APhA-ASP
AMERICAN PHARMACISTS ASSOCIATION
ACADEMY OF STUDENT PHARMACISTS

APhA

Region 8 Midyear Regional Meeting
Las Vegas, NV
October 25-27, 2019

Proposed Resolutions

R8.1

Proposing APhA-ASP Chapter:
California Health Sciences University

Proposed Resolution Title/Topic:
Amendment to APhA-ASP Resolution 2019.2

Proposed wording*:*
APhA-ASP supports the amendment of Resolution 2019.2 to read:

1. APhA-ASP supports state and federal legislation to increase access to opioid reversal agents.
2. APhA-ASP encourages pharmacists and student pharmacists to provide public education about opioid reversal agents, including proper administration in situations of opioid-related drug overdose.
3. APhA-ASP encourages all schools and colleges of pharmacy to incorporate APhA Naloxone Administration, Competency-Based Certificate Training opioid reversal agent training as a requirement prior to completion of the pharmacy program. APhA-ASP recommends this training includes a didactic course, as well as a live, hands-on component, identification of high-risk patients, and recognition of the stigma surrounding opioid use disorder.

Background Statement:
The opioid epidemic continues to make a devastating impact. More than 130 people die every day due to opioid overdose from prescription and illicit opioid use. In 2017, of the 70,000 people who died from drug overdose, a leading cause of injury related death in the United States, 68% involved opioid use. Even when taking opioid medication as prescribed, patients are at risk of accidental overdose. This unpredictability has contributed to the serious national crisis.

The U.S. Surgeon General's office emphasized the importance of naloxone competency in 2018. An advisory of the office states, "Knowing how to use naloxone and keeping it within reach can save a life". Research also shows that overdose deaths decrease in the communities where naloxone and overdose education are available. Pharmacists in across the United States are able to furnish naloxone in various practice settings, and student pharmacists must have the background knowledge and necessary hand-on skills to administer naloxone before graduation.

Currently, naloxone training is available as continued education courses for licensed pharmacists through online video certification trainings. Naloxone administration competency-based trainings have been initiated as pilot programs in some pharmacy school curricula in the United States. Qualitative data from a pilot program conducted at the Ohio State College of Pharmacy suggests that students found naloxone competency based, hands-on training to be beneficial and valuable. Similar pilot programs in California pharmacy schools have received similar feedback as student trainees of naloxone administration "feel more comfortable" with administration.

The APhA immunization certification program has been successful in providing student pharmacists with necessary educational and practical implementation of competency-based skills according to the educational guidelines of the Centers of Disease Control. Similarly, APhA-ASP encourages competency-based certification training in naloxone administration per the US Surgeon General's advisory

Pros

- Competency-based training encompasses skills training and hands-on learning that supplement and enforce didactic instruction
- Students can confidently and accurately educate patients and their caretakers in the proper administration of naloxone
- Implementation could have an exponential impact on mitigating the opioid epidemic by increasing the number of fully-trained professionals
- Training could normalize naloxone administration training as a need and help reduce opioid overdose stigma
- Proactively provides critical training that encourages content mastery
- Competency-based training is not standardized across pharmacy schools, which could imply deficits in students' abilities to provide immediate care in heavier-risk communities
- Current training methods involve video based abstract learning, which are insufficient to provide skills for the actual practice of naloxone delivery
- Potential APhA certification analogous to immunization training certification may be offered

Cons

1. Standardization and cost

References:

1. CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC; 2019. https://wonder.cdc.gov. Accessed October 3, 2019
2. CDC/NCHS, Opioid Overdose. CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC: 2019. https://www.cdc.gov/drugoverdose/index.html. Accessed October 3, 2019
3. Office of the Surgeon General. U.S. Surgeon General's Advisory on Naloxone and Opioid Overdose. Washington D.C. U.S. Department of Health and Human Services. SGO; 2018. https://www.hhs.gov/surgeongeneral/priorities/opioids-and-addiction/naloxone-advisory/index.html. Accessed October 13, 2019
4. Walley AY, Xuan Z, Hackman HH, et al. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. *BMJ (Clinical research ed.).* 2013;346:f174.
5. Maguire MA, Pavlakos RN, Mehta BH, Schmuhl KK, Beatty SJ. .A Naloxone and Harm Reduction Program Across Four Years of a Doctor of Pharmacy Program. Curr Pharm Teach Learn. 2018 Jan - Feb;10(1):72-77. doi: 10.1016/j.cptl.2017.09.007. Epub 2017 Oct 6.
6. Joseph of COP, California Health Sciences University. Role Playing in the Classroom: Pharmacy Students Simulate an Opioid Overdose Situation. CHSU News. 2019 October. https://chsu.edu/role-playing-in-the-classroom-pharmacy-students-simulate-an-opioid-overdose-situation/. Accessed October 13, 2019.

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:

2019.2 Amendment to APhA-ASP Resolution 2015.4 (Increased Access to Opioid Reversal Agents)

Rationale for Proposed Resolution:

The proposed resolution stipulates a competency-based versus standalone training and education that provide only an abstract review of naloxone administration. There should be a measure of the students' competency for the course.

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R8.2

Proposing APhA-ASP Chapter:
California Northstate University, College of Pharmacy

Proposed Resolution Topic:
Opioid Checklist

Proposed wording:
APhA-ASP encourages the use of a standardized "Opioid Checklist" to be completed prior to the first dispensing of an opioid medication.

Background Statement:
From 1999 to 2014, opioid sales in the United States have nearly quadrupled. Additionally, deaths from opioids have also quadrupled since 1999. This substance abuse problem is commonly known as the "Opioid Epidemic". Pharmacists are part of the first line of defense when drafting a plan to combat the opioid epidemic. However, there is no generalized procedure followed by pharmacists when filling opioid medications.

Currently, each pharmacist goes through their unique set of checks when filling opioid prescriptions. This proposal attempts to standardize these checks, while maintaining pharmacist autonomy. Included in the Opioid Checklist are: prescription check (right paper used, signatures, refills, etc…), prescriber check (DEA), Controlled Substance Utilization Review and Evaluation System (CURES) check, diagnosis code documentation, and decision to fill or not (documentation for why a fill was refused). This checklist is to be completed by the pharmacist once per calendar year for each unique opioid medication.

Pros: An opioid checklist standardizes the checks involved when filling opioid prescriptions in a pharmacy. First of all, this ensures that every opioid leaving the pharmacy has legal documentation attached to it. Second of all, it eliminates any guesswork involved when checking an opioid prescription, and replaces that with a standard list. Because of this proposal, the opportunity for conscious and unconscious bias to affect the clinical decisions of a pharmacist is limited.

