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 in which patient care delivery would not be possible if a pharmacist who held multiple licenses left a pharmacy, only because the other pharmacists in that pharmacy may not hold a pharmacy license in other states. The Committee further agreed that by addressing the burdens of pharmacist licensure, 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 operate under different laws when treating patients across state lines. (2)
7. The goal of this statement is to address the laws and regulations affecting pharmacists, student pharmacists, and pharmacy technicians in any practice settings. The Committee considered including the location (e.g., community or healthcare 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 the 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 as "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 healthcare, 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 makes 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 focus 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 in the same way 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 their state's budget and/or direction from the state 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 that 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 for license transfer. 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, maintenance of the original licensure would still be required. (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 to which questions are submitted by all states. 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 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 the discussion. (8)

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** policy 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 (PPE) 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 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, acting as decision-makers, and serving as 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 policy 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. Therefore, 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 pharmacists' 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 that often 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 public health emergency. (5)
15. The Committee considered the language around chronic versus acutely needed medications and felt that during public health emergencies 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 term 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 that 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 the need for 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 acknowledged that the current strategy used by APhA in its advocacy is to ensure that 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 does 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)