get-and-pharmacists-can-provide-naloxone-pharmacy-why-dont-they?is_sso_called=1
https://www.pharmacytoday.org/article/S1042-0991(18)31245-3/pdf
https://www.michigan.gov/opioids/0,9238,7-377-88143_88334-506089--,00.html
https://www.michigan.gov/documents/mdhhs/Naloxone_Distribution_Day_Instructions_665376_7.pdf

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: Nicholas Reid & Addison Sember

Author Phone Number: 567-230-2136,

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Please use only one form for each proposed resolution. Forms must be submitted by the Chapter via email to the APhA-ASP Regional Delegate 4 weeks prior to the start of the Midyear Regional Meeting.

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PROPOSED RESOLUTION FORM

Region #: 4

Proposing APhA-ASP Chapter: University of Illinois at Chicago College of Pharmacy

Proposed Resolution Title/Topic:
Reducing HIV/AIDS Prevalence in US Correctional Facilities

Proposed wording *(desired action(s)):*
APhA-ASP supports legislation requiring all prisoners to be tested for HIV/AIDs upon entering prison and that condoms to be made accessible to all US prisoners.

Background Statement (list reasons for the action(s) / pros and cons / references or resources):
Currently, most prisons only offer opt-in testing for HIV upon incarceration. North Carolina is the only state that requires HIV/AIDs testing upon admission to prison. Many inmates do not find out about their diagnosis until they are hospitalized. Additionally, the vast majority of correctional facilities do not allow inmates access to condoms, despite the high prevalence of HIV and other sexually transmitted infections in these settings.

- 25% of all US patients living with HIV/AIDS have a history of incarceration.
- 15% of all US patients living with HIV/AIDS pass through a correctional facility annually.
- The rate of HIV among prisoners is 5 to 7 times that of the general population.
- The consequences of opt-in HIV/AIDS testing up incarceration include: the high cost of hospitalization, an increase in incidence of opportunistic infections and cancers, transmission of HIV/AIDS in an overcrowded setting, and transmission of HIV/AIDS to the general public upon release from prison.
- Denying adult inmates access to condoms put them at a high risk of exposure to HIV/AIDS and other STIs.

Possible Solution:
- Requiring mandatory HIV/AIDS testing upon admission to prison.
- Making condoms accessible to all adults in US correctional facilities.
- Condoms provide a low-cost method to help prevent the spread of HIV/AIDS and other sexually transmitted infections. The cost of providing condoms to adults in correctional facilities is substantially cheaper than the cost of HIV/AIDS regimens.

References:
Prisons and Jails. Prisons and Jails | The Center for HIV Law and Policy. https://www.hivlawandpolicy.org/issues/prisons-and-jails. Accessed September 20, 2019.
AIDS. 2005 Oct;19 Suppl 3:S41
PLoS One. 2009 Nov 11;4(11):e7558
J Acquir Immune Defic Syndr. 2010 Dec 15;55 Suppl 2:S78

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:

Please use only one form for each proposed resolution. Forms must be submitted by the Chapter via email to the APhA-ASP Regional Delegate 4 weeks prior to the start of the Midyear Regional Meeting.

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Please use only one form for each proposed resolution. Forms must be submitted by the Chapter via email to the APhA-ASP Regional Delegate 4 weeks prior to the start of the Midyear Regional Meeting.

PROPOSED RESOLUTION FORM

Region #: 4

Proposing APhA-ASP Chapter: University of Kentucky College of Pharmacy

Proposed Resolution Title/Topic: Naloxone co-prescription mandates for health care providers.
This proposal may be considered for addition as an amendment to APhA-ASP Resolution 2015.4: Increased Access to Opioid Reversal Agents in addition to the 2019.2 amendment.

Proposed wording *(desired action(s)):*

1. APhA-ASP supports legislation implementing naloxone co-prescription mandate laws for prescribers and/or pharmacists.
2. APhA-ASP supports pharmacists proactively screening for and co-dispensing naloxone for at risk-patients under pharmacy-based access laws in order to improve accessibility to naloxone, reduce opioid overdose deaths, and promote opioid stewardship practices until prescriber co-prescription mandate laws can be established nationwide.

