



California State Board of Pharmacy
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STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
ARNOLD SCHWARZENEGGER, GOVERNOR

NOTICE OF MEETING and AGENDA **Licensing Committee**

Date: December 11, 2007
Time: 9:30 – 12:30

Place: **Samuel Greenberg Board Meeting Room**
(Los Angeles International Airport) – see detailed directions below
1 World Way
Los Angeles, California 90045

This committee meeting is open to the public and will be held in a barrier-free facility in accordance with the Americans with Disabilities Act. Any person with a disability who requires a disability-related modification or accommodation in order to participate in the public meeting may make a request for such modification or accommodation by contacting Michelle Leech (916) 574-7912, at least five working days before the meeting.

Opportunities are provided for public comment on each agenda item. Board members who are not on the committee may also attend and comment.

Note: Pharmacists and pharmacy technicians who attend the full committee meeting can be awarded two hours of CE, in accordance with the board's CE policy. A maximum of four CE hours can be earned each year by attending the meetings of two different board committees.

Call to Order

9:30 a.m.

1. Approved Regulation Amendment to 16 CCR 1749 – Fee Schedule
2. Update of Emergency Preparedness for California Pharmacy Including Presentations by
Thomas N. Aherns, Pharm.D. Department of Public Health
Mark Chew, Pharm.D. Orange County Health Care Agency
Glen Tao, Pharm.D. Los Angeles County Public Health
3. Discussion of Emergency Response by Pharmacies and Wholesalers to the October 2007 California Wildfires
4. Accreditation Standards for Continuing Pharmacy Education by the Accreditation Council for Pharmacy Education
5. Competency Committee Report.

Adjournment

12:30 p.m.

Meeting materials will be available from the board's Web site by December 6, 2007

Memorandum

To: Licensing Committee

Date: December 6, 2007

From: Board of Pharmacy

Subject: Fee Schedule Regulation

FOR INFORMATION

The Office of Administrative Law recently approved the rulemaking to increase the board's fee schedule. To allow time for implementation and appropriate notice to all affected individuals and businesses, the effective date for the new fees is January 1, 2008.

Board staff is working through an implementation work plan, and all licensees with an expiration date in January 2008 were provided with written notice highlighting the change along with the renewal application. In addition staff are revising necessary initial and renewal applications and instructions, and continue to work with programmers to modify the board's computers systems. Staff will continue to highlight the changes to licensees by including a notice with renewal applications sent to all licensees through June 2008. Information about the change is also posted on the board's Web site and an article will be included in the next issue of *The Script*.

Memorandum

To: Licensing Committee

Date: December 6, 2007

From: Board of Pharmacy

Subject: Emergency Preparedness

During the meeting the committee will resume discussion for emergency preparedness. Presentations from three different government agencies about their respective emergency response plans will be provided and diversion emergency response scenarios may be discussed.

- Thomas N. Ahrens, PharmD - Department of Public Health
- Mark Chew, PharmD - Orange County Health Care Agency
- Glen Tao, PharmD – Los Angeles County Public Health

Attached are various articles about emergency response as well as a presentation given by the Emergency Medical Services Authority (EMSA) to DCA's Executive Officers on December 6, 2007, regarding California Medical Volunteers.

Prescription Drugs and Disaster Planning

Key Informant Executive Summary

Prepared for:

Key Informant Interviews

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October 2007

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KEY INFORMANT EXECUTIVE SUMMARY

Chronic disease and the reliance on health-maintenance medications is an ever-increasing public health concern in Los Angeles County (LAC), where chronic medical illnesses account for 80% of the total burden of disease (LAC DHS, 2000) and 15% of LAC residents over age 18 (est. 1,085,000) use a chronic disease medication (LAC Department of Public Health, 2007a).

The societal and medical impacts of chronic disease are further magnified when one considers how persons with chronic illness and those dependent upon health-maintenance drugs will manage in the face of a natural, technological, or terrorism disaster. In the aftermath of Hurricane Katrina of 2005, 29% of households in one Gulf state community required urgent medication refills for chronic conditions (Centers for Disease Control, 2006). To extrapolate this percentage to the LAC community would certainly strain our existing prescription network resources (pharmacies, insurers, providers).

In addition, it is important to note that while many with chronic illness may not be directly affected or injured in a disaster, they nonetheless may experience indirect health outcomes of displacement from their usual source of healthcare and delayed prescription drug access. These indirect outcomes can contribute to detrimental health effects when routine, stabilizing prescription drugs suddenly become unavailable, inaccessible, or scarce commodities (Eisenman, Wold, & Fielding et al., 2006; Boscarino, Adams, & Figley, et al., 2006). Furthermore, inadequate chronic disease medication stockpiles (personal, public, private) are a universal concern affecting not only the individual with the illness, but also community planners, retailers, pharmacists, providers, and insurers who face financial and professional challenges to meet customer/patient/beneficiary needs.

However, despite these foreseeable hazards, little attention and mitigation has yet been paid to medical 'surge' or prescription drug planning for the care of evacuated or internally displaced populations across California, in LA County, or elsewhere (California State DHS, 2007; Shewry, 2007; Currier, King, & Wofford, 2006). In addition, chronic disease medications and their network resources are regularly neglected in national stockpiles and emergency management plans, which instead focus on acute medical and pharmaceutical 'emergency response' disaster needs rather than the short- and long-term chronic 'recovery' needs necessary to sustain community well-being.

To assess this discrepancy, as well as generate feasible recommendations to facilitate greater chronic medication provisions in disaster planning tools for Los Angeles County, this report explored: (1) general prescription drug availability and accessibility for persons with chronic medical illness, (2) disaster preparedness needs of chronic disease patients, especially in acquiring extra supplies or stockpiles of life-saving medications, and (3) how the pharmacy benefits system is prepared for or could respond to a community-wide or national disaster.

Data collection included key informant interviews with insurers, pharmacists & regulatory agencies, and physicians, and focus group interviews with those who have chronic disease or who are caregivers of those with chronic disease. Data were collected January-June 2007.

Lessons Learned Hurricane Katrina

The following lessons on health care systems and disasters were learned from Hurricane Katrina. These lessons served as benchmarks for the current study in guiding proposal development, analyzing key findings, and generating system recommendations.

1. No single entity, whether it is a local, state or federal government, national relief organization, or even the military, can necessarily respond efficiently and effectively in an overwhelming catastrophe without the coordinated partnership of others.
2. The absolute magnitude of people dependent upon prescription drugs for chronic disease health maintenance is overwhelming and will tax the current system in a national disaster. One research study reported that over 70% of Hurricane Katrina survivors identified as having one or more chronic conditions before the hurricane, and that the storm interrupted their disease treatment plan resulting in lack of access to health care, unavailability of prescription medicine, and disrupted insurance coverage (Kessler et al., 2007).
3. Critical health infrastructures, such as medical/pharmaceutical insurance authorization, pharmaceutical delivery, and pharmacy/health care facilities are dependent upon electric and phone service to verify patient insurance eligibility, recall patient medical histories, order supplies, manage care centers, and transmit reimbursement, among other power-essential services. Maintaining an electronic network is essential to disaster relief from sustaining access to phone relay towers to Internet communication; all of these communication technologies failed or were severely limited as a consequence of the Hurricane Katrina storm damage.

Key Findings

Key informant and focus group interviews were transcribed verbatim and then coded qualitatively using the framework recommended by Reutzler (1998) for assessing the structure, function, and cause-effects of outpatient drug insurance and health care programs, as well as the theoretical models by Donabedian (1980) on quality assurance in health care. The following key findings emerged as primary issues reflecting routine and emergency management practices, as well as comprehension of disaster planning needs across prescription drug care and delivery systems.

1. Prescription Drug Insurance Sector

- Insurers prefer that members do not run low on their medications, and therefore encourage mail-order policies with higher dispensing units (60-100 days). However, less than 10% of members use these services, choosing instead 30-day, retail prescription access, which allows for smaller co-pays and “just-in-time” refills.

- Many insurers have continuity of service plans for internal or external organizational emergencies, such as back-up databases, executive decision-making for mass overrides ('early' refills, faster claims processing), and a willingness help pharmacies or members reconstruct personal medication profiles.
- Continuity of service barriers for local/regional insurers include a lack of partnerships with non-network pharmacies, while national insurers lack partnerships with local and state emergency managers. All insurers lack inter-industry partnerships with their competitors in order to share resources and enhance member service in a disaster.
- The key informant interviews gave insurers a new realization that their internal disaster planning must include collaborative outreach with providers, pharmacies, and wholesalers if the goal is to maximize members' access to medication in a disaster.

2. Pharmacy & Government Regulatory Agencies

- Pharmacists and retailers identified the standard 30-day dispensing unit as a major impediment for those consumers invested in creating an emergency supply of their maintenance medications.
- Retailers with large pharmacy networks were more adaptive to disruptive events and could easily reroute resources from unaffected regions to those stressed by a disaster. Local/independent retail pharmacies had less regional contacts, which, in a disaster, limited their ability to resume work and required rerouting clients to competitors.
- Time constraints, coupled with absent financial incentives, were the primary factors inhibiting proactive outreach by pharmacists in consumer disaster education and participation in community-based disaster drills.
- In general, regional inventory levels and distribution networks are adequate for fulfilling the drug maintenance needs of displaced persons affected by a disaster. As most prescription drugs are distributed through ground transport, weaknesses in this model are the same factors affecting other resources sent via ground delivery, such as compromised infrastructure (roads, bridges) and inadequate fuel supply.
- Retailers and pharmacists cite communication, resource coordination, and leadership as issues requiring the most attention to strengthen future disaster response efforts.
- Maintenance medication 'stockpiling'/preparedness costs must be appropriately allocated to insurers, retailers, and consumers, and this issue is driving the agenda of future taskforce initiatives addressing community-wide disaster preparedness.

3. Health Care Providers

- Clinicians' rationale for 30-day drug prescription units is linked to the belief that insurance companies want to minimize risk and contain costs.
- For patients who need chronic disease maintenance medications and who are medically stable, there is no medical reason for a restriction of a 30-day supply with two refills.
- Current prescription drug benefits that (1) limit the overall amount dispensed to patients and (2) limit the time frame for acquiring prescription refills to 75% of use, are inconvenient and at times harmful to patient health.
- Clinicians support extending prescription drug benefits for patients especially in consideration of disaster planning.
- Clinicians would like to do more towards helping patients prepare for disasters, but currently lack sufficient training and/or educational materials to do so.

4. Community Focus Groups

- People who use prescription medications are motivated to have on hand an extra month supply to prevent personal emergencies of running out, as well as for disaster planning.
- Patient barriers to maintaining extra maintenance medication supplies include: restrictive insurance policies; hesitation to use mail-order due to worry about loss, theft, and spoilage; and additional out-of-pocket costs.
- While some health insurance companies do permit extra medications through 'vacation' exceptions, these allowances are not well-publicized or well-understood by consumers.
- Patients who have physicians who know how to maximize the insurance system to gain prescription 'exceptions' are more able to get extra medication supplies.
- Patients typically wait until they are almost out of medicine before seeking retail prescription refills. In general, consumers like smaller pharmacies because of relationships with pharmacists, however some appreciate the efficiency of the larger, national, retail chains.
- Patients/consumers who are less acculturated, have fewer resources, and lack health insurance are more vulnerable to not obtaining sufficient medications or running out of medications.

Recommendations

Based on this study's key findings and lessons learned from Hurricane Katrina, the following recommendations are encouraged to strengthen prescription drug care and delivery systems and their continuity of service during disasters.

1. Maximize patients' ability to independently maintain adequate home supplies of chronic disease medications. Options:
 - a. Increase retail pharmacy dispensing from 30-day to 90-day prescription units.
 - b. Encourage mail-order pharmacy (60-100 days units) for chronic disease drugs.
 - c. Prompt members with re-fill reminders at 60-70% re-fill time frames.
 - d. Reduce barriers to vacation or early re-fill exceptions.
2. Encourage policy advocacy within governmental, professional, and consumer rights coalitions and organizations to change prescription benefits policies.
3. Train providers, pharmacists, and insurers to speak with each other and their patients about disaster planning and building additional maintenance medication supplies.
4. Encourage greater two-way communication, partnership, and disaster drill exercise between emergency managers and pharmaceutical network resources (insurers, retailers, wholesalers, providers) at local, State, and federal levels.

KEY INFORMANT SUMMARY REPORT BACKGROUND

The following sections offer a brief overview of the methodological design, key informant and focus group interview demographics, and data analysis outputs generated from this study.

METHODOLOGY

Phase 1 Policy Ethnography Evaluation: identifying and assessing written policies within current health insurance plans (both public and private) that do business in Los Angeles County, California; specifically, policies as they relate to time frames for filling and refilling drug prescriptions for patients diagnosed with a chronic medical condition.

Key findings:

- Most insurers offered combined medical and prescription drug benefits plans.
- All insurers offered a minimum 30-day prescription unit through a retail/in-network pharmacy for a single co-payment.
- Many insurers allowed higher units (60- to 100-day units) through mail-order commensurate with additional co-payments.
- Co-payments for generic medications were typically half the cost of brand name medications regardless of retail or mail-order dispensing.
- Prescription refills were available through retail/hospital pharmacy after using 70-75% of medication, while mail-order typically provided refills after 60-70% of use.
- Most insurers verbally noted that members could use mail-order programs (or vacation/travel overrides) to get “extra” medication supplies; although few included this strategy in their Evidence of Coverage documents that were sent to clients detailing their benefits.

Table 1: Evidence of Coverage (EOC) for Prescription Drug Benefits

Type of Benefit	Covered Service	Percentage of Insurers (n=9)	Cost	
			Generic	Brand
Prescription Unit & Method of Distribution	30-day supply, retail/hospital pharmacy	100%	\$0-\$20	\$5-\$80
	90-day supply, retail/hospital pharmacy	33%	\$10-\$33	\$40-\$120
	60-day supply, mail-order	11%	\$20-\$22	\$40-\$80
	90-day supply, mail order	66%	\$10-\$33	\$40-\$120
	100-day supply, mail order	11%	\$20	\$80
Access to additional “extra” supply of medications	Vacation/Exception request program	22.5%	Co-payment	
	Encourage use of mail order program	55%	Co-payment	
	No program exists	22.5%	Out-of-pocket	

Phase 2 Key Informant Interviews: identifying and interviewing 30 selected professionals engaged in the delivery of health and pharmaceutical care, and the distribution of prescription drugs to patients with chronic medical conditions, as well as those professionals involved in the creation and maintenance of drug benefits policies within public and private health insurance plans doing business in LAC. This has included interviewing health care providers, pharmacists, regulatory boards, and representatives of health plans.

Key Findings:

- Health care insurers (n=9) included public and private, local and national organizations that represented over 88% of Los Angeles County residents
- Pharmacists (n=12) exemplified local and national organizations and included a broad range of retail, mail-order, and specialized home delivery services
- Clinicians (n=8) represented practices in internal medicine, pain management, pediatrics, cardiopulmonary disease, HIV, and psychiatry
- Three California regulatory boards were consulted on pharmacy guidelines and emergency management

Table 2: Key Informant Characteristics

Key Informant	Characteristic	Category	Percentage
Insurers (n=9)	Type of insurance service	Public	55%
		Private	45%
	Scope of policy benefits	National	66%
		Local/Regional/State	33%
Pharmaceutical (n=10)	Type of pharmaceutical service	Retail only	56%
		Mail-order only	11%
		Retail & Mail	22%
		Specialty	11%
		Wholesaler	11%
Scope of service	National	55%	
	Local/Regional/State	45%	
Government (n=3)	Type of government agency	Pharmaceutical regulatory	50%
		Emergency management	50%
Clinicians (n=8)	Gender	Male	50%
		Female	50%
	Age	Range	40-58 years
		Mean	41.8 years
Type of practice	Private practice	62.5%	
	Public hospital/clinic	25%	
	Government agency	12.5%	
Percentage of weekly work expenditures	Clinical work	70-100%	
	Administrative tasks	15-25%	
	Education/Teaching	10-25%	

Phase 3 Focus Group Interviews: recruiting individual participants and conducting focus group interviews from amongst specific target audiences to determine knowledge, attitudes and beliefs of health plan medication rules, current medication supplies, and individual access to medication during a disaster.

Key Findings:

- Fourteen community focus groups were held across LA County; 158 participants.
- Eligibility for focus group participation required having a chronic condition or taking care of a person with a chronic condition (elderly person or child).
- Focus groups included Asian-Americans (n=3 groups), Hispanics (n=4), African-Americans (n=1), and English native speakers (n=6). Within these groups, four consisted of elderly adults, five of parents whose children had chronic conditions, and the remaining five were adults with one or more chronic conditions.

Table 3: Characteristics of Focus Group Participants

Characteristic	Category	Percentage (n=158)	Characteristic	Category	Percentage (n=158)
Gender	Male	20%	Employment Status	Employed	39.2%
	Female	80%		Unemployed	20.9%
Age	20-29 years	12%		Retired	21.5%
	30-39 years	11%		Stay at-home parent	16.5%
	40-49 years	16.5%	Household Income	\$19,999 or less	4.3%
	50-59 years	21.5%		\$20,000-\$29,999	14.6%
	60 years +	39%		\$30,000-\$39,999	5.7%
Ethnicity	African American	14.6%		\$40,000-\$49,999	10.8%
	Asian American	17.7%		\$50,000 or more	11.4%
	Caucasian	20.9%	No response	13.3%	
	Hispanic/Latino	35.4%	Type of Health Insurance	PPO	11.4%
	Other*	10.1%		HMO	10.8%
Languages Spoken	English	72.8%		Kaiser	12%
	Spanish	22.8%		Medi-Cal	23.4%
	Other*	4.4%	None	31%	
			Disaster Supplies at Home	Yes	50.6%
				No	47.5%

Table 3 (cont.): Characteristics of Focus Group Participants

Characteristic	Category	Percentage (n=158)	Characteristic	Category	Percentage (n=158)
Education	Middle school or less	5.7%	Are items kept in a designated place or kit?	Yes	38%
	Some high school	19%		No	51.9%
	High school diploma	14.6%		No response	10.1%
	Some college	19%	How often are supplies replaced?	Monthly	7%
	College degree	31.6%		Every 6 months	12%
	Graduate degree	10.1%		Once a year	10.1%
Marital Status	Married	39.9%	Not regularly	20.9%	
	Divorced/Separated	15.2%	Never	26.6%	
	Single	22.2%	No response	23.4%	
	Living with partner	7%			
	Widowed	15.2%			
Other Ethnicity: Chinese, Filipino, French, Iranian, Navajo Indian, Nicaraguan, Persian, Portuguese, Puerto Rican, Spanish, Thai					
Other Languages: Cebuano, Dutch, Filipino, German, Tagalog, Thai, Turkish, Ukrainian, Visayan, Yiddish					
Other Insurance: Blue Cross, Blue Shield, HealthNet, Medicare, Veteran's Administration					

DATA ANALYSIS: COMPARISONS BETWEEN PROFESSIONAL GROUPS

The prescription drug care industry is a complex, interdependent system that relies on many qualifiers to achieve a successful outcome: insurers to authorize benefits, providers to write prescriptions, pharmacists to fill & carry medications, wholesalers to deliver supplies, governments to legislate quality, and consumers to understand & navigate this process. Therefore, the study's data analysis required a systematic focus, and the frameworks of Reutzel (1998) and Donabedian (1980) were used to assess the structure, function, quality, and cause-effects of outpatient drug insurance and health care.

The following excerpts reflect common themes and concerns that resonated throughout the professional groups of insurers, pharmacists, providers, and government agencies. These themes provide insight on how this "system" works, and at times fails to work, under routine and disaster (real or perceived) situations.

Drug prescription policies – prescription units

Insurers, pharmacists, and clinicians agree that the average drug prescription unit is administered in 30-day units, and all rationalized this restriction as tied to reimbursement/premium monies and to reduce wasted/unused medications. Furthermore, if patients did want additional or early medication refills, insurers viewed this as a call-in exception request by the provider, while pharmacists and clinicians saw this as a lengthy ordeal.

“That’s when premiums are paid. For the most part, premiums are paid on a monthly basis. So benefits [are] on a monthly basis.” (*Local, public insurer*)

“We do 30-days because of the nature of the treatment – the dose may change. They’re very expensive and we wouldn’t want to ship a 90-day supply and have the dose get changed within that time period and that dose be wasted.” (*National, private insurer*)

“It came from managed care, and with efforts to reduce cost, I suppose [insurers] looked at 30-day supply as the most cost-effective quantity to dispense in a retail setting.” (*Retail Exclusive*)

“The absolute reason is reimbursement. The insurance companies that provide prescription drug benefits determine that.” (*Pharmacy Regulatory Agency*)

“It is tradition; a round, even number. Pharmacies like 1-month intervals. Most people are stable on their medications where you can write a 1-3 month prescription.” (*Clinician 5*)

“...a member [can] get an extra month supply of the chronic medication if they call and request Vacation Buy policy...members can call their provider ask the provider to call on their behalf for an additional supply...it’s an exception-based processing...they have to call and ask for the exception.” (*National, private insurer*)

“Most of these PBMs are not really fond of having patients ask for extra quantities or emergency supplies... Even a vacation day supply is a major ordeal.” (*Retail Exclusive*)

Recommendations & responsibility for additional drug supplies

Insurers, clinicians, and pharmacists were asked about benefits, barriers, and responsibility if patients were encouraged to keep a 2-week supply of medications on-hand for disasters. In general, each group thought this was a good idea, but barriers perceived by insurers were wasted/expired medications, while pharmacy and clinician barriers included who would pay for these medications. To resolve this issue, all groups thought patients should and could take more responsibility for getting medications by refilling prescriptions early to keep extra on hand, while pharmacies again thought insurers could pitch-in with fee waivers for patients already burdened by co-pays.

“I think it would be reasonable to think of options around patients always having at least a couple weeks supply of chronic medications on hand, and never getting to the point where you’re down to one or two days.” (*Regional, private insurer*)

“Great recommendation, but who’s going to pay for it? That’s my biggest concern. Insurance companies aren’t going to let people have an extra supply of drug on hand. They’re just not willing to pay for it, unless there’s some kind of an edict from the government.” (*National, retail pharmacy*)

“I’m happy for them to have a couple of refills around, I think. The problem is trying to have the insurance would cover it and pay for it.” (*Clinician 8*)

“[I]f someone is very diligent about it they can technically accumulate two months worth of drug over the period of a year. Most of these PBMs are not really fond of having patients ask for extra quantities or emergency supplies.” (*National, retail pharmacy*)

“...either the person would have pay out of their own pocket...[or] the physician would call the [insurer for] pre-certification ...the physician would give the medical reason why somebody needed it.” (*National, private insurer*)

“...the patient needs to work with the prescriber to get the prescription that authorizes the patient to have a stockpile of meds available. You may need your third party payers to pay for those meds.” (*Government pharmacy agency*)

“...it’s enough of a hurdle just to get [patients] to accept taking medication and getting them to stockpile them. It requires a lot of education of how they have a chronic illness and that they’re going to relapse if they don’t take medication on a regular basis.” (*Clinician 6*)

Pharmacy discretion in dispensing medication in an emergency

Universally, insurers, pharmacists, and government agencies agreed that pharmacists maintain professional privilege that allows them to dispense drugs in the best interest of a patient during an emergency. It is less clear if all parties understand the amount of drug that can be dispensed or if other liability or restrictions apply to pharmacist behavior.

“...usually the pharmacist will give [members] an emergency supply of maybe a day to tide them over...it’s professional judgment – [pharmacists] are allowed to dispense in a declared emergency using their professional judgment.” (*Local, public insurer*)

“...when they had the fires up in northern California. The pharmacies were just giving people two to three day supplies of drugs to make sure that they had some of their medications ...it’s in their professional opinion...then they are able to give an initial 72-hour supply.” (*Local, public insurer*)

“A pharmacist may in good faith furnish a dangerous drug or dangerous device in reasonable quantities without a prescription during a federal, state, or local emergency, to further the health and safety of the public. That’s in California law.” (*Pharmacy Regulatory Agency*)

“...the emergency could be a disaster...or it could be any emergency; what [the law] clearly says is that it gives the pharmacist the leeway to go ahead and act in their professional judgment. To go ahead and serve the patient and take care of the patient.” (*Retail Exclusive*)

Decision-making in activating continuity-of-service plans in an emergency

All professionals see this issue the same way – the CEO, executive staff, or clinical provider would make this decision. While each group may look for guidance from local, state, or federal emergency managers, in general, the decision to act is an in-house, immediate one.

“[The continued delivery of services] was initiated by our corporate office down to the regional pharmacy vice-president of the area and the district managers and all of the associates where they did collaborate together...to continue to provide medications to the individuals in need.” (*Retail Exclusive*)

“It was simply a proactive move - the chief medical officer felt strongly that access to medications during the disaster was going to be critical for our members and asked the pharmacy, the PBM that we own to pull back on any prior authorization.” (*National, private insurer*)

“...as far as us as a company, we will always look towards the city, state, county, governments for guidance of what role they would like us to be playing [in a community disaster].” (*Retail & Mail-order*)

“Hurricane Katrina, we based implementing our different edits upon what was coming out of each state agency...incorporate into our plans what’s happening at a federal, and state, and local level with a particular disaster.” (*National, private insurer*)

Collaboration between competitors/non-network partners in a disaster

Insurers were less likely to report self-initiated relationships with other competitors or non-network partners in a disaster or consider building relationships with these groups in their continuity-of-service plans. However, when insurers did work together, as in Hurricane Katrina, it was at the behest of a federal organization. Similarly, clinicians did not report individual-level organization, but rather relied on their professional agencies to take the lead and organize clinical volunteers in a disaster. On the other hand, pharmacy groups seemed more willing to work collaboratively, and in the case of Hurricane Katrina, it was executive relationships that brought several competitor pharmacy networks together to provide medications for displaced evacuees.

“Can the pharmacy benefits manager provide information on ... medications that person needs to take if it was a non-network pharmacy? Respondent: Probably not.” (*Local, public insurer*)

“During Hurricane Katrina, we provided prescription history for all of [our insurer] membership in the Gulf state counties that were affected to a company called RX Hub... [it was a] clearinghouse where any physician or pharmacy could call...and obtain a prescription history... This was something that the federal government put together.” (*National, private insurer*)

“You know, the clinician community is not the unified community, so we don’t have individually a set-up disaster plan.” (*Clinician 6*)

“[During Hurricane Katrina] I started calling the other major retailers. I called [Marivn] at [national, retail pharmacy A], I called [Paul] at [national, retail pharmacy B]. I called my friends at [national, retail pharmacy C]. I called my friends at [regional, retail pharmacy D] down in Florida because they had stores in Louisiana. I called people around the industry and told them that we had adopted some stores [to donate medications to], I was working with the state board, that these guys were in dire straits. Would they be willing to help?” (*Retail & Mail-order*)

Sharing of patient profile/medication history information in a disaster

In general, insurers perceived themselves as willing to share patient medication/history information with in-network pharmacies during a disaster to facilitate care and service for their members. This same perception was not portrayed by pharmacies, who instead felt insurers would not relay much-needed patient medication information.

“Moderator: So that profile history is something that your office would be willing to release to a pharmacist? Respondent: Yes, in emergency situations, certainly...” (*National, private insurer*)

“If our PBM’s not affected by the disaster, the pharmacies can call their customer service line and get information on [the member’s] medication history.” (*Local, public insurer*)

“You could not ask [the insurer about] a history; I don’t think they would allow that. You might say that you are trying to fill X drug and ‘is it refillable right now?’ and they might say ‘yes or no’, but I don’t think they would volunteer any other information.” (*Retail Exclusive*)

“Moderator: Would you ever contact the insurer?...Respondent: No. They can’t tell us if there was a refill for that particular medication and how many.” (*Retail Exclusive*)

Continuity-of-Service through back-up facilities or systems

All key informants (insurers, pharmacies, and clinicians) maintained back-up facilities or databases as part of their continuity-of-service plans. However, most of these services required electricity or Internet access to maintain their functions and few knew if back-up generators or other communication pathways were available if these systems failed. As a pre-emptive strategy, clinicians encouraged giving all patients a paper medical history.

“We maintain a couple of data centers in different locations and each is protected by a power grid, and the data from the primary system is replicated in a secondary system...we back up all our data daily, weekly to magnetic media and stored offsite for protection and we test that quarterly.” (*National, private insurer*)

“...from the PBM’s perspective, they have backup sites, technically they could transmit the claims data for refills or any other recorded claims...immediately to another site...they are connected either through the Internet or phone lines.” (*Local, public insurer*)

“We have the ability to dispatch [information through] portable satellites very quickly and that was one of the biggest things I think for us in Hurricane Katrina, Rita, and Wilma in 2005, that we did differently as a learning point from 2004.” (*Retail & Mail order*)

“...[our stores] are linked via satellite so any individual store can pull up that [displaced] patient’s profile and continue to provide service...we also have backup generators.” (*Retail Exclusive*)

“Patients could be provided in the clinician’s office with a health history and a medications list. For instance, it’s particularly simple if you use an electronic medical record. If you don’t, it’s a lot harder. But if you have a BMR, that’s a printable, two-second job to give

patients a list of their medications and their health history that they could tuck away in the event of an emergency.” (*Clinician 1*)

Insurers, pharmacies, and partnerships with government in disasters

Both insurers and pharmacies were interested in greater partnerships with government agencies. While these groups thought government could help with more decision-making and guidance in an emergency, they were also deterred by the slowness of government decisions as compared to the prompt, CEO decisions made in private industry.

“The Administration can take as long as it likes to approve [Medicaid & Medicare] waivers. With Katrina, the Administration really didn’t try to rush them through...”
(*National, public insurer*)

“[In a disaster] you have a State that is trying to help make decisions for the Counties...you have the Feds...and so we were looking for some greater view, or consensus, or direction from a single entity...but the Feds kind of pushed back down and said "You are a private company, you are going to have to make your own decisions"...[we realized] government does not move as quickly as we move...and unfortunately [it] becomes very convoluted, and sometimes a mess to work through.”
(*National, retail & mail order pharmacy*)

RECOMMENDATIONS FOR DISASTER PREPAREDNESS

The propositions below are an extension of the earlier-noted recommendations, and provide greater detail and insight on how these recommendations might be implemented.

- A. Maximize patients’ ability to independently maintain adequate home supplies of chronic disease medications.
 - Most insurance companies allow a 30-day supply with 2 to 5 refills, and a one week window between months to replenish supply. Reasons for this practice are mainly cost-containment. MediCal and Medicare insurance programs allow 90 to 100-day prescriptions and refills at retail pharmacies, a model based on efficiency rather than cost-containment.
 - Encouraging stable chronic disease patients to keep a 15- to 30-day stockpile of medications is reasonable given the current system. One-time vacation or extra supply provisions could accomplish this, however the requirement for special paperwork or approval by a physician/pharmacist make this option resistant.
 - Mail-order options are in place for greater supply, but many people do not take advantage of them, and also mail-order means that retail pharmacies lose some business. With current Internet and easy ordering systems, mail-order should be encouraged as the primary option for many patients needing maintenance medications; up from the 10 % who currently use it. The outcome would be that people can have a

greater stock of medicines at home and will be less likely to run out during an extended disaster, as well as less likely to run out in non-disaster situations, a more common occurrence than many seem to realize.

- This type of policy shift would require more outlay on the part of insurance companies. It would not necessarily be for all medications but for specific prescription medications deemed essential to maintaining health for people with chronic conditions, such as insulin, asthma inhalers, HIV/AIDS medications, psychotropic medications, and the like. Formularies could easily be created that would allow people to get more of these maintenance types of medications.
- Computerized systems to help patients do this are available; they need to be used more proactively on the part of providers. Many patients need prompts and reminders to enact preventive or planning behaviors. These computerized records can become an essential part of records that people need to keep in their disaster kits.

- B. Encourage policy advocacy within governmental, professional, and consumer rights coalitions and organizations to change prescription benefits policies.

Disaster planners need to build on current advocacy efforts underway within the California Medical Association and the American Medical Association vis-à-vis resolutions to increase pharmacy benefits for people with chronic disease maintenance medications. In addition, resolutions can be advocated through other professional associations such as the American Public Health Association.

A state advisory committee on this issue could be convened that would include leaders in government, insurance, pharmacy, physicians, and consumer rights organizations. Out of this could come a policy position. If insurance companies will not change rules based on advisory recommendations then legislative action can be pursued through the California State assembly.

- C. Train providers, pharmacists, and insurers to speak with each other and their patients about disaster planning and building additional maintenance medication supplies.

Whether or not policy changes take place, it is important to create outreach and training materials for providers, pharmacists, and insurers about this particular aspect of disaster training. These can consist of interactive training opportunities offered for CEU and CME credits. They can be linked to print materials and web-based materials. Not only should providers be up-to-speed on current prescription benefits, most would like more concrete suggestions to give to their chronic disease patients in regards to building prescription drug supplies.

