2020-2021 House of Delegates
Report of the Policy Committee

- ❖ Multi-State Practice of Pharmacy
- ❖ Continuity of Care and the Role Pharmacists During Public Health and Other Emergencies

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2020-21 APhA Policy Committee Report

Multi-State Practice of Pharmacy

The Committee recommends that the Association adopt the following statements:

1. APhA affirms that pharmacists are trained to provide patient care and have the ability to address patient needs, regardless of geographic location.
   [Refer to Summary of Discussion Item 5]

2. APhA advocates for the continued development of uniform laws and regulations that facilitate pharmacists, student pharmacists, and pharmacy technicians' timely ability to practice in multiple states to meet practice, and patient care needs.
   [Refer to Summary of Discussion Items 6 and 7]

3. APhA supports individual pharmacists' and student pharmacists' authority to provide patient care services across state lines whether in person or remotely utilizing appropriate telecommunication or other telehealth technologies in accordance with harmonized state pharmacy practice acts and regulations.
   [Refer to Summary of Discussion Items 8,9,10,11,12, and 13]

4. APhA supports consistent and efficient centralized processes across all states for obtaining and maintaining pharmacist, pharmacy intern, or pharmacy technician licensure and/or registration.
   [Refer to Summary of Discussion Items 14,15,16,17,18,19,20,21, and 22]

5. APhA urges state boards of pharmacy to reduce administratively and financially burdensome requirements for licensure while continuing to uphold patient safety.
   [Refer to Summary of Discussion Items 21,22,23,24,25,26,27 and 28]

6. APhA encourages the evaluation of current law exam requirements for obtaining and maintaining initial state licensure, as well as licensure in additional states, to enhance uniformity and reduce duplicative requirements.
   [Refer to Summary of Discussion Items 29 and 30]

7. APhA urges state boards of pharmacy to involve a member of the board of pharmacy and a practicing pharmacist in the review and updating of state jurisprudence licensing exam questions.
   [Refer to Summary of Discussion Item 31]

8. APhA calls for development of profession-wide consensus on licensing requirements for pharmacists and pharmacy personnel to support contemporary pharmacy practice.
   [Refer to Summary of Discussion Item 32]

Summary of Discussion

1. The Committee discussed pharmacy versus pharmacist licensure in the context of patient care delivery across state lines but agreed that this policy topic should be focused on the pharmacist, student pharmacist, and pharmacy technician. The Committee highlighted a situation where if one pharmacist who held multiple licenses left a pharmacy, then patient care delivery across state lines would not be possible by other pharmacists in that pharmacy, only because the other pharmacists may not hold a pharmacy license in other states. The Committee further agreed that by addressing the burdens of pharmacist licensure then the issues of pharmacy licensure would be solved. (all)
2. The Committee considered calling for consistent/harmonized pharmacy practice laws and regulations relative to pharmacy licensure and noted that existing APhA policy 2002 National Framework for Practice Regulation covered the intent of the statement. The committee did not believe this needed to be restated. (all)
3. The Committee recognized that there is existing policy pertaining to multistate licensure of pharmacists to address growing needs of pharmacists, **2017, 2012 Contemporary Pharmacy Practice**, and agreed that this existing policy would cover pharmacists requiring additional licensure to react to public health emergencies. (all)
4. The Committee discussed the full scope of pharmacists' services in the context of multi-state licensure and intended for the statements to apply to all pharmacist-provided services, including dispensing functions. (all)
5. The Committee reviewed the Joint Commission of Pharmacy Practitioners (JCPP) Pharmacists Patient Care Process (PPCP) as background for this statement. The Committee acknowledged that the PPCP would apply to all practice settings and is incorporated into the PharmD curriculum. Find more information on the PPCP here: https://jcpp.net/patient-care-process/. (1)
6. The Committee reviewed existing examples of nursing compacts and acknowledged the increased work on the state level to develop pharmacy related compacts. Instead of calling for this same model to be developed for pharmacists, the Committee developed this statement to instead develop uniform laws and regulations to ease the burden for pharmacists to try and operate under different laws when treating patients across state lines (2).
7. The goal of this statement is to address the laws and regulations effecting pharmacist, student pharmacists, and pharmacy technicians in any practice settings. The Committee considered including the location (e.g. community or health care system) where patient care is provided and included "practice needs" to encompass any type of practice setting. (2)
8. The Committee reviewed the concepts of telehealth, telepharmacy, and telemedicine in the context of this policy topic. After review of existing APhA policy **2005, 2004, 1999 Telemedicine/Telehealth/Telepharmacy**, the Committee agreed that this existing policy language is broad enough to encompass the issue of pharmacy practice across state lines during public health emergencies. (3)

9. Telepharmacy is defined in policy **2005, 2004, 1999 Telemedicine/Telehealth/Telepharmacy** as a component of telehealth and is "the provision of pharmaceutical care to patients through the use of telecommunications and information technologies." (3)
10. The Committee reviewed the definition from the Center for Connected Health Policy: "Telehealth is a collection of means or methods for enhancing health care, public health and health education delivery and support using telecommunications technologies." https://www.cchpca.org/about/about-telehealth (3)
11. The Committee noted that including the phrase "in person" encompasses any gray areas that would exist in areas where practices routinely cross state lines and in-person communication could be reasonably expected. (3)
12. The Committee recognized variability across states that make the provision of patient care services a challenge across multiple states and wanted to call for the need for "harmonized" laws and regulations. The Committee discussed the use of the word "harmonized" and whether it encompassed what the Committee's intent of the statement was. It was acknowledged that "harmonized" means, in the context of music, different voices or parts working to achieve the same goal, which aligns with the intent of the statement. (3)
13. The Committee agreed that "patient care services" in the context of this statement was not inclusive of dispensing services. Dispensing of products through a remote process would be a separate policy discussion and the Committee believes this is covered in the **2005, 2004, 1999 Telemedicine/Telehealth/Telepharmacy** policy statements. (3)
14. The Committee discussed the broad variances in existing state pharmacy practice laws and regulations regarding licensure and registration of pharmacists, pharmacy interns, or pharmacy technicians. It was acknowledged that consistency in these laws and regulations will reduce the administrative burden to obtain and maintain licensure or registration in multiple states. (4)
15. The Committee reviewed the impact of the NABP Passport program during the COVID-19 pandemic and believes this type of program would facilitate the intent behind this statement to streamline multi-state licensure of pharmacists and should be continued and adopted more broadly among States. (4)
16. The Committee desired these policy statements to apply to pharmacists, student pharmacists, and pharmacy technicians and as such included "licensure and/or registration" throughout the policy statement to capture various methods that State Boards of Pharmacy use to track individuals within their systems. (4)
17. The Committee discussed that some administrative processes can be substantiated through "evidence-based" research, but acknowledged that similar to randomized clinical trials, such evidence cannot practically be conducted on licensure requirements. Additionally, the use of rational thought would be sufficient in place of evidence in many instances. The Committee recognized that formal research is not always necessary as expert opinion may be sufficient. (4)
18. The Committee reviewed the NABP Passport program and desired for this program to be used as a model in the future with further evaluation on improvements. The Passport program was not specifically included in the policy statement, but the Committee intentionally used the same wording used by NABP, "Centralized submission process" to

draw a stronger connection to the Passport program. NABP made the decision to no longer accept COVID-19 applications for the Passport program beginning October 1, 2020 and Passports issues prior to October 1 will remain in effect until Dec. 31, 2020. Per NABP, the program was developed in response to coronavirus disease 2019 (COVID-19), and it allows states to efficiently grant temporary or emergency licensure. More information on the Passport program can be found here: https://nabp.pharmacy/coronavirus-updates/passport/. (4)

19. The Committee discussed the differences between "intern" and "student pharmacist" as it relates to licensure and agreed that "intern" is a more appropriate term to use in this case. (4)
20. The Committee considered a statement calling for the creation of a task force to develop and advocate for a program that efficiently facilitates timely license transfer. The Committee agreed that this may not be the best option to specifically include as a statement and encouraged this to be listed as a potential implementation step for the APhA Board of Trustees to consider to achieve the intent behind this statement. (4)
21. These statements are similar in nature, but the Committee specifically felt the need to address more "efficient processes" for licensure in statement 4 and also felt that "burdensome requirements" were necessary to have in statement 5. The Committee discussed that efficient processes typically focuses on the Boards of Pharmacy and the burdensome requirements typically focuses on the practitioner. The Committee highlighted a potential process to fill out one licensure or registration form for all Boards of Pharmacy that would create an efficient process and reduce the burdensome requirements for practitioners. (4,5)
22. The Committee discussed examples of processes that increase administrative burden and included "uphold patient safety" to ensure the focus is on the patient. The Committee highlighted a mail-in only application process for licensure as an example of an administrative burden that would not uphold patient safety like a process such as background checks would. (4,5)
23. The Committee discussed fingerprinting requirements as being both an administrative and financial burden for student pharmacists seeking licensure in multiple states for experiential purposes. (5)
24. The Committee acknowledged that some state boards of pharmacy may not have the authority to change fees for licensure due to direction from their state's budget and/or legislature, but believes Boards of Pharmacy should consider the financial burden that may exist for pharmacists, student pharmacists, or technicians who are applying to multiple states for licensure. (5)
25. The Committee acknowledged that APhA works with multiple other National pharmacy organizations through its regular activities and many of these policy statements will be implemented through these types of collaborations. (5)
26. The Committee discussed whether the term "application processes" should replace or be included alongside the term "requirements". The Committee acknowledged that the application itself is not a burden, but rather other requirements of obtaining licensure, and did not replace the original term. (5)

27. The committee discussed the fees required for pharmacists and student pharmacists to apply for and obtain additional licenses as a potential financial burden to be addressed in the policy. (5)
28. The Committee acknowledged the recent National Association of Boards of Pharmacy (NABP) process change that required the maintenance of an original licensure to be allowed to transfer your license. NABP now allows, with concurrence from State Boards of Pharmacy, a license transfer to occur with at least one active license. This new policy from NABP only applies when trying to obtain additional licensure in other states and if that other state has not signed on in support of NABP's policy then you would still need to maintain your original licensure. (5)
29. The Committee debated the need to have pharmacists retested on Federal Pharmacy Law questions when taking MPJE exams for additional state pharmacist licensure, as well as the need for a law exam in general. The Committee decided to call for the revaluation of existing requirements to reduce duplication between states instead of calling for the removal of the MPJE altogether. (6)
30. The Committee intends for some implementation steps of this statement to be directed toward the National Association of Boards of Pharmacy (NABP), State Boards of Pharmacy, and State Pharmacy Associations. (6)
31. The Committee reviewed the process for development of the existing MPJE exam and how NABP utilizes a centralized question pool for the exam where questions are submitted by all states into the pool. Questions are then reviewed by each state for inclusion in their own exam. Some of the reviewers may be a lawyer, an inspector, or a pharmacist, with each looking at questions through a different lens. Some of the questions might have been intended to test the law in one state but may be included in another state's pool if the person reviewing the question feels that the question has a correct answer according to their state law. This leads to a process where the test-taker must choose the "most-correct" answer to questions. Therefore, the Committee felt that a pharmacist looking at the questions might lessen confusion on questions because a pharmacist would look at questions from a practice standpoint. (7)
32. The Committee intends for the profession-wide consensus referenced in this statement to include discussion on developing a national license. States are to be included in discussion. (8)

Multiple State Practice of Pharmacy

Background Paper Prepared for the 2020-2021 APhA Policy Committee

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Issue

The American Pharmacists Association (APhA) Board of Trustees has directed the 2020–2021 Policy Committee to recommend policy to the APhA House of Delegates related to Multiple State Practice of Pharmacy. The Board's guidance on this topic included, but was not limited to NABP requirements for licensure state to state, new state regulations related to multistate licensure, how multistate licensure would affect current pharmacists, retesting requirements and state board of pharmacy implementation, benefits of multistate licensure, potential federal level regulations for pharmacist licensure, student pharmacist and technician registration, and policies on telehealth and the burden of licensure for providing care via electronic means.

Summary of Key Concepts

- Access to care for patients in rural areas or living on state lines may be below standards necessary to reduce morbidity & mortality rates.[1]
- There is a high cost burden for pharmacists who are maintaining licenses in multiple states.
- Telehealth provides solutions to patients who have typically had little access to care, and it has expanded tremendously during the COVID-19 pandemic.
- Many other healthcare professions currently have licensure compacts in place to allow for streamlined multi-state licensure in much of the country.
- The NABP Passport program has been enacted due to COVID-19, and allows for efficient licensure reciprocation in many states for pharmacists
- Idaho has allowed for multi-state licensure with states entering into an agreement to allow the same treatment for Idaho pharmacists, and have eliminated the MPJE requirement
- The current model for transferring and reciprocating pharmacist licenses includes varying regulations between each state, time delays, and significant cost
- Each state differs widely in renewal periods, CE requirements, and examination requirements.
- License application process time can be subject to lengthy delays, exacerbated by the COVID-19 pandemic and limited availability of examination sites.