Background Statement (list reasons for the action(s) / pros and cons / references or resources):

The Centers for Disease Control and Prevention (CDC) released pain management guidelines, Guideline for Prescribing Opioids for Chronic Pain, in March 2016. The guidelines were born from a need for safer clinical practices and increased efficacy of managing chronic pain to reduce risk of opioid use disorders, overdoses, and death. The CDC states over 11.5 million Americans age 12 and up reported misusing prescription opioids in 2016, and in 2017 an estimated 130 people died from opioid-related overdoses every day.[1] The CDC provides four approaches to overdose prevention: improve opioid prescribing, prevent opioid use disorder (OUD), treat OUD, and reverse overdose.[2] Given these staggering statistics and the ability of pharmacists to play an active role in opioid stewardship practices, APhA-ASP chapter at the University of Kentucky College of Pharmacy recommends support of legislation mandating the co-prescription of naloxone for at-risk patients. Until then, the chapter recommends pharmacists screen patients receiving prescription opioids, and then initiate prescriptions to dispense naloxone to identified at-risk patients.

According to the CDC, prescribers should prescribe the lowest effective opioid dose and use additional precautions when exceeding over 50 morphine milligram equivalents (MME) per day. For patients receiving more than 50 MMEs per day, the CDC advises increased monitoring and assessments, and to consider offering naloxone. The CDC recommends avoiding, or justifying, dosages over 90 MMEs per day. At dosages equal to or above 50 MME per day, the risk of overdose is doubled compared to dosages under 20 MME per day. According to the Veterans Health Administration (VHA), of patients receiving chronic opioids, those who died of opioid overdose received an average of 98 MME per day.[3]

The CDC recommends clinicians mitigate overdose risk by offering naloxone when the following factors are present: history of overdose, history of substance use disorder, higher opioid dosages (greater than or equal to 50 MME/day), or concurrent benzodiazepine use.[iii] Pharmacists, as front-line providers, can capitalize on patient interaction opportunities by providing regular counseling and screening for opioid dependency or opioid use disorders. Additionally, pharmacists should independently screen for at-risk patients upon receipt of each prescription, evaluating the patient profile, PDMP data, and patient interview for risk criteria as listed above. For these patients, pharmacists should offer to initiate a prescription for naloxone.

As of January 2019, 16 states had board authorized protocols for pharmacists to dispense naloxone, in four states pharmacists can dispense naloxone without a prescription, and 31 states (including Washington D.C.)

have standing orders. Through this, pharmacists can directly dispense naloxone to patients as deemed necessary.[4] This allows for additional screening opportunities, bringing pharmacists into the assessment of opioid misuse. Pharmacists are at the front line of the opioid epidemic and can play a major role in helping patients nationwide, especially because these naloxone access laws are already in place. Support should be given, with urgency, for pharmacies to implement naloxone accessibility into existing infrastructure.

Recently, some states have moved to co-prescription mandates. In 2017, Virginia and Vermont passed laws requiring prescribers to co-prescribe naloxone to patients at high risk for overdose. One year later, Arizona, California, and Rhode Island followed suit. According to Sohn, et al., having a legal mandate for naloxone co-prescription resulted in a near 8-times increase in dispensed naloxone prescriptions.[5] These mandates directly relate to reversal of overdoses, one of the CDC's four core approaches mentioned earlier.

Until more states follow suit, pharmacists should assume the responsibility to initiate prescriptions for and dispensing of naloxone to at-risk patients. According to Abouk, et al., states with naloxone access laws that gave pharmacists direct authority and autonomy to dispense naloxone experienced statistically significant decreases in mortality from opioid-related overdoses.[6] Thus, pharmacists have a clear path and ability to make meaningful interventions when it comes to patients receiving opioids.

Finally, offering naloxone to patients may provide another platform to discuss the associated risks of opioids. As pharmacists are required to provide education on naloxone, patients will receive more information on signs and symptoms of an overdose due to opioids. This can provide a vital alert to patients who may not have received extensive counseling from their prescriber on the opioid, or simply reinforce the message about the dangers of opioids, thus supporting the important and extensive patient education pharmacists are already providing daily.