Cons: With the main goal of combatting the opioid epidemic in mind, we must understand that this proposal will create additional workload for pharmacists. Moreover, some pharmacists may feel that this proposal reduces their autonomy as a provider.

References:
1. Guideline for Prescribing Opioids for Chronic Pain. Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/pdf/pharmacists_brochure-a.pdf. Accessed September 24, 2019.
2. HealthITAnalytics. Pharmacists Play Key Role in Opioid Management. HealthITAnalytics. https://healthitanalytics.com/news/pharmacists-play-key-role-in-opioid-management. Published July 9, 2019. Accessed September 25, 2019.
3. Kulkarni D, Thomas A, Tunnard A. Rx Gatekeeper: Looking at the Opioid Crisis from the Pharmacy Perspective. *The American Health Lawyers Association*. May 2018:22-26. https://www.healthlawyers.org/find-a-

resource/HealthLawHub/Documents/Opioids/May2018_Feature3.pdf. Accessed September 24, 2019.
4. Reynolds V, Causey H, Mckee J, Reinstein V, Muzyk A. The Role of Pharmacists in the Opioid Epidemic. *North Carolina Medical Journal*. 2017;78(3):202-205. doi:10.18043/ncm.78.3.202.

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

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R8.3

Proposing APhA-ASP Chapter:
Chapman University School of Pharmacy

Proposed Resolution Title/Topic:
Advancement of Medication Therapy Management (MTM) Services-Opioids and Pain Management

Proposed wording*:*
APhA-ASP encourages pharmacists and student pharmacists to actively incorporate medication therapy management (MTM) services as routine practice. In addition to the current services offered MTM services should include the management of chronic pain, counseling on proper opioid use, and alternative options for pain management.

Background Statement:
The prevalence of prescription opioid abuse in the United States has increased at an alarming rate over the past 2 decades. Opioids are prescribed for different types of pain including acute and chronic pain. Prescribers should be mindful of how long they are prescribing opioids and at what MME (morphine milligram equivalent) because it does not take long for patients to become addicted to opioids. Upon the prescribing of opioids, doctors and pharmacists should discuss the risk of addiction with patients and how to minimize the risk.

Medication therapy management (MTM) could be used to address pain management. MTM services use a patient-centered approach to improve patient outcomes through collaboration and effective drug therapy. It would serve as a route of communication between patients and their providers, specifically pharmacists. Community pharmacists are accessible healthcare providers and routinely interact with patients. With MTM services, patients gain insight and autonomy over their prescribed medications. MTM leads to "improved patient compliance, better pharmacist-patient relationships, and improved disease state management." Studies show that MTM makes a beneficial economic and health impact. In the case of opioids, it would lead to the appropriate use of opioids and ideally defer patients from abuse and misuse.

With MTM services:

- Pharmacists would identify patients who are starting a new prescription for opioids or are on a pain management regime for chronic pain.
- Pharmacists would recommend alternatives to opioid use such as physical therapy or over the counter options.
- Pharmacists would note OTC and prescribed medications to look for interactions and potential barriers to optimal pain management.
- Pharmacists would monitor and follow up with patients during the course of their treatment.

Pros: Provides support to patients who are using opioids for legitimate pain; provides alternatives for pain management; hopefully decreases opioid abuse and misuse.
Cons: Increased workload for pharmacists; lack of compensation for MTM services.

References:

1. "Community Pharmacists and Medication Therapy Management | CDC | DHDSP." Centers for Disease Control and Prevention, www.cdc.gov/dhdsp/pubs/guides/best-practices/pharmacist-mtm.htm.

2. "Expanding the Pharmacist's Role in Preventing Opioid Abuse: Understanding Abuse-Deterrent Formulations and Identifying Risks." Power-Pak C.E., 2019, www.powerpak.com/course/content/115940.

3. The American Pharmacists Association and the National Association of Chain Drug Stores Foundation. *Medication Therapy Management in Pharmacy Practice: Core Elements of an MTM Service Model Version 2.0,* 2008.

4. "What Pharmacy Students Need to Know about MTM." Pharmacy Times, 2016, www.pharmacytimes.com/publications/career/2016/pharmacycareers_february2016/what-pharmacy-students-need-to-know-about-mtm.

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:
2011.3 Advancement of Medication Therapy Management (MTM) Services

Rationale: This proposal discusses alternatives for pain management when educating about opioids. Additionally, we want to include opioids and pain management to MTM services because pain can be a chronic condition that needs MTM.

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R8.4

Proposing APhA-ASP Chapter:
Keck Graduate Institute

Proposed Resolution Title/Topic:
Pharmacy School Certification for Furnishing Contraceptives

Proposed wording:
APhA-ASP encourages incorporation of comprehensive contraceptive education into pharmacy school curriculum that would enable graduating pharmacists to become certified to furnish contraceptives to patients, in compliance with relevant state laws.

Background Statement:
As of today, thirteen US states permit pharmacists to prescribe birth control; despite this, very few pharmacists offer such services to the public, and few people are aware that such laws even exist. Currently there are contraceptive education classes in place outside of school for pharmacists to become certified in prescribing birth control. While curriculum in pharmacy schools have evolved to include education on prescribing birth control in accordance with certain state laws, a formal certification process completed before graduation may enable students to more adequately and confidently offer such services to the public upon graduation.

One limitation is lack of reimbursement for such services—though that is looking to improve as states like California have started to reimburse under MediCal for counseling fees charged by pharmacists.

Resources:

https://www.calhealthreport.org/2019/02/15/pharmacists-can-now-prescribe-birth-control-but-few-do-%EF%BB%BF/

https://www.pharmacist.com/increasing-access-hormonal-contraceptive-products

https://oregon-state.catalog.instructure.com/browse/all/pharmacy/pharmacist-continuing-ed/courses/ca-2019

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

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R8.5

Proposing APhA-ASP Chapter:
Loma Linda University, School of Pharmacy

Proposed Resolution Title/Topic:
Insulin Pricing Crisis

Proposed wording*:*
APhA-ASP encourages legislators to end the insulin pricing crisis by limiting the insulin price increase from pharmaceutical companies and capping the copay of prescription insulin at $100 for a 30-day supply.