Definition and Recent News Stories

Multistate License Authority: Maintain one active license and practice in multiple states through an agreement with a license compact or reciprocity, etc.

- The Washington Post published an article on July 25, 2020 finding that cities are facing health care worker shortages during the COVID-19 pandemic. The article specifically

mentions pharmacists as an area of need as resources are stretched and the number of infections rises. Texas, South Carolina, Florida, and Indiana are listed as top priorities, though hot spots stretch across the country and demands for healthcare workers follow that trend.[3]

- An article in PharmCompliance published in October 2019 questions why pharmacists are one of the only healthcare professions that has yet to pursue pathways for multi-state licensure, citing a system similar to the physician medical licensure compact as a potential solution for the hardships multi-state licensure creates. Written by a pharmacist, the primary concerns in maintaining multiple licenses include keeping track of multiple date ranges for renewal, and composition of the CE that is acceptable. Some states even have further licensure required to manage specific types of pharmacies including inpatient or long-term care.[4]

Background

Current Pharmacy Landscape

Problems:

- Pharmacists who are working on or near state lines and rural areas desiring to treat patients where there is a shortage of healthcare professionals have difficulty in obtaining and maintaining licensure in both jurisdictions. Americans living in rural areas are more likely to die from the five leading causes than their urban counterparts. 129 rural hospitals have closed since 2010, further increasing the risk of mortality due to increased travel time and decreased access.[1]
- Each state has a different exam process (outlined in Appendix B).
- There is a high cost burden for taking multiple exams and initial and renewal licensure fees.
- Many states have different CE requirement to maintain licensure (Outlined in Appendix B).

Telehealth can allow for treating patients without access to transportation, adequate services, or those living across state lines via electronic means. It can also limits excessive healthcare spending because of the efficiency. Pharmacists are not currently considered 'telehealth providers' for payment purposes, but can still fill many roles in patient care using telehealth across state lines such as managing medications, MTM, and addressing pressing primary care needs that would not otherwise be met.[1]

ASHP recently released their policy on interstate pharmacist licensure: "To advocate for interstate pharmacist licensure to expand the mobility of pharmacists and their ability to practice remotely."[2]

Some of the most prominent issues with access to care were exacerbated by the COVID-19 pandemic. Most elective procedures and preventative care visits were canceled for several months, and access to care fell for many Americans.

Before the public health emergency, only 14,000 beneficiaries received a Medicare telehealth service in a week. During the public health emergency, over 10.1 million beneficiaries have received a Medicare telehealth service from mid-March through early-July, 1.7 million alone in the last week of April. 43.5% of Medicare fee-for-service primary care visits were provided via telehealth in April as compared to 0.1% before the public health emergency.[1]

President Trump signed an Executive Order on Improving Rural and Telehealth Access. According to the order, this will allow for a new payment model that will give rural providers flexibility from Medicare rules and establish predictable payments. The Administration said it will also invest in physical and communications infrastructure in the healthcare communities in rural areas. This order also proposed extending new measures beyond the duration of the public health emergency.[1]

Current Pharmacy Licensure Model

Transferring or reciprocating licenses between states currently is the model pharmacists must follow in order to obtain multiple licenses, besides taking individual licensure exams. Each state varies in the requirements in place in order to obtain a license. These requirements and special cases for Florida and California licensees are outlined below in Appendix A.

CE requirements, licensure renewal periods, and examinations required also vary between each state, further complicating the process of pharmacists obtaining multiple licenses. These requirements are outlined below in Appendix B. All states require NAPLEX & MPJE unless otherwise noted in Appendix B.[17]

Cost Burden

Cost to maintain licenses in multiple states (active or inactive), take exams for each state, and keep up to date on specific CE requirements is a hardship for many pharmacists, and increases with an addition of more state licenses. Currently, the NAPLEX costs $575, the MPJE costs $250 (non-MPJE state law exams are similar price), and state licensure fees vary between $150-$300 for initial and each subsequent license renewal. A background check and fingerprinting are often also required, costing between $50-150. Many other fees may apply, especially when transferring a license or examination score between states. This means that being licensed in one state costs a minimum of $1000, usually exceeding that amount. Being licensed in multiple states and keeping up to date on differing renewal requirements will continue to cost licensees thousands of dollars yearly.[20]

Application Process Time

Delays in retrieval of license information, verification of new background checks, fingerprinting, examination availability and process time can all cause the licensure obtaining process to be very slow. Delay may result in lost wages by pharmacists relocating or attempting to expand practice services. This also continues to delay access to care by patients who may benefit by the newly licensed pharmacist’s services.

Disruption in licensure has been exacerbated during the COVID-19 pandemic due to lessened availability of testing sites for the NAPLEX & MPJE. These testing sites were closed temporarily and are now adhering to social distancing measures, diminishing capacity to 50% in most cases. COVID-19 has caused cancellations and delays in many pharmacists taking their licensure examinations and therefore qualifying for licensure.[21]

Student Pharmacists

Delayed retrieval of licenses and/or registrations impact the ability of student pharmacists to conduct out of state rotations. There is also a large cost burden for students maintaining multiple licenses due to their desire to work or complete rotations across state lines. There can also be difficulty in meeting all requirements for licensure in timely manner after rotations are set.

Other Healthcare Profession Licensure Models

Physicians

An interstate medical licensure compact has passed in 29 states which allows an expedited pathway to licensure for physicians practicing in multiple states. It became operational in April 2017. Participating physicians must receive a letter of qualification from the state of their principal license and must hold a full unrestricted license in a state that is a member and is their state of primary residence, contains 25% of their practice, is where their employer is located, or is used for federal income tax purposes.[6]

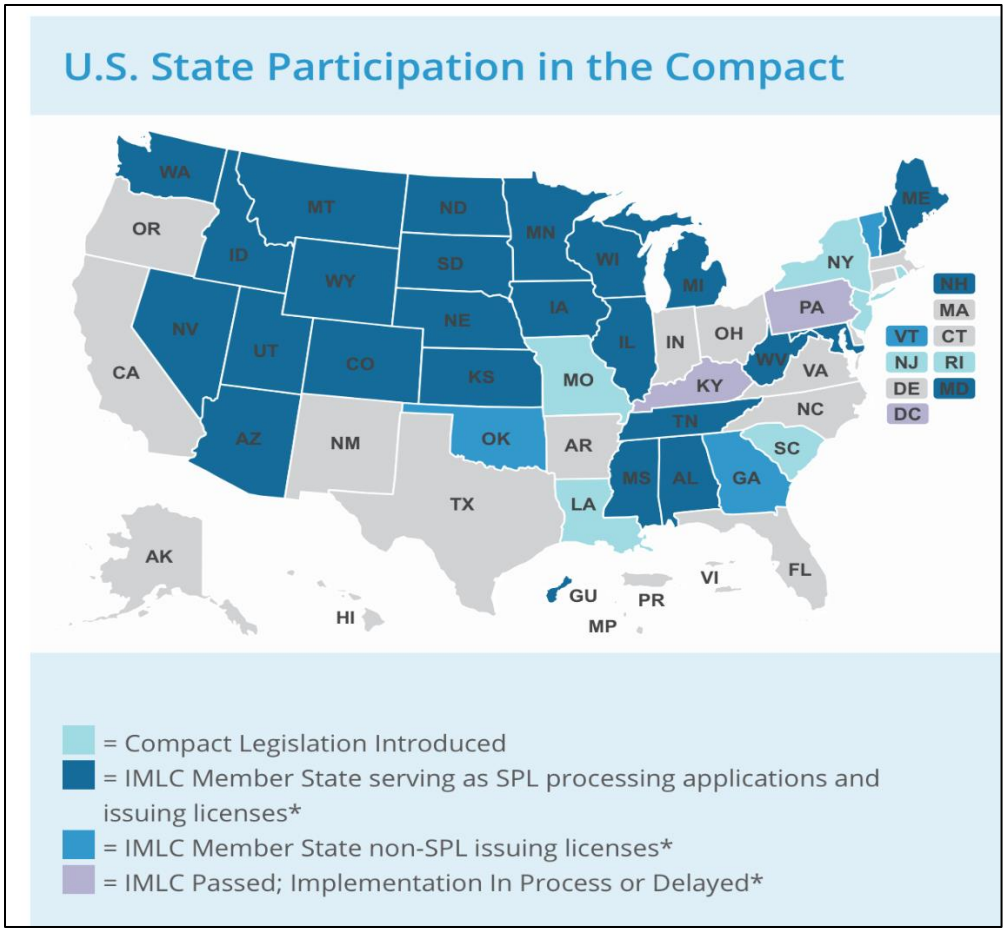


Figure 1: Interstate Medical Licensure Compact Participant States[6]

Nurses

Currently a nurse licensure compact with 34 member states exists, including RNs, LPNs, and VNs. This compact has been in effect for more than 15 years and allows for uniform licensure requirements to be sure nurses meet requirements from all states.[7]

Testimonies from nurses showing the effects of the NLC include stories of moving often and being able to continue working seamlessly and the importance of healthcare being driven by patient needs rather than traditional state lines and boundaries on a map.[8]

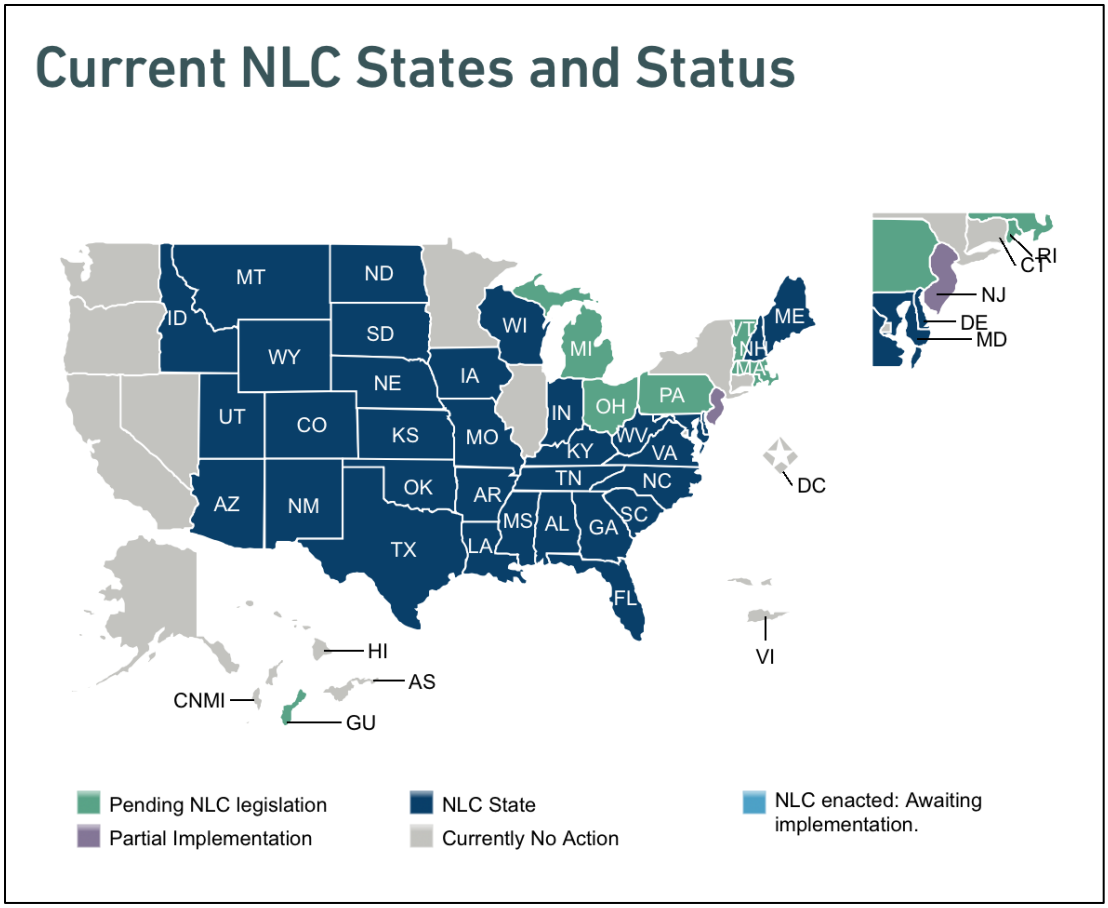


Figure 2: Nursing Licensure Compact Participant States[7]

Physical Therapists/Physical Therapy Assistants

There is currently a licensure compact with 21 state members which started in April 2017.[9]

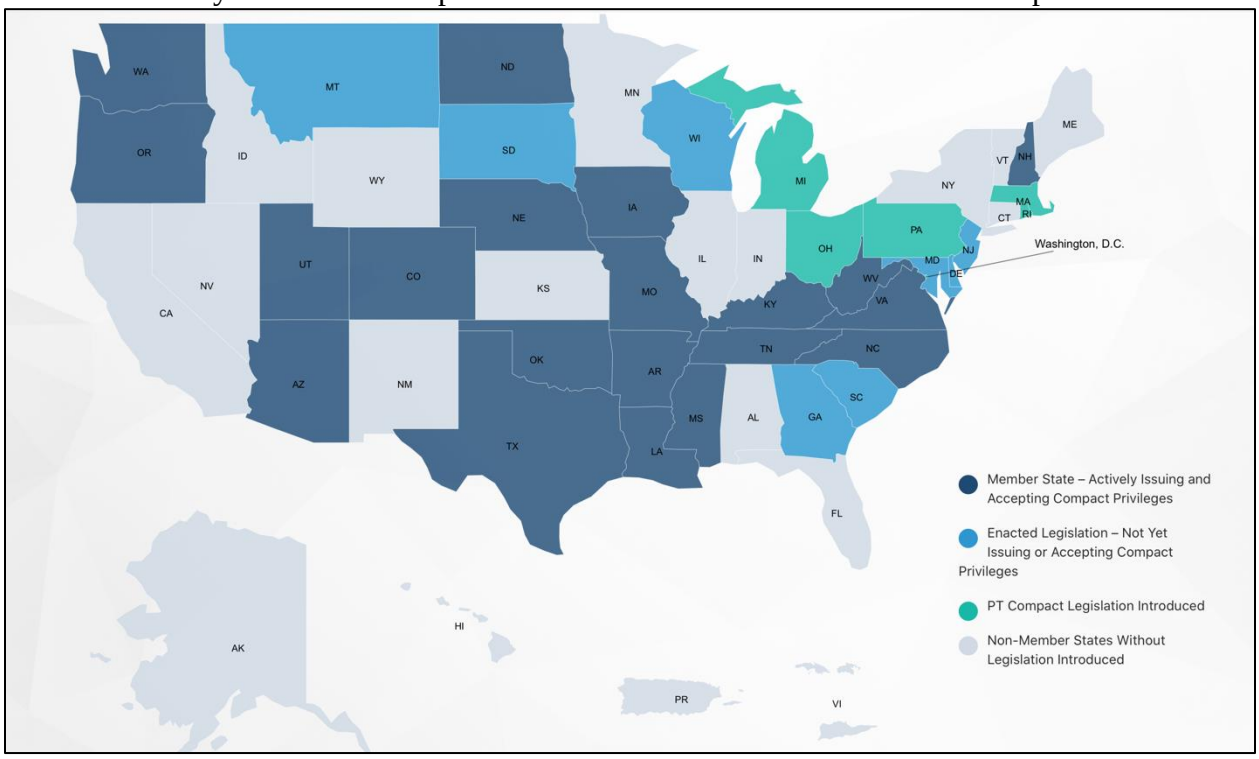


Figure 3: Physical Therapist Licensure Compact Participant States[9]

Other Healthcare Providers

A licensure compact for occupational therapists is being created with a goal operational date in 2024. This is an American Occupational Therapy Association and NBCOT join initiative.[10] Audiology and Speech-Language Pathology has created an interstate compact (ASLP-IC) which will be active when 10 states have enacted the legislation necessary for the compact. Currently, it is active in 5 states.[22]

Considerations for Pharmacist Licensure Compact

NABP Passport Program

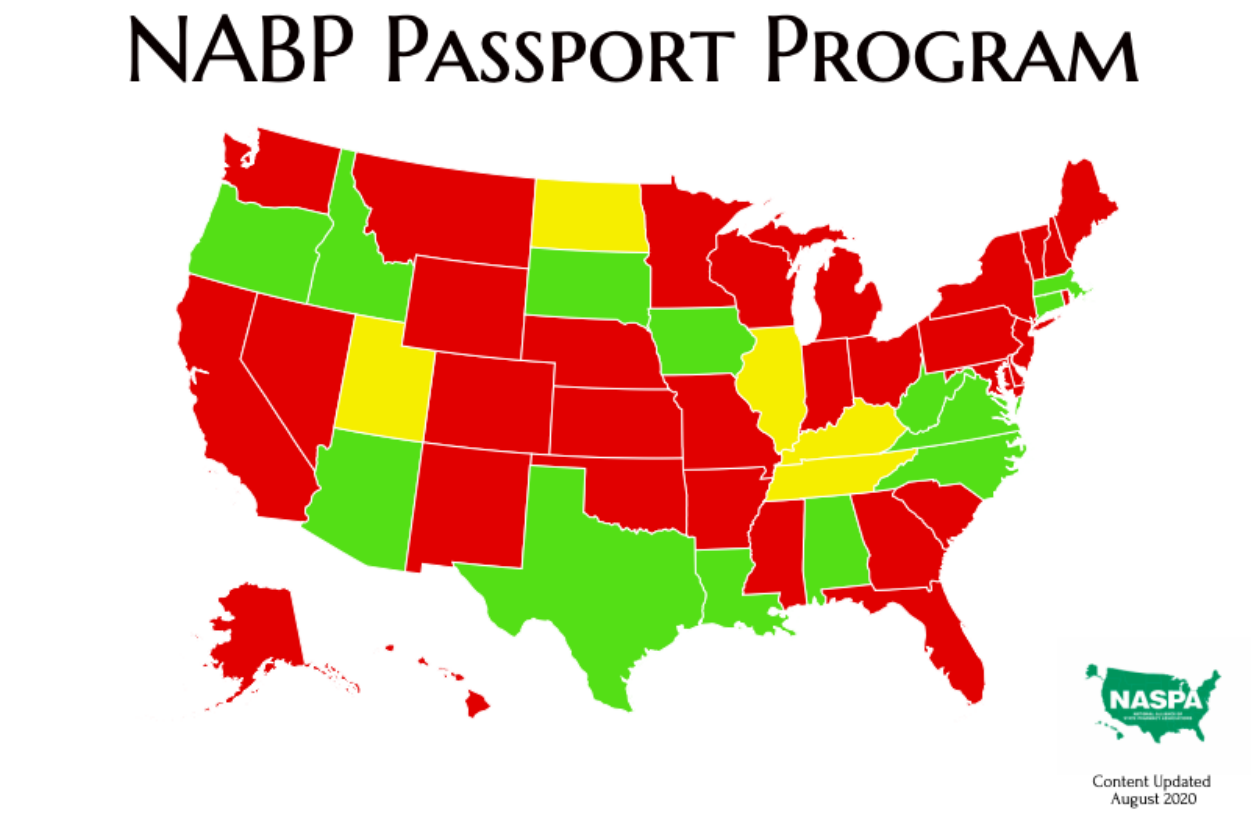
This program allows states to grant temporary or emergency authorization for licensure that facilitates non-resident pharmacists, pharmacy technicians, interns, and pharmacies practicing in another state. The program was developed recently in response to COVID-19.
Boards of pharmacy can recognize the NABP passport as temporary/emergency licensure or can require NABP passport as a pre-requisite for temporary/emergency licensure.

NABP screens applicants who apply and issues the NABP passport to approved applicants (pending board approval in some states). NABP provides a centralized submission and tracking of license applications to assist in reducing the burden on pharmacists and pharmacies and ensure continuity of care and increased access to medications. License verifications by the NABP are conducted at no cost to the applicant or boards of pharmacy. In order to apply pharmacists must have at least one active and in good standing license and pharmacy technicians must have a license or registration OR hold a PTCB or CPhT certification. Pharmacy interns can only apply if the state licenses interns and has included interns in their emergency declarations. The states that accept the NABP passport can be found in Table 1. A visual map representation is available in Figure 4.[11,12]

Table 1: States accepting the NABP Passport[11]

Key: Yellow=Expired

STATE	PROFESSION	EXPIRATION DATE
Alabama	Pharmacist, Technician	December 31
Arizona	Pharmacist, Technician, Intern, Pharmacy	December 31
Connecticut	Pharmacist, Technician	December 31
District of Columbia	Pharmacist, Technician, Intern	October 9
Iowa	Pharmacist, Technician	August 23
Idaho	Pharmacist, Technician, Intern, Pharmacy	December 31
Louisiana	Pharmacist, Technician, Intern, Pharmacy	December 31
Massachusetts	Pharmacist, Technician	December 31
North Carolina	Pharmacist, Technician	December 31
Oregon	Pharmacist, Technician	December 31
South Dakota	Pharmacist, Technician, Intern, Pharmacy	December 31
Texas	Pharmacist, Technician	December 31
Virginia	Pharmacist, Technician	December 31
West Virginia	Pharmacist, Technician, Intern	December 31
Illinois	Pharmacist, Technician	May 13
Kentucky	Pharmacist	June 30
Kentucky	Technician, Intern	May 21
North Dakota	Pharmacist, Technician	April 17
Tennessee	Pharmacist, Technician	June 30
Utah	Pharmacist, Technician	June 18



Key

Color	Meaning
Green	Active
Yellow	Expired
Red	Never participated

Figure 4: Map of States accepting the NABP Passport[11]

Idaho Model

2019 House Bill No. 10 established provisions regarding multistate practice of pharmacy. The bill defines multistate practice of pharmacy and grants same practice privileges to pharmacy professionals who are participating. Pharmacists, Technicians, or Pharmacist interns who are licensed in another state (their primary state of residence) that has entered into mutual recognition agreement with the board do not have to get a license or registration in Idaho in order to practice pharmacy. Mutual recognition agreements can be entered into if the state has similar requirements for licensure, requires fingerprint criminal history check, and grants the same practice privileges to Idaho licensed pharmacists, interns, or certified technicians.[13,14]
The Idaho MPJE is no longer required due to Chapter 2 Pharmacy administrative rule changes by the Board of Pharmacy. Idaho has put similar rules into place for nurses, physicians, and EMS in the past.[15]

Arizona Model

HB 2569, passed in 2019, allows for occupational licenses in Arizona. Arizona was previously ranked within the top five most burdensome for license requirements, so this bill allows anyone with an existing license from another state to have instant reciprocity with Arizona if they establish residency in the state. This bill encompassed all licensed and regulated professions.[23]

Potential Issues with Licensure Compacts

The fee structures of licensure compacts currently in existence have garnered some controversy due to push back from state licensure authorities such as the Board of Pharmacy and/or Health Agencies. These authorities may lose money typically garnered through licensure fees, but they still have the responsibility of oversight. These authorities also have the obligation to discipline a licensee when necessary, but a compact could put that ability in jeopardy. These issues must be addressed before a nation-wide compact can be put in place.

Federal Approach

Source: Gabriel Scheffler, Unlocking Access to Health Care: A Federalist Approach to Reforming Occupational Licensing, 29 Health Matrix 293 (2019) Available at: https://scholarlycommons.law.case.edu/healthmatrix/vol29/iss1/8

This article highlights several features of the existing occupational licensing system that impede access to health care without providing appreciable protections for patients. Licensing restrictions prevent health care providers from offering services to the full extent of their competency, obstruct the adoption of telehealth, and deter foreign-trained providers from practicing in the United States. Scholars and policymakers have proposed reforms to this system over the years, but these proposals have had a limited impact for political and institutional reasons.

A federalist approach to licensing reform, in which the federal government encourages the states to reform their licensing regimes, while largely preserving states' control over the system, could have a dramatic impact. This article argues that a federalist approach represents the most promising path toward reforming occupational licensing in health care. Federal intervention in licensing is necessary, due to states' lack of incentives to experiment with licensing reforms, the externalities of their licensing regimes, and their inability to resolve their own collective action problems. Large-scale federal preemption of state licensing laws is unlikely, due to a combination of interest group politics, Congress's tendency toward incrementalism, and its reliance on the states to administer federal policies

Conclusion

In order for pharmacists to provide adequate care to those living in rural areas, across state lines, and without access to transportation, a revision to the current licensure regulations may be needed. States vary widely in their requirements for licensure and pharmacists are subject to a high cost burden when pursuing licensure in multiple states. Many other healthcare professions currently employ a streamlined system to allow licensees to obtain licenses in other states quickly and efficiently. During the COVID-19 pandemic, these issues have been exacerbated as access to care has been further fragmented, telehealth has surged into prominence, delays in licensure exams have occurred, and the need for healthcare professionals has increased.

Appendix A

State Restrictions for Licensure Transfer[16]

STATE	REQUIREMENTS	MAINTAIN ORIGINAL LICENSURE BY EXAMINATION
Alabama	Pass the MPJE.	Yes. The Board will require license transfer applicants to maintain their license by original examination.
Alaska	Pass the MPJE.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Arizona	Pass the MPJE.	Yes. The Board will require license transfer applicants to maintain their license by original examination.
Arkansas	Must be licensed for at least 6 months. Pass Non-MPJE Law Examination.	Yes. The Board will require license transfer applicants to maintain their license by original examination.
California	Must have passed the NAPLEX after January 1, 2004. Pass Non-MPJE Law Examination.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Colorado	Must be licensed for at least one year. Pass the MPJE prior to submitting a license transfer application.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Connecticut	Pass the MPJE.	Yes. The Board will require license transfer applicants to maintain their license by original examination.
Delaware	Pass the MPJE.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
District of Columbia	Pass the MPJE and DC Examination.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a

		member board and transferred their license through the NABP Clearinghouse after.
Florida	Passed a nationally recognized exam. Pass the MPJE.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Georgia	Pass the MPJE and a practical examination.	Yes. The Board will require license transfer applicants to maintain their license by original examination.
Hawaii	Pass the MPJE.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Idaho		No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Illinois	Pass the MPJE.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Indiana	Pass the MPJE.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Iowa	Pass the MPJE.	Yes. The Board will require license transfer applicants to maintain their license by original examination.
Kansas	Pass the MPJE.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Kentucky	Pass the MPJE prior to submitting a license transfer application.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Louisiana	Pass the MPJE.	Yes. The Board will require license transfer applicants to maintain their license by original examination.
Maine	Pass the MPJE prior to submitting a license transfer application.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Maryland	Must have 520 hours of active practice after graduation. Pass the MPJE.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.

Massachusetts	Pass the MPJE.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Michigan	Pass the MPJE prior to submitting a license transfer application.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Minnesota	Pass the MPJE.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Mississippi	Pass the MPJE.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Missouri	Must have completed an internship similar to that required by the Missouri Board. Pass the MPJE.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Montana	Pass the MPJE.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Nebraska	Pass the MPJE prior to submitting a license transfer application.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Nevada	Pass the MPJE.	Yes. The Board will require license transfer applicants to maintain their license by original examination.
New Hampshire	Pass the MPJE.	Yes. The Board will require license transfer applicants to maintain their license by original examination.
New Jersey	Must have 1,500 active practice hours within two years prior to licensure transfer. Pass the MPJE.	Yes. The Board will require license transfer applicants to maintain their license by original examination.
New Mexico	Pass the MPJE.	Yes. The Board will require license transfer applicants to maintain their license by original examination.
New York	Must be licensed for at least one year as well as have at least one year of active practice as a pharmacist. Pass the MPJE.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
North Carolina	Pass the MPJE.	Yes. The Board will require license transfer applicants to maintain their license by original examination.

North Dakota	Pass the MPJE.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Ohio	Standards at the discretion of the Board.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Oklahoma	Pass the MPJE.	Yes. The Board will require license transfer applicants to maintain their license by original examination.
Oregon	Must be licensed for one year. The Board may grant permission to applicants licensed less than one year if they are working in an approved residency program. Pass the MPJE prior to submitting a license transfer application.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Pennsylvania	Pass the MPJE, unless licensed prior to January 26, 1983, or have taken the Federal Drug Law Examination for the license being used as the basis for transfer.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Puerto Rico	Pass Non-MPJE Law Examination.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Rhode Island	Pass the MPJE prior to submitting a license transfer application.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
South Carolina	Pass the MPJE.	Yes. The Board will require license transfer applicants to maintain their license by original examination.
South Dakota	Must be licensed for one year. Pass the MPJE.	Yes. The Board will require license transfer applicants to maintain their license by original examination.
Tennessee	Must be licensed for one year. Pass the MPJE.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Texas	Pass the MPJE.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Utah	Pass the MPJE prior to submitting a license transfer application.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.

Vermont	Pass the MPJE.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Virgin Islands	Must be licensed and actively practicing as a pharmacist for one year.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Virginia	Pass the MPJE.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Washington	Pass the MPJE.	Yes. The Board will require license transfer applicants to maintain their license by original examination.
West Virginia	Pass the MPJE.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Wisconsin	Pass the MPJE.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.
Wyoming	Pass the MPJE.	No. The Board will not require license transfer applicants to maintain their license by original examination, but the license transfer applicant must have a license in good standing from a member board and transferred their license through the NABP Clearinghouse after.

Note: Florida & California license transfers have specific requirements outside what is outlines in Table 2.

Appendix B

CE requirements, license renewal period, examination requirements[17]

State	CE Requirements	Renewal Period	Examinations Required
Alabama	15 hours ACPE approved with 3 live hours	1 year	
Alaska	30 hours	2 years	
Arizona	30 hours with 3 hours in law	2 years	
Arkansas	30 hours, 12 hours ACPE accredited	2 years	NAPLEX & Arkansas Jurisprudence exam

California	30 hours ACPE or CA Pharmacy Foundation accredited	2 years	NAPLEX & California Practice Standards & Jurisprudence Exam
Colorado	24 hours	2 years	
Connecticut	15 hours with 1 hour in law	1 year	
Delaware	30 hours ACPE approved with 2 hours in med safety or errors	2 years	
District of Colombia	40 hours with 2 hrs med errors, 2 hrs HIV, 2 hrs immunizations, 10 live hours	2 years	
Florida	30 hours with 2 hrs med errors, 10 live hours	2 years	
Georgia	30 hours	2 years	NAPLEX & MPJE & Georgia Practical Exam
Hawaii	30 hours	2 years	
Idaho	15 hours with 12 hours ACPE/CME approved, 1 hr in law	1 year	NAPLEX
Illinois	30 hours	2 years	
Indiana	30 hours with 15 ACPE approved, 24 hours practice related	2 years	
Iowa	30 hours ACPE accredited, 15 hrs drug therapy, 2 hrs law, 2 hrs med safety, 1 hr immunization law	2 years	
Kansas	30 hours	2 years	
Kentucky	15 hours, 1 hour in HIV every 10 years	1 year	
Louisiana	15 hours ACPE approved with 3 live	1 year	
Maine	15 hours board approved with 2 hrs on drug admin	1 year	
Maryland	30 hours with 2 hrs med errors, 2 live hours	2 years	
Massachusetts	20/year	2 years	
Michigan	30 hours with 1 hr pain management, 10 live hours	2 years	
Minnesota	30 hours	2 years	

Mississippi	10 hours	1 year	
Missouri	30 hours	2 years	
Montana	15 hours with 5 live hours	1 year	
Nebraska	30 hours ACPE approved	2 years	
Nevada	30 hours with 1 hr in law	2 years	
New Hampshire	15 hours with 5 live hours	1 year	
New Jersey	30 hours with 3 hours law, 10 live hours	2 years	
New Mexico	30 hours with 2 hours in law, 2 hrs safety, 10 live hours	2 years	
New York	45 hours with 3 hours med errors, 23 live hours	3 years	
North Carolina	15 hours, 8 live hours	1 year	
North Dakota	15 hours	1 year	
Ohio	60 hours with 3 hrs in law, 2 hrs safety	3 years	
Oklahoma	15 hours	1 year	
Oregon	30 hours with 2 hrs law and 2 hrs safety	2 years	
Pennsylvania	30 hours with 2 hrs injectables, 2 hrs safety	2 years	
Rhode Island	15 hours with 5 live hours	1 year	
South Carolina	15 hours with 8+ hours in drug therapy/management, excess hours carried one year only	1 year	
South Dakota	12 hours	1 year	NAPLEX & SD Practical Jurisprudence Exam
Tennessee	30 hours with 15 live hours	2 years	
Texas	30 hours	2 years	
Utah	30 hours with 15 hrs in drug therapy, 1 hr law, 12 live hours	2 years	
Vermont	30 hours with 10 live hrs	2 years	
Virginia	15 hours	1 year	NAPLEX & VA law exam
Washington	15 hours	1 year	
West Virginia	30 hours with 3 hours drug diversion, 5 live hours	2 years	NAPLEX & MPJE & WV Errors and Omissions Exam
Wisconsin	30 hours	2 years	

Wyoming	12 hours	1 year	

References

1. https://www.whitehouse.gov/presidential-actions/executive-order-improving-rural-health-telehealth-access/
2. https://www.healthrecoverysolutions.com/blog/enhancing-primary-care-with-remote-clinical-pharmacy-services
3. https://www.ashp.org/-/media/10FA130E071C471AA209F6FDD2FCD418.ashp
4. https://www.washingtonpost.com/national/houston-miami-and-other-cities-face-mounting-health-care-worker-shortages-as-infections-climb/2020/07/25/45fd720c-ccf8-11ea-b0e3-d55bda07d66a_story.html
5. https://www.pharmcompliance.com/post/where-are-the-multi-state-pharmacist-licenses
6. https://www.imlcc.org/information-for-physicians/
7. https://www.ncsbn.org/nurse-licensure-compact.htm
8. https://www.ncsbn.org/nlc-stories.htm
9. http://ptcompact.org
10. https://www.aota.org/Advocacy-Policy/State-Policy/Licensure/Interstate-Professional-Licensing-Compact.aspx
11. https://nabp.pharmacy/coronavirus-updates/passport/
12. https://nabp.pharmacy/newsroom/news/nabp-supports-boards-of-pharmacy-to-expedite-emergency-licensure-for-pharmacists-and-pharmacy-technicians/
13. https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2019/legislation/H0010.pdf
14. https://www.idahopress.com/news/local/house-health-welfare-approves-bill-easing-pharmaceutical-regulations/article_317861b4-3891-5b2d-8def-5729ca62e7a7.html
15. https://nabp.pharmacy/wp-content/uploads/2019/03/Idaho-Newsletter-March-2019.pdf
16. https://nabp.pharmacy/wp-content/uploads/2019/09/Licensure-Transfer-State-Restrictions-May-2020.pdf
17. https://www.medscape.org/public/pharmcestaterequirements
18. https://www.dictionary.com/browse/harmonize?s=t
19. https://www.drugtopics.com/view/pharmacists-where-do-you-want-practice
20. https://www.tldrpharmacy.com/content/immediate-post-grad-expenses
21. https://nabp.pharmacy/coronavirus-updates/
22. https://aslpcompact.com
23. https://asunow.asu.edu/20190409-arizona-impact-license-thrive-arizona-bill-would-allow-reciprocity-regulated-professions

Related APhA Policy
2017, 2012 Contemporary Pharmacy Practice

1. APhA asserts that pharmacists should have the authority and support to practice to the full extent of their education, training, and experience in delivering patient care in all practice settings and activities.

2. APhA supports continuing efforts toward establishing a consistent and accurate perception of the contemporary role and practice of pharmacists by the general public, patients, and all persons and institutions engaged in health care policy, administration, payment, and delivery.

3. APhA supports continued collaboration with stakeholders to facilitate adoption of standardized practice acts, appropriate related laws, and regulations that reflect contemporary pharmacy practice.

4. APhA supports the establishment of multistate pharmacist licensure agreements to address the evolving needs of the pharmacy profession and pharmacist-provided patient care.

5. APhA urges the continued development of consensus documents, in collaboration with medical associations and other stakeholders, that recognize and support pharmacists' roles in patient care as health care providers.

6. APhA urges universal recognition of pharmacists as health care providers and compensation based on the level of patient care provided using standardized and future health care payment models.

(JAPhA NS52(4) 457 July/August 2012)(Reviewed 2016) (JAPhA 57(4): 441 July/August 2017)(Reviewed 2019)

2004, 1991 Updating of State Pharmacy Practice Acts

1. APhA recommends and supports enactment of state pharmacy practice act revisions enabling pharmacists to achieve the full scope of APhA's Mission Statement for the Pharmacy Profession.

2. APhA supports standards of pharmacy practice reflecting the APhA Mission Statement for the Pharmacy Profession.

(Am Pharm NS31(6):28 June 1991) (JAPhA NS44(5):(551 September/October 2004) (Reviewed 2007)(Reviewed 2012)(Reviewed 2017)

2020–21 APhA Policy Committee Report

Continuity of Care and the Role of Pharmacists During Public Health and Other Emergencies

The Committee recommends that the Association adopt the following statements:

1. APhA asserts pharmacists, student pharmacists, pharmacy technicians, and pharmacy support staff are essential members of the healthcare team and should be actively engaged and supported in surveillance, mitigation, preparedness, planning, response, recovery, and countermeasure activities related to public health and other emergencies.
   [Refer to Summary of Discussion Items 6 and 7]

2. APhA reaffirms the 2016 policy on the Role of the Pharmacist in National Defense and calls for the active and coordinated engagement of all pharmacists in public health and other emergency planning and response activities.
   [Refer to Summary of Discussion Items 8, 9, and 10]

3. APhA advocates for the timely removal of regulatory restrictions, practice limitations, and financial barriers during public health and other emergencies to meet immediate patient care needs.
   [Refer to Summary of Discussion Item 11]

4. APhA urges regulatory bodies to recognize pharmacists' training and ability to evaluate patient needs, provide care, and appropriately refer patients during public health and other emergencies.
   [Refer to Summary of Discussion Items 12 and 13]

5. APhA advocates for pharmacists’ authority to ensure patient access to care through the dispensing, prescribing, and administering of medications, as well as provision of other patient care services during times of public health and other emergencies.
   [Refer to Summary of Discussion Items 14,15,16, and 17]

6. APhA calls for fair and equitable processes to ensure access and availability to all pharmacies and pharmacist patient care services during public health and other emergencies.
   [Refer to Summary of Discussion Item 18]

7. APhA calls on public and private payers to establish and implement payment policies that compensate pharmacists providing patient care services, including during public health and other emergencies, within their recognized authority.
   [Refer to Summary of Discussion Item 19]