References

[i] Centers for Disease Control and Prevention. (2018). Understanding the Epidemic. Web accessed 26 Aug. 2019. https://www.cdc.gov/drugoverdose/epidemic/index.html#combatting-the-epidemic

[ii] Centers for Disease Control and Prevention. (2017). Overdose Prevention. Web accessed 26 Aug. 2019. https://www.cdc.gov/drugoverdose/prevention/index.html

[iii] Centers for Diseases Control and Prevention. (2016). CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016. Web accessed 26 Aug. 2019. https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm

[iv] National Alliance of State Pharmacy Associations. (2019). Naloxone Access in Community Pharmacies. Web accessed 26 Aug. 2019. https://naspa.us/resource/naloxone-access-community-pharmacies/

[v] Sohn M, Talbert JC, Huang Z, Lofwall MR, Freeman PR. Association of Naloxone Coprescription Laws With Naloxone Prescription Dispensing in the United States. JAMA Network Open. Published online June 21, 2019(6):e196215. doi:10.1001/jamanetworkopen.2019.6215

[vi] Abouk R, Pacula RL, Powell D. Association Between State Laws Facilitating Pharmacy Distribution of Naloxone and Risk of Fatal Overdose. JAMA Intern Med. Published online May 06, 2019 179(6):805–811. doi:10.1001/jamainternmed.2019.0272

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

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:

1998.5: Medication Administration by Pharmacists
2010.2: Substance Abuse Education
2014.2: Dispensing and Administering Medications in Life-Threatening Situations
2015.4: Increased Access to Opioid Reversal Agents
2019.2: Amendment to APhA-ASP Resolution 2015.4 (Increased Access to Opioid Reversal Agents)

Author of Proposed Resolution: **Alexsandra Nilges, Cody Sullivan**

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PROPOSED RESOLUTION FORM

Region #: 4

Proposing APhA-ASP Chapter: University of Michigan College of Pharmacy

Proposed Resolution Title/Topic:
Mental Health First Aid certification training in the pharmacy school curriculum

Proposed wording *(desired action(s)):*
APhA-ASP recommends the inclusion of Mental Health First Aid certification training into the curricula of all schools and colleges of pharmacy.

Background Statement (defend your proposed resolution including the reasons for the action(s) / pros and cons / references or resources / supplementary research):

Currently in the United States, more than 40 million people have a mental health condition or substance abuse disorder. More than half of people with these conditions do not have adequate health care due to high costs, misunderstandings of accessing care, and reluctance to seek help at all. With the signs of mental health and substance use being difficult to recognize, it is important for pharmacists and pharmacy students to notice risk factors and warning signals and intervene to direct these patients to treatment.[1] APhA has taken great initiative to increase mental health awareness in the pharmacy profession through policies working to reduce mental health stigma and address professional burnout. However, implementing an evidence-based mental health training program can provide standardized education for pharmacy students to have meaningful interventions and provide reliable resources to patients with mental health and substance abuse disorders. Currently in the pharmacy curriculum, cardiopulmonary resuscitation certification and immunization certification are offered to provide pragmatic skills that are utilized in the healthcare field. Allowing students to have an additional certification in mental health care training can be incorporated in the curriculum through the program Mental Health First Aid.

Mental Health First Aid (MHFA) is a program originating in Australia and brought to the United States in 2008 by the National Council for Behavioral Health. During a single training, MHFA teaches participants: (1) The signs and symptoms of certain illnesses like depression and substance use disorder, (2) The risk factors warnings of concerns involving mental health and substance use, and (3) Skills and tools to help assess a mental health crisis through interactive exercises and role playing. Over the years, MHFA has trained more than 1.5 million people and has been enacted in twenty state policies.[1]

MHFA training has seen positive impacts in pharmacy schools and in the pharmacy profession. At the University of Sydney in Australia, O'Reilly et. al conducted a study randomly selecting 60 of their pharmacy students to participate in a 12-hour MHFA training. Compared to students who did not receive training, results showed that MHFA significantly improved student's abilities to identify mental illnesses, recognize helpful interventions for mental health crises, offer pharmaceutical services to patients with a mental health illness, and ultimately reducing stigmatizing attitudes.[2] In an article written by Azita Alipour, PharmD for CPNP, MHFA was offered at the Marshall B. Ketchum University College of Pharmacy as a one-unit elective of the summer for students entering their third year of pharmacy school. A quarter of the class enrolled in the course and received positive feedback from the students, many feeling prepared for their psychiatry therapeutic course in the coming months.[3] Last year, the Iowa Pharmacy Association hosted seven MHFA trainings for 90 pharmacists, pharmacy technicians, and student pharmacists. With the importance of mental health, APhA's House of Delegates have made MHFA for pharmacists an important policy topic this year.[4] These ultimately show an opportunity for MHFA training in the pharmacy curriculum to increase a student's confidence and skill set when providing care for this demographic.

Some of the limitations with MHFA are costs and class sizes. Materials for an 8-hour MHFA training can range from $25-170 per person for up to a maximum of 30 in attendance.[5] With pharmacy school cohorts around 50-150 students, this can become problematic in terms of room reservations and financial costs. However, given the positive results seen in previous MHFA training in pharmacy schools, the opportunity for pharmacists to be a driving force in mental health care significantly outweigh the risks.

Pharmacists are in a unique position to provide health care services to patients with mental health conditions and substance abuse disorders. Incorporating a certification program such as MHFA equips students with sufficient knowledge and interventional skills to successfully handle mental health care crisis during their educational career and their professional career. Having a standardized, evidence-based program ensures consistency in a student's training to care for this patient population. Overall, pharmacy schools offering MHFA certification training in the curriculum can provide service to those suffering from mental health and substance use disorders and lead to positive patient outcomes.

References:

1. The National Council (2019). Mental Health First Aid Policy Handbook [PDF file]. Retrieved from: https://www.thenationalcouncil.org/wp-content/uploads/2019/03/031219_NCBH_MHFAPolicyHandbook_v6.pdf
2. O'Reilly CL, Bell JS, Kelly PJ, Chen TF. Impact of mental health first aid training on pharmacy students' knowledge, attitudes and self-reported behaviour: a controlled trial (2011). Australian and New Zealand Journal of Psychiatry; 45(7): 549-557.
3. Alipour A. Mental Health First Aid: Student and Pharmacy School Perspectives (2018). CPNP. Retrieved from: https://cpnp.org/perspective/2018/09/377129
4. Bonner L. On the frontlines: Equipping pharmacists with Mental Health First Aid (2018). Pharmacy Today. Retrieved from: https://www.pharmacytoday.org/article/S1042-0991(18)31660-8/fulltext
5. SAMHSA-HRSA (2019). Quick Start Guide [PDF]. Retrieved from: https://www.mentalhealthfirstaid.org/cs/wp-content/uploads/2013/10/UPDATED-Quick-Start-guide-FINAL.pdf

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:

2019.1 - Addressing Professional Burnout and 2017.3 - Efforts to Reduce Mental Health Stigma: While these active resolutions support educational institutions to include mental health education and working to focus on preventing and reducing burnout to members of the pharmacy profession, the addition of a certification program like Mental Health First Aid allows for a standardized training program and ensuring consistency in a student's education for care to patients with mental health and substance abuse disorders.

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PROPOSED RESOLUTION FORM

Region #: 4

Proposing APhA-ASP Chapter: University of Toledo College of Pharmacy and Pharmaceutical Sciences

Proposed Resolution Title/Topic: Prescription Drug Direct-to-Consumer (DTC) Advertising to the General Public

Proposed wording *(desired action(s)):* APhA-ASP opposes direct-to-consumer (DTC) advertising of prescription drugs to the general public (specifically patients) via television commercials, magazines, etc.

Background Statement (list reasons for the action(s) / pros and cons / references or resources):

Direct-to-consumer (DTC) advertising is only allowed in two countries around the world – the United States and New Zealand. Efforts for DTC advertising of prescription drugs began to grow in the 1980s and 1990s; previously, efforts had been focused on advertising to health care providers.[1] However, concerns began to rise, particularly with advertising prescription drugs that had been on the market for less than two years. These concerns grew due to the lack of long-term safety data for these medications. This prompted the Institute of Medicine to recommend the FDA to require pharmaceutical companies to refrain from DTC advertising during the first two years following a drug's approval.[2] Despite efforts like this, the FDA is still hesitant to take action.

In 2017, the pharmaceutical industry spent $6.1 billion on DTC advertising of prescription drugs.[3] In a 2013 study, 78% of physicians agreed that DTC prescription drug advertising increases the overall cost of healthcare.[4] Often times, the prescription drugs being advertised are very expensive, new to the market, and not covered through insurance. Instead of spending billions of dollars on advertising medications and consequently making patients pay more for their care, pharmaceutical companies should re-allocate the funds so that patients have a way to pay less money for their healthcare. When patients see an advertisement for a medication, it is often for a specific brand rather than the generic version. In some instances, patients are insistent on receiving the brand name version of the medication, which can cost 30-80% more than the generic version.[3]

DTC prescription drug advertisements can influence patients in multiple ways. For example, television commercials for prescription drugs are usually limited to 30 seconds or a minute in length. When healthcare professionals evaluate a medication's potential role for a patient, they typically read most parts of a drug monograph – contraindications, precautions, FDA-approved and non-approved uses (off-label), boxed warnings, dosage, administration, monitoring, drug interactions, adverse reactions, pharmacokinetic considerations, patient counseling information, etc. Typically, it will take healthcare providers longer than 30-60 seconds to read and comprehend the important information about the drug. In addition, patients may not understand everything presented about the drug, especially when pharmaceutical companies are forced to choose which benefits/risks are most important to include in the short amount of time allowed. Patients do not receive the full information about the drug in the short amount of time and may thus be misinformed.[3] In addition, patients may see one risk identified and think that they should not receive the drug in fear of something bad happening to them.

List of Pros/Cons of DTC prescription drug advertising (from https://prescriptiondrugs.procon.org/

PROS	CONS
DTC prescription drug ads encourage people to seek medical advice from health professionals	DTC drug ads misinform patients
DTC prescription drug ads inform patients about diseases/medical conditions and possible treatments	DTC prescription drug ads promote drugs before long-term safety information is known
DTC prescription drug ads encourage patient compliance with treatment instructions	Normal conditions and bodily functions are medicalized and stigmatized by DTC prescription drug ads
Diseases and medical conditions are more likely to be treated when consumers see DTC prescription drug ads	DTC prescription drug ads encourage over-medication
DTC prescription drug ads help remove the stigma	Healthcare professionals may feel pressured by DTC

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associated with certain diseases and medical conditions	prescription drug ads to prescribe drugs that may not be in the best interest of the patient
DTC prescription drug ads create revenue for drug companies, which can be used for research & development (R&D) to create new life-changing drugs	DTC prescription drug ads weaken relationships between patients and healthcare providers
DTC prescription drug ads should be allowed as protected free speech	DTC prescription drug ads increase healthcare costs
	DTC prescription drug ads are banned in every country but the United States and New Zealand

1. https://prescriptiondrugs.procon.org/history-of-prescription-drug-ads/
2. https://www.cbo.gov/sites/default/files/112th-congress-2011-2012/reports/5-25-prescriptiondrugadvertising.pdf
3. https://prescriptiondrugs.procon.org/
4. https://worldofdtcmarketing.com/majority-of-physicians-believe-dtc-ads-should-be-cut-back/

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:
1974.6 Prescription Price Information and Advertising – this proposed resolution focuses on prescription drug advertising to consumers, not pricing

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PROPOSED RESOLUTION FORM

Region #: 4

Proposing APhA-ASP Chapter: University of Wisconsin-Madison School of Pharmacy

Proposed Resolution Title/Topic: Pay-For-Delay Patent Settlements

Proposed wording *(desired action(s)):*

APhA-ASP supports the Federal Trade Commission in its efforts to pursue legislation prohibiting anticompetitive "pay-for-delay" patent settlements that delay the entry of low-cost generic medications to the market.

Background Statement (list reasons for the action(s) / pros and cons / references or resources):

In 1984, the United States Congress passed the Hatch-Waxman Act, which was designed to lower drug prices and encourage innovation through policies impacting both generic and brand name drug manufacturers. The bill was somewhat successful in accomplishing its goals but had the unintended consequence of allowing what we now call “pay-for-delay” or “reverse payment” deals. The Hatch-Waxman act encouraged generic manufacturers to challenge the active patents of brand name drugs by submitting an Abbreviated New Drug Application and obtaining generic exclusivity for six months if successful. Ideally, this act would encourage generic competition and ensure that the patents filed by brand name manufacturers represent substantial innovation. In this ideal scenario, brand name manufacturers who lose their patent suits would have to reduce the price of their medication in order to compete with the new generic alternative. However, in practice these patent challenges often result instead in pay-for-delay deals. In these deals, the brand name manufacturer pays the generic manufacturer a settlement to drop its patent challenge. The result is that the entry of the generic alternative is delayed, thereby maintaining market exclusivity for the brand name manufacturer.

Pay-for-delay deals are incentivized under the Hatch-Waxman Act because they benefit both the generic and brand name drug manufacturers involved. The brand name manufacturers continue to profit because they maintain market exclusivity and thus the ability to charge higher prices for their medication. It is estimated that the entry of generic drugs saved the United States healthcare system an estimated $1.5 trillion over the ten-year period from 2004-2013,[1] so brand name manufacturers have a monetary incentive to prevent the entry of generic competition. Meanwhile, the generic manufacturers profit from the monetary settlement simply by delaying introduction of their generic alternative to the market. The mutually beneficial nature of pay-for-delay deals has resulted in as many as 142 such deals being made between 2005 and 2013[2].

Although these deals are a win-win for brand name and generic manufacturers, they are made at the expense of the parties who pay for the drugs. The deals force consumers and taxpayers (through Medicare and Medicaid) to continue to pay higher prices for the brand name drugs. U.S. Public Interest Research Group found that the brand name drugs involved in a sample of twenty pay-for-delay deals were about ten times more expensive on average than their generic equivalents.[2] The cumulative impact of these deals is substantial, as a study conducted by the Federal Trade Commission (FTC) estimated that pay-for-delay deals cost taxpayers and consumers $3.5B per year.[3] These costs are substantial in themselves, but may also lead to worse health outcomes among patients who are non-adherent due to the cost of their medications. In one study on medication adherence in adults with chronic conditions, 18% of patients reported at least one episode of medication underuse due to cost in the last year.[4] Legislating an end to pay-for-delay deals could help to alleviate the cost burden on patients and improve their health outcomes.

Not only do these deals hurt consumers and taxpayers through higher drug prices, but they also stifle

innovation within the pharmaceutical industry. As mentioned previously, one of the goals of the Hatch-Waxman Act was to encourage innovation. However, the possibility of pay-for-delay ensures the opposite. If the Hatch-Waxman Act did function as intended, brand name manufacturers would be incentivized to innovate, recognizing that making very small changes to existing drug products could result in a patent challenge and a subsequent loss of market exclusivity. Instead, brand name manufacturers recognize that they can likely maintain market exclusivity even if their patent is challenged through pay-for-delay deals. Pay-for-delay settlements stifle innovation because brand name manufacturers have one less disincentive to invest their resources in low-risk, less innovative products.

In addition to the societal costs incurred by pay-for-delay deals, these deals also violate free market principles and US antitrust law. Because both the brand name and generic manufacturers benefit from these settlements, both manufacturers are often accused of colluding to profit at the expense of the consumers. In the landmark 2013 case of *FTC v. Actavis, Inc.,* the Supreme Court ruled that pay-for-delay deals "tend to have significant adverse effects on competition" and that the FTC has a right to make general antitrust claims against these deals.[5] Although this ruling was a win for the case against pay-for-delay deals, more specific and aggressive legislation is required to prohibit these deals from occurring. Joining the FTC in its efforts to end these deals through legislation will help to accomplish this goal.

References

1. Generic Pharmaceutical Association. Generic pharmaceutical savings reach highest-ever watermark of $239 billion in 2013. http://www.gphaonline.org/gpha-media/press/generic-pharmaceutical-savings-reach-highest-ever-watermark-of-239-billion-in-2013/. Accessed September 26, 2019.

2. United States Public Interest Research Group and Community Catalyst. Top 20 Pay-For-Delay Drugs: How the Drug Industry Payoffs Delay Generics, Inflate Prices and Hurt Consumers. July 2013. https://www.communitycatalyst.org/doc-store/publications/top-20-pay-for-delay-drugs.pdf. Accessed October 10, 2019

3. Federal Trade Commission. Pay-for-delay: how drug company pay-offs cost consumers billions. A Federal Trade Commission staff study. https://www.ftc.gov/reports/pay-delay-how-drug-company-pay-offs-cost-consumers-billions-federal-trade-commission-staff. Accessed September 26, 2019.

4. John D. Piette, Michele Heisler, Todd H. Wagner, "Cost-Related Medication Underuse Among Chronically Ill Adults: the Treatments People Forgo, How Often, and Who Is at Risk", *American Journal of Public Health* 94, no. 10 (October 1, 2004): pp. 1782-1787. Accessed September 26, 2019.

5. *FTC v. Actavis, Inc.*, 133 S. Ct. 2223, 2231 (2013).

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: N/A

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PROPOSED RESOLUTION FORM

Region #: 4

Proposing APhA-ASP Chapter: Wayne State University

Proposed Resolution Title/Topic: Behind the Counter Insulin

Proposed wording *(desired action(s)):*
APhA-ASP supports legislation mandating that all OTC insulin sales require counseling from a pharmacist.

Background Statement (list reasons for the action(s) / pros and cons / references or resources):

The 1951 Durham-Humphrey Amendment to the 1938 Food, Drug, and Cosmetic Act designated that medications requiring administration by injection, or that were of such toxicity that a patient could not self-treat, were made prescription only. Insulin was inexplicably exempted from these laws despite clearly meeting both criteria.[1,2] The insulin available as a behind the counter product is Regular Human Insulin, as opposed to the more stable Analog Insulin that is prescription only. Human Insulin is identical to the insulin produced in the human body however it does not act the same way when administered though subcutaneous injection. Human Insulin has undesirable features, including delayed onset of action, variable absorption, and variable duration of action, which can lead to dangerous peaks and troughs in diabetic patients, especially in those who are switching insulin products due to cost without counseling.[3] There have been several cases of injury and death due to the use of behind the counter insulin products.[4,5] Due to the complexity of diabetes and the health literacy of the population that this product targets socioeconomically, especially recently on social media platforms, counseling by a physician or pharmacist is necessary to assure safe use of this medication. With that said, if patients decide to use these products over prescription only insulin products, then they should be counseled appropriately by the pharmacist overseeing the sale, with regard to the patient's personal circumstances, in order to prevent avoidable medication errors that can be caused by switching to or switching between human and analog insulin products.

1. Pray WS. *A History of Nonprescription Product Regulation*. New York, NY: Haworth Press, Inc; 2003.
2. Behind-the-Counter Products: A Third Class of Drugs. *US Pharm*. 2011;36(9):11-15
3. Human Insulin. *Diabetes Teaching Center at the University of California, San Francisco.* Retrieved from https://dtc.ucsf.edu/types-of-diabetes/type1/treatment-of-type-1-diabetes/medications-and-therapies/type-1-insulin-therapy/types-of-insulin/human-insulin/
4. Bote, J. A man who switched to more affordable insulin died. USA Today, 2019. Retrieved from: https://www.usatoday.com/story/news/nation/2019/08/09/man-dies-otc-insulin/1942908001/
5. Tribble, SJ. You Can Buy Insulin Without A Prescription, But Should You? National Public Radio, 2015. Retrieved from: https://www.npr.org/sections/health-shots/2015/12/14/459047328/you-can-buy-insulin-without-a-prescription-but-should-you

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:
2009-8: Behind the Counter Status of Certain Medications; The proposed resolution does not detract from this resolution in any way. Insulin can cause severe harm in low doses if not used and/or monitored correctly, and therefore should not be available without proper counseling.

Author of Proposed Resolution: **Derek Volgyi**

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Please use only one form for each proposed resolution. Forms must be submitted by the Chapter via email to the APhA-ASP Regional Delegate 4 weeks prior to the start of the Midyear Regional Meeting.

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