Background Statement:
According to the National Diabetes Statistics Report from the Centers for Disease Control [(1)] and Prevention (CDC), there are more than 30 million Americans living with diabetes. The lives of these patients are determined by the many types of insulin that they use throughout the day. Most patients are dependent on more than one type of insulin to keep their glucose level optimal at different times of the day. Unfortunately, accessibility and affordability of insulin in the United States have become increasing problematic in the past decades, as the price of insulin continues to skyrocket. In 1996, the price of 1-month supply of Humalog was $21, it rose to $35 in 2001, to $234 in 2015, and currently, one vial costs $275. This is an increase of over 1,200% from its original price [(2)]. Contrarily, the cost of production for a vial of biosimilar insulin is only $3.69 to $6.16[(3)]. The Health Care Cost Institute [(4)] reported that patients with diabetes spend approximately $18,494 a year and more than 30% of that ($5,705) is from expenditure on insulin.

As health care professionals, patient's health is our first priority. When drug companies capitalize on our patient's heavy necessity of insulin, it is time for action and for changes to happen. Worrying about the cost of their medications should be the least of these patients' concerns. If there is no regulation in these insulin prices from pharmaceutical companies, there will continue to be hindrance in providing optimal management for patients with diabetes. For example, the contracts between insurance and pharmaceutical companies can sometimes change, which forces patients to switch to a different insulin, and not every patient can use the insulin that is covered or afford the pocket-cost of the one that they have been using. This leads to serious medical complications that are completely preventable.

In May of 2019, Colorado has been the first state to pass a legislation in putting a $100 cap on the price of monthly insulin. This cap is regardless of the type of insulin, and any amount over $100 would be pushed onto insurance companies [(5)]. Although this might not be the best solution to the insulin pricing crisis, anything that can be done to ease the burden of insulin cost for our patients is a good starting point for action. There needs to be stronger support in creating legislations that prevent drug companies from pricing insulin over a reasonable percentage of production cost. The process that are used to determine the prices of insulin should be transparent to consumers as well as under federal regulations.

Pros:
1) Reduce the burden of cost for patients with diabetes
2) Better manage patient's health

3) Decrease preventable complications and mortality from patients not having insulin

Cons:

1) Shifting cost to insurance might increase premium or shift cost elsewhere

References:

1. Estimates of Diabetes and Its Burden in the United States. *National Diabetes Statistics Report* 2017 https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf
2. Roberts, D., The Deadly Costs of Insulin. *American Journal of Managed Care* June 10, 2019 https://www.ajmc.com/contributor/danielle-roberts/2019/06/the-deadly-costs-of-insulin
3. Gotham, D., Barber M., Hill, A., Production costs and potential prices for biosimilars of human insulin and insulin analogues. *BMJ Global Health* 2018; 3(5) http://dx.doi.org/10.1136/bmjgh-2018-000850
4. Biniek, J., Johnson, W., Spending on Individuals with Type 1 Diabetes and Role of Rapidly Increasing Insulin Prices *Health Care Cost Institute* January 2019 https://www.healthcostinstitute.org/research/publications/entry/spending-on-individuals-with-type-1-diabetes-and-the-role-of-rapidly-increasing-insulin-prices
5. Colorado House Bill 19-1216 https://leg.colorado.gov/sites/default/files/2019a_1216_signed.pdf

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

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R8.6

Proposing APhA-ASP Chapter:
Midwestern University - Glendale

Proposed Resolution Title/Topic:
Require clinical indication (diagnosis or therapeutic objective) be on all prescription orders and that at the patient's discretion, indication(s) be placed on the pharmacy dispensing label.

Proposed wording:
APhA-ASP encourages the passage of state and federal legislation mandating clinical indication(s) or equivalents, such as a diagnosis or therapeutic objective, be required on all prescription orders and provide patients with the option to have this information included on their pharmacy dispensing labels to enhance patient understanding of, and adherence to, their medications and improve pharmacists' ability to make more informed clinical decisions.

Background Statement:
From the pharmacist perspective, requiring the indication on the prescription order will help determine the counseling points that are necessary and pertinent to provide to the patient, as medications may be prescribed for approved and off-label uses. In addition, knowing the indication for use, is helpful to determine if the medication is complimentary to the current medications the patient is taking. As prescriber visits can be stressful for patients, they may not remember what the prescriber told them regarding the purpose of the medication. Pharmacists are legally obligated to assess the safety and appropriateness of prescribed medication therapy, unfortunately, some do not have the opportunity to have immediate access to pertinent clinical information that may be essential in proper medication therapy management.[1] Research has supported that providing pharmacists with access to the clinical indication improves the quality of pharmacists clinical decisions and is more time efficient by preventing unnecessary prescriber contacts to clarify orders.[2] It is necessary for a pharmacist to know and understand the therapeutic objective to advise the patient appropriately. To bypass confusion and frustration, this is a simple fix.

From the patient perspective, the option to include an indication on prescription labels will increase adherence and understanding of their medication(s) and medical condition(s). Patients, especially those on multiple medications, may get confused as to which of their medications are for treating which medical condition. This is true for patients with low health literacy and the growing elderly population, who have a higher incident rate of dementia. Although patients are given consumer medication information each time they pick up a new or refill prescription, many are overwhelmed by the font size, layout, and level of information and thus do not read or if they do read, may not understand the information. Providing the medical condition, including an off-label use, on the prescription dispensing label, will ensure patients know what the medication is for in a straightforward and concise manner. This small improvement will help to increase adherence, and positively impact the patient's knowledge of their medication and knowledge of their disease.[3,4]

Possible opposition to requiring the diagnosis code be on the prescription order, is patient and possible HIPAA violation as diagnosis or diagnosis code is considered protected health information (PHI) under HIPAA[5] Though, as prescribers transition to e-prescribing, this becomes less of an issue than their addition to paper prescription orders. The addition of the diagnosis to the pharmacy dispensing label

would not violate privacy laws, as patients would be required to give permission to include it on the label.

Implementing the addition of the diagnosis code to the pharmacy dispensing label can easily be done by including the information as part of the "directions for use" to the patient for any community-based pharmacy. For example, the directions for use for a prescription order written for a calcium channel blocker could read as "Take one tablet by mouth daily for hypertension (high blood pressure)". This addition is simple, efficient, and would take little to no extra computer programming or staff effort.

1. Rupp MT. "The Pharmacist's Role in Off-label Prescribing" *Arch Intern Med*, April 12, 2010;170:652. Warholak-Juarez T, Rupp MT, Salazar T and Foster S. "The Effect of Patient Information on the Quality of Pharmacists' Drug Use Review Decisions" J Am Pharm Assoc 2000;40:500-8.