To create successful outcomes among chronic disease patients vis-à-vis disaster medications, all three sets of health professional groups need to participate to educate

consumers, clients, and patients facing a chronic disease and who require medication to think about a one- or two-month extra supply of medication. In the current system, mail-order offers the most viable way to do this and patients need to be encouraged to use these services. If other changes occur then health professionals need to encourage patients to use these systems, refill early, and assist in verifying prescription medications directly when orders are put in.

- D. Encourage greater two-way communication, partnership, and disaster drill exercise between emergency managers and pharmaceutical network resources (insurers, retailers, wholesalers, providers) at local, State, and federal levels.

As we finalized this report and reflected on what people in different parts of the health sector told us, one problematic aspect of current disaster training and drills by governmental agencies is that it does not really include many representatives from the private health care sector. In other words, providers and pharmacists are not really apprised or engaged in current disaster prevention thinking, guidelines, programs, or exercises. As disaster preparedness drills and table-top exercises continue to be enacted at local, regional, and state levels, it is important to include private sector providers so they begin to grasp current plans and protocols, as well as taking a more active role in disaster preparedness with their patients.

CONCLUSION

Disasters are a foreseeable hazard for many U.S. communities; so, too, is the increasing hazard of chronic disease and reliance on maintenance medications that has proliferated across America in recent decades due to improved chronic disease maintenance and an aging population. These two issues, the burden of chronic disease and the scope of modern disasters, present a significant, and often neglected, challenge in identifying how to sustain community well-being when usual sources of healthcare and prescription drug access are delayed or displaced in the aftermath of disaster. Prescription drug/health industry providers have begun to contemplate these issues and initiate internal planning mechanisms, such as secondary databases, policy to facilitate refill overrides, and training of staff. Still, more preparedness is needed, as disasters (and prescription drug care) do not occur in a vacuum, and require external, systematic collaborations between industry stakeholders to ensure patients' continuity of medication care in an emergency. One option, explored in this study, recommended that patients acquire extra supplies of maintenance medications for personal disaster kits. Such an approach exemplifies a systematic solution, and was considered feasible by many stakeholders. The charge, then, to industry stakeholders (insurers, pharmacists, clinicians, government) is to collaborate on strategies towards implementing this, or similar, external and system-wide solutions that coordinate efforts, distribute tasks, and succeed in promoting community well-being before and after a disaster.

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Pharmacy Organizations Create Guide To Prepare For Pandemics

APhA, ASHP and NACDS Foundation Detail Important Role of Pharmacists in Fighting Influenza

BETHESDA, Md.—A new guide designed to help pharmacists respond to pandemic influenza has been created through a collaborative effort of the American Pharmacists Association (APhA), American Society of Health-System Pharmacists (ASHP) and National Association of Chain Drug Stores (NACDS) Foundation. The document details how pharmacies can help raise awareness and educate the public in the fight against a pandemic and how planning by pharmacists and others can significantly reduce the impact of this disease.

With specific instructions, the document advises that pharmacists, who play an important role in responding to pandemics, should learn about government preparedness and response plans, understand resources available in their health systems, corporations, and community and actively participate in planning meetings dealing with pandemics. The guide also recommends that pharmacists take part in immunization training opportunities and establish a plan to maintain a week's supply of resources, such as prescription drugs and consumable supplies.

"Pharmacists serve as community health resources and will play a significant role in helping the public respond to a pandemic outbreak. This guide will not only share important information to pharmacists, but also help them educate and raise awareness with their patients," said NACDS President and CEO Steven C. Anderson, IOM, CAE.

The guide features a "Pandemic Flu Pharmacy Checklist" that lists supplies for immunizations, such as alcohol swabs and latex gloves; consumables such as bottled water and electrolyte solution; and drugs such as anti-nausea medications and opioids. In addition, the plan encourages pharmacists to have an action plan for their practice and home.

The document also lists top medications dispensed during Hurricane Katrina, including hydrochlorothiazide and albuterol, as reported by a major pharmacy chain, as an example of non-influenza medications that might be needed to meet the needs of patients.

"Pharmacists now have a clear-cut and organized resource to advise them on how to be thoroughly prepared in the event of a pandemic," said APhA Chief of Staff and Project Coordinator Mitchel Rothholz. "The knowledge gained from this document can help pharmacists become an invaluable resource for their patients and their community during a pandemic outbreak of influenza."

ASHP lauded the valuable partnership between APhA, ASHP and the NACDS Foundation that led to the generation of this document. "This is a great example of how

organizations representing pharmacists in different practice settings can contribute their distinct perspectives to address this serious health concern," said ASHP President Janet Silvester, M.B.A.

The guide to preparing for pandemics will be available at no cost on the Web sites of APhA, ASHP and NACDS Foundation.

APhA

The American Pharmacists Association, founded in 1852 as the American Pharmaceutical Association, represents more than 60,000 practicing pharmacists, pharmaceutical scientists, student pharmacists, pharmacy technicians, and others interested in advancing the profession. APhA, dedicated to helping all pharmacists improve medication use and advance patient care, is the first-established and largest association of pharmacists in the United States.

ASHP

For more than 60 years, ASHP has helped pharmacists who practice in hospitals and health systems improve medication use and enhance patient safety. The Society's 30,000 members include pharmacists and pharmacy technicians who practice in inpatient, outpatient, home-care, and long-term-care settings, as well as pharmacy students. For more information about the wide array of ASHP activities and the many ways in which pharmacists help people make the best use of medicines, visit ASHP's Web site, www.ashp.org, or its consumer Web site, www.SafeMedication.com.

NACDS Foundation

The NACDS Foundation is the education, research and charitable affiliate of the National Association of Chain Drug Stores. The NACDS Foundation supports programs that advance and strengthen the chain pharmacy industry for the benefit of the public it serves. Among its activities, the Foundation provides scholarships for pharmacy students and supports pharmacy education programs that address the needs of community pharmacy practice. Additionally, the Foundation supports research efforts which document community pharmacy's role and value in America's healthcare system. For more information about the NACDS Foundation, visit www.nacdsfoundation.org.



<http://www.latimes.com/news/local/la-me-flu17nov17,1.7324983.story?track=rss>
From the Los Angeles Times

Drive-through flu shots test ways to speedily deliver vaccines

Hundreds of motorists take advantage of clinics in Los Angeles and Ventura counties.

By Catherine Saillant
Los Angeles Times Staff Writer

November 17, 2007

Instead of fast food, it was fast flu shots Friday for hundreds of motorists converging on drive-through vaccination clinics at community colleges in Los Angeles and Ventura counties.

At Moorpark College, about 100 cars idled in the morning chill, snaking around orange traffic cones as drivers inched to the front of the line. Over the next four hours, nurses there administered more than 500 doses of flu vaccine. At College of the Canyons in Santa Clarita, 1,076 people were vaccinated, said Deborah Davenport, a director of community services for the Los Angeles County Department of Public Health.

"It's free and I get to stay in my car," said Summer Healthcote, her 7-year-old son, Andrew, strapped into a booster seat in the back of a green Suburban at the Moorpark campus. "I couldn't pass it up."

But public health officials said the one-day exercise wasn't designed to cater to Southern California's time-strapped, car-crazed culture. If the drive-through concept proves successful, they said, it could become the model for speedily inoculating entire cities in the event of a deadly pandemic or bioterrorism.

"This is how we would vaccinate the entire population of Ventura County in 48 to 72 hours if necessary," said Dan Wall, a spokesman for the Ventura County Public Health Department. "This is a good opportunity to test it out."

Vaccines at Friday's test run were free. Flu shots delivered car-side are not entirely new. Hospitals have offered them in the past at scattered clinics in order to inoculate older people and those with limited mobility.

But mass vaccinations have begun cropping up in recent years in response to 9/11 and heightened awareness about the potential for bioterrorism or a widespread viral outbreak, such as smallpox. Many of the clinics are funded by state and federal anti-terrorism grants because they are viewed as preparatory drills, officials said.

Los Angeles County's Public Health Department pioneered the model with a Santa Clarita clinic last year. Orange County health officials also gave it a try, with mixed results. Logistical problems can quickly throw a monkey wrench into plans, officials said.

Traffic control is crucial, said Howard Sutter, spokesman for the Orange County Health Care Agency. At Cal State Fullerton last year, several "walk-ups" weaved through the lines of cars to see if they could get shots, he said.

"You have the potential for an incident even though we've never had one," Sutter said.

With greater control of perimeters, large drive-through clinics earlier this month at Cypress College and Soka University in Aliso Viejo went smoothly, he said. Orange County officials set up a separate area just for walk-up patients, Sutter said.

In Los Angeles County, the biggest logistical challenge is traffic. Davenport, of the county Public Health Department, said traffic engineers are asked to identify sites that are convenient for motorists and to design a

traffic-flow plan for each clinic.

"If the line is built right, you can pull people out to fill out forms and then ease them back in once they're done," she said. "That alleviates backups. But you have to keep an eye out so people don't drift into each other's bumpers."

Also, after a couple of nurses almost got bitten, motorists with dogs now are asked to step out of their vehicles for their shots, Davenport said.

One issue health officials have tiptoed around is whether the pollution emitted by all the idling cars should be cause for concern. Davenport said most cars move through so quickly -- in three to five minutes -- that there isn't a lot of idling.

Orange County's Sutter said the exhaust is nothing out of the ordinary.

"I doubt that one exposure would be more than you get driving through a fast-food restaurant," he said.

At the Moorpark clinic, motorists just seemed grateful for the convenience.

Frederick Lehmkuhl, 58, a retired aerospace technician, was the first to roll through. As he moved through the line, he stopped at two checkpoints, the first to fill out a short form and the second to answer a few medical questions. When he pulled into the inoculation area, a white-coated student nurse walked up to the driver's side and asked him to pull up his sleeve.

Lehmkuhl complied, sticking his arm out the window for a shot. Within a minute, he was driving toward a final checkpoint, where workers made sure he was not having a bad reaction to the injection before sending him on his way. It was "pretty well organized," Lehmkuhl said.

"I hate to be pessimistic but it will just be some time before we have a dirty bomb or an outbreak of anthrax," he said. "The community needs to be prepared."

The cars moved a bit slowly at first, hampered by a traffic bottleneck that officials soon fixed. Once things got rolling, the student nurses and volunteers directing traffic were able to get most cars through in about 15 minutes.

The wait got even shorter, about eight minutes, once the morning rush had passed. David Lambert, 65, a retired LAPD officer, arrived mid-morning on his sparkling green-and-white Honda Shadow motorcycle. He pushed the bike through the line, waiting his turn.

"This is great," he said as the sun rose over golden hills and puffy white clouds skidded by. "You can go to Costco and get in line. Or you can come here and enjoy the beautiful day."

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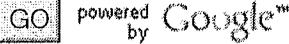
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Safe Drug Use after a Natural Disaster

The Center for Drug Evaluation and Research (CDER) at the FDA offers the following information on the use of drugs that have been potentially affected by fire, flooding or unsafe water and the use of temperature-sensitive drug products when refrigeration is temporarily unavailable.

Drugs Exposed to Excessive Heat, such as Fire

The effectiveness of drugs can be destroyed by high temperatures associated with fires. You should consider replacing your medications if there's a possibility that your medication was exposed to excessive heat, such as fires.

Lifesaving drugs

In a disaster, it is especially important to assure the effectiveness of lifesaving drugs, and therefore these should be replaced as soon as possible. However, if the lifesaving medication in its container looks normal to you, the medication can be used until a replacement is available.

Drugs Exposed to Unsafe Water

Drugs (pills, oral liquids, drugs for injection, inhalers, skin medications) that are exposed to flood or unsafe municipal water may become contaminated. This contamination may lead to diseases that can cause serious health effects.

We recommend that drug products – even those in their original containers – should be discarded if they have come into contact with flood or contaminated water. In the ideal setting, capsules, tablets, and liquids in drug containers with screw-top caps, snap lids, or droppers, should be discarded if they are contaminated. In addition, medications that have been placed in any alternative storage containers should be discarded if they have come in contact with flood or contaminated water.

Lifesaving Drugs

In many situations, these drugs may be lifesaving and replacements may not be readily available. For these lifesaving drugs, if the container is contaminated but the contents appear unaffected – if the pills are dry – the pills may be used until a replacement can be obtained. However, if a pill is wet, it is contaminated and should be discarded.

Reconstituted Drugs

For children's drugs that have to be made into a liquid using water (reconstituted), the drug should only be reconstituted with purified or bottled water. Liquids other than water should not be used to reconstitute these products.

Drugs that Need Refrigeration

Some drugs require refrigeration (for example, insulin, somatropin, and drugs that have been reconstituted). If electrical power has been off for a long time, the drug should be discarded. However, if the drug is absolutely necessary to sustain life (insulin, for example), it may be used until a new supply is available. Because temperature sensitive drugs lose potency if not refrigerated, they should be replaced with a new supply as soon as possible. For example, insulin that is not refrigerated has a shorter shelf life than the labeled expiration date. (Please see [Information Regarding Insulin Storage](#) for more details.)

If a contaminated product is considered medically necessary and would be difficult to replace quickly, you should contact a healthcare provider (for example, Red Cross, poison control, health departments, etc.) for guidance.

If you are concerned about the efficacy or safety of a particular product, contact your pharmacist, healthcare provider or the manufacturer's customer service department.

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FDA/Center for Drug Evaluation and Research

Community Practice

New federal, state reforms to ease disaster relief kinks

Kathryn Foxhall

As the emergency phase after Hurricane Katrina passed, there were many people who had worked diligently to get medications to those in need. "There were big pharmacies and little pharmacies," said Chris Worrall, special assistant in the administrator's office of the Centers for Medicare & Medicaid Services. CMS had worked with private industry, he said, and retailers and wholesalers were amazingly responsive and efficient. He cited instances when companies had massive shipments headed to shelters 30 minutes after a phone call about specific needs.

But after all that effort, many of the pharmacies and other industry people had no way of knowing who to bill, whether it was a local board for pharmacy, local government, or the Federal Emergency Management Agency (FEMA). Indeed, some of those payment problems are ongoing to this day, said Worrall, who spoke at the recent Fall Legislative Conference of the National Association of Boards of Pharmacy in Arlington, Va.

New program

That's why the federal agencies have created the "Emergency Prescription Assistance Program" (EPAP), which was approved by FEMA last March, as a payer of last resort to cover medications and some durable medical equipment for people affected by major disasters who have no other coverage, Worrall said. The program has a predefined formulary. The system also includes provisions for communications between government and industry and for facilitation of product donation.

Eligible consumers—who must be from the disaster area—may bring a prescription or a refill to a retail pharmacy. Pharmacies may also deliver to a shelter.

Worrall noted that if evacuees went from Louisiana to Maine, the system could serve them. The pharmacy will check eligibility, adjudicate the claims, and dispense the medications with no co-pay.

The EPAP process will pay pharmacies for "eligible clean claims" through a claims processor that will have the contract for that purpose.

Worrall said the program will provide more than 50,000 locations to get necessary medications and equipment, while allowing pharmacists to be first responders without taking on excessive financial risk. It will leverage the efficiencies of the private drug distribution system and lower the costs of government, he asserted.

Crossing the line

In another example of post-Katrina reforms, a piece of proposed legislation will be before many state legislatures next spring to help healthcare practitioners, including pharmacists, cross state lines and practice, to provide aid in emergencies.

Raymond Pepe, an attorney who chaired the drafting committee for that proposal, told the NABP meeting there were widespread reports of problems and barriers for volunteer health practitioners eager to help after the 2005 hurricanes. In light of that, the National Conference of Commissioners on Uniform State Laws formed a study group to look at what changes in state law would make systems more workable. It approved a model state law in July of this year.

The proposal, which each state can adopt, reject, or adopt in an amended form, would have the state recognize the licenses of out-of-state practitioners in emergencies if the volunteers are registered under the systems established for that purpose. The registration systems will be those set up by governmental agencies, by private organizations that work with disaster relief, or by healthcare organizations that have demonstrated their ability to carry out this kind of effort. Systems will determine whether the volunteers are licensed and in good standing.

In cases in which practitioners are injured or killed, the proposal would provide workers' compensation coverage by the host state as a source of last resort, if no other coverage is available.

The proposal has already been adopted or introduced in several states. Information on the act is provided at www.UEVHPA.org.



Raymond Pepe (left) and Chris Worrall spoke at the NABP session on emergency preparedness.

THE AUTHOR is a writer based in the Washington, D.C., area.

The Role of Pharmacy in a Disaster

Lessons learned during the Katrina disaster showed thousands of people would not have their medications and would not be able to contact their physician or their own pharmacist to refill or refill prescriptions during a disaster.

Pharmacists provide critical expertise, experience and knowledge that is of great value during an emergency. Pharmacists can conduct patient interviews, screen patient medication history and recent medication use. They can supervise pools of volunteers, both pharmacy professionals and others during mass distribution of drugs.

Disaster and terrorist attacks can occur at any time. Pharmacy needs to be prepared for natural and manmade events that could affect a community. Disaster could arrive in many forms. Examples include:

Natural

Earthquakes, influenza pandemic, floods, tidal surges, volcano eruptions, hurricanes, tornados and wild fires.

Technological

Interruption of utilities, loss of electronic data, cyber terrorism, transportation accidents and hazardous material spills.

Civil Disorder

Chemical/radiological biological terrorism, bombings and riots.

Coordination of Disaster Response starts on the local level. First response agencies are responsible for the initial response to a disaster. In most counties in California the Sheriff's Department is responsible for the incident disaster command center and the public health officer is responsible for medical response to a disaster.

During a disaster, the Governor's Office of Emergency Services (OES) will declare the impacted areas and facilitate the flow of information and resources. There is a Standardized Emergency Management System (SEMS) that coordinates help from various agencies.

If the emergency situation is serious enough the Governor to issue a proclamation declaring a "State of Emergency" in a county or statewide. If a pharmacy is operating within a declared area it may operate under special rules to allow for emergency pharmaceutical care. There could be a need for pharmacists to dispense emergency medications without a prescription during a declared disaster.

Current California law, Business and Professions Code, section 4062(a) provides the board with broad waiver authority.

4062, (a) Notwithstanding Section 4059 or any other provision of the law, a pharmacist may in good faith, furnish a dangerous drug or dangerous device in reasonable quantities without a prescription during a federal, state, or local emergency, to further the health and safety of the public. A record containing the date, name and address of the person to whom the drug or device is furnished, and the name and strength, and quantity of the drug or device furnished shall be maintained. The pharmacist shall communicate this information to the patient's attending physician as soon as possible. Notwithstanding section 4060 or any other provisions of the law, a person may possess a dangerous drug or device furnished without a prescription pursuant to this section.

(b) During a declared federal, state, or local emergency, the board may waive application of any provisions of this chapter or regulations adopted pursuant to it if, in the board's opinion, the waiver will aid in the protection of the public.

The Board has made a policy statement stating:

The California State Board of Pharmacy wishes to ensure complete preparation for, and effective response to, any local, state, or national disaster, state of emergency, or other circumstances requiring expedited health system and/or public response. The skills, training, and capacities of board licensees, including wholesalers, pharmacies, pharmacists, intern pharmacists, and pharmacy technicians, will be an invaluable resource to those affected and responding. The Board also wishes to encourage an adequate response to any such circumstance affecting residents of California, by welcoming wholesalers, pharmacies, pharmacists, intern pharmacists, and pharmacy technicians licensed in good standing in other states to assist with health system and/or public response to residents of California.

The Board also continues to be actively involved in such planning efforts at every level. The Board further encourages its licensees to assist in any way they can in any emergency circumstance or disaster. Under such conditions, the priority must be the protection of public health and provision of essential patient care by the most expeditious and efficient means. Where declared emergency conditions exist, the Board recognizes that it may be difficult or impossible for licensees in affected areas to fully comply with regulatory requirements governing pharmacy practice or the distribution or dispensing of lifesaving medications.

In the event of a declared disaster or emergency, the Board expects to utilize its authority under BPC 4062(b) to encourage and permit emergency provision of care to affected patients and areas, including by waiver of requirements that may be implausible to meet under these circumstances, such as prescription requirements, record-keeping requirements, labeling requirements, employee ratio requirements, consultation requirements, or other standard pharmacy practices and duties that may interfere with the most efficient response to those affected. The Board encourages its licensees to assist, and follow directions from, local, state, and national health individuals. The Board expects licensees to apply their judgment and training to providing medication to patients in the best interests of the patients, circumstances on the ground dictating the extent to which regulatory requirements can be met in affected areas. The Board further expects

that during such emergency, the highest standard of care possible will be provided, and that once the emergency has dissipated, its licensees will return to practices conforming to state and federal requirements.

Pharmacy personnel should be prepared for the medical management of anticipated injuries and illnesses. This could range from assisting with trauma and burns to medical care of victims of chemical, radiological, and biological terrorism.

If you have questions or need information on how to volunteer there are two excellent websites that can get you started as a medical volunteer. The sites can be found at: www.medicalvolunteer.ca.gov (California) and www.medicalreservecorps.gov (Federal)

Most pharmacies currently operate under just-in-time inventory practices. Provisions for contacting vendors should be established before a disaster occurs since normal communication could be interrupted. Pharmacies should plan on being on their own for at least two days. If a pharmacy does develop a medication stockpile it should inform the local emergency management agency so that need of the entire community is considered.

A prominent federal resource for pharmaceutical re-supply that can be requested by the governor is the Strategic National Stockpile (SNS), available through the Department of Homeland Security (DHS). Their reserve of specialized supplies includes pharmaceuticals and medical supplies, IV fluids, antibiotics and antitoxins for treating casualties of various bioterrorism acts. Pharmaceuticals for primary care are not part of the SNS "Push Packages." Pharmacies should plan for the local acquisition of these types of pharmaceuticals. If the exact threat is known, the state may receive specific pharmaceuticals through the SNS Vendor Managed Inventory (VMI) program. An example: Terrorists release anthrax spores; the governor requests federal assistance; the Communicable Disease Center (CDC) deploys VMI; and the state receives appropriate antibiotics in bulk and/or unit of use packaging.

The Board has participated in the Healthcare Surge Standards and Guidelines Project. The work of this group will support planning for the delivery of care to California during an emergency surge event where normal standards of care are diminished or nonexistent. When completed, the guidelines will be distributed to local health departments, communities, healthcare facilities, individual licensed healthcare professionals and healthcare insurers.

In the aftermath of Hurricane Katrina, the Centers for Medicare & Medicaid Services (CMS) partnered with community pharmacies to successfully assist victims and evacuees at hundreds of evacuee sites with virtually no drug shortages or other logistical difficulty. CMS has established an Emergency Prescription Assistance Program (EPAP) that will utilize the existing pharmaceutical supply chain infrastructure as the distribution network for future emergency responses. CMS (through Argus Health Systems, Inc) will be establishing a national network of pharmacies specifically for emergency response. Once established, any participating network pharmacy can respond to a federally declared

event of national significance to process prescriptions for drugs and durable medical equipment.

By preparing to be a disaster responder, pharmacists will be prepared to help their patients with pharmaceutical services during a disaster. Pharmacy has an obligation to their community and nation to share their expertise in preparing for and managing the medical consequences of disasters.

CMS

Emergency
Response

Q&A: Access to refills during a declared emergency

Question: Will beneficiaries be able to obtain early refills on their Part D medications that were lost or misplaced during a declared emergency?

Answer: We expect that Part D plans would guarantee immediate refills of Part D medications to any beneficiary located in an "emergency area" defined as the area in which there has been a Stafford Act or National Emergencies Act declaration and a public health emergency declaration. In addition, we would expect all "refill too soon edits" to be removed beginning with any voluntary or mandatory state or federal evacuations and lasting for the period of the emergency declaration. Additionally, with the possibility of only a limited number of operational pharmacies, limitations on transportation and travel and the disruption of US Mail, we expect plans to allow the beneficiary to obtain the maximum plan extended day supply, if requested and available at time of refill.

CMS
Emergency
Response

Q&A Access to Avian Flu vaccines and Medications

Question:

What happens during a public health emergency such as an avian flu epidemic, will beneficiaries need to use a network pharmacy for urgent access to necessary medications?

Answer:

During any state or federal disaster declaration, or other public health emergency declaration in which beneficiaries are evacuated or otherwise displaced from their place of residence and cannot be reasonably be expected to obtain covered Part D drugs at a network pharmacy, Part D plans are required to assure that their enrollees have adequate access to drugs dispensed at out-of-network pharmacies. In addition, in circumstances where normal distribution channels are unavailable, Part D plans are expected to liberally apply their out of network policies to facilitate access to medications.

California Medical Volunteers



Jeffrey L. Rubin, Chief
Disaster Medical Services Division

What is California Medical Volunteers?

- California Medical Volunteers is California's Emergency System for Advance Registration of Volunteer Health Professionals
- Federally funded mandate for development of registries of volunteer health professionals.
- "Volunteer health professionals" – MDs, RNs, PharmD, social workers, veterinarians, etc.
- Volunteers help with surge response (fires, floods, disasters, pandemic) and mass prophylaxis staffing.
- Single-source volunteer registration for all health-related and "caring" professions in California

Development of California Medical Volunteers

- EMSA is now in the process of rolling out a full-fledged system, (following a proof of concept pilot).
- Successful pilot based on partnership with DCA, Board of Registered Nursing, Medical Board, Pharmaceutical Board
- Web-based state system will be county controlled and administered, and available to MRCs, hospital response teams, and other medical response entities.
- Very broad stakeholder involvement and support, including several boards and professional associations, in our program advisory committee for the last few years

System Components

- Powerful notification engine capable of calling up tens of thousands of volunteers per hour using two-way telephone, pager, text, or email notification.
 - Allows volunteers to accept/reject specific volunteer opportunities
- Mission management of each deployed volunteer – where were they deployed, mission parameters, etc.
- Extremely secure system with state-of-the-art privacy and confidentiality safeguards, as well as deep disaster recovery capabilities and high uptime guarantees.
- Two years' worth of stakeholder-based policy guidance, training and program development, and other support materials.

Credentialing: The Key to It All

- Automatic checking of clinical license status, coupled with verification of credentials
- Four tiers of credentialing, from “hospital ready” down to “unlicensed but received education”
- Credentialing – including license checking – needed to meet Federal guidelines and real-world requirements for a “full and unencumbered” license.
- License checking done at registration and routinely via automated interfaces to Department of Consumer Affairs, State EMS Authority, and the California Department of Public Health.

Critical Partnerships: Roles of the Licensing Boards and Bureaus

- Opportunity to:
 - Help recruit volunteers who make the difference during a disaster
 - Promote your profession's ability to help
- What we need from you: Boards and Bureaus are critical partners
 - Now: License checking and technical assistance, in collaboration with Department of Consumer Affairs
 - Technical contact who can help with understanding your database codes
 - Soon: Outreach and marketing
 - Partnership in marketing strategies and outreach tactics
 - Something to consider: recruitment opportunities at license renewal, partnerships to seek volunteers from new members of the profession
 - Later: Policy development
- You will continue to have the opportunity to help steer this system to meet the disaster response needs of California.

Detailed Timeline Through 8/31/08

- By the end of the first quarter 08:
 - Complete all credential-checking data interfaces, training, system configuration, and related system activities.
 - Begin rolling the system out to the first group of counties through a series of pilots. We're planning on bringing up counties in small batches every couple of months, based on each county's readiness and interest.
 - Initiate volunteer recruitment efforts.
 - Continue policy and procedure development efforts.

Detailed Timeline Through 8/31/08

- By the end of the third quarter, 2008:
 - Continue the roll-out.
 - Conduct test of CAL-MED Volunteer system, including activation and deployment management capabilities.
 - Hold a “best practices” summit to harvest lessons learned from counties using the system.
 - Continue development of policies and procedures.

Questions?

For more information, please contact:

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CAL-MED Homepage

Welcome to California

Home
Register Now
Contact Us
FAQ
Terms of Service
Privacy Policy

search

GOVERNOR
SPURLOCK
Click to Visit His Home Page

DIRECTOR
Visit the Director's Home Page

- Job Announcements
- Paramedic Information
- Hospital Bioterrorism Preparedness Program
- EMSA Publications
- EMS Personnel
- Vision Implementation
- Local EMS Agency/County Information
- EMSAAC
- EMDAC
- Traumat Centers
- Child Care Training Program Information
- CHHS

Username: Password:

Log In

Forgot Username or Password?
Not Registered?

Welcome to the California Medical Volunteer Site (training), the online registration system for medical and health responders for the State of California.

If you're a California nurse, doctor, pharmacist, or paramedic with an active license who would like to volunteer for disaster service, you've come to the right place! The California Medical Volunteer Site (training) is your secure, confidential site to register with the State of California for volunteer emergency/disaster service. (In the future, mental health and other allied health professionals will also be able to register here.) During the on-line registration process, you will be asked to enter information regarding your license, the best way to contact you, and other relevant background information. (If you have already completed the registration process or wish to return to a registration which you've started but not completed, you can log in and update your profile.)

Once you've registered, your credentials will be validated - before an emergency - so that you can be deployed quickly and efficiently. Your information will only be viewed by authorized system managers. During a State or national disaster, (e.g., an earthquake, severe weather event, or public health emergency), this system will be accessed by authorized medical health officials at the State Emergency Operations. If a decision is made to request your service, you will be contacted using the information you enter on the site. If you agree to deploy, your information will be forwarded to the appropriate field operational officials. Thanks for volunteering!

REGISTER NOW

Welcome Page

State of California | MEDICAL VOLUNTEER SITE

Search: Responders | HELP (?) LOG OUT

HOME | PROFILE | MISSIONS | MESSAGES | RESPONDERS AND GROUPS | SYSTEM ADMINISTRATION

Welcome in Williams

Your occupation(s) are Community and Social Services, Interpreter. Please be sure to keep your account information up-to-date and accurate.

Missions
3 out of 7 Missions are in progress.
0 out of 10 Deployment Groups are awaiting deployment.
728 Responders have been requested for all missions.
0 Responders are currently rostered for all missions.
728 Responders are still needed for all missions.

Messages
You do not currently have any messages.

Profile
Your Account Status: Active
Your Willingness to Travel for a Deployment: Locally / In State / Out of State
The Period of Time You are Willing to be Deployed: Up to 7 days
Your Willingness to Participate under the Authority of the Federal Government: No
[Edit Account Status](#) | [Edit Deployment Preferences](#)

Welcome page shows missions, messages, and profile information.

Profile and Identity

State of California | MEDICAL VOLUNTEER SITE

Search Responders [] HELP [] LOG OUT []

HOME PROFILE MISSIONS MESSAGES RESPONDERS AND GROUPS SYSTEM ADMINISTRATION
Affiliation Employment Preferences Contact Occasions Training Competencies Medical History Account Settings

Home > Profile > Identity > Edit Identity

REQUIRED (*)

Edit Identity

Name and Address
Please enter your name and current residence information:

Prefix:
Example: Dr, Capt, Mr, Mx

* First Name:

Middle Name:

* Last Name:

Suffix:
Example: Jr, Sr, PhD, MD

* Permanent Residence Line 1:

Permanent Residence Line 2:

* City:

* State:

* County:

* Zip Code:

Identifying Information
Enter information exactly as it appears on your state-issued identification card.

* Date of Birth: / /

View and edit profile information.

Comprehensive Data Collection

State of California | MEDICAL VOLUNTEER SITE
Search: Responders
HELP LOG OUT

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[Account Settings](#)

[REQUIRED \(*\)](#)

Medical Volunteer

Professional Status

Please select the status for your occupation; if you selected a medical occupation and are currently in a medical occupation, please select the appropriate status.

* What is your current professional status for this occupation?

Place of Practice

If you are employed as either a student/intern, full time, or volunteer, please provide the following information. You can add additional places of practice by clicking the Add Additional Practice button.

Your place of practice is:

Board Certification

Do you possess a board certification? Yes No

Professional License

Please provide your license information. If you are licensed in the state in which you live, please enter that license first. You can add additional licenses by clicking the Add Additional License button.

Is the name on this license the same as the name you provided in your personal information?
 Yes No

License Type:

[Add Additional Practice](#)

Standardized collection and verification of professional license information.

Managing Missions

State of California
MEDICAL VOLUNTEER SITE

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[HELP ?](#)
[LOG OUT](#)

Search:

Display Mission Status: All

All Missions

3 out of 7 Missions are in progress.
0 out of 10 Deployment Groups are awaiting deployment.
There are 0 Messages for all Missions.

All Requests

Overall Current Staffing Needs

728 Responders have been requested
27 Responders are currently rostered
704 Responders are still needed for all

Below is a list of all missions and their current responders needs. You can change which missions are shown by changing the filter.

Name	Staffing	Needed	Information	Status
Mission Name 101	15 Staffed	65	Location: Not Defined	No Deployment Groups Created
Mission Name 102	15 Staffed	65	Location: Not Defined	All Deployments Complete
Mission Name 103	15 Staffed	65	Location: Service Location 103	All Deployments Complete
Mission Name 104	12 Staffed	176	Location: Not Defined	All Deployments Complete
Mission Name 105	9 Staffed	265	Location: Not Defined	Deployments In Progress
Mission Name 106	9 Staffed	265	Location: Service Location 106	Deployments In Progress
Mission Name 107	9 Staffed	203	Location: Not Defined	Deployments In Progress

Create and manage missions, deployments, and responder requests.

Search for Volunteers

State of California | MEDICAL VOLUNTEER SITE

[Search](#) | [Responders](#) | [HELP](#) | [LOG OUT](#)

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[Manage Groups](#) | [Manage Unit Affiliation](#) | [Invite Responder](#) | [Register Responder](#)

Home > Responders and Groups > Search

Search

Use the search form below to find responders according to the criteria that you specify. You can search for individual responders or responders. Click on the gray bars to toggle the display of the specified search field categories. Hiding a section will not prevent you from finding responders that meet the criteria.

▼ Identity Information

▼ Account Information

▼ Account Type:

- Responder
- Call Center Representative
- Local Administrator
- Regional Administrator
- System Coordinator

▼ Account Status:

- Active
- Inactive
- Suspended

▼ Emergency Credential Level:

ECL: Level 1 - Hospital Active
 Level 2 - Clinically Active
 Level 3 - Licensed or Equivalent
 Level 4 - Indeterminate Credentials

▼ Competencies:

Skills and Certifications:

- Automated External Defibrillator
- Cardio-pulmonary Resuscitation
- Clerical Work
- Computer Networking
- Data Entry

Languages:

- Aboriginal Languages of Australia
- Afrikaans
- Albanian
- American Sign Language
- Amharic

Trainings:

- Advanced Cardiac Life Support
- Advanced Disaster Life Support
- Advanced Trauma Life Support
- Basic Disaster Life Support
- Basic Trauma Life Support / Prehospital Trauma Life Support

▼ Languages:

I want to match Any All of the following languages:

▼ Trainings:

I want to match Any All of the following trainings:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

Locate volunteers according to over 150 different criteria.

Reports and Logs

State of California | MEDICAL VOLUNTEER SITE

HOME | PROFILE | MISSIONS | MESSAGES | RESPONDERS AND GROUPS | SYSTEM ADMINISTRATION

Skills | Training | Credential Verification | Failed Verifications | Export

Search: Responders

HELP LOG OUT

Home > System Administration > Reports and Logs

Reports and Logs

Reports consist of sorted information organized for specific administrative needs and purposes. Choose from the available reports and View Reports and Logs

There are 1001 active responders registered in this system.
There are 0 responders currently logged in.

EXPORT CSV EXPORT PDF

Site Statistics

Type of Account	Number of Accounts	Percentage of Total Accounts
Responder	601	60.04%
Local Administrator	249	24.88%
System Coordinator	51	5.09%
Regional Administrator	50	5%
Call Center Representative	25	2.5%
ERC Administrator	25	2.5%
System Administrator	0	0%

Total Accounts: 1001

Results Per Page: 50

1-7 of 7

View, print, and export reports and logs.

Memorandum

To: Licensing Committee

Date: December 6, 2007

From: Board of Pharmacy

Subject: Emergency Response by Pharmacies and Wholesalers to the October 2007
Wildfires

The committee will discuss actions taken by licensees during the California wildfire emergency.

Also, attached are various articles about this topic.



Office of the Governor

ARNOLD SCHWARZENEGGER
THE PEOPLE'S GOVERNOR*Disaster
Response***PRESS RELEASE**

10/27/2007 GAAS:869:07 FOR IMMEDIATE RELEASE

Governor Schwarzenegger Announces Additional Assistance for Fire Victims

Governor Arnold Schwarzenegger today announced cash grants of up to \$10,000 are available to help some individuals who have suffered losses in the southern California fires. The grants are administered by the California Department of Social Services as a supplemental program to FEMA-administered assistance. The grants help fire victims with expenses caused by a direct result of the disaster such as housing, replacing household items, medical costs and transportation.

"California stands ready to provide fire victims all the assistance they need to get their lives back on track. Even after the fires are extinguished, we will still be here to help fire victims in need," said Gov. Arnold Schwarzenegger.

Individuals must first apply for assistance through FEMA, which forwards applications to the California Department of Social Services. Only individuals who have received the maximum FEMA award are eligible for state supplemental grants. California Department of Social Services staff are at local assistance centers to help with information about the program. For more information, contact the California Department of Social Services, State Supplemental Grant Program at 1-800-759-6807 (TTY for hearing and speech impaired: 1-800-822-6268).

In addition to providing state cash assistance, departments throughout the California Health and Human Services Agency continue to help individuals affected by the fires by offering medical assistance at shelters, assisting residents in returning to skilled-nursing and residential care facilities and helping fire victims get disaster food stamps and replacement medication.

Specifically:

- In San Diego, Riverside and San Bernardino counties, California Medical Assistance Teams (CalMATs) continued to provide care and assess for unmet medical needs. CALMATs are teams of 35 physicians, nurses, pharmacists and other support personnel who are deployed during disasters and coordinated by the Emergency Medical Services Authority.
- Licensing staff from the Department of Public Health and Department of Health Care Services continued their efforts to help residents return to skilled nursing facilities and hospitals in Orange, San Diego, Riverside and San Bernardino counties. As of Friday afternoon, 22 of 26 facilities affected by the fires had been cleared by state licensing staff to reopen. Three evacuated facilities in Fallbrook remained under fire threat and an evacuated intermediate care facility in Ramona had no running water.
- The Department of Health Care Services expedited requests for approximately 20 Medi-Cal beneficiaries who lost their medicines in the fires.
- Staff members from the Department of Developmental Services evaluated regional centers in the areas affected by the fires to assess the impact of the fires on developmentally disabled consumers. In addition, staff helped arrange transportation, served as language interpreters and conducted functional assessments of people with disabilities arriving in shelters.



Office of the Governor

ARNOLD SCHWARZENEGGER
THE PEOPLE'S GOVERNOR*Disaster
Response***PRESS RELEASE**

10/23/2007 GAAS:847:07 FOR IMMEDIATE RELEASE

Gov. Schwarzenegger Announces Additional Resources for Californians Displaced by Wildfires with Special Medical Needs

Governor Arnold Schwarzenegger announced the activation of a California Medical Assistance Team (CalMAT) and two federal Disaster Medical Assistance Teams (DMAT). The CalMAT is currently en route to San Diego and will be based at Qualcomm Stadium. DMATs are preparing to deploy and will arrive in southern California tomorrow from Washington and New Mexico.

"We will continue to coordinate the state's response with local officials as requests come in and are directing resources throughout the affected counties," said Governor Schwarzenegger. "Everyone is working together to make sure the appropriate personnel and equipment are in the right spots."

Each DMAT and CalMAT is composed of approximately 35 civilian volunteers from the medical, health and mental health care professions. The teams provide medical care in disaster areas or medical services at transfer points and reception sites associated with patient evacuation, and in this case the devastating southern California fires. These teams are scheduled to be deployed for approximately 10 days, after which time their need will be reevaluated.

Governor Schwarzenegger's Administration is working with the affected counties to identify sites where the DMATs need to be directed for maximum effectiveness.

In addition to activating the medical teams, the state has mobilized additional supplies and equipment for 2,000 medical beds known as "alternate care site beds" that can be deployed as needed to evacuation centers. Supplies are divided into caches, each of which provide enough supplies and equipment to care for 50 patients for 7 to 10 days. The California Department of Public Health (CDPH) will be sending a total of 20 trucks, each carrying two 50 patient caches, for a total of 2,000 alternate care site beds. The primary cache contents are packaged into nine categories providing all hazard medical care, including:

1. IV Fluids
2. Bandages and Wound Management
3. Airway Management
4. Immobilization
5. Patient Bedding, Gowns, Cots, Misc.
6. Personal Protective Equipment and Supplies
7. Exam Supplies
8. General Supplies
9. Defibrillators

CDPH Director Dr. Mark Horton and California Emergency Medical Services Director Dr. Cesar Aristeiguieta are in southern California to ensure the state's resources are being utilized to the fullest capacities. Additionally, in response to reports that displaced Californians with critical medical needs were evacuated to ill-equipped facilities, such as the San Diego High School, a team of CDPH facility licensing nurses have been on hand to assist patients in need of specialized skilled nursing care.



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Disaster Response

NEWSROOM

The latest news from Rx Response.

- BE PREPARED**

Are you prepared for an emergency?
- PARTNERS**

Effective emergency response is a team effort.
- NEWSROOM**

The latest news from Rx Response.
- LEARN MORE**

Our mission is to get medication to patients in emergencies.

Rx Response Monitoring Wildfire Emergency in California

(Back)

As a result of the wildfire emergency in California, the Rx Response Pre-Emergency Planning phase has been activated -- monitoring medicine delivery and healthcare availability in Southern California, and working with our partners and government emergency officials to receive up-to-the-minute information.

After careful review among the partners of Rx Response, we have determined that normal business practices are currently able to handle the situation in California. At this time, the normal pharmaceutical supply system is operating effectively.

On the whole, pharmacies are open, very few hospital systems have been ordered to evacuate and our Rx Response members are not reporting product shortages. As a result of this discussion, Rx Response will not formally activate, but will continue to operate in alert mode and monitor the situation.

Individuals impacted by the wildfires and those ordered to evacuate their homes are strongly encouraged to pack their medicines. It's important that people always carry a list of their medications with the specific dosage, and if applicable, a list of medications for all the members of their family. [Click here for a wallet card](#) individuals may fill out and print.

For those evacuees who no longer have access to their prescription medicines and are in need of them, there are several options for refilling prescriptions. They may visit their local pharmacy or a pharmacy within their chain network. Additionally, community pharmacies can obtain and fill some patients' prescriptions through a secure network that has been activated due to this crisis, even when the prescription is at another pharmacy. As always, patients may contact their doctor to obtain a new prescription that may be filled at an open pharmacy. For more information go to www.ICERX.org or call 1-888.ICERX.50 (1-888-423-7950).

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Disaster
Respus

GlaxoSmithKline aids California fire relief efforts

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Donations of more than \$1 million worth of prescription medicines and consumer products offered

Research Triangle Park, NC - October 26, 2007 -

GlaxoSmithKline (GSK) shares the nation's concern for residents and communities of California's San Diego region that are being ravaged by widespread fires. As a demonstration of support, GSK has offered to the people impacted more than \$1 million dollars worth of respiratory medicines and \$100,000 worth of consumer products, including *Aquafresh* products and *Tums*.

"GSK is committed to helping the relief effort by providing the State of California and its state-based, disaster-response organizations with medicines and other healthcare products that are needed by those whose lives have been turned upside down by this tragedy," said Christopher Viehbacher, President, US Pharmaceuticals, GlaxoSmithKline.

GSK has already shipped \$300,000 worth of asthma medicine to Direct Relief International, a Santa Barbara-based relief organization with expertise in fast delivery of medicines in times of disaster. Direct Relief's close proximity to the regions affected by the fires means they have been able to provide immediate emergency relief to those in need.

GSK has also reached out to other relief organizations - AmeriCares, MAP International, Project HOPE and Interchurch (IMA) - to assess the ongoing needs of residents and communities throughout San Diego county. If these organizations ask for additional medicines, GSK will seek to fulfill the requests.

GSK is also helping its employees and their families based in the San Diego region recover from the fires. A disaster relief fund is available to provide employees with up to \$5,000 grants to cover emergency needs, such as temporary housing, food and transportation.

GlaxoSmithKline - one of the world's leading research-based pharmaceutical and healthcare companies - is committed to improving the quality of human life by enabling people to do more, feel better and live longer.

Inquiries:

US Media inquiries: Robert Sutton (919) 483 2319

CMS
Emergency
CA Wildfires

I am writing this e-mail to begin an information sharing process concerning the California Wildfire Crisis. The following table lists health care facilities that have been evacuated due to the crisis.

Facility Name	City	County	Status
Palamor Pomerado Hospital	Poway	San Diego	Will reopen Friday October, 26.
Manor Care Nursing Home	Poway	San Diego	Closed
Aurora Behavioral Health Center	Rancho Bernardo	San Diego	Closed
Casa De Las Companes (SNF)	Rancho Bernardo	San Diego	Closed
Villa Rancho Bernardo	Rancho Bernardo	San Diego	Closed
Fallbrook Hospital	Fallbrook	San Diego	Will Reopen Later this week.
Mountains Hospital	Lake Arrowhead	San Bernardino	Closed

We plan to send an updated list of these evacuated facilities and any other pertinent information that becomes available on a daily basis as this crisis continues. We are hopeful that you will use this information as you help to coordinate care and ensure coverage for affected Medicare beneficiaries.

We are also asking that you provide us with information concerning any significant developments affecting health care delivery in the area. Specifically, we are looking for information concerning any health care provider locations (e.g. hospitals, nursing homes, medical groups, physician offices) in your provider networks that have been evacuated or face capacity issues due to transfers from evacuated facilities. We will pass this information on to all Medicare health plans in the Southern California area through this information sharing process. Please e-mail this information to Greg Snyder in the CMS San Francisco Regional Office at Gregory.Snyder@cms.hhs.gov.

Thank you very much.

October 28, 2007

Virginia Herold, EO, California State Board of Pharmacy
Bill Powers, President, California State Board of Pharmacy

Dear Ginny and Bill

The following is a rundown of my observations from the recent fires in San Diego County and the response by the pharmacy community.

I know of 3 pharmacies that were evacuated during the fires; Ramona Health Mart Pharmacy, Fallbrook Pharmacy and Rancho Santa Fe Health Mart Pharmacy, there may have been more. I have not had the opportunity to speak with the owner/pharmacists of Ramona and Fallbrook pharmacies so I will limit my comments to my pharmacy.

We were evacuated from the pharmacy on Monday morning (10/22) at about 11AM. Dr. Jason Kim and I worked the pharmacy alone from about 7AM until we were told to leave by the Deputy Sheriffs at 11AM. During that time we were able to serve a number of patients who were being evacuated and needed meds. Due to significant power spikes that were occurring, I shut down the computers before leaving out of fear that even if the building survived my computers might be fried and I would not be able to operate after repopulation of the area. As a result of this action I was unable to access the data base remotely. Our telephone system continued to be operational and as a result I was able receive emergency calls and retrieve voice messages left on the pharmacy telephone system. Most of these calls were from evacuees who had left their meds behind or were running out of meds.

Monday and Tuesday were difficult because without database access I had to communicate with pharmacists in non-impacted areas to try and supply my patients with emergency supplies of needed meds without accurate knowledge of their prescription history. The vast majority of my patients either had old prescription bottles or knew what meds they were taking. In a few instances we were at a loss since the patient only knew that, for example, they were taking a beta-blocker but not which one or which strength. Physicians were hard to get hold of since many had also been evacuated. The pharmacists I worked with at both chain and independent pharmacies were very cooperative, but several expressed confusion as to exactly what their authority was under these emergency circumstances. Overall, we were very successful in obtaining emergency meds for the evacuees. On Wednesday morning I was able to get a police escort to the pharmacy and

restart the computers. From that point on I was able to transfer prescriptions via remote access from home.

I would like to thank Dieter who owns Coast Compounding Pharmacy in Oceanside. He immediately call me and offered to accommodate my patients needs. During the first 2 days we put a message on our telephone system directing patients to his store. Unfortunately most of our patients had evacuated to areas ranging from LA to Chula Vista, however Dieter did help a number of patients from Rancho Santa Fe.

We were repopulated on Thursday afternoon and have been operating normal hours since. Other than the ash surrounding the building which had to be cleaned up there was thankfully no damage to the pharmacy.

Dr Jason Kim, one of my business partners, and his fiancée Tiffany volunteered at the Del Mar evacuation center under the auspices of RxERT. They worked with the volunteer physicians and nurses to take histories, make rounds, advise on appropriate therapy and dispense meds that had been donated by local pharmacies, hospitals and brought in by CALMAT. Jason indicated that he treated a number of patients from the evacuated Rancho Santa Fe area. I have already communicated to both of you the great work that Dr. John Johnson (JJ) and the RxERT team did at 3 sites; Qualcomm, Del Mar and San Diego High. Your suggestion to honor the volunteers at our San Diego Board meeting in January is an excellent idea and should be implemented.

Both Jason and JJ commented on the issue of record keeping. During the initial hectic hours at the evacuation centers record keeping was probably less than optimal but was quickly rectified by JJ and Jason. I have suggested to JJ that he develop a document for the volunteer workers to use as a guide indicating what the procedures with respect to emergency service record keeping should be. In addition, I think that the BOP should develop a short (1 page) guide to the authority of pharmacists during emergencies. We could cite the laws and regs that apply and clarify just what powers they have and what their limitations are.

I also spoke with my wholesaler, McKesson, at the Senior Vice-President level. They asked what more they could do. They had already contacted their impacted pharmacies to offer financial aid to help with recovery of the businesses but they wanted to also help the community. We discussed a number of alternatives, such as their being prepared to supply needed meds on an emergency basis to the evacuation sites. While nothing has been finally approved our discussions continue. Some of the suggestions with respect to what McKesson can do may need staff attention to be implemented. For an immediate response they are providing non-prescription meds and supplies to the San Diego Health Mart Pharmacies. We are initially receiving cases of masks to give out to protect our patients from the poor air quality and especially from the dust generated during clean-up of their properties.

I am very proud of the pharmacy community in San Diego. My fellow pharmacists and owners conducted themselves in a professional manner while meeting the immediate

needs of the consumers of the County. I am also happy to hear that very few calls came into the Board. This would seem to indicate that things went very smoothly with respect to pharmacy response to the disaster.

Thank you both for your concern, assistance and prayers during this difficult time.

Sincerely,

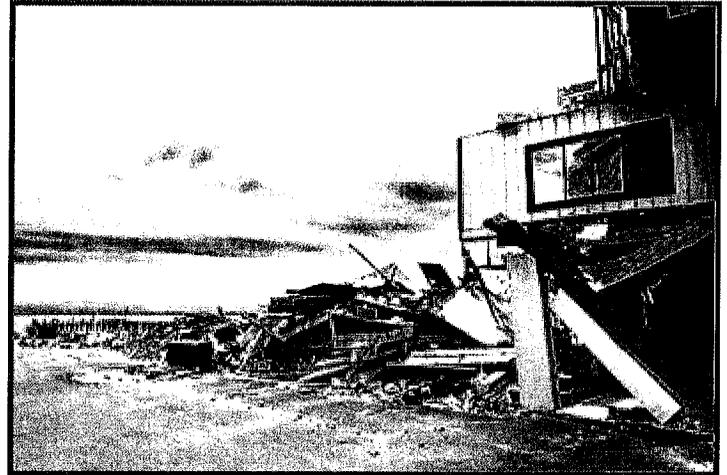
Bob Graul


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For Pharmacists

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[Considerations »](#)
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Overview



As a pharmacist, you have a critical need to be able to provide prescription drugs in correct dosages to evacuees in the event of a disaster. ICERx.org, a secure web site operated by private organizations and made possible with the assistance of federal, state and local governments, provides you with a secure portal to obtain this information.

Evacuee outpatient prescription history

- drug name and dosage
- quantity and day supply
- name of pharmacy that filled the script (if available)
- name of provider who wrote the script

Available patient clinical alerts

- drug interaction alerts
- therapeutic duplication alerts
- elderly alerts

Clinical Pharmacology® drug reference information

- drug monographs
- interaction reports
- drug identifier tool

The information provided through ICERx.org is meant to complement, not replace, complete information provided to you by your patient. Medication information pertaining to selected sensitive healthcare conditions is not available through ICERx.org.

Call 1.888.ICERX.50 for more information

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For Patients

[Security »](#)[Gaining Access »](#)

Overview



If you were forced to move from your home following a disaster, you may have run out of medications. Or you might not remember which prescription drugs you are taking or the proper dosage. Often, evacuees are unable to contact their regular doctor, clinic, or hospital. In many cases, paper medical records have been destroyed in the disaster.

It is because of this dilemma that ICERx.org was created.

ICERx.org is a secure, online service that allows licensed doctors and pharmacists anywhere in the United States to help you get information about your prescription medicines. It will help your doctors and pharmacists know which drugs you have been prescribed, the correct dosages, whether you have refills available, which doctor prescribed them, and which pharmacies have information about your prescription.

If you are an evacuee from an area affected by a disaster and you need to renew your prescriptions or get a new one, please let any doctor or pharmacist know that ICERx.org is available for their use.

ICERx.org was created by a unique collaborative of national charities, private businesses, the American Medical Association, and federal, state, and local governments to help people get vital medicines during times of disaster.


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For Doctors

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As a physician, you have a critical need to be able to access evacuees' medication histories to provide continuity of care in the event of a disaster. ICERx.org, a secure web site operated by private organizations and made possible with the assistance of federal, state, and local governments, provides you with a secure portal to obtain this information.

Evacuee outpatient prescription history

- drug name and dosage
- quantity and day supply
- name of pharmacy that filled the script
- name of provider who wrote the script

Available patient clinical alerts

- drug interaction alerts
- therapeutic duplication alerts
- elderly alerts

Clinical Pharmacology® drug reference information

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- drug identifier tool

The information provided through ICERx.org is meant to complement, not replace, complete information provided to you by your patient. Medication information pertaining to selected sensitive healthcare conditions is not available through ICERx.org.

Call 1.888.ICERX.50 for more information

NATIONAL ASSOCIATION OF
CHAIN DRUG STORES*Disaster
Response*

News Releases

State of Patient Care and Humanitarian Aid Amid the California Wild Fires

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October 24, 2007

Contact: Chrissy Shott; (703) 837-4266

Alexandria, VA - The National Association of Chain Drug Stores (NACDS) and community pharmacy join with our neighbors nationwide in sympathy, support, care and prayer for those affected by the tragic wild fires in California. We would like to provide information that might be helpful to those who are impacted by, or engaged with, this situation.

Most Pharmacies Open; ICERx Activated

We understand that most pharmacies are operational. Also, many NACDS member companies offer the capability for their patients to fill their prescriptions at any of the chain's locations. In addition, it is appropriate to mention the role of SureScripts, of which NACDS is a co-founder. SureScripts is a leader in the electronic exchange of prescription information between pharmacies and physicians. For chain pharmacies providing care to evacuees displaced by the fires in Southern California, SureScripts and the nation's pharmacies have activated access to Emergency Rx History. This will make it possible for pharmacies to obtain and fill some people's prescriptions through the use of a secure network, even when the prescription is at another pharmacy. For more information, go to www.ICERx.org or call 1-888.ICERX.50 (1-888-423-7950).

Of course, patients who find themselves unable to have their prescription filled at their pharmacy also may contact their doctors to obtain new prescriptions that may be filled at an open pharmacy.

NACDS would like to take this opportunity to remind the public that it always is a good idea to maintain a record of one's prescriptions, including the medications and dosages. The "Be Prepared" section of the www.RxResponse.org web site includes a feature that allows patients to customize and create a convenient card that lists this information.

RxResponse Alert, but Activation Not Currently Necessary

NACDS participates in RxResponse, a collaborative effort designed to help support the continued delivery of medicines during a severe public health emergency. Please see www.RxResponse.org to view a public statement on behalf of RxResponse, and for more information. In summary, with the pharmaceutical supply chain operating without disruption and most pharmacies able to serve their patients, RxResponse will not be formally activated at this time, but will continue to remain on alert to assess the situation and respond as needed. This is good news, in terms of the current state of prescription medication availability, as well as the fact that RxResponse is demonstrating its ability to facilitate communications and quickly assess situations.

Commending Humanitarian Efforts

NACDS would like to pay tribute to the firefighters and rescue workers, and to all those aiding the individuals who have been evacuated. From those who risk their own wellbeing to fight the fires, to neighbors helping neighbors, this time of need is bringing out the best in so many true heroes.

NACDS also would like to recognize and commend the response of its member companies. Their response includes continuing pharmacy operations, but also the contributions of financial resources, products and services to the people in the evacuated areas. Their humanitarian efforts are consistent with their day-to-day commitment to patient and customer care, as well as with their swift and vital responses to prior tragedies, including Hurricane Katrina.

Print

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Pharmacy Board
<pharmacy_subscriberlist@d
ca.ca.gov>

10/23/2007 12:50 PM

To pharmacy_subscriberlist@dca.ca.gov

cc

bcc

Subject California State Board of Pharmacy Subscriber Alert

The Board of Pharmacy is concerned about the well-being of Southern Californians and their challenges in responding to the multiple fires burning throughout this area. In this regard, the board's emergency response plan is ready to assist those with concerns or who need assistance.

Licensees who need to evacuate or relocate their facilities are encouraged to contact the board for assistance in maintaining care services to the public and the health community once the imminent danger is passed.

Please contact the board at (916) 574-7900 and at the prompt -- use "0" to reach a receptionist and ask for assistance with emergency response.

Thank you.



Pharmacy Board
<pharmacy_subscriberlist@d
ca.ca.gov>

10/26/2007 01:21 PM

To pharmacy_subscriberlist@dca.ca.gov

cc

bcc

Subject California State Board of Pharmacy Subscriber Alert

The Board of Pharmacy continues to strongly support the efforts of our licensees in caring for patients impacted by the Southern California wildfires. We have received stories of how pharmacies have been aiding patients, and in several weeks will actively seek such reports so that we can build a record.

We remind all licensees of the board's disaster response policy (http://www.pharmacy.ca.gov/publications/disaster_policy.pdf) and the existing (everyday) authority of pharmacists to provide emergency refills of medicine when the prescriber is not available (California Business and Professions Code section 4064).



Pharmacy Board
<pharmacy_subscriberlist@d
ca.ca.gov>

10/26/2007 01:24 PM

To pharmacy_subscriberlist@dca.ca.gov

cc

bcc

Subject California State Board of Pharmacy Subscriber Alert

The Board of Pharmacy continues to strongly support the efforts of our licensees in caring for patients impacted by the Southern California wildfires. We have received stories of how pharmacies have been aiding patients, and in several weeks will actively seek such reports so that we can build a record.

We remind all licensees of the board's disaster response policy (http://www.pharmacy.ca.gov/publications/disaster_policy.pdf) and the existing (everyday) authority of pharmacists to provide emergency refills of medicine when the prescriber is not available (California Business and Professions Code section 4064).



Pharmacy Board
<pharmacy_subscriberlist@dca.ca.gov>

11/19/2007 06:56 AM

To pharmacy_subscriberlist@dca.ca.gov

cc

bcc

Subject California State Board of Pharmacy Subscriber Alert

The California State Board of Pharmacy thanks its licensees and members of the pharmaceutical supply chain who provided assistance to Southern California during October's wildfire emergencies. The public was very well served by your efforts. Thank you.

The board is interested in receiving information about and recognizing those who assisted in this effort. If you or others you know of provided assistance in this regard, please email these reports to Virginia_Herold@dca.ca.gov.

Also, discussion of emergency response efforts generally in California will be a discussion item for the December 11 Licensing Committee Meeting.

The board is also interested in learning if additional statutory law or regulations need amendment to permit better/stronger/faster response to the public during emergencies. Please provide any such proposals also to Virginia Herold.

Thank you.

State of California

Department of Consumer Affairs

Memorandum

To: Licensing Committee

Date: December 6, 2007

From: Board of Pharmacy

Subject: Accreditation Council for Pharmacy Education

FOR INFORMATION

Following is a copy of the new Accreditation Standards for Continuing Pharmacy Education. These new standards take effect January 1, 2009 and are a result of a two-year revision process completed by the ACPE.



ACCREDITATION COUNCIL FOR PHARMACY EDUCATION

20 North Clark Street, Suite 2500 • Chicago, Illinois 60602-5109 • www.acpe-accredit.org
312/664-3575 • FAX 312/664-4652 • E-mail: dtravlos@acpe-accredit.org

October 25, 2007

MEMORANDUM

TO: Providers of Continuing Pharmacy Education, Pharmacy Colleges and Schools, State Boards of Pharmacy, and Professional Pharmacy Organizations

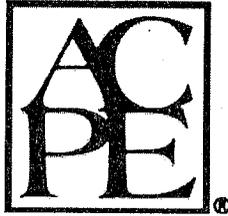
FROM: Dimitra V. Travlos, PharmD, BCPS
Assistant Executive Director and Director, CE Provider Accreditation

RE: *Accreditation Standards for Continuing Pharmacy Education*

Enclosed is a copy of the new *Accreditation Standards for Continuing Pharmacy Education*. The standards were released at ACPE's 12th Conference on Continuing Pharmacy Education October 4-7, 2007. The *Accreditation Standards for Continuing Pharmacy Education* will be in effect January 1, 2009.

ACPE underwent a two-year revision process that included feedback received via web-based surveys, focus groups, CE committees, practitioners, stakeholders, and ACPE's Continuing Pharmacy Education Commission. ACPE would like to thank the profession for its valuable feedback to produce quality standards.

If you have any questions, please do not hesitate to contact us.



Accreditation Council for Pharmacy Education

Accreditation Standards for Continuing Pharmacy Education

Adoption: June 20, 2007

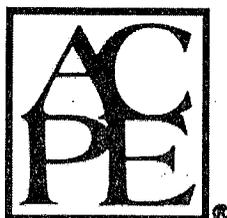
Released: October 5, 2007

Effective: January 1, 2009

Accreditation Council for Pharmacy Education

Chicago, Illinois

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Standard 2: Educational Needs Assessment

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Appendix I: Accreditation Council for Pharmacy Education Definition of Continuing Education for the Profession of Pharmacy

Appendix II: Standards for Commercial Support adapted from Accreditation Council for Continuing Medical Education, 2004

Glossary

Accreditation Council for Pharmacy Education (ACPE) Overview

The Accreditation Council for Pharmacy Education is the national agency for the accreditation of professional degree programs in pharmacy and providers of continuing pharmacy education. ACPE was established in 1932 for the accreditation of professional degree programs in pharmacy. In 1975 its scope was broadened to include accreditation of providers of continuing pharmacy education (www.acpe-accredit.org).

THE MISSION OF ACPE IS TO ASSURE AND ADVANCE QUALITY IN PHARMACY EDUCATION.

ACPE is an autonomous and independent agency whose Board of Directors is appointed by the American Association of Colleges of Pharmacy (AACCP), the American Pharmacists Association (APhA), the National Association of Boards of Pharmacy (NABP), and the American Council on Education. Since the inception of its accreditation agency recognition program in 1952, ACPE has been recognized by the U.S. Department of Education, and in April 2004, received recognition by the Council for Higher Education Accreditation.

State boards of pharmacy require that licensure applicants from the United States be graduates of an accredited pharmacy degree program to be eligible to sit for the North American Pharmacist Licensure Examination™ (NAPLEX®). In addition, all state boards of pharmacy require pharmacists to participate in accredited or otherwise approved continuing education activities for relicensure. A growing number of state boards of pharmacy require pharmacy technicians to participate in continuing education for re-registration or relicensure. These Standards were created in order to meet those requirements.

Revision of Standards: Background

All accrediting bodies, including ACPE, periodically review and revise their standards for currency and appropriateness. The factors that prompted ACPE to conduct a reassessment of existing CPE requirements for provider accreditation include:

- Experience gained by ACPE in its accreditation reviews since the adoption of the *ACPE Criteria for Quality and Interpretive Guidelines* in 1977.
- Feedback from ACPE stakeholders regarding quality improvement of the *ACPE Criteria for Quality and Interpretive Guidelines*.
- Revision of the *Accreditation Standards and Guidelines for the Professional Degree Program in Pharmacy Leading to the Doctor of Pharmacy Degree* ("Standards 2007"): The standards and guidelines have been refined to ensure the development of students who can contribute to the care of patients and to the profession by practicing with competence and confidence in collaboration with other health care providers. The standards place greater emphasis on desired scientific foundation and practice competencies, the manner in which programs need to assess students' achievement of competencies, and the importance of the development of the student as a professional and lifelong learner. The standards focus on the development of students' professional knowledge, skills, attitudes, and values, as well as sound and reasoned judgment and the highest level of ethical behavior. (www.acpe-accredit.org)
- Revision of AACP's Center for the Advancement of Pharmaceutical Education (CAPE) Educational Outcomes in 2004 was guided by a consultant and an advisory panel of educators and practitioners. These educational outcomes are intended to be the target toward which the evolving pharmacy curriculum should be aimed. (www.aacp.org)
- The 2005 publication of The Joint Commission of Pharmacy Practitioners' *Vision of Pharmacy Practice 2015*, accepted by the governing boards of 11 pharmacy organizations, including ACPE.
- The Medicare Modernization Act of 2003 that established the need for medication therapy management services provided by pharmacists for high-risk patients (www.cms.hhs.gov).
- Reports from the Institute of Medicine (www.iom.edu) suggesting changes in the current health care system to improve medication safety and patient outcomes, including the five competencies that all health care professionals should attain during their education and training.
- The growing number of pharmacy technicians who require continuing education to renew their certification and/or registration.
- Revision of ACPE's *Definition of Continuing Education for the Profession of Pharmacy* to differentiate CPE for pharmacy technicians as defined by the practice analysis for certified pharmacy technicians.

Revision of Standards: Differences

- Title: Changed from ACPE Criteria for Quality and Interpretive Guidelines to *ACPE Standards for Continuing Pharmacy Education* for clarity and organizational consistency.
- Philosophy and emphasis: The CPE standards were designed to facilitate the continuum of learning as defined in Standards 2007. Standards 2007 emphasizes the foundation needed for development of the student as a lifelong learner and the *Standards for Continuing Pharmacy Education* should provide a structure as students make the transition to practicing pharmacists.
- The Standards emphasize that pharmacists and pharmacy technicians should:
 - identify their individual educational needs
 - pursue educational activities that will produce and sustain more effective professional practice in order to improve practice, patient, and population health care outcomes
 - link knowledge, skills, and attitudes learned to their application of knowledge, skills, and attitudes in practice
 - continue self-directed learning throughout the progression of their careers
- The Standards guide CPE providers to:
 - advocate for the lifelong learning of pharmacists and technicians
 - emphasize systematic, self-directed learning
 - educate pharmacists and technicians about available activities in their specific practice areas
 - identify and meet the educational needs of pharmacists and technicians
 - focus on the educational needs of pharmacists and technicians rather than on the number of participants or activities conducted
 - assure that faculty take an active role in delivering content so that pharmacists and technicians are actively engaged in their learning
 - include active learning strategies to enhance knowledge retention and application in practice
 - assess participant learning from a CPE activity
 - evaluate the impact of CPE activities in pharmacy practice
- Format: The Standards are organized in four sections - Content, Delivery, Assessment, and Evaluation - with an introductory paragraph describing the intent and context of each section. The Standard is defined and an explanatory Guidance section follows.
- Terminology: The Standards use the phrase 'pharmacists and technicians' as the recipients for CPE activities. Please note that it is acceptable for some providers to design CPE activities for pharmacists only; to design CPE activities for pharmacy technicians only; and, for some providers to design CPE activities for both pharmacists and pharmacy technicians.

Standards for Continuing Pharmacy Education

Section I: Content of Continuing Pharmacy Education (CPE) Activities

The purpose of the standards in this section is to ensure that the provider's continuing pharmacy education program has a clearly articulated mission, desired goals and a planning process to achieve the mission and goals. The mission, goals, and activities must be related to the vision and educational needs of the profession of pharmacy to better serve society. As recommended by the Institute of Medicine for all health care professionals, pharmacists and pharmacy technicians must be educated to deliver patient-centered care as members of an interprofessional team, emphasizing evidence-based practice, quality improvement approaches, and informatics.

Standard 1: Goal and Mission of the CPE Program

Standard 2: Educational Needs Assessment

Standard 3: Continuing Pharmacy Education Activities

Standard 4: CPE Activity Objectives

Standard 5: Standards for Commercial Support

Standard 1: Goal and Mission of the CPE Program

The provider must develop a CPE goal and mission statement that defines the basis and intended outcomes for the majority of educational activities the provider offers.

Guidance

A CPE *goal* is a concise written statement of what the provider intends to achieve for pharmacy education. The CPE goal should address how a provider will assist pharmacists and technicians* to maintain and enhance their professional competencies to practice in various settings. These may include, but are not limited to:

- ensuring optimal medication therapy outcomes and patient safety,
- managing practice settings,
- satisfying the educational requirements for pharmacist relicensure, and
- meeting recertification requirements for pharmacy technicians.

A CPE *mission* statement should be consistent with the goals and specifically indicate the provider's short-term intent in conducting CPE activities, including the intended audience and the scope of activities. The mission and goals should be systematically evaluated and periodically updated to assure consistency among the mission, overall goals, and individual activities.

CPE is a structured educational *activity* designed to support the continuing professional development of pharmacists and technicians in order to help them maintain and enhance their competence. Each CPE activity should promote problem-solving and critical thinking and be applicable to the practice of pharmacy as defined by the current *Definition of Continuing Pharmacy Education* (Appendix I). CPE activities should be designed according to the appropriate roles and responsibilities of the pharmacists and technicians.

Note: The appendices are guides for ACPE-accredited providers as they develop CPE activity content appropriate for pharmacists and technicians.

Standard 2: Educational Needs Assessment

The provider must develop CPE activities based on a multifaceted process where educational needs are prospectively identified.

Guidance

Needs assessment should be completed before planning specific CPE activities and should guide content development and delivery.

* Terminology: The Standards use the phrase 'pharmacists and technicians' as the recipients for CPE activities. Please note that it is acceptable for some providers to design CPE activities for pharmacists only; to design CPE activities for pharmacy technicians only; and, for some providers to design CPE activities for both pharmacists and pharmacy technicians.

A needs assessment should employ multiple strategies to identify the specific gaps in knowledge or skills or areas for enhancement for pharmacists' and technicians' competence. The provider should identify gaps between what pharmacists and technicians do and what is needed and desired in practice.

Strategies for needs assessment should incorporate a method or methods in which representatives of the intended audience participate in identifying their own continuing education needs.

Standard 3: Continuing Pharmacy Education Activities

The provider must structure each CPE activity to meet the knowledge-, application- and/or practice-based educational needs of pharmacists and technicians.

Guidance:

Knowledge-based CPE activity. These CPE activities should be designed primarily for pharmacists and technicians to acquire factual knowledge. This information must be based on evidence as accepted in the literature by the health care professions. The minimum credit for these activities is 15 minutes or 0.25 contact hour.

Application-based CPE activity. These CPE activities should be designed primarily for pharmacists and technicians to apply the information learned in the time frame allotted. The information must be based on evidence as accepted in the literature by the health care professions. The minimum credit for these activities is 60 minutes or one contact hour.

Practice-based CPE activity. These CPE activities should be designed primarily for pharmacists and technicians to systematically acquire specific knowledge, skills, attitudes, and performance behaviors that expand or enhance practice competencies. The information within the practice-based CPE activity must be based on evidence as accepted in the literature by the health care professions. The formats of these CPE activities should include a didactic component and a practice component. The minimum credit for these activities is 15 contact hours.

Providers are not required to offer all three activity types. The CPE activities should be consistent with the provider's mission and appropriate to meet the identified pharmacist and technician needs.

Providers are encouraged to *guide* pharmacists and technicians to the best combination of CPE activities to meet their practice needs.

Standard 4: CPE Activity Objectives

The provider must develop objectives for each CPE activity that define what the pharmacists and technicians should be able to do at the completion of each CPE activity.

Guidance

Objectives must be:

- specific and measurable
- developed to specifically address the identified educational need (Standard 2)
- addressed by an active learning activity (Standard 7) and
- covered by a learning assessment (Standard 9)

Standard 5: Standards for Commercial Support (Appendix II)

The provider must plan all CPE activities independent of commercial interest. The educational content must be presented with full disclosure and equitable balance.

Appropriate topics and learning activities must be distinguished from topics and learning activities which are promotional or appear to be intended for the purpose of endorsing either a specific commercial drug, device or other commercial product (as contrasted with the generic product/drug entity and its contents or the general therapeutic area it addresses), or a specific commercial service (as contrasted with the general service area and/or the aspects or problems of professional practice it addresses).

Guidance:

The provider must:

- ensure independence in planning and delivery of CPE activities, and
- implement a mechanism to prospectively identify and resolve conflicts of interest during the planning process, and
- use commercial support appropriately, and
- manage commercial promotion appropriately, and
- present content that is without commercial bias, and
- disclose required information.

Section 2: Delivery of CPE Activities

The purpose of the standards in this section is to ensure that the provider delivers CPE activities to promote pharmacists' and technicians' learning and application of learned principles to practice. The teaching and learning methodologies used should foster the continued development of critical thinking and problem-solving skills, be applicable to the diverse learning needs of the pharmacists and technicians, and encourage the continuing professional development of pharmacists and technicians.

Standard 6: Faculty

Standard 7: Teaching and Learning Methods

Standard 8: Educational Materials

Standard 6: Faculty

The provider must communicate and collaborate with CPE activity faculty regarding the identified educational needs, intended audience, objectives, active participation, and learning assessments for each CPE activity.

Guidance

- a. Faculty should be selected based upon their knowledge of the subject matter; experience and teaching ability; and ability to meet the educational needs of the pharmacists and technicians.
- b. Information, verbal and written, should be provided to faculty to assure that CPE activities meet ACPE's *Standards for Continuing Pharmacy Education* for developing objectives, incorporating active learning opportunities, and appropriate assessments of learning.
- c. Faculty should disclose to the provider all relevant financial relationships with any commercial interest. In addition, the provider must have implemented a mechanism to identify and resolve any conflicts of interest prior to the education activity being delivered (Standard 5).

Standard 7: Teaching and Learning Methods

The provider must assure that all CPE activities include active participation and involvement of the pharmacist and technician.

Guidance

The methodologies employed should be determined by the CPE activity planned (Standard 3), objectives, educational content, and the size and composition of the intended audience.

The provider should design and implement active learning exercises as a component of live and home study instructional methods.

Standard 8: Educational Materials

The provider must offer educational materials for each CPE activity that will enhance participants' understanding of the content and foster applications to pharmacy practice.

Guidance

Educational materials should serve as a guide, provide additional sources of information, and include reference tools usable in practice.

Section 3: Assessment

The purpose of the standards in this section is to ensure that CPE activities employ appropriate learning assessments and that feedback is provided to pharmacists and technicians in a timely manner, enabling them to apply the learned content to practice.

Standard 9: Assessment of Learning

Standard 10: Assessment Feedback

Standard 9: Assessment of Learning

The provider in collaboration with faculty must include learning assessments in each CPE activity to allow pharmacists and technicians to assess their achievement of the learned content. Completion of a learning assessment is required for CPE credit.

Guidance

The provider may select formal and informal techniques for assessment of learning. Informal techniques typically involve participant discussions. Formal techniques, such as tests and quizzes, are typically individualized, written, and graded. The assessment should be consistent with the identified CPE activity objectives (Standard 4) and activity type (Standard 3).

Knowledge-based CPE activity. Each CPE activity in this category must include assessment questions structured to determine recall of facts.

Application-based CPE activity. Each CPE activity in this category must include case studies structured to address application of the principles learned.

Practice-based CPE activity. Each CPE activity in this category must include formative and summative assessments that demonstrate that the pharmacists and technicians achieved the stated objectives.

Standard 10: Assessment Feedback

The provider must ensure learner assessment feedback is provided to participants in an appropriate, timely, and constructive manner.

Guidance

The feedback provided should be consistent with the learning assessment (Standard 9), activity objectives (Standard 4), and activity type (Standard 3). Verbal and written feedback may be provided as follows:

Knowledge-based CPE activity. Feedback may include the correct response to questions. For incorrect responses, the provider is encouraged to communicate that the question was answered incorrectly and provide the rationale for the correct responses.

Application-based CPE activity. Feedback may include the correct evaluation of case studies. When responses are incorrect, the provider is encouraged to explain the rationale for the correct responses.

Practice-based CPE activity. Feedback should be provided based on the formative and summative assessments that were used to demonstrate that the pharmacist or technician achieved the stated objectives.

Section 4: Evaluation

The purpose of the standards in this section is to ensure that providers evaluate the effectiveness of CPE activities and program. Providers must have an evaluation plan that allows for a determination of the degree to which the mission and goals have been achieved. They must use this information for continuous quality improvement of their CPE programs.

Standard 11: Evaluation of CPE Activities

Standard 12: Achievement and Impact of CPE Mission and Goals

Standard 11: Evaluation of CPE Activity

Providers must develop and conduct evaluations of each CPE activity. The evaluations must allow pharmacists and technicians to provide feedback on the following items:

- applicability of the CPE activity to meet their educational needs
- achievement of each stated objective
- quality of faculty
- usefulness of educational material
- effectiveness of teaching and learning methods, including active learning
- appropriateness of learning assessment activities
- perceptions of bias or commercialism

Guidance

The above items are the minimum requirements for CPE activity evaluations. Providers are encouraged to evaluate additional items and assess whether the provider's stated mission and goals are achieved.

The feedback should be summarized for pharmacists and technicians separately and used in a systematic fashion for the purpose of ongoing improvement of the overall CPE program.

Standard 12: Achievement and Impact of Mission and Goals

Providers must establish and implement evaluation plans that assess *achievement* and *impact* of stated mission and goals (Standard 1). They must use this information for continuous development and improvement of the CPE program.

Guidance

An evaluation plan, that includes data collection and analysis, should be developed to document achievement of the provider's CPE mission and goals. Based on the results of the evaluation plan, the provider's mission and goals should be periodically updated.

In general, the impact of the provider's CPE program should be measured using the following levels:

- Participation: number of participants attending CPE activities
- Satisfaction: directly measuring satisfaction with learning activities, topic, level of content, and speaker's organization of the material
- Learning: pre- and post-tests, self-assessment tools, multiple choice, short answer, essays, presentations
- Performance: demonstration of skills, application of treatment guidelines
- Patient Health: compliance rates, reduced physician visits
- Population Health: morbidity/mortality, infection rates, readmission rates

Depending on the activity type, these six levels may be evaluated as follows:

Knowledge-based CPE activity. The levels that must be evaluated are participation, satisfaction, and learning.

Application-based CPE activity. The levels that must be evaluated are participation, satisfaction, learning, and performance (demonstration during the activity and intended application in practice).

Practice-based CPE activity. The levels that must be evaluated are participation, satisfaction, learning, performance (demonstration during the activity and application in practice post-activity), and, if applicable, patient and/or population health.

Appendix I. Accreditation Council for Pharmacy Education Definition of Continuing Education for the Profession of Pharmacy

What is the definition of continuing education?

Continuing education for the profession of pharmacy is a structured educational activity designed or intended to support the continuing development of pharmacists and/or pharmacy technicians to maintain and enhance their competence. Continuing pharmacy education (CPE) should promote problem-solving and critical thinking and be applicable to the practice of pharmacy.

What does 'applicable to the practice of pharmacy' mean?

In general, for guidance in organizing and developing CPE activity content, providers should ensure that, as for all health care professionals, pharmacists should develop and maintain proficiency in five core areas*:

- delivering patient-centered care,
- working as part of interdisciplinary teams,
- practicing evidence-based medicine,
- focusing on quality improvement and
- using information technology.

*Adapted from Institute of Medicine's Health Professions Education: A Bridge to Quality, April 2003.

Pharmacist competencies. Pharmacists should always strive to achieve the *Future Vision of Pharmacy Practice* (see Appendix A). Specific competency statements have been developed by the American Association of Colleges of Pharmacy and are expected to be achieved upon graduation from an ACPE-accredited professional degree program in pharmacy (see Appendix B: Center for the Advancement of Pharmaceutical Education, Educational Outcomes 2004). Pharmacy graduates need to take and pass the pharmacy licensure exam, NAPLEX[®], in order to practice pharmacy. NABP has developed the NAPLEX[®] Blueprint (see Appendix C: The NAPLEX[®] Competency Statements) as the competencies needed to pass the exam. These documents are synergistic in establishing the competencies required of pharmacists to enter practice and to continue as a student of pharmacy for a lifetime.

Pharmacy Technician Competencies. The Pharmacy Technician Certification Board (PTCB) has developed the Pharmacy Technician Certification Exam (PTCE) Blueprint as the competencies needed to pass the exam (see Appendix D: PTCB Exam Content Outline).

Note: The appendices should be used by ACPE-accredited providers as guides in developing CE activity content appropriate for pharmacists and/or pharmacy technicians.

How will CPE activities for pharmacists and pharmacy technicians be designated?

Promotional materials (brochures, advertisements, memoranda, letters of invitation, or other announcements) should clearly and explicitly identify the target audience that will benefit from the CPE activity. A CPE activity that includes pharmacists and pharmacy technicians should have specific and separate learning objectives described for both.

In addition, a Universal Program Number—an identification number—is assigned to each CPE activity developed and sponsored, or cosponsored, by an ACPE-accredited provider. This number is developed by appending to the ACPE provider identification number (e.g. 197), the cosponsor designation number (000 for no cosponsor, 999 for all non-ACPE-accredited cosponsors), the year of CE activity development (e.g., 07), the sequential number of the CPE activity from among the new CPE activities developed during that year (e.g., 001), and the topic and format designators (see below).

Cosponsor Designators:

- 000 - no cosponsoring organization
- 999 - cosponsoring with a non-ACPE-accredited organization

Format Designators:

- L - Live activities
- H - Home study and other mediated activities
- C - Activities that contain both live and home study or mediated components

Topic Designators - activities are related to:

- 01 - Disease State Management/Drug therapy
- 02 - AIDS therapy
- 03 - Law (related to pharmacy practice)
- 04 - General Pharmacy
- 05 - Patient Safety

Target audience designator

- P - Pharmacist
- T - Pharmacy Technician

If a CPE activity's target audience is exclusively for *pharmacists* the designation "P" will be used as follows:

- 01-P Disease State Management/Drug therapy
- 02-P AIDS therapy
- 03-P Law (related to pharmacy practice)
- 04-P General Pharmacy
- 05-P Patient Safety: The prevention of healthcare errors, and the elimination or mitigation of patient injury caused by healthcare errors (An unintended healthcare outcome caused by a defect in the delivery of care to a patient.) Healthcare errors may be errors of commission (doing the wrong thing), omission (not doing the right thing), or execution (doing the right thing incorrectly). Errors may be made by any member of the healthcare team in any healthcare setting. (definitions approved by the National Patient Safety Foundation® Board July 2003)

If a CPE activity's target audience is exclusively for *pharmacy technicians* the designation "T" will be used as follows:

- 01-T Disease State Management/Drug therapy
- 02-T AIDS therapy
- 03-T Law (related to pharmacy practice)
- 04-T General Pharmacy
- 05-T Patient Safety: The prevention of healthcare errors, and the elimination or mitigation of patient injury caused by healthcare errors (An unintended healthcare outcome caused by a defect in the delivery of care to a patient). Healthcare errors may be errors of commission (doing the wrong thing), omission (not doing the right thing), or execution (doing the right thing incorrectly). Errors may be made by any member of the healthcare team in any healthcare setting. (definitions approved by the National Patient Safety Foundation® Board July 2003)

Note: If the CPE activity is intended for both pharmacists and pharmacy technicians, that activity will have the same Universal Program Number with respect to the provider identification number, cosponsor designation, year of release, sequence number and format; however, the topic designator in the number will be specific to each audience, either a "P" or "T." For example:

197-000-06-001-L05-P (program number to be used for pharmacists)

197-000-06-001-L05-T (program number to be used for pharmacy technicians)

What are the responsibilities of an ACPE-accredited provider?

It is the responsibility of the provider to assure that each activity complies with the Definition of Continuing Education, be applicable to the practice of pharmacy, identifies the appropriate target audience as it relates to the content, and adheres to ACPE *Criteria for Quality and Interpretive Guidelines*.

As outlined in the ACPE *Criteria for Quality and Interpretive Guidelines*, every ACPE-accredited provider is ultimately responsible for CPE activity planning, faculty selection, content of the activity, site selection, method of delivery, marketing to the appropriate target audience and assurance that the activity is fair, balanced and free from bias and/or promotion. In addition, the provider is responsible for explaining and guiding the faculty in its expectations regarding development of learning objectives and instructional materials and incorporation of active learning and learning assessment mechanisms within the activities. The provider should also ensure that the statements of credit include the appropriate designation as well as the other required elements noted in the *ACPE Criteria for Quality*, Guideline 8.1 Statements of Credit.

Have questions?

If you have any questions as to what constitutes continuing education for the profession of pharmacy, please contact the ACPE staff at ceinfo@acpe-accredit.org or phone 312-664-3575.

Appendix A. Joint Commission of Pharmacy Practitioners Future Vision of Pharmacy Practice

Joint Commission of Pharmacy Practitioners

Academy of Managed Care Pharmacy
703-683-8416
Judith A. Cahill, Executive Director

National Community Pharmacists Association
703-683-8200
Bruce T. Roberts, Executive Vice President

American College of Apothecaries
901-383-8119
D. C. Huffman, Jr., Executive Vice President

Liaison Members

American College of Clinical Pharmacy
816-531-2177
Michael S. Maddux, Executive Director

American Association of Colleges of Pharmacy
703-739-2330
Lucinda L. Maine, Executive Vice President

American Pharmacists Association
202-628-4410
John A. Gans, Executive Vice President

Accreditation Council for Pharmacy Education
312-664-3575
Peter H. Vlases, Executive Director

American Society of Consultant Pharmacists
703-739-1300
John Feather, Executive Director

National Association of Boards of Pharmacy
847-391-4400
Carmen A. Catizone, Executive Director

**American Society of Health-System
Pharmacists**
301-664-8794
Henri R. Manasse, Jr., Executive Vice
President

**National Council of State Pharmacy
Association Executives**
804-285-4145
Rebecca P. Snead, Administrative Manager

For Immediate Release
September 6, 2005

Contact Dana Easton
901-383-8119

Joint Commission of Pharmacy Practitioners Releases "Future Vision of Pharmacy Practice"

The JCPP Future Vision of Pharmacy Practice is a consensus document that articulates a vision for pharmacy and how it will be practiced. Equally important, the document describes how pharmacy practice will benefit society. The document was officially adopted by the JCPP members' executive officers following the November 2004 JCPP meeting and has subsequently been endorsed by each JCPP member's board of directors.

The stakeholders group identified and prioritized the top groups and organizations pharmacy must engage in efforts to work toward the vision of optimized medication use. While pharmacy intends to take leadership roles in improving the use of medications in health and wellness it can not do so in isolation of the many other players in the medication use process.

Vision Statement

Pharmacists will be the health care professionals responsible for providing patient care that ensures optimal medication therapy outcomes.

Pharmacy Practice in 2015

The Foundations of Pharmacy Practice. Pharmacy education will prepare pharmacists to provide patient-centered and population-based care that optimizes medication therapy; to manage health care system resources to improve therapeutic outcomes; and to promote health improvement, wellness, and disease prevention. Pharmacists will develop and maintain:

- a commitment to care for, and care about, patients
- an in-depth knowledge of medications, and the biomedical, sociobehavioral, and clinical sciences
- the ability to apply evidence-based therapeutic principles and guidelines, evolving sciences and emerging technologies, and relevant legal, ethical, social, cultural, economic, and professional issues to contemporary pharmacy practice.

How Pharmacists Will Practice. Pharmacists will have the authority and autonomy to manage medication therapy and will be accountable for patients' therapeutic outcomes. In doing so, they will communicate and collaborate with patients, care givers, health care professionals, and qualified support personnel. As experts regarding medication use, pharmacists will be responsible for:

- rational use of medications, including the measurement and assurance of medication therapy outcomes
- promotion of wellness, health improvement, and disease prevention
- design and oversight of safe, accurate, and timely medication distribution systems.

Working cooperatively with practitioners of other disciplines to care for patients, pharmacists will be:

- the most trusted and accessible source of medications, and related devices and supplies
- the primary resource for unbiased information and advice regarding the safe, appropriate, and cost-effective use of medications
- valued patient care providers whom health care systems and payers recognize as having responsibility for assuring the desired outcomes of medication use.

How Pharmacy Practice Will Benefit Society. Pharmacists will achieve public recognition that they are essential to the provision of effective health care by ensuring that:

- medication therapy management is readily available to all patients
- desired patient outcomes are more frequently achieved
- overuse, underuse and misuse of medications are minimized
- medication-related public health goals are more effectively achieved cost-effectiveness of medication therapy is optimized.

Appendix B. Center for the Advancement of Pharmaceutical Education Educational Outcomes
2004

1. Provide pharmaceutical care in cooperation with patients, prescribers, and other members of an inter-professional health care team based upon sound therapeutic principles and evidence-based data, taking into account relevant legal, ethical, social, cultural, economic, and professional issues, emerging technologies, and evolving biomedical, pharmaceutical, social, behavioral, and clinical sciences that may impact therapeutic outcomes.
 - a. Provide patient-centered care.
 - b. Provide population-based care.
2. Manage and use resources of the health care system, in cooperation with patients, prescribers, other health care providers, and administrative and supportive personnel, to promote health; to provide, assess, and coordinate safe, accurate, and time-sensitive medication distribution; and to improve therapeutic outcomes of medication use.
 - a. Manage human, physical, medical, informational, and technological resources
 - b. Manage medication use systems.
3. Promote health improvement, wellness, and disease prevention in cooperation with patients, communities, at-risk populations, and other members of an inter-professional team of health care providers.
 - a. Assure the availability of effective, quality health and disease prevention services.
 - b. Develop public health policy.

*Adapted from American Association of Colleges of Pharmacy's, *Center for the Advancement of Pharmaceutical Education (CAPE), Educational Outcomes, 2004*, www.aacp.org

Appendix C. The NAPLEX Competency Statements

Area 1 Assure Safe and Effective Pharmacotherapy and Optimize Therapeutic Outcomes

1.1.0 Obtain, interpret and evaluate patient information to determine the presence of a disease or

medical condition, assess the need for treatment and/or referral, and identify patient-specific

factors that affect health, pharmacotherapy, and/or disease management.

1.2.0 Identify, evaluate, and communicate to the patient or health-care provider, the appropriateness of

the patient's specific pharmacotherapeutic agents, dosing regimens, dosage forms, routes of

administration, and delivery systems.

1.3.0 Manage the drug regimen by monitoring and assessing the patient and/or patient information,

collaborating with other health care professionals, and providing patient education.

Area 2 Assure Safe and Accurate Preparation and Dispensing of Medications

2.1.0 Perform calculations required to compound, dispense, and administer medication.

2.2.0 Select and dispense medications in a manner that promotes safe and effective use.

2.3.0 Prepare and compound extemporaneous preparations and sterile products.

Area 3 Provide Health Care Information and Promote Public Health

3.1.0 Access, evaluate, and apply information to promote optimal health care.

3.2.0 Educate the public and health-care professionals regarding medical conditions, wellness, dietary

supplements, and medical devices.

*Adapted from the National Association of Boards of Pharmacy's *NAPLEX Blueprint*, 2005, www.nabp.net

Appendix D. PTCB Exam Content Outline

The pharmacy technician performs activities related to three broad function areas. The specific responsibilities and activities that pharmacy technicians may perform within each function area are:

I. Assisting the Pharmacist in Serving Patients (66% of exam)

- A. Receive prescription/medication order(s) from patient/patient's representative, prescriber, or other healthcare professional
 - 1. Accept new prescription/medication order from patient/patient's representative, prescriber, or other healthcare professional
 - 2. Accept new prescription/medication order electronically (for example, by telephone, fax, or electronic transmission)
 - 3. Accept refill request from patient/patient's representative
 - 4. Accept refill authorization from prescriber or other healthcare professional electronically (for example, by telephone, fax, or electronic transmission)
 - 5. Contact prescriber/originator for clarification of prescription/medication order refill
 - 6. Perform/accept transfer of prescription/medication order(s)
- B. Assist the pharmacist in accordance with federal rules and regulations in obtaining from the patient/patient's representative such information as diagnosis or desired therapeutic outcome, disease state, medication history (including over-the-counter [OTC] medications and dietary supplements), allergies, adverse reactions, medical history and other relevant patient information, physical disability, and payor information (including both self-pay and third party reimbursement)
- C. Assist the pharmacist in accordance with federal rules and regulations in obtaining from prescriber, other healthcare professionals, and/or the medical record such information as diagnosis or desired therapeutic outcome, disease state, medication history (including [OTC] medications and dietary supplements), allergies, adverse reactions, medical history and other relevant patient information, physical disability, and payor information (including both self-pay and third party reimbursement)
- D. Collect and communicate patient-specific data (for example, blood pressure, glucose, cholesterol levels, therapeutic drug levels, immunizations) to assist the pharmacist in monitoring patient outcomes
- E. Collect and communicate data related to restricted drug distribution programs (for example, thalidomide, isotretinoin, and clozapine)
- F. Collect and communicate data related to investigational drugs
- G. Assess prescription or medication order for completeness (for example, patient's name and address), accuracy, authenticity, legality, and reimbursement eligibility
- H. Update the medical record/patient profile with such information as medication history (including [OTC] medications and dietary supplements), disease states, compliance/adherence patterns, allergies, medication duplication, and/or drug-disease, drug-drug, drug-laboratory, drug-dietary supplement and/or OTC, and drug-food interactions
- I. Assist the patient/patient's representative in choosing the best payment assistance plan if multiple plans are available to patient
- J. Process a prescription/medication order
 - 1. Enter prescription/medication order information onto patient profile
 - 2. Select the appropriate product(s) for dispensing (for example, brand names, generic substitutes, therapeutic substitutes, formulary restrictions)
 - 3. Obtain pharmaceuticals, durable and non-durable medical equipment, devices, and supplies (including hazardous substances, controlled substances, and investigational products) from inventory

4. Calculate quantity and days supply of finished dosage forms for dispensing
 5. Measure or count quantity of finished dosage forms for dispensing
 6. Process and handle radiopharmaceuticals
 7. Perform calculations for radiopharmaceuticals
 8. Process and handle chemotherapeutic medications commercially available in finished dosage forms (for example, Efudex, mercaptopurine)
 9. Perform calculations for oral chemotherapeutic medications
 10. Process and handle investigational products
 11. Package finished dosage forms (for example, blister pack, robotic/automated dispensing vial)
 12. Affix label(s) and auxiliary label(s) to container(s)
 13. Assemble patient information materials (for example, drug information sheets, patient package inserts, Health Information Portability and Accountability Act [HIPAA] literature)
 14. Check for accuracy during processing of the prescription/medication order (for example, National Drug Code [NDA] number, bar code, and data entry)
 15. Verify the data entry, measurements, preparation, and/or packaging of medications produced by other technicians as allowed by law (for example, tech check tech)
 16. Prepare prescription or medication order for final check by pharmacist
 17. Prepare prescription or medication order for final check by pharmacy technician as allowed by law (for example, tech check tech)
 18. Perform Nuclear Regulatory Commission (NRC) required checks for radiopharmaceuticals
- K. Compound a prescription/medication order:
1. Assemble equipment and/or supplies necessary for compounding the prescription/medication order
 2. Calibrate equipment (for example, scale or balance, total parenteral nutrition [TPN] compounder) needed to compound the prescription/medication order
 3. Perform calculations required for preparation of compounded IV admixtures
 4. Perform calculations for extemporaneous compounds
 5. Compound medications (for example, topical preparations, reconstituted antibiotic suspensions) for dispensing according to prescription and/or compounding guidelines
 6. Compound medications in anticipation of prescriptions/medication orders (for example, compounding for a specific patient)
 7. Prepare sterile products (for example, TPNs, piggybacks, IV solutions, ophthalmic products)
 8. Prepare radiopharmaceuticals
 9. Prepare chemotherapy
 10. Record preparation and/or ingredients of medications (for example, lot number, control number, expiration date, chemotherapy calculations, type of IV solution)
- L. Provide prescription/medication to patient/patient's representative:
1. Store medication prior to distribution
 2. Provide medication and supplemental information (for example, package inserts) to patient/patient's representative
 3. Package and ship pharmaceuticals, durable and non-durable medical equipment, devices, and supplies (including hazardous substances and investigational products) to patient/patient's representative. Place medication in dispensing system (for example, unit-dose cart, automated systems)
 4. Deliver medication to patient-care unit
 5. Record distribution of prescription medication
 6. Record distribution of controlled substances
 7. Record distribution of investigational drugs
 8. Record distribution of restricted drugs (for example, isotretinoin, clozapine, thalidomide)

- 9. Record distribution of prescription/medication to patient's home
- M. Determine charges and obtain reimbursement for products and services
- N. Communicate with third-party payers to determine or verify coverage
- O. Communicate with third-party payers to obtain prior authorizations
- P. Communicate with third-party payers and patients/patient's representatives to rectify rejected third-party claims
- Q. Identify and resolve problems with rejected claims (for example, incorrect days supply, incorrect ID number)
- R. Provide supplemental information (for example, disease state information, CDs) as requested/required
- S. Direct patient/patient's representative to pharmacist for counseling
- T. Perform drug administration functions under appropriate supervision (for example, perform drug/IV rounds, check pumps, anticipate refill of drugs/IVs)
- U. Process and dispense enteral products

II. Maintaining Medication and Inventory Control Systems (22% of exam)

- A. Identify pharmