House of Delegates

Recommendations from the 2021 House of Delegates

The delegate[s] who introduced each Recommendation is [are] noted. Each Recommendation is forwarded to the appropriate body within ASHP for assessment and action as may be indicated.

1. **Use of Derogatory Terms in Healthcare**  
   Washington State delegation: Rena Gosser, Roger Woolf, Susan Teil Boyer, Karen White

   We encourage the development of a statement rejecting the use of derogatory and/or stereotypical terms in healthcare.

   **Background:** For example, “Red Man Syndrome” reinforce stereotypes and phrasing such as vancomycin induced flushing are more accurate and appropriate. The IDSA has come out with a policy statement requesting that this phrase not be used. We would like to see ASHP adopt this stance as well and ensure that terms such as these are not included in CE offerings, print materials, presentations, as well as encourage education on more appropriate terms.

2. **Universal Removal of the Term "Red Man Syndrome"**  
   Paul C. Walker, ASHP Board of Directors

   ASHP should issue a position statement, alone or in collaboration with SIDP and/or other organizations, supporting universal removal of the term "Red Man Syndrome" from the healthcare lexicon and recommending replacement with a more suitable term that lacks discriminatory connotations.

   **Background:** The term “red man” is a racial epithet used as a slur to derogatorily refer to persons of Native American descent. As ASHP seeks to make our profession, healthcare, and society more diverse, equitable and inclusive, removal of this offensive terminology from our lexicon will help us build trust with and improve care among Native Americans and help dismantle structural racism. The term "Red Man Syndrome" should be replaced with more appropriate terms that lack discriminatory connotations, such “vancomycin flushing syndrome,” “vancomycin histamine release syndrome,” or "vancomycin infusion reaction," as have been suggested by other professional associations.

3. **Patient Access to Pharmacies within Provider Networks**  
   Paul Driver, Idaho
With the HOD removing pharmacies from the policy adopted on 6/4/21 from the CPM, there is a need to develop a separate policy that addresses inclusion of pharmacies in networks.

**Background:** There was a perceived substantial difference between pharmacists and pharmacies in payer networks. As such, there appears to be a need for a separate policy to address this gap.

4. **Student Economic Impact**
   Ashley Duty, Missouri

ASHP should continue to evaluate the economic impact of ASHP managed and related activities (e.g. Midyear Clinical Meeting) on students.

**Background:** During the COVID-19 pandemic, ASHP offered the Midyear Clinical Meeting for free to students as many of them had been negatively impacted by the economy. There is a benefit to in-person meetings for networking and face time, but the economic burden of the registration and travel may prevent engagement from interested students with limited resources. With engagement from the Pharmacy Student Forum Executive Committee, ASHP should investigate virtual, meeting-lite, or discounted options for students.

5. **The Pharmacist’s Role in Spiritual Care**

To recognize that the spiritual dimension is an important aspect in the health of our patients and practitioners, further;

To encourage ASHP to explore the impact of current curriculums in U.S. Pharmacy Schools in addressing training needs for future pharmacists in the elements of spirituality recognizing the cultural diversity of our patients and pharmacy practitioners, further;

To encourage ASHP to evaluate ASHP Residency Accreditation Standards to address gaps in learning experiences to intentionally address spiritual needs (e.g. chaplaincy rotations), further;

To encourage ASHP to promote the well-being and resilience of the pharmacy workforce by addressing the spiritual health of pharmacy practitioners.

**Background:** Numerous publications have outlined the role of spirituality in health care. Some medical schools and pharmacy schools have developed curriculum with a consensus faculty group of the Association of American Medical Colleges developing goals and learning objectives for curriculum on spirituality in 1999.[1][2] Specific curriculums have been designed to address gaps among physician specialties.[3]
Joint Commission (TJC) standards incorporate references to religious and spiritual beliefs in the elements of performance and TJC provides a Joint Commission Resource (JCR) that was updated in 2018; Cultural and Religious Sensitivity: A Pocket Guide for Health Care Professionals.[4] Although some pharmacy schools have developed curriculum which incorporate the spiritual health of the patient in the training of pharmacists, there is not a broad consensus of how or what training should be delivered and as the pharmacy professional assumes more responsibility for a patient’s well-being, it is vital that the spiritual needs of the patient be addressed by every member of the healthcare team.


6. Update to CPP 1909 Pharmacist Authority to Provide Medication-Assisted Treatment

Federal Pharmacy Caucus: Heather Ourth, Department of Veterans Affairs; LCDR Carl Coats, U.S. Public Health Service; Lt. Col. Rohin Kasudia, Air Force; LTC Joe Taylor, Army; Julie Groppi, ASHP Board of Directors and Department of Veterans Affairs

On behalf of the Federal Pharmacy Caucus, I would like to recommend the Council on Public Policy consider updating ASHP Policy 1909 with the following: 1. Replace the term “medication assisted treatment (MAT)” with the updated language “medications for opioid use disorder (MOUD)” 2. Add an additional clause which would advocate for states to authorize pharmacist prescribing of controlled substances including MOUD to their scopes of practice, 3. Update the rationale to include updated HHS guidelines for the administration of buprenorphine for treating OUD.

Background: SAMHSA recommends replacing the term MAT with MOUD. The term “MAT” implies that medications are an adjuvant role to other treatment approaches, while the term “MOUD” supports the idea that medication is an independent treatment
The DEA has stated that SAMHSA waivers and practice agreements cannot authorize a pharmacist practitioner to engage in MAT when state law, the Controlled Substances Act, or DEA regulations do not authorize such treatment. States need to authorize prescriptive authority for controlled substances, including MOUD, within their state scope of practice regulations. In the 9 states where pharmacists are authorized to prescribe controlled substances, it is important to ensure the addition of MOUD to allow the ability of DEA to authorize SAMHSA waivers and practice agreements. Additionally, the updated HHS practice guidelines for the administration of buprenorphine still excludes pharmacists as eligible providers due to the issues stated above. Current ASHP Policy, Pharmacist Authority to Provide Medication-Assisted Treatment (1909) Source: Council on Public Policy To advocate for the role of the pharmacist in medication-assisted treatment (MAT) for opioid use disorder, including patient assessment, education, prescribing, and monitoring of pharmacologic therapies; further, To pursue the development of federal and state laws and regulations that recognize pharmacists as providers of MAT for opioid use disorder; further, To foster additional research on clinical outcomes of pharmacist-driven MAT; further, To advocate for the removal of barriers for all providers to be able to provide MAT to patients.

7. **Healthcare workers using their medical skills to harm patients intentionally**

Tricia Meyer, Texas

With the recent conviction of a Wisconsin pharmacist who left COVID 19 vaccines out of refrigeration in hopes of tainting the vaccine, ASHP should provide awareness to members of incidences of misguided healthcare professionals/workers intentionally seeking to cause harm and possible death to patients (although it is assumed this is rare) and signs that may indicate this occurring.

**Background:** Not all patient harm is accidental. Although we were all shocked at the Wisconsin pharmacist's action, most of us assume that intentional harm is a rarity, however the literature and news reports cite patients experiencing a range of events from recoverable intentional harm to "mercy killings". In 2019 an ICU physician was reported to have given excessive doses of fentanyl to at least 27 near death patients. When these workers are finally unmasked, it becomes clear that many co-workers saw red flags but never thought the flags may have been intentional. The recent event highlights how trusted clinicians have access to patients or therapies and most stakeholders do not consider this can intentional action can occur. As co-workers, we are unaware and unknowing of this possibility. These events are difficult to prove and hospitals may be hesitant to report details or suspicions. This is thought to be rare but perhaps it is underreported just like in the past we thought med errors were not common but they were actually under reported.