2. Warholak TL, Rupp MT, Leal S, et al. "Assessing the effect of providing a pharmacist with patient diagnosis on electronic prescription orders" Research in Soc & Admin Pharm 2014;10:246-51.

3. Kron K, Myers S, Volk L, et al. Incorporating medication indications into the prescribing process. *American Journal of Health-System Pharmacy*. 2018;75(11):774-783. doi:10.2146/ajhp170346.

4. Garada M, McLachlan AJ, Schiff GD, Lehnbom EC. What do Australian consumers, pharmacists and prescribers think about documenting indications on prescriptions and dispensed medicines labels?: A qualitative study. *BMC Health Services Research*. 2017;17:1-8. doi:10.1186/s12913-017-2704-3.

5. Schiff G, Mirica MM, Dhavle AA, Galanter WL, Lambert B, Wright A. A Prescription For Enhancing Electronic Prescribing Safety. *Health Affairs*. 2018;37(11):1877-1883. doi:10.1377/hlthaff.2018.0725.

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:
1997.9 - Inclusion of Disease State/Intended Use on Prescriptions
APhA-ASP shall support a position of prescription reform to include the indication for use/disease state of the prescribed medication, possibly in coded format (e.g., ICD-9 format), on all prescriptions in order to allow the pharmacist or student pharmacist to provide more effective patient care.

Rationale: Although this resolution addresses the addition of an indication to prescriptions, it does not discuss adding the indication to the dispensing labels. This is a prospective supplement that needs to be looked further into.

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R8.7

Proposing APhA-ASP Chapter:
Regis University

Proposed Resolution Title/Topic:
Certified Pharmacy Technician Status regarding theft, diversion, and substance abuse.

Proposed wording*:*

1. APhA-ASP encourages Pharmacists and Human Resource Departments to hold their technicians to the standards expected of the profession as outlined in the national certification exam and report infractions of theft, diversion, and substance abuse to the State Board.
2. APhA-ASP supports the inclusion of technicians in the rehabilitation and counseling programs available to Pharmacists addressing work-place abuse of drugs and alcohol.

Background Statement:

The majority of chain community pharmacies have a human resources department to handle disciplinary action for terminable offenses like diversion, theft, and use of illicit substances. When property has been recovered, criminal charges are infrequently filed, and incidents are not reported to the State Board, particularly when that technician is still completing a probationary period. A terminated technician is able to gain new employment with another organization or at another branch of the same organization. We have a system in place to prevent these incidents from being overlooked. It is to everyone's advantage to utilize that system and report all infractions to the State Board regardless of the human resources penalty imposed.

Additionally, both student Pharmacists and practicing Pharmacists have access to behavioral counseling and rehabilitation services for substance abuse. The position of Technician can be stressful and subject to the same exposures as Pharmacists. State Boards, as well as national organizations like APhA, should support anybody in the pharmaceutical profession seeking treatment for drug or alcohol addiction.

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

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R8.8

Proposing APhA-ASP Chapter:
Roseman University of Health Sciences College of Pharmacy

Proposed Resolution Title/Topic:
Addressing Barriers to Research of Schedule I Drugs

Proposed wording*:*
APhA-ASP supports the lowering of regulatory and other barriers of Schedule I drugs, such as marijuana, methylenedioxymethamphetamine (MDMA), lysergic acid diethylamide (LSD), and psilocybin, in order for more medical research to be conducted that explores the use of these drugs and their possible therapeutic potentials.

Background Statement:
Social as well as ethical attitudes have been in place in our society for many years that have limited the advancement of research on Schedule I drugs. Many of these substances are deemed as having no currently accepted medical use which creates doubt in the minds of researches, institutional review boards, funding and other regulatory agencies. Along with inability to access these agents, these additional concerns deter the undertaking of studies on the effectiveness and therapeutic properties of Schedule I agents. Because of this, the potential of marijuana, methylenedioxymethamphetamine (MDMA), lysergic acid diethylamide (LSD), and psilocybin (magic mushrooms) as therapeutic agents has been completely undervalued and understudied.

Europe and the United Kingdom have been evaluating the efficacy of Schedule I substances such as marijuana, cocaine, and ketamine and have found that they do have considerable therapeutic protentional in many chronic disease states such as pain, epilepsy, depression and mental illnesses. Additionally, systematic reviews of psychedelics, including psilocybin and LSD, have shown that these agents reduce symptoms of anxiety and depression and are generally well-tolerated with no severe adverse effects. Clinical trials, however, are sparse and studies are limited because of the negativity surrounding these substances.

In order to better understand these agents and to help patients who are unresponsive to traditional therapies, more research must be conducted on certain Schedule I drugs. Reform is needed within the FDA and DEA so that research on these substances will be less restricted and more feasible for investigators to undertake. If access to these agents becomes easier for researchers, the knowledge provided by these studies will help medical professionals to better treat their patients.

Pros:
Lowering barriers to conducting research on Schedule I drugs will allow the potential therapeutic properties of these treatments to be determined. If the safety and efficacy of these drugs are found, not only will it allow new therapies to be used for certain disease states, it will incorporate a new attitude towards the war on drugs, addiction, and other stereotypes surrounding these agents. The information gained from studying such drugs can reduce cost burdens in health care by promoting the appropriate prescription of effective treatments, reduce inappropriate drug use, and reduce societal consequences associated with Schedule I drugs.

Cons:
Social and ethical issues regarding the use of Schedule I drugs as therapeutics can possibly infect studies with bias. It will be a challenge to conduct clinical trials that eliminate preconceptions and prejudices surrounding Schedule I agents.

References:
1) Andreae MH, Rhodes E, Bourgoise T, et al. An ethical exploration of barriers to research on controlled drugs. *Am J Bioeth*. 2016; 16(4):36-47. doi: 10.1080/15265161.2016.1145282.
2) Muttoni S, Ardissano M, John C. Classical psychedelics for the treatment of depression and anxiety: a systematic review. *N Engl J Med*. 2019; 258:11-14. doi: 10.1016/j.jad.2019.07.076.

3) Begola MJ, Schillerstrom JE. Hallucinogens and their therapeutic use: a literature review. *J Psychiatr Pract*. 2019. 25(5):334-346. doi: 10.1097/PRA.0000000000000409.

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

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R8.9

Proposing APhA-ASP Chapter:
Touro University California

Proposed Resolution Title/Topic:
Student Pharmacist Training in Proper Inhaler Technique(s)

Proposed wording*:*
APhA-ASP supports the requirement for student pharmacists to complete proper inhaler technique training prior to graduating pharmacy school. Such hands-on training must include, but is not limited to, identifying at-risk patient populations, relaying clinical pearls associated with each inhaler type, and properly recognizing and demonstrating the correct technique for a particular inhaler type to patients.

Background Statement:
One of the biggest challenges with patients, such as those who suffer from COPD and asthma, is being able to control their potential exacerbations by maintaining proper inhaler techniques. With such a wide variety of inhaler types, including metered-dose inhalers (MDIs), dry powder inhalers (DPIs), and soft-mist inhalers (SMIs), health care providers usually will demonstrate and explain how to properly use such pulmonary devices but fail to follow-up with their patients at later appointments to make sure they are still continuing to use a particular inhaler in the proper way.

Currently, pharmacy schools are not required but highly encouraged to hold some type of interactive, hands-on training to demonstrate to student pharmacists how to properly identify inhaler types, provide proper pharmacist-provided education on these inhaler types, and be able to demonstrate the proper technique associated with that inhaler type and ask of their patients to show them what they had just learned. Studies have shown that teaching this to students before pharmacy school is complete allows them to be better future health care providers by not only providing pharmacist education on inhaler techniques to patients but also making sure that every time an inhaler is dispensed or a patient comes into a clinic, that they are continually mastering and maintaining such proper inhaler technique.

Requiring student pharmacists to complete training on all types of inhaler for certain indications, not only will provide them with better comprehension on the inhalers and their importance, but better patient outcomes for those who require these life-saving pulmonary devices by following up with patients post-initial inhaler technique education.

Pros: If pharmacy students are required to complete this training prior to graduation, this could potentially help patients prevent future exacerbations or begin a step-down approach to their therapy as they are better able to maintain their proper inhaler technique. This training could also allow the student pharmacists to identify at-risk patients, who may need a different inhaler type since they are not able to master a certain inhaler technique.
Cons: This requirement may be too broad for pharmacy schools as it allows a lot of leeway as to what information must be provided and discussed in these interactive, hands-on training sessions. A set list of requirements might be needed to make sure there is uniformity in its education amongst pharmacy schools across the nation.

References:

1. Al-Jahdali, H., Ahmed, A., Al-Harbi, A., Khan, M., Baharoon, S., Bin Salih, S., Halwani, R., & Al-Muhsen, S. (2013). Improper inhaler technique is associated with poor asthma control and frequent emergency department visits. *Allergy, Asthma, & Clinical Immunology 9, Article 8*. doi: 10.1186/1710-1492-9-8.
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Are there any adopted resolutions currently on the books related to this Proposed Resolution? No

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R8.10

Proposing APhA-ASP Chapter:
University of Arizona

Proposed Resolution Title/Topic:
Reimbursing Pharmacists in Collaborative Practice

Proposed wording:
APhA-ASP encourages reimbursement to pharmacists that can be made from providing services in the ambulatory care setting.

Background Statement:
The issue of pharmacists being recognized as healthcare providers has been at the forefront of legislature as far back as 1995 when only nine states allowed pharmacists to immunize. Since then, the profession has grown immensely and slowly allowed pharmacists to take over certain roles that were traditionally occupied by physicians under collaborative agreements. Collaborative practice allows team-based care where a physician can delegate certain duties to a licensed pharmacist for efficient health care.[1] The problem is, since pharmacists have yet to gain health care provider status, they cannot individually bill payers in state and federal programs.[2] States like Texas have already passed legislation that recognizes all pharmacists in team-based care with collaborative practice clarification and that allow for payment for services as well as recognition of pharmacists as a healthcare practitioners.[1] Under the new legislation in Texas, pharmacists may now be part of provider networks and be reimbursed for pharmacist-provided services that are within the pharmacist's scope of practice. Pharmacists will be reimbursed for medication management, administering CLIA-waived tests like those for flu, cholesterol, and blood glucose testing; chronic disease management, like diabetes self-management; and other patient education programs.[1] Given that one of the largest states in the US was able to recognize pharmacists for their critical role in promoting community health, it is essential that we follow in their footsteps to allow pharmacists to practice at the full extent of their education and to better the public health of our communities.

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2. https://www.pharmacytoday.org/article/S1042-0991(17)30973-8/fulltext

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

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R8.11

Proposing APhA-ASP Chapter:
University of Colorado – Skaggs School of Pharmacy and Pharmaceutical Sciences

Proposed Resolution Title/Topic:
Opioid Stewardship

Proposed wording*:*

1. APhA-ASP encourages hospitals, other health systems, and community pharmacies to implement and optimize opioid stewardship programs according to current guidelines.

2. APhA-ASP encourages pharmacists and student pharmacists to take an active role in the implementation and continuation of opioid stewardship practices, including, but not limited to, prospective audits, formulary restrictions, dose optimization, and education to minimize prescription drug abuse and improve clinical outcomes.

Background Statement:
Opioid Stewardship Programs (OSP) provide structured efforts to diminish the number of patients who experience or are at risk of developing opioid use disorder (OUD), with potential to decrease opioid-related deaths and protect human health. Pharmacists and student pharmacists are imperative members of the healthcare team, alongside physicians and nurses, who can aid in implementation of OSPs.

Currently, OSPs are modeled after antimicrobial stewardship practices to address prescribing, treatment of OUD, information technology (IT) tools, and education for patients and providers. Many health systems have individuals working on opioid-related projects that may be beneficial to enacting OSPs at their institutions. Fairview Health Services have placed their pharmacists in important roles to mitigate the risk of diversion, overdose, and medication abuse.

Patient-centered care should remain the priority throughout implementation of OSPs. Improving the quality of pain management should be optimized through OSPs and include consultation services and consideration of current therapy plans. OSPs can have an immensely positive impact should they be implemented during this time of the US opioid epidemic.

Pros:
OSPs have potential to successfully reduce opioid prescribing and the number of individuals who become addicted. Reduction in opioid reliance will be beneficial in minimizing OUD, opioid-related overdoses, and supporting human health.
Cons:
Implementation and maintenance of OSPs may be costly for institutions needing to hire or promote individuals to fill roles as part of an organization-wide OSP. Funding for these positions may be an obstacle for organizations.

References:
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Are there any adopted resolutions currently on the books related to this Proposed Resolution? No

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R8.12

Proposing APhA-ASP Chapter:
The Daniel K. Inouye College of Pharmacy - University of Hawaii at Hilo

Proposed Resolution Title/Topic:
Influenza Testing, Assessment, and Prescriptive Authority for Antiviral Flu Treatment

Proposed wording:
APhA-ASP recommends granting pharmacists the prescriptive authority to administer and assess nasopharyngeal swabs for influenza along with the capability to prescribe oseltamivir (Tamiflu) or zanamivir (Relenza) if test results are positive.

Background Statement:
Influenza is a respiratory infection caused by influenza viruses, primarily infecting the nose, throat, and lungs. It is highly contagious and ranges in severity, from mild to severe and is potentially life-threatening, especially among the elderly and immunocompromised individuals. According to a 2018 study done by the Centers for Disease Control and Prevention (CDC), which observed symptomatic influenza incidences in the U.S. in 2010-2016, approximately 8% of the U.S. population is infected by the flu each season. [4] Although influenza vaccinations are readily available for patients, seasonal epidemics occur every year due to antigenic variation of the virus.

Rapid influenza diagnostic tests (RIDTs) are commonly used in the U.S. to identify and diagnose the influenza virus in symptomatic patients because of its low cost, ease of use, and rapid results. [3] The tests cost approximately $15 to $22 per test and provide results that can be read visually within 10-15 minutes without additional equipment. RIDTs have been noted to have high specificity and low sensitivity, where negative RIDT tests must be carefully interpreted due to false negative results, which may be common when influenza activity is high. [1] However, when used in combination with an analyzer, sensitivity and accuracy can be increased. The analyzer would standardize result interpretation in contrast to visual assessments made by the human eye, reducing human error. [9] Difficulty may arise as the patient's specimen must be collected 24-72 hours after the start of symptoms. Nasopharyngeal specimens that is collected less than 1 day or more than 4 days can alter sensitivity results.

APhA-ASP would like to advocate towards providing pharmacists prescriptive authority to administer and assess nasopharyngeal swabs for influenza along with the capability to prescribe oseltamivir (Tamiflu) or zanamivir (Relenza) for positive test results. Pharmacists are considered one of the most accessible and trusted healthcare professionals, allowing more direct access to care without requiring scheduled appointments, reducing delays in patient treatment, and providing travel convenience for the patient as well. The use of RIDTs in pharmacies would aid in ensuring proper influenza diagnosis, further lowering inappropriate antibiotic use and increasing antiviral prescriptions. [1, 2] According to the Clinical Practice Guidelines by the Infectious Diseases Society of America: 2018 Update on Diagnosis, Treatment, Chemoprophylaxis, and Institutional Outbreak Management of Seasonal Influenza, patients who have confirmed influenza should be given either oral oseltamivir 75mg twice daily for 5 days or zanamivir 10mg two inhalations twice daily for 5 days, both of which have activity against influenza viral types A and B. Longer duration of treatment may be considered in patients who are severely ill and immunocompromised. [6, 10]

Currently, there are approximately 15 states (including Idaho, Minnesota, Mississippi, and others) who have successfully passed legislations to allow pharmacists to administer and assess RIDTs, as well as prescribe appropriate medication for seasonal influenza. Enabling pharmacists to provide these tests will reduce the burden on other medical providers and nurses, decreasing the possible wait times in facilities, such as urgent care or the emergency room, freeing up capacity for patients who may need immediate medical attention in cases of stroke or and acute myocardial infarction (MI). By increasing the accessibility to influenza testing, the spread of the virus in the community would ultimately be reduced.

Are there any adopted resolutions currently on the books related to this Proposed Resolution? Yes
2015.3 - Point of Care Testing → We would like to give pharmacists the capability to prescribe olsetamavir (Tamiflu) or zanamivir (Relenza) for positive test results

References:
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R8.13

Proposing APhA-ASP Chapter:
University of New Mexico

Proposed Resolution Title/Topic:
Pharmacy Staffing Shortages in Retail Pharmacies

Proposed wording:
APhA-ASP recommends retail pharmacies' number of scheduled hours assigned be based not only on product-based reimbursement (i.e. workflow and dispensing) but to include number of clinical encounters performed and their outcomes. Clinical encounters include but are not limited to MTM, CMM, and Medication Synchronization.

Background Statement:
As we move into the future of pharmacy, the retail pharmacy experience is changing. It is more than just filling prescriptions. Pharmacy is moving in a more clinical direction and this resolution would supply more incentive for clinical outcomes in the retail setting. It would motivate technicians, interns and pharmacists to become properly trained in these fields in order to help keep the numbers of hours high.

"Product-based reimbursement (for example, payment for drug products and the act of dispensing the drug products) drive current payment policies for pharmacy services rather than the direct-care services that pharmacists provide patients." (F.Isasi and E. Krofah 8.) This stems from pharmacists not being recognized as providers under Medicare Part B. This means we are unable to directly bill for these services. Approximately 9 states, New Mexico included, are able to bill Medicaid for these services as of 2014, but most of the services are more preventative than the treatment of chronic disease. Insurance companies would be more likely to pay for these services if they bring in profit from them like they do from product based reimbursement.

In 2012 in Ohio, CareSource Medicaid joined an MTM program for eligible patients and it showed that "pharmacists provided 106,239 MTM services, and CareSource reported a $4.40-to-$1 return on investment (ROI) for total health care expenditures." (F.Isasi and E. Krofah 7.) If pharmacists are more involved in chronic disease management, patients are less likely to be at risk for adverse events, which lowers the number of re-admissions to hospitals. "pharmacists participating in multidisciplinary teams shows that more intensive and direct care of chronically ill patients by pharmacists reduces preventable adverse drug events and prescribing errors and reduces costs" (F.Isasi and E. Krofa 5.)

"Approximately 70% of the pharmacists practicing in an outpatient setting at the national level agreed that lack of sufficient compensation to cover costs was a barrier to providing MTM." A 2011 study shows that pharmacists on average are willing to be compensated approximately $1.44/ minute or $86.4/h for clinical services. (Wang 390.) This price included factors such as new or returning patient, number of chronic diseases, number of prescription medications and duration of services. The study stated that the compensation would have to be higher for patients with multiple chronic diseases because these patients are likely to be on more medications.

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Isasi, Fredrick, and Esther Krofah. "The Expanding Role of Pharmacists in a Transformed Health Care System." *National Governors Association Center for Best Practices*, 13 Jan. 2015, pp. 1–14

- Wang, Junling, et al. "Pharmacists' Acceptable Levels of Compensation for MTM Services: A Conjoint Analysis." *Research in Social and Administrative Pharmacy*, vol. 7, no. 4, 2011, pp. 383–395., doi:10.1016/j.sapharm.2010.09.003. https://www.ncbi.nlm.nih.gov/pubmed/21272533
- https://www.pharmacist.com/sites/default/files/files/mtm_billing_tips.pdf

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

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R8.14

Proposing APhA-ASP Chapter:
University of California, San Diego Skaggs School of Pharmacy and Pharmaceutical Sciences

Proposed Resolution Title/Topic:
3rd Party Websites Can Reduce Medication Costs and Improve Adherence

Proposed wording:
APhA-ASP encourages Intern Pharmacists in all settings to educate patients about available resources to reduce medication costs for patients.

Background Statement:
The rising cost of medications is one of the most concerning issues in healthcare. One consequence of unaffordable medications is that patients may become non-adherent to their medications (not taking them or taking less to make them last longer). This can lead to preventable deaths and avoidable healthcare expenses due to inadequate therapeutic outcomes, thus affecting the entire health-system [1].

Within the health-system, the high cost of medications is a concern for pharmacy management. Patients who are seen in clinics then present to pharmacies, unable to afford their medications. Consequently, patients stop or decrease their therapy and may end up hospitalized due to various life-threatening emergencies, specifically when diagnosed with chronic diseases such as diabetes and hypertension. An alarming 61% of Americans are struggling to find ways to reduce the costs of their prescription medications, while 43% will not fill their prescription medications due to lack of information [2]. In addition to counseling patients and ensuring safe and effective outcomes, pharmacists are now concerned with finding affordable alternatives. Educating our pharmacy staff and patients about available resources should become our priority to eliminate future complications.

The goal is to encourage the use of third-party websites by pharmacists and physicians which will improve adherence, save money by utilizing discounted drugs, and save time for pharmacists and patients. As a student pharmacists, we can ensure that patients and pharmacy staff in San Diego know of third-party websites by creating posters and reference sheets in various languages. We can also provide our student organizations with these posters to be used at all patient-related events and post them at, for instance, UC San Diego's Student Run Free Clinic locations. In addition, we can create educational step-by-step videos on YouTube in English, Arabic, and Spanish, to teach patients how to use these third-party websites.

The rising cost of medications is an issue distracting pharmacists from focusing on providing our patients the best care they deserve. In concordance with the PBM Anti 'Gag Clauses' law that was signed, if pharmacists, interns, and technicians have the right tools available this issue could be resolved.

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3. "APhA Applauds Laws Prohibiting PBM 'Gag Clauses'." *Home*, 10 Oct. 2018, https://www.pharmacist.com/press-release/apha-applauds-laws-prohibiting-pbm-gag-clauses?fbclid=IwAR0rQqajku2lqF2yxceY57llMr1e27igRmhLH49_Jw2HeoDrJWhsdKIt9kE&is_sso_called=1.

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

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R8.15

Proposing APhA-ASP Chapter:
University of California, San Francisco

Proposed Resolution Title/Topic:
Incentives in medically underserved areas

Proposed wording*:*
APhA-ASP supports incentive programs that encourage advanced practice pharmacy experiences and post-graduate training programs in medically-underserved areas.

Background Statement:
Pharmacists are an integral part of delivering health services to medically underserved communities in the United States of America. In many underserved locations, local pharmacist act as an accessible and affordable medical resource.

In many rural areas that have fewer available resources, the local pharmacist offers a much needed source of clinical expertise. This is also true in impoverished urban areas. There is a current lack of all healthcare professionals in rural settings, and patients have a more difficult time accessing healthcare. Patients in medically-underserved areas have a higher rate of death in comparison to their urban counterparts.[1] Not only are people who live in rural locations more likely to die prematurely from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke compared to those who live in an urban setting , they also experience a shortage of healthcare providers.[2]

According to data from the National Council for Prescription Drug Programs (NCPDP) Pharmacy Database, from 2003 to 2018, 16.1% of independently owned rural pharmacies in the United States closed and 630 rural communities that had at least one retail pharmacy in March 2003 had no retail pharmacy in March 2018.[3] While nearly 20% of Americans live in rural areas, only 12% of pharmacist practice in rural locations.[4] Within several states, Critical Access Hospitals (CAHs) cannot employ a full-time pharmacist due to the low volume of patients. This causes may pharmacist to be limited within their scope of practice and unable to sit on key hospital committees that address medication issues.[5] In order to improve access to care in rural and underserved communities, it is important to support programs that train and/or incentivize student pharmacists and pharmacy residents to work in these areas.

An example of a program that encourages student pharmacists to work in rural areas is at UNC Eshelman School of Pharmacy. UNC has created a program that recruits students from rural areas and prepares these students to practice in these rural communities. The program includes education about rural communities, five pharmacy practice experiences in rural settings, a health project, etc.[6] The program aims to pipeline pharmacy students into these rural areas due to a shortage of healthcare access and worsening health disparities.[6] This program will have its first graduates in 2019, and data will be published regarding the outcomes of this program after five years of students' graduation.

Other health professionals have demonstrated a positive correlation of rural rotation sites and careers in rural areas post-graduation. Medical residency programs that required at least one rotation site in a rural area demonstrated an increase of medical doctors working in rural communities after residency.[7] In addition, a study done at West Virginia University concluded that dental students who completed a

rotation in a rural site could possibly increase a student's likelihood to practice in a rural area.[8] Furthermore, student pharmacists from New Zealand who have practiced in rural areas have reported increased awareness and changed preconceptions of rural practice settings.[9]

Prior studies have been conducted to observe the potential impact of expanding medical programs to include rural courses and experiential rotations on increasing the population of physicians to practice in rural locations as well. In a systematic review it was found that financial incentives and special training programs, combined with personal characteristics could help support more medical students to practice in rural locations.[10] Studies have also shown that financial aid along with rural practice programs and professional opportunities are the main factors for healthcare professionals to work in rural areas.[7]

Although there is no one way to solve the issue of health disparities and shortages of healthcare providers in rural locations, it is important to invest in programs and students who choose to help fill this important gap within the healthcare system. As more pharmacy programs integrate rural health education and as more programs for loan repayment emerge, there is potential for the profession of pharmacy to grow within rural areas.

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10. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5007145/pdf/nihms-769096.pdf

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

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R8.16

Proposing APhA-ASP Chapter:
University of the Pacific

Proposed Resolution Title/Topic:
Medicare MTM Eligibility Criteria

Proposed wording*:*
APhA-ASP supports inclusive Medicare MTM enrollment criteria that is optimized to improve patient safety.

Background Statement:
Current Centers for Medicare and Medicaid Services (CMS) guidelines for 2020 state that a patient must take between 2-8 prescriptions, have 2-3 chronic conditions, and be likely to accumulate medication costs of at least $4,255 in 2020 to qualify for Medication Therapy Management (MTM) services.[1] Due to financial costs, most Part D insurance plans choose to require the maximum of 8 Part D prescriptions and 3 chronic conditions for patients to be eligible for their MTM services. In 2015, however, only 12.5% of Medicare beneficiaries qualified for this service.[2] A study done by the University of the Pacific found that many patients that did not meet the CMS eligibility requirements, and thus would not be able to receive free MTM services, had at least one drug related problem (DRP).[2] In 2017, the estimated hospitalization costs related to DRPs was $2 million in the United States.[3] MTM services are effective at reducing health care costs and improving patient quality of life.[2, 4] Making Medicare MTM enrollment criteria more inclusive to patients by lowering the required number of Part D prescriptions, lowering the number of chronic disease states, and lowering the minimum Part D drug cost requirement can make MTM services more accessible and improve patient safety.

1. https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Memo-Contract-Year-2020-Medication-Therapy-Management-MTM-Program-Submission-v-041019-.pdf
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Are there any adopted resolutions currently on the books related to this Proposed Resolution? No

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R8.17

Proposing APhA-ASP Chapter: University of Southern California

Proposed Resolution Title/Topic: Mail order and online pharmacies

Proposed wording:
APhA-ASP encourages legislation that would require patients to receive pharmacist-provided medication therapy management (MTM) services for mail order and online pharmacies unless patients actively opt out as part of the counseling process.

Background Statement:
With the speed at which technology has changed the landscape of healthcare, patients are often posed with variety of options by which they can purchase their prescription medications. Recognizing a potential consumer market, businesses such as Amazon and Express Scripts now allow patients to receive their medications without ever having to leave their homes. Mail order and online pharmacies advertise themselves to be a convenient and cost effective alternative to traditional brick-and-mortar pharmacies. Despite the increased number of regulations, there are still many scenarios where patients may be harmed due to lack of proper adherence education and follow up. While the most thorough of the mail order/ online pharmacy companies provide consultation services, patients are often left to navigate through a myriad of online tabs to finally land upon the correct web page to request these educational services. In the same way that there is a recognized need for patient counseling for every new prescription, it is important to provide checkpoints for patient education. Every time a patient picks up their medications in person, there is an opportunity for the pharmacist to re-evaluate and answer and questions a patient may have. However, if the patient simply orders automatic refills to be sent to their house, the patient may never address any potential miscommunications thus affecting proper adherence.

Pros:
- Increased patient awareness of medication adherence
- Minimizes long term healthcare costs per individual, especially those with chronic diseases
    - Potentially reducing the number of hospital visits (ER, Urgent Care, etc.)
- Patients become more familiar with asking their local community pharmacist for clarification

Cons:
- Not all patients will want to participate
- Most companies will not want to incorporate a new section for MTM services in their budget
- Many MTM services provided by pharmacists are currently not reimbursed
    - Companies may take advantage of this and this may become yet another service that becomes expected of pharmacists but not properly reimbursed for

References:

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

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R8.18

Proposing APhA-ASP Chapter:
West Coast University

Proposed Resolution Title/Topic:
Ban on the advertisement of electronic cigarettes and related products

Proposed wording*:*
APhA-ASP supports the regulation on the ban on advertising of tobacco products including electronic cigarettes and related products.

Background Statement:
On April 1, 1970, President Richard Nixon signed the Public Health Cigarette Smoking Act (PHCA), which banned the advertisement of cigarette on television and radio. In 1998 the Master Settlement Agreement (MSA) additionally banned billboard advertisements. In 2003, a pharmacist in China developed the first commercially successful electronic cigarette. In 2006, electronic cigarettes were introduced in the United States. Electronic cigarettes do not fall under PHCA nor MSA. Both PHCA and MSA were placed well before the first commercially successful electronic cigarette was introduced to the United States. Electronic cigarettes companies advertise on television, radio, and billboards targeting teens and adults. Some electronic cigarette companies are advertising their products as safer than traditional cigarettes.

References:
https://www.congress.gov/bill/95th-congress/house-bill/839
https://truthinitiative.org/who-we-are/our-history/master-settlement-agreement
https://www.theguardian.com/society/2015/jun/09/hon-lik-e-cigarette-inventor-quit-smoking-dual-user

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

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R8.19

Proposing APhA-ASP Chapter:
Western University of Health Sciences

Proposed Resolution Title/Topic:
Pharmacists Professional Discretion and Corresponding Responsibility

Proposed wording:
APhA-ASP supports protection of the rights of pharmacists to use professional discretion and corresponding responsibility to dispense schedule II to V controlled substances.

Background statement:
Pharmacists have a corresponding responsibility according to the Code of Federal Regulations to ensure that medications prescribed are for a legitimate medical purpose. The DEA mandates that pharmacists check to see if prescriptions raise any red flags signifying forgery or fraudulence. Beyond this, pharmacists verify with prescribers before dispensing medication.

However, when a pharmacist determines that a prescription should not be dispensed based on their professional discretion and corresponding responsibility, then the Board of Pharmacy, such as the one in Alaska, threatens to take disciplinary action. In Alaska, patients were denied their controlled substances so the Board of Pharmacy sent out a letter detailing the disciplinary actions that pharmacists would face if they did not practice in a reasonable manner. The prescriptions that were denied were not based on forgery or fraudulence.

It is important that we protect pharmacists and their ability to practice with professional discretion and corresponding responsibility beyond checking for red flags. The prescription should meet the diagnosis of the patient and a pharmacist should be protected if they chose to deny a prescription for a controlled substance.

References:
1. CDC Pharmacist: On the Front Lines [brochure] U.S. Department of Health and Human Services. Available from: https://www.cdc.gov/drugoverdose/pdf/pharmacists_brochure-a.pdf
2. U.S. Department of Justice. A Pharmacist's Guide to Prescription Fraud [Internet] Springfield, VA: Diversion Control Division; 2000 [cited 2019 Oct 1] Available from: https://www.deadiversion.usdoj.gov/pubs/brochures/pharmguide.htm?fbclid=IwAR3uGx-oWGyrocPQ4nnH41_o7YRh7g_aAsnpTkyxTgzYoyAkIE46JjqkyCY
3. Duensing, K. When Opioid Prescriptions Are Denied [Internet]. Practical Pain Management. 2019. [updated 2019 May 6; cited 2019 Oct 1] Available from: https://www.practicalpainmanagement.com/resources/ethics/when-opioid-prescriptions-are-denied

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