8. APhA advocates for the inclusion of pharmacists as essential members in the development and implementation of alternate care sites or delivery models during public health and other emergencies.
   [Refer to Summary of Discussion Item 20]

9. APhA reaffirms the 2015 Interoperability of Communications Among Health Care Providers to Improve Quality of Care and encourages pharmacists, as members of the healthcare team, to communicate care decisions made during public health and other emergencies with other members of the healthcare team to ensure continuity of care.
   [Refer to Summary of Discussion Item 13]

Summary of Discussion

1. The proposed policy statements were developed by the Committee to address pharmacist engagement and response in public health and other emergencies. The Committee recognizes extensive existing policies relating to natural disasters, infectious diseases and bioterrorism events, and national defense. The Committee felt strongly that calling out public health and other emergencies is important at this time. (all)
2. While APhA continues to advocate for recognition, payment and authority for pharmacists' patient care services, these proposed policies highlight and address the significant role pharmacists play in patient care during emergencies. The Committee felt these activities, along with the ongoing patient care activities provided in non-emergency time by pharmacists further support the case for pharmacist provider status. These proposed statements do not detract from the current APhA policy and efforts to gain recognition and coverage for pharmacists' patient care services. (all)
3. The Committee intends for these policies to apply broadly and is specifically why "public health and other emergencies" is referenced as opposed to only "public health emergencies". Other emergencies as used in these statements encompasses such events as civil unrest, natural disasters, and terrorism. (all)
4. The Committee discussed the importance for pharmacy personnel to have access to adequate personal protective equipment and reviewed existing APhA policy **2020 Protecting Pharmacy Personnel During Public Health Crisis** and agreed that these existing statements encompass the intent and no new statements were necessary to be proposed on this topic. (all)
5. The Committee considered rationing of medication, as well as patient prioritization as background information when discussing the issues. The Committee did not create specific statements addressing these issues as they believed the intent is covered in the following existing APhA policy statements: **2020 Protecting Pharmaceuticals as a Strategic Asset, 2012 Drug Supply Shortages and Patient Care**, and **2015 Disaster Preparedness**.(all)
6. The Committee discussed the use of countermeasures to combat public health emergencies, which are defined as FDA-regulated products (biologics, drugs, devices) that may be used in the event of a potential public health emergency, to diagnose, prevent, protect from, or treat conditions associated with chemical, biological, radiological, or nuclear threats, or emerging infectious diseases (https://www.fda.gov/emergency-preparedness-and-response/about-mcmi/what-are-medical-countermeasures#:~:text=About%20MCMs-,Medical%20countermeasures%2C%20or%20MCMs%2C%20are%20FDA%2Dregulated%20products%20(,a%20naturally%20occurring%20emerging%20disease). (1)
7. The Committee included the term "supported" in this statement to ensure staffing, training, PPE, supplies, policies, and professional autonomy are incorporated when discussing engagement of pharmacy personnel. (1)
8. The Committee reviewed APhA policy **2016, 2011, 2002, 1963 Role of the Pharmacist in National Defense** and specifically reaffirmed statement 4 of this previous policy to send a clear message to public health stakeholders that pharmacists should have an active role in emergency planning and response activities. The Committee recognized the need for a coordinated effort among pharmacy stakeholders with other members of planning and response initiatives. (2)
9. In the context of this statement, the Committee discussed multiple ways in which the pharmacist should be actively engaged including, but not limited to educating the

public, decision-makers, and team members on proposed treatments during a public health emergency. The Committee also noted that the pharmacist's role could also include mitigating misinformation and helping the public understand available research on treatments. (2)

10. The Committee reviewed existing APhA policy **2016, 2011, 2002, 1963 Role of the Pharmacist in National defense** and noted that while this covers a broad array of national issues, it doesn't specifically call out public health emergencies that could at times only occur at the State or local level. Due to this the committee further expanded the proposed policy to incorporate any public health emergency and response activity. (2)
11. The Committee identified variability among states in the length of time it has taken for issued orders and waivers to grant authority to pharmacists to meet patient and community needs. In addition, the Committee recognized that practice policies can also hamper pharmacist ability to provide care and that the inability or lack of compensation of services is a barrier as highlighted in current COVID-19 response activities. (3)
12. The Committee discussed the ability of pharmacists to conduct triage services, and how oftentimes pharmacists are not initially looked to provide triage. The Committee wanted not only the authority to provide triage services, but recognition that pharmacists should be among the frontline providers that are available to provide triage services. (4)
13. The Committee discussed whether it was necessary to include a policy statement related to communication between pharmacists and other health professionals during public health and other emergencies. The Committee reviewed existing policy and noted that the following APhA policies covered this concern: **2019 Referral System for the Pharmacy Profession, 2015 Interoperability of Communications Among Health Care Providers to Improve Quality of Patient Care, 2012 Drug Supply Shortages and Patient Care, 2006 Continuity of Care**. (4,9)
14. The Committee commented on pharmacists' growing role in public health as it relates to contraception, opioid use, vaccinations and many other public health areas. The Committee believed that this role should continue to expand regardless of the presence of a public health emergency. The need for pharmacist engagement in addressing unintended consequences related to the emergency is important as patients might experience indirect outcomes (such as opioid addiction, uncontrolled diabetes, etc). The Committee noted that payment to pharmacists for these types of services may be an issue during a PHE. (5)
15. The Committee considered the language around chronic versus acutely needed medications and felt that during public health emergencies that pharmacists needed authority to manage all aspects of medication therapy, including refill renewal and medication titration. (5)
16. The Committee discussed the differences between the terms "gaps in care", "continuity of care", and "access to care". The Committee ultimately decided that "access to care" was the most all-encompassing iteration and included that in the statement. (5)
17. The Committee discussed the terms "prescribing" and "ordering" as they pertain to the statement and decided that "prescribing" was the most appropriate term to use in this case. The Committee discussed how some states have laws that allow independent authority of pharmacists to prescribe and administer medications when a public health

emergency arises. The Committee was pleased with these laws and wanted to encourage broader adoption by the states. The Committee wanted to clarify that this is not just concerning refills, but rather a wide scope that includes scenarios in which medications need to be initiated for the first time, an example given was certain antibiotics in acute scenarios. The Committee believes this stance aligns with similar APhA Policy, namely **2013, 2009 Independent Practice of Pharmacists,** and **2017 Patient Access to Pharmacist-Prescribed Medications.** (5)

18. The Committee reviewed existing APhA policy **2004, 1990 Freedom to Choose** and agreed the patient should still be able to select a pharmacy or pharmacist of their choosing when accessing care. The Committee acknowledge the current strategy used by APhA in its advocacy is to ensure any willing and able pharmacy practitioner is not excluded from providing care, in particular during any public health or other emergency. (6)
19. The Committee specifically developed this statement to highlight the need for payment of services during public health emergencies. The Committee did review the following existing APhA policies and still felt a statement regarding payment during public health emergencies was necessary: **2011, 1994 APhA's Role and Development of New Payment Systems**, **2017, 2012 Contemporary Pharmacy Practice**, and **2014 Care Transitions**. (7)
20. The Committee specifically included the language "alternate care sites" as this is a reference to the numerous temporary care sites established, as needed, in many states. The CDC does not have a single definition of an alternate care site, but they do provide lengthy descriptions. The CDC breaks down these sites into three categories, Non-Acute Care, Hospital Care, and Acute Care. Additional information can be found here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/alternative-care-sites.html. The inclusion of "delivery models" in this statement encompasses activities such as telehealth and other forms of virtual care. (8)

Continuity of care and the role of pharmacists in public health emergencies

Background Paper Prepared for the 2020-2021 APhA Policy Committee

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Issue

The American Pharmacists Association (APhA) Board of Trustees has directed the 2020-2021 Policy Committee to recommend policy to the APhA House of Delegates related to continuity of care and the role of pharmacists in a public health emergency (PHE). The Board's guidance on this topic included, but was not limited to, pharmacists' role in triaging and testing, supporting the patient through continuity of care, and education from colleges/schools of pharmacy as well as through continuing education for the pharmacy team.

Summary of Key Concepts

- Diseases that cause PHE can be devastating to individuals, communities, as well as the healthcare system.
- Pharmacists are valuable, essential healthcare team members able to assess the needs of individual patients, triage situations, and provide patient care services, both in person or through telehealth.
- Pharmacists can conduct point-of-care testing for patients at pharmacies, and when authorized, prescribe medications (test and treat model), providing easy access to care and preventing unnecessary utilization of health system resources.
- Many people forgo necessary healthcare during a PHE and pharmacists have a role in helping patients to continue to seek and access appropriate medical care.
- Pharmacists know what medications patients are taking, are familiar with their medical conditions, and generally see patients more frequently than other healthcare providers - providing ample opportunity to encourage patients not to forgo important healthcare services during a PHE.
- Included in the continuity of care is promoting that patients receive immunizations according to recommended schedules, as well as any novel vaccines for the PHE illness.
- Pharmacists and student pharmacists can benefit from ongoing education regarding the identification, mitigation and management of a PHE and their role(s) within community response.

Background

Definitions

Continuity of Care

ASHP's Continuity of Care Task Force defines continuity of care as "a longitudinal process that is coordinated and provided among practitioners and organizations over time, consistent with the ongoing needs of the individual patient."[1]

Public Health Emergency

The World Health Organization (WHO) defines a public health emergency (PHE) as: "an occurrence or imminent threat of an illness or health condition, caused by bio-terrorism,

epidemic or pandemic disease, or a novel and highly fatal infectious agent or biological toxin, that poses a substantial risk of a significant number of human facilities or incidents or permanent or long-term disability."[2]

Current Landscape

Evaluation of the pharmacist's role in a PHE is timely given the unprecedented COVID-19 pandemic facing the world in 2020. This PHE has impressed upon pharmacists the realization that:

1) Pharmacists are "essential" professionals,[3]
2) The delivery of health care is changing quickly,[4] and
3) The safety of patients, pharmacy staff, and the general public is of utmost importance.

The PHE also caught many businesses off guard, including pharmacies, as many entities have realized their PHE preparedness policy was not sufficient—or even in in existence. As a result, many pharmacies across the country quickly implemented new policies, and in subsequent weeks revised those policies to better meet the changing needs of patients and employees alike.[5,6,7]

In addition to the policy-related and financial challenges that a PHE presents, pharmacists have an even more important challenge related to the continuity of patient care. It has been well established that pharmacists have a significant role to play in the continuity of care in a patient's health care journey.[8] Adding to that process the nuances of PHE response, command structures, resource limitations, politics, and a lack of consistent recognition for the pharmacist's role in team-based care, it becomes apparent a PHE creates an environment ripe for suboptimal care.

The following statements provide context for the role of pharmacists' during a PHE.

The Joint Commission of Pharmacy Practitioners (JCPP) is a group comprised of 13 leading pharmacy organizations in the country that help provide consensus, widely agreed upon statements for the pharmacy community. In their Vision for Pharmacists' Practice,[9] JCPP states the following as 1 of the 5 responsibilities of pharmacists: "As members of the patient-centered health care team, pharmacists will be accountable for health, medication-related, and patient and population-specific needs by assuming responsibility for: The promotion of wellness, health improvement, and disease prevention."

Within the Accreditation Council for Pharmacy Education (ACPE) Standards for the doctor of pharmacy (PharmD) program,[10] one of the required didactic content areas, viewed as central to a contemporary, high-quality pharmacy education in the Doctor of Pharmacy curriculum, reads as follows: "Public Health: Exploration of population health management strategies, national and community-based public health programs, and implementation of activities that advance public health and wellness, as well as provide an avenue through which students earn certificates in immunization delivery and other public health-focused skills."

These statements identify that pharmacists have a responsibility when it comes to public health matters and should have the ability to meet public health expectations of patients and communities.

Further exploration of comments made by public health organizations support the role of pharmacists in PHE.

The American Public Health Association (APHA) describes pharmacists[11] as having "many functions that align with those of the essential health services that are critical to public health. Pharmacists are in a unique setting central to the community that enables them to monitor health status, develop and mobilize community partners and empower community members through education, screening, and dissemination of information."

A 2017 report[12] issued by Johns Hopkins Bloomberg School of Public Health describes pharmacy as "an untapped resource for public health," and go on to state "expanding pharmacists' roles could benefit the public during an infectious disease crisis," and "public health benefits greatly from repeated successful partnerships with community pharmacy during disease emergencies; however more can be done in planning so that pharmacies can fulfill valuable public health roles, particularly during a pandemic."

Despite JCPP stating that pharmacists are responsible for population-specific needs and disease prevention and ACPE requiring education on public health for all pharmacists, many pharmacists need more education and resources to help them prepare for their current and future roles during a PHE. The public health associations clearly believe that pharmacists have an important role to play, yet questions remain among decision-makers and healthcare practitioners as to what exactly the role of pharmacists is when it comes to PHE.

- Does the role differ from the traditional sense?
- Are there extra responsibilities or expectations?
- Are there new priorities that must be taken into consideration?
- How does the pharmacy profession adapt in order to best serve patients and communities in a PHE?

The answers to these questions may partially depend on the pharmacy practice setting.

Taking a closer look at the following three categories will help guide pharmacists in all practice settings as they respond to a PHE and provide continuity of care for patients. It is important to consider pharmacists' roles in a PHE as it relates to triaging and testing, continuity of medical care, and future preparedness.

Triaging and Testing

When a public health emergency is declared, it can put a great strain on the healthcare system and increase demand upon healthcare practitioners. To alleviate some of this strain and demand, pharmacists are an accessible, highly trained resource that can make substantial impacts at the start of the course of illness or even before it. As noted in his June 9, 2020, white paper[13] entitled "Preparing for the Next Pandemic", Chairman Lamar Alexander of the U.S. Senate Committee on Health, Education, Labor, and Pensions (HELP) Committee asserts that "many states lack capacity to evaluate, diagnose, and treat large numbers of patients that would present during a public health emergency." Although the report doesn't mention pharmacists, it is clear that certain policy makers recognize the gap that exists in healthcare when it comes to patient evaluation during a public health emergency. Chairman Alexander goes on to recommend that

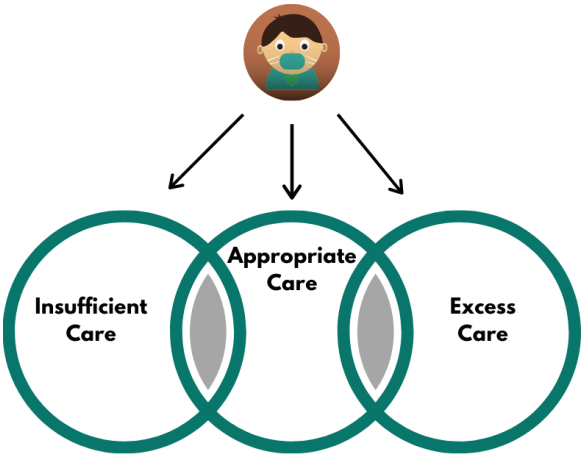
"CDC, states, and healthcare professionals should work together to identify barriers to earlier identification of cases."

Pharmacists' Roles in Triaging

Pharmacists are ready and able to step in and facilitate a professional triaging and screening process through interviewing patients and assessing their symptoms or lack of symptoms. Engaging pharmacists in this activity can provide patients with easier access to a knowledgeable healthcare provider.[14] It also frees up physicians' time to focus on more seriously ill patients. In a recently published article examining the accessibility of pharmacists, researchers found that median yearly encounters with community pharmacy statistically outnumbered encounters with primary care physicians by 13 to 7, respectively.[14] This is noteworthy and relevant to a PHE because during many PHE, physicians, already in high demand, should focus on their complicated patients and not on triaging that can adequately be done by other healthcare practitioners. After Hurricane Matthew devasted some North Carolina counties in 2016, many pharmacists leapt into action to serve patients in this PHE.[15] Local pharmacies collaborated to manage patients' medical issues onsite, which reduced the expenditure of resources from reserved supplies. As two North Carolina pharmacists involved with this regional emergency put it, "[p]harmacists have the ability to perform health screenings, ensure pharmaceutical resources are appropriately and safely expended, disseminate medical information, triage, ensure appropriate storage conditions of pharmaceutical products, and provide immunizations."[15]

As access points to the community, pharmacists should feel empowered to help in community surveillance, triaging patients toward the appropriate care based on their level of symptoms and/or exposure, mitigation activities and management of patients. Pharmacists can assist patients with discerning if they need to go to the emergency department, urgent care, call a doctor for an appointment, or self-manage by simply staying home and monitoring for symptoms. This can help to avoid unnecessary pressures on the healthcare system and limited resources, but on the other hand, prevent some patients from staying home when they actually need emergency assistance. As healthcare providers, pharmacists have a responsibility to help patients to understand the level of care necessary for them as individuals. Figure 1 depicts the triaging system that pharmacists can facilitate; it includes some gray areas of overlap because there is not always a straightforward answer as to which level of care is appropriate at any given time.

Figure 1. Pharmacist Triaging System



As proven with COVID-19, patient triaging can be done both in person and/or through various telehealth technologies. Telehealth can facilitate PHE mitigation strategies by promoting social distancing, which is a safer option for patients and healthcare personnel alike.[4]

Pharmacists should be equipped with the ability, knowledge and resources to utilize telehealth technologies to continue to provide triaging services remotely. Triaging via telehealth could be especially useful for patients who live in rural areas or those without reliable transportation.

Pharmacists should not only be aware this technology exists, but also be trained and ready to implement it when needed. Until such time as the use of telehealth becomes codified as a standard tool for the delivery of patient care by pharmacists and other members of the healthcare team, utilizing emergency declarations during a PHE will play an important role in enabling pharmacist participation.

During the declared PHE, there could be regulatory changes such as removal of interstate restrictions on practice or restrictions on where the provider and/or patient is located that impact the delivery of telehealth services. It would also behoove pharmacists to stay current with telehealth changes (authority and reimbursement) as they potentially occur in a PHE.

The recent uptake in telehealth by patients and providers alike has spurred many healthcare organizations, such as the American Pharmacists Association and American Society of Health-System Pharmacists to advocate[16,17] for telehealth flexibilities to be maintained - showing this is likely a long-term change for pharmacy.

Pharmacists' Roles in Testing

If the triaging process leads the pharmacist to identify that the patient qualifies for testing, if the pharmacist receives an order from a physician for testing, or if the patient simply requests testing, pharmacists, as authorized, can provide specimen collection and point-of-care testing.

It is clear that the federal authorities are aware that pharmacists have a major role to play when it comes to point-of-care testing as well as patient assessment. In recent regulatory rule changes, the Centers for Medicare and Medicaid Services (CMS) acknowledged the importance of having pharmacists help to provide both patient assessment and specimen collection services by permitting pharmacists to "order" COVID-19 tests.[18] Early on in COVID-19 regulations, CMS noted of pharmacies that "such point-of-care sites are a key component in expanding COVID-19 testing capacity."[19] However, without legislative action by the Congress, pharmacists currently need approval from CMS to conduct point-of-care testing or an "incident to," relationship with a physician or non-physician practitioner (NPP) authorized to directly bill Medicare services in order to receive payment for conducting all of these services.[18] CMS' efforts to create these workarounds within current statutory authority means pharmacists have an opportunity to demonstrate the value they can bring as healthcare team members during PHE.

In May 2020, the National Community Pharmacists Association (NCPA) sent a survey[20] to 8,000 pharmacy owners and managers regarding COVID-19 and received 315 responses. One of the questions related to the offering of point-of-care testing in the early days of the COVID-19 pandemic:

"Did you offer point-of-care testing prior to March 2020?

72% responded No

28% responded Yes"

Broad engagement of pharmacies and pharmacists has been limited for numerous reasons, including regulatory barriers, authority, supply access (personal protective equipment), practice challenges, payment, and more. It remains to be seen how many community pharmacies will incorporate point-of-care testing into their workflow in 2020 and beyond. Although historically point-of-care testing in pharmacies has been underutilized, it is becoming clear that pharmacists could have a significant role to play in this arena.

Depending on the PHE at hand, pharmacists could likely interpret the results of point-of-care testing and take appropriate mitigation and/or countermeasures, including prescribing medications based on the results of the test or the referral of patients as appropriate. Pharmacists could also conduct point-of-care tests to rule out other respiratory infections, such as flu and respiratory syncytial virus (RSV).

Involving pharmacists in the beginning stages of potential illness, through triaging and point-of-care testing, reduces a major barrier to early identification of cases. In addition, pharmacists are able to coordinate with health departments to record and track emerging diseases through the electronic reporting of test results or other surveillance measures. This early system of reporting the data could be very valuable, and having surveillance relating to others potentially exposed to illness could save lives. Pharmacists can make a big impact at this initial point of contact, and it is clear that pharmacists have an important role in triaging and testing for disease.

Continuity of Medical Care

When a PHE arises, people have very different responses as to how the PHE declaration will impact their lives and alter their personal habits. Inconsistent response across society, as seen in COVID-19, is understandable given that most people make their decisions based on their own personal circumstances and what they perceive as best for them and their loved ones. However, some of these decisions can be detrimental to a person's health if they suddenly halt medical care they had previously received, or forgo medical care they now need as a result of the PHE. Not seeking appropriate medical care early on can lead to progression of conditions, increased rates of hospitalizations[21] overall worse health outcomes.[22] It has been well documented that many people have avoided proper medical treatment during the COVID-19 pandemic,[23] which could mean life-threatening health issues are being left untreated. There are care needs beyond those directly related to the disease or illness of the PHE. Not maintaining control of chronic illness, preventive care or ignoring the need to address acute illness could lead to worsening health conditions and more costly treatment.

A study published in the New England Journal of Medicine in July 2020 by researchers at Vanderbilt University Medical Center[24] surveyed more than 1300 patients about returning to routine health care. More than half (55%) of respondents admitted to delaying routine health care during the COVID-19 pandemic. The primary motivator was anxiety about contracting COVID-19 (48%), followed closely by following government stay-at-home orders (47%), then following doctor's advice (43%), and lastly, wanting to free up healthcare resources to address COVID-19 (38%). When asked what the major concerns were for returning to normal health care, the greatest response was severe concern about getting sick from other patients.[24]

In addition, a recent Centers for Disease Control and Prevention (CDC) study found that by June 30, 2020, because of concerns about COVID-19, an estimated 41% of U.S. adults had delayed or avoided medical care including urgent or emergency care (12%) and routine care (32%).[25] Avoidance of urgent or emergency care was more prevalent among unpaid caregivers for adults, persons with underlying medical conditions, Black adults, Hispanic adults, young adults, and persons with disabilities.[25]

While these concerns are legitimate, pharmacists have an important role in helping patients discern the best course of action related to their individual care needs unrelated to the illness causing the PHE. In the aforementioned white paper "Preparing for the Next Pandemic"[13], Senator Alexander makes recommendations to "[g]et Americans back to their routine health care safely, and develop better plans for the future so that doctors and hospitals can continue to provide health care services and outpatient treatment during a pandemic." While the Senator uses the word "pandemic," his message is applicable to the larger public health emergency realm. Delaying medical care for some things, such as elective surgeries or yearly checkups, might be appropriate, but there are many procedures or preventive and maintenance exams that should not be delayed.

Critical to overcoming the hesitancy of individuals to accessing medical and pharmacy care is an understanding of the steps being taken by pharmacies to protect them from a PHE illness. This includes the wearing of masks by pharmacy personnel, the patient and caregivers, wearing of gloves, social distancing, curb-side care delivery, hand washing and sanitization, etc.

Pharmacists have been highly trained to recognize signs and symptoms of serious medical issues, such as heart attack, heart failure or COPD, and are capable of helping patients recognize these symptoms as well. During a PHE, this recognition and subsequent referral is perhaps even more important. Many pharmacists are familiar with patients' medical conditions, and usually have multiple opportunities[14] to ask the patient how well controlled their condition is, or to check if they are adherent to prescribed medications. Pharmacists' promotion of uninterrupted medical care could prevent unnecessary use of emergency room visits and a decline in patients' health. On March 20, 2020, the American Pharmacists Association, along with 11 other pharmacy associations, released joint policy recommendations to combat the COVID-19 pandemic. These recommendations[26] included for pharmacists to independently evaluate and manage medications through therapeutic interchange, chronic care dose adjustment, refill authorizations, quantity modifications, for any pharmacy to provide early refills, prescriptions over 30-day supply, and emergency fills for non-controlled drug substances without a prescription when no refills remain. These practical methods for aiding in the continuity of care are of the utmost importance, and pharmacists must understand their role in this process. Employing these methods, if and when they become legally authorized, becomes part of the responsibility of pharmacists during PHE.

During a PHE, information is rapidly evolving, evidence-based data can be lacking, and conflicting messages can cause confusion. Pharmacists have an important role to play in acknowledging patient concerns empathetically, and being proactive in providing factual information and sound medical advice during the PHE. Pharmacists continue to rank very high in terms of Americans' views of professions with high honesty and ethics[27], showing the level of trust that the American public places on pharmacists. Patients take pharmacists'

recommendations seriously—if the pharmacist actively offers his/her professional opinion. Preventing the neglect of established health issues can be a lifesaving intervention that pharmacists can quickly make in the lives of many patients during a PHE. If a patient insists on delaying medical care in some way, the pharmacist could still intervene by discussing what symptoms the patient should be aware of and look out for while at home. Pharmacists' support goes beyond pharmacological advice during a PHE and could include more psychological support. Pharmacists know their patients well, and by paying attention to their words and actions could recognize emotional or psychological conditions the patient might be experiencing, such as anxiety or loneliness. COVID-19 has also taught us that PHE can cause a myriad of uncommon medications or unproven, experimental products to come on the market[28,29] and patients might be desperate to try things they wouldn't normally take. Many patients don't know what to believe, but pharmacists' knowledge and counseling can address misinformation and provide appropriate guidance. Furthermore, pharmacists should be aware that patients who claim to have recovered from the PHE illness might still experience health changes or newfound adverse effects of medications they have been taking for a long time. A PHE illnesses could cause unknown long-term effects, and the patient needs the pharmacist to help them recognize symptoms or reactions that seem abnormal. Pharmacists will be able to recognize new adverse reactions to medications and report them to FDA MedWatch, state health departments or drug manufacturers.

In addition to assisting with managing patients' conditions, pharmacists should continue to follow CDC and Advisory Committee on Immunization Practices (ACIP) guidelines related to the administration of immunizations during a PHE. Pharmacists have a longstanding history of being champions of delivering immunizations, with at least 1 in 4 adults who receive a seasonal influenza vaccine doing so in a pharmacy or retail setting.[30] In PHE people may feel that immunizations are suddenly not important, necessary, or a priority. Although many patients might fear going out in public or having another person (the administering pharmacist) in very close proximity to them, pharmacists can ease this anxiety by providing factual knowledge about the necessity of getting immunized on schedule and the steps the pharmacy is taking to protect the patient and pharmacy staff. Pharmacists should align their recommendations on immunizations and other patient care services with that of entities like the CDC and ACIP. Pharmacists are able to exercise their professional judgement to advise patients on appropriate steps for each patient. During the COVID-19 pandemic, the CDC has advised pharmacists to evaluate the risk of an in-person patient encounter versus the benefits of receiving the service.[31] Pharmacists are able to counsel patients on the importance of staying up to date with all traditional immunizations recommended for their age group and risk level (shingles, pneumonia, etc.). Delaying these vaccines could prove to be just as detrimental to a patient's health as the cause of the PHE. For example, the WHO recently stated that 117 million children could be at risk of missing out on measles vaccines as COVID-19 surges.[32] Furthermore, lack of routine vaccination could lead to a situation in which the patient is fighting off multiple different pathogens simultaneously, such as influenza and COVID-19. If the PHE is related to a new disease for which a novel vaccine is imminent, pharmacists' strong support of immunizations for the PHE illness is crucial. Pharmacists can be an extremely valuable member of the healthcare team when it comes to addressing the PHE through the support and promotion of receiving immunizations, treatments, and prophylaxis, both novel and traditional.

Future Preparedness

In order to better prepare for future PHE, a shift is required so that pharmacy is proactive about PHE. To make this happen, increased education is necessary for both students and practitioners.

Students are expected to be taught some degree of public health management strategies, but ACPE's "Standard Statement on Public Health," is a relatively minor statement in the current standards document. The lack of sufficient instruction to schools about PHE protocols or roles that should be assumed by pharmacists in PHE has led pharmacists to graduate without a complete understanding as to how to adapt their role. A recently published article looking into Pharmacy Emergency Preparedness and Response (PEPR)[33] notes that the 2013 Center for the Advancement of Pharmacy Education (CAPE) outcomes, which guide pharmacy school curricula, "make no mention of Emergency Preparedness and Response, nor related topics such as disaster or emergency preparedness, pandemic planning, or civil defense."[34] The PEPR article continues to explain that the American Association of Colleges of Pharmacy (AACP)'s Advocacy Committee conducted research in 2010 that looked at pharmacy schools' alignment of their education with the strategic goals of the Health Resources and Services Administration (HRSA). One of HRSA's goals is to "[e]nhance the ability of the health care system to respond to public health emergencies."

In this survey, 24 of the 38 reporting colleges/schools of pharmacy reported activities relating to Emergency Preparedness and Response.[35] The majority of these 24 simply noted immunization education and training as their Emergency Preparedness and Response activity. If this trend were to be extrapolated for all pharmacy colleges/schools, this would mean that 37% of pharmacists are graduating without Emergency Preparedness and Response activities. Perhaps more concerning is that even if most colleges/schools think they are covering Emergency Preparedness and Response, the education is related only to immunization training. ACPE Standards, as well as the CAPE outcomes, need to provide colleges/schools of pharmacy with more direct guidance on training pharmacists to be prepared to handle PHE. It is worth noting that one of the North American Pharmacist Licensure Examination (NAPLEX) Competency Statements (1.5.5) is to "advocate individual and population-based health and safety, considering: emergency preparedness protocols."[36]

Practicing pharmacists also deserve better training when it comes to PHE to ensure that they are appropriately prepared. Over the last 20 years, a multitude of public health emergencies have influenced emergency preparedness planning, including COVID-19, Ebola (2014), Bird flu (2013), Hurricane Sandy (2012), MERS (2012), H1N1 (2009), Hurricane Katrina (2005), SARS (2002), and the September 11, 2001 attacks. Many pharmacists are learning about emergency preparedness from "on the job" experience, continuing education, or other resources. In addition, there are also significant new public health resources available now, both technological[4] and traditional[37] that were not available 20 years ago. For that reason, it is crucial that pharmacists continue to educate themselves on how to handle PHE and what their role is. To help fill in gaps in knowledge, continuing pharmacy education (CPE) is available and required of pharmacists. A quick analysis of ACPE's P.L.A.N. tool[38] to help pharmacists find CPE offerings reveals how prevalent Emergency Preparedness and related topics to continuity of medical care currently are in CPE offerings. Table 1 shows the number of CPE offerings currently available to pharmacists,

over the span of 8/2/2020 to 8/2/2021, based on keyword searches for both live and home study knowledge-based events. Other keywords are added for comparison.

Table 1 – Keyword search of Live and Home Study Knowledge-based events

Criteria	Emergency Preparedness	Heart Failure	Cancer	Immunizations	Diabetes
Knowledge + Live	9	14	25	16	210
Knowledge + Home study	17	8	52	75	90

While it is encouraging that some material on Emergency Preparedness exists, it is clear that there is room for growth in this area. Pharmacy colleges/schools, associations, and employers should encourage pharmacists to invest in the Emergency Preparedness area of their professional development.

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule applies during PHE, although there may be some alterations and flexibilities made to assist healthcare providers. Pharmacists would be well served to be familiar with these changes in order to best serve their patients. For example, in March 2020, after declaration of the nationwide emergency for COVID-19, HHS exercised the authority to waive sanctions and penalties against a covered hospital that does not comply with the following provisions of the HIPAA Privacy Rule during the public health emergency:[39]

- the requirements to obtain a patient's agreement to speak with family members or friends involved in the patient's care. See 45 CFR 164.510(b).
- the requirement to honor a request to opt out of the facility directory. See 45 CFR 164.510(a).
- the requirement to distribute a notice of privacy practices. See 45 CFR 164.520.
- the patient's right to request privacy restrictions. See 45 CFR 164.522(a).
- the patient's right to request confidential communications. See 45 CFR 164.522(b).

These examples of changes in the HIPAA Privacy Rule could affect pharmacists' day-to-day work and underscore the importance of pharmacists being properly informed and educated about public health emergencies. Other areas of PHE education that colleges or schools of pharmacy or CPE could cover include telehealth services, engineering disease-control tactics, administrative disease control tactics, empathy and destigmatizing, surveillance and reporting, and coordinating the local triaging response. Pharmacists and student pharmacists alike need better PHE preparation from their colleges/schools of pharmacy, employers, and pharmacy associations, through incorporation into pharmacy curricula guided by CAPE outcomes and ACPE Standards, as well as new CPE offerings that are practical and modern.

Conclusion

Pharmacists' roles in public health emergencies are continuing to expand, especially as we learn from the current COVID-19 pandemic. Diseases that cause a PHE can be devastating to the healthcare system, but pharmacists are valuable healthcare team members able to provide critical assistance. Pharmacists are highly capable of providing triaging services, both in person or

through telehealth if necessary. Pharmacists can conduct point-of-care testing for patients at pharmacies, providing easy access to care and preventing unnecessary utilization of hospital resources. For a number of reasons, many people forgo necessary healthcare during PHEs, and pharmacists have a role in helping patients in managing their conditions and seeking appropriate medical care. Pharmacists know what medications patients are taking, are familiar with their medical conditions, and see patients more frequently than other healthcare providers. This provides ample opportunity to encourage patients not to interrupt important healthcare services during PHE. Included in the continuity of care is promoting that patients receive immunizations as regularly scheduled, as this can help prevent a variety of problems down the road. Furthermore, pharmacists' strong support of any novel vaccine to prevent the PHE illness is crucial. Pharmacists and student pharmacists may lack proper education about PHEs and their role if one occurs. Through improved education in colleges/schools of pharmacy as well as CPE offerings, the pharmacy profession can become better prepared for the next PHE.

References

1. Continuity of care in medication management: Review of issues and considerations for pharmacy. (2005). *American Journal of Health-System Pharmacy, 62*(16), 1714-1720. doi:10.2146/ajhp050257
2. World Health Organization. Humanitarian Health Action: Definitions: Emergencies. (2014, November 17). Retrieved August 1, 2020, from https://www.who.int/hac/about/definitions/en/
3. Kennedy, L., & Hultin, S. (2020, May 21). National Conference of State Legislatures. COVID-19: Essential Workers in the States. Retrieved August 1, 2020, from https://www.ncsl.org/research/labor-and-employment/covid-19-essential-workers-in-the-states.aspx
4. Centers for Disease Control and Prevention. Using Telehealth to Expand Access to Essential Health Services during the COVID-19 Pandemic. (2020, June 10). Retrieved August 1, 2020, from https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html
5. CVS Health. CVS Health response to the COVID-19 outbreak. (2020, March 17). Retrieved August 1, 2020, from https://cvshealth.com/news-and-insights/press-releases/cvs-health-response-to-the-covid-19-outbreak
6. Pharmacy Times. CVS Health to Provide Bonuses, Benefits, Hire 50,000 in Response to COVID-19 Pandemic. (2020, March 26). Retrieved August 1, 2020, from https://www.pharmacytimes.com/news/cvs-health-to-provide-bonuses-benefits-hire-50000-in-response-to-covid-19-pandemic
7. Demrovsky, C. (2020, January 28). Forbes. What Businesses Can Do In Response To The Coronavirus. Retrieved August 1, 2020, from https://www.forbes.com/sites/chloedemrovsky/2020/01/28/what-businesses-can-do-about-the-coronavirus/
8. Tetuan, C. E., Guthrie, K. D., Stoner, S. C., May, J. R., Hartwig, D. M., & Liu, Y. (2018). Impact of community pharmacist–performed post-discharge medication reviews in transitions of care. *Journal of the American Pharmacists Association, 58*(6), 659-666. doi:10.1016/j.japh.2018.06.017
9. JCPP Vision for Pharmacists' Practice. Complementary Piece to JCPP Vision for Pharmacists' Practice. (2014, May). Retrieved August 1, 2020, from https://jcpp.net/resourcecat/jcpp-vision-for-pharmacists-practice/
10. Accreditation Standards and Key Elements For The Professional Program In Pharmacy Leading To The Doctor Of Pharmacy Degree. (2015, February 2). Retrieved August 1, 2020, from https://www.acpe-accredit.org/pdf/Standards2016FINAL.pdf
11. American Public Health Association. The Role of the Pharmacist in Public Health. (2006, November 8). Retrieved August 1, 2020, from https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/07/13/05/the-role-of-the-pharmacist-in-public-health
12. Serving The Greater Good. Public Health & Community Pharmacy Partnerships. (2017, October). Retrieved August 1, 2020, from https://www.centerforhealthsecurity.org/our-work/pubs_archive/pubs-pdfs/2017/public-health-and-community-pharmacy-partnerships-report.pdf
13. Alexander, L. (2020, June 9). Preparing for the Next Pandemic: A White Paper. Retrieved August 1, 20200, from https://www.alexander.senate.gov/public/_cache/files/0b0ca611-05c0-4555-97a1-5dfd3fa2efa4/preparing-for-the-next-pandemic.pdf
14. Berenbrok, L. A., Gabriel, N., Coley, K. C., & Hernandez, I. (2020). Evaluation of Frequency of Encounters With Primary Care Physicians vs Visits to Community Pharmacies Among Medicare Beneficiaries. *JAMA Network Open, 3*(7). doi:10.1001/jamanetworkopen.2020.9132
15. Moore, A. (2017, May 30). Disaster Relief: A Look Into the Pharmacist's Role. Retrieved August 1, 2020, from https://pubmed.ncbi.nlm.nih.gov/28576961/
16. American Pharmacists Association. APhA coronavirus watch: Pharmacists eye advocacy for telehealth. (2020, June 22). Retrieved August 1, 2020, from https://www.pharmacist.com/article/apha-coronavirus-watch-pharmacists-eye-advocacy-telehealth?is_sso_called=1
17. American Society of Health-System Pharmacists. COVID-19 Advocacy: Working with the Federal Agencies. (n.d.). Retrieved August 1, 2020, from https://www.ashp.org/Professional-Development/ASHP-Podcasts/COVID-19-Updates/COVID-19-Advocacy-Working-with-the-Federal-Agencies?loginreturnUrl=SSOCheckOnly
18. Department Of Health And Human Services. Medicare and Medicaid Programs, Clinical Laboratory Improvement Amendments (CLIA), and Patient Protection and Affordable Care Act; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency. (2020, August 24). Retrieved August 24, 2020, from https://www.cms.gov/files/document/covid-ifc-3-8-25-20.pdf
19. Centers for Medicare & Medicaid Services. Trump Administration Issues Second Round of Sweeping Changes to Support U.S. Healthcare System During COVID-19 Pandemic. (2020, April 30). Retrieved August 1, 2020, from

https://www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweeping-changes-support-us-healthcare-system-during-covid
20. National Community Pharmacists Association: Survey: COVID-19 Will Have Lasting Changes in the Way Local Pharmacies Operate. (2020, June 1). Retrieved August 1, 2020, from https://ncpa.org/sites/default/files/2020-06/covid-survey-results-june-2020.pdf
21. Agency for Healthcare Research and Quality. Ch 8. Efficiency. (2014, May 09). Retrieved August 1, 2020, from https://archive.ahrq.gov/research/findings/nhqrdr/nhqr13/chap8.html
22. Prentice, J., & Pizer, S. (2007, April). Delayed access to health care and mortality. Retrieved August 1, 2020, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955366/
23. Centers for Disease Control and Prevention. Impact of the COVID-19 Pandemic on Emergency Department Visits - United States, January 1, 2019–May 30, 2020. (2020, June 11). Retrieved August 1, 2020, from https://www.cdc.gov/mmwr/volumes/69/wr/mm6923e1.htm?s_cid=mm6923e1_w
24. Patel, S., Lorenzi, N., Smith, T., Carlson, B., & Sternberg, P. (2020, July 13). Critical Insights from Patients during the Covid-19 Pandemic. Retrieved August 1, 2020, from https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0299
25. Centers for Disease Control and Prevention. Delay or Avoidance of Medical Care Because of COVID-19–Related Concerns - United States, June 2020. (2020, June). Retrieved September 16, 2020, from https://www.cdc.gov/mmwr/volumes/69/wr/mm6936a4.htm
26. PHARMACISTS AS FRONT-LINE RESPONDERS FOR COVID-19 PATIENT CARE. (2020, March 20). Retrieved August 1, 2020, from https://www.pharmacist.com/sites/default/files/files/APHA%20Meeting%20Update/PHARMACISTS_COVID19-Final-3-20-20.pdf
27. Reinhart, R. (2020, January 6). Gallup. Nurses Continue to Rate Highest in Honesty, Ethics. Retrieved August 1, 2020, from https://news.gallup.com/poll/274673/nurses-continue-rate-highest-honesty-ethics.aspx
28. Heilweil, R. (2020, April 17). Vox. Coronavirus scammers are flooding social media with fake cures and tests. Retrieved August 1, 2020, from https://www.vox.com/recode/2020/4/17/21221692/digital-black-market-covid-19-coronavirus-instagram-twitter-ebay
29. Federal Trade Commission. Consumer Information. Cracking down on fake COVID-19 cures. (2020, July 31). Retrieved August 1, 2020, from https://www.consumer.ftc.gov/blog/2020/07/cracking-down-fake-covid-19-cures
30. Fitzgerald, T. J., Kang, Y., Bridges, C. B., Talbert, T., Vagi, S. J., Lamont, B., & Graitcer, S. B. (2016). Integrating pharmacies into public health program planning for pandemic influenza vaccine response. *Vaccine, 34*(46), 5643-5648. doi:10.1016/j.vaccine.2016.09.020
31. Centers for Disease Control and Prevention. Guidance for Pharmacies. (2020, June 28). Retrieved August 1, 2020, from https://www.cdc.gov/coronavirus/2019-ncov/hcp/pharmacies.html?fbclid=IwAR3iN830jGJl9nL4ZC_3-6oYqtfBb_uJGkaQK1bzupq-sMnFluKJnIkTACI
32. World Health Organization. More than 117 million children at risk of missing out on measles vaccines, as COVID-19 surges. (2020, April 17). Retrieved September 15, 2020, from https://www.who.int/immunization/diseases/measles/statement_missing_measles_vaccines_covid-19/en/
33. Aruru, M., Truong, H., & Clark, S. (2020, April 10). Research in Social and Administrative Pharmacy. Pharmacy Emergency Preparedness and Response (PEPR) framework for expanding pharmacy professionals' roles and contributions to emergency preparedness and response during the COVID-19 pandemic and beyond. Retrieved August 1, 2020, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7146711/#bib51
34. Medina, M. (2013). Center for the Advancement of Pharmacy Education 2013 Educational Outcomes. Retrieved August 1, 2020, from https://www.ajpe.org/content/ajpe/77/8/162.full.pdf
35. AACP Reports. Report of the 2009-2010 Standing Committee on Advocacy. (2010). Retrieved August 1, 2020, from https://www.ajpe.org/content/ajpe/74/10/S18.full.pdf
36. National Association of Boards of Pharmacy. NAPLEX Competency Statements. (n.d.). Retrieved August 1, 2020, from https://nabp.pharmacy/naplex-competency-statements/
37. Centers for Disease Control and Prevention. Healthcare Preparedness and Response. (2018, October 15). Retrieved August 1, 2020, from https://www.cdc.gov/cpr/readiness/healthcare/index.htm
38. Accreditation Council for Pharmacy Education. Continuing Education Provider Accreditation. (n.d.). Retrieved August 1, 2020, from https://www.acpe-accredit.org/continuing-education-provider-accreditation/
39. Department of Health & Human Services. COVID-19 & HIPAA Bulletin Limited Waiver of HIPAA Sanctions and Penalties During a Nationwide Public Health Emergency. (2020, March). Retrieved August 1, 2020, from https://www.hhs.gov/sites/default/files/hipaa-and-covid-19-limited-hipaa-waiver-bulletin-508.pdf?language=es

Related APhA Policy

2016,2011,2002,1963 Role of the Pharmacist in National Defense

APhA endorses the position that the pharmacist, as a member of the health care team, has the ethical responsibility to assume a role in disaster preparedness and emergency care operations. These responsibilities include:

1. Pharmacists, by their education and training as medication experts, should be involved intimately in all elements of the procurement, storage, handling, compounding, and dispensing of drugs and supplies in planning for as well as during any national emergency.
2. Pharmacists, by their education in anatomy, physiology, and pharmacology, are readily adaptable to assist in the emergency medical treatment of patients and for training the public in medical self-help.
3. Pharmacists, by their constant contact with the members of the health team, as well as a significant portion of their communities, provide the potential for coordinating preparedness measures, and establishing meaningful standby emergency operational plans.

In view of these responsibilities, it shall be the further policy of APhA

1. To cooperate with all responsible agencies and departments of the federal government.
2. To provide leadership and guidance for the profession of pharmacy by properly assuming its role with other health profession organizations at the national level (e.g., American Medical Association, American Hospital Association, American Dental Association, American Nurses Association, and American Veterinary Medical Association).
3. To assist and cooperate with all national specialty pharmaceutical organizations to provide assistance and coordination in civil defense matters relevant to their area of concern.
4. To encourage and assist the state and local pharmacy associations in their efforts to cooperate with the state and local governments as well as the state and local health profession organizations in order that the pharmacist may assume his proper place in civil defense operations.
5. To provide leadership and guidance so that individual pharmacists can contribute their services to civil defense and disaster planning, training, and operations in a manner consistent with their position as a member of the health team.

(JAPhA NS3:330 June 1963) (JAPhA NS42(5): Suppl. 1:S62 September/October 2002) (Reviewed 2006)(Reviewed 2010) (JAPhA NS51(4) 483;July/August 2011)(JAPhA 56(4); 379 July/August 2016)

2015 Disaster Preparedness

APhA encourages pharmacist involvement in surveillance, mitigation, preparedness, planning, response, and recovery related to terrorism and infectious diseases.
(JAPhA N55(4); 365 July/August 2015)

2011,2002,1996 Health Mobilization

APhA should continue to:

1. Emphasize its support for programs on disaster preparedness which involve the services of pharmacists (e.g., Medical Reserve Corps) and emergency responder registration networks [e.g., Emergency System for Advance Registration of Volunteer Health Professions (ESAR-VHP)].

2. Improve and expand established channels of communication between pharmacists; local, state and national pharmacy associations, boards and colleges of pharmacy and allied health professions.
3. Maintain its present liaison with the Office of the Assistant Secretary for Preparedness and Response (ASPR) of the Department of Health and Human Services and continue to seek Office of Emergency Management (OEM) assistance through professional service contracts to further develop pharmacy's activities in all phases of preparation before disasters.
4. Encourage routine inspection of drug stockpiles and disaster kits by state boards of pharmacy.

(JAPhA N)S6:328. June, 1966) (JAPhA NS42(5) Suppl. 1:S62. September/October 2002) (Reviewed 2006) (JAPhA NS51(4) 483;July/August 2011)(Reviewed 2016)

2005,2002 Emergency Preparedness

APhA supports the continuing efforts of the Joint Commission of Pharmacy Practitioners working group on emergency preparedness and response to network with the Office of Homeland Security and with any other relevant governmental and/or military agency.

(JAPhA NS42(5): Suppl. 1:S61 September/October 2002)(JAPhA NS45(5):559 September/October 2005)(Reviewed 2006)(Reviewed 2009)(Reviewed 2014)

1979 Dispensing and/or Administration of Legend Drugs in Emergency Situations

1. APhA supports making insect sting kits and other, life-saving, emergency, treatment kits available for lawful dispensing by pharmacists without a prescription order, based on the pharmacist's professional judgment.
2. APhA supports permitting pharmacists to lawfully dispense and administer legend drugs in emergency situations, without an order from a licensed prescriber, provided that
   (a) There is an assessment on the part of the pharmacist and the patient that the drug is needed immediately to preserve the well-being of the patient, and;
   (b) The normal legal means for obtaining authorization to dispense the drug must not be immediately available, such as in cases where the patient's physician is not available, and;
   (c) The quantity of the drug, which can be dispensed in an emergency situation, is enough so that the emergency situation can subside and the patient can be sustained for the immediate emergency, as determined by the pharmacist's professional judgment.
3. APhA supports expansion of state Good Samaritan Acts to provide pharmacists immunity from professional liability for dispensing in emergency situations without order from a licensed prescriber.
4. APhA supports permitting pharmacists to lawfully dispense and/or administer legend drugs without an order from a licensed prescriber during disaster situations.

(Am Pharm NS19(7):68 June 1979) (Reviewed 2002) (Reviewed 2006) (Revised 2007)(Reviewed 2012)(Reviewed 2012)(Reviewed 2017)

2014 Use of Social Media

1. APhA encourages the use of social media in ways that advance patient care and uphold pharmacists as trusted and accessible health care providers.

2. APhA supports the use of social media as a mechanism for the delivery of patient-specific care in a platform that allows for appropriate patient and provider protections and access to necessary health care information.
3. APhA supports the inclusion of social media education, including but not limited to appropriate use and professionalism, as a component of pharmacy education and continuing professional development.
4. APhA affirms that the patient's right to privacy and confidentiality shall not be compromised through the use of social media.
5. APhA urges pharmacists and student pharmacists to self-monitor their social media presence for professionalism and that posted clinical information is accurate and appropriate.
6. APhA advocates for continued development and utilization of social media by pharmacists and other health care professionals during public health emergencies.
(JAPhA 54(4) 357 July/August 2014)

2011 The Role and Contributions of the Pharmacist in Public Health
In concert with the American Public Health Association's (APHA) 2006 policy statement, "The Role of the Pharmacist in Public Health," APhA encourages collaboration with APHA and other public health organizations to increase pharmacists' participation in initiatives designed to meet global, national, regional, state, local, and community health goals.
(JAPhA NS51(4) 482;July/August 2011)(Reviewed 2012)(Reviewed 2016)

2007 Pharmacy Personnel Immunization Rates
1. APhA supports efforts to increase immunization rates of healthcare professionals, for the purposes of protecting patients, and urges all pharmacy personnel to receive all immunizations recommended by the Centers for Disease Control (CDC) for healthcare workers.
2. APhA encourages employers to provide necessary immunizations to all pharmacy personnel.
3. APhA encourages federal, state, and local public health officials to recognize pharmacists as first responders (like physicians, nurses, police, etc.) and prioritize pharmacists to receive medications and immunizations.
(JAPhA NS45(5):580 September/October 2007) (Reviewed 2009)(Reviewed 2014)(Reviewed 2019)

2007 WHO Policy on Infectious Diseases
1. APhA supports the World Health Organization's (WHO's) requirements for accurate and expeditious reporting of infectious diseases from all countries, including unrestricted sharing of infectious substance samples with WHO.
2. APhA supports access to affordable vaccines in all countries.
(JAPhA NS45(5):580 September-October 2007)(Reviewed 2012)(Reviewed 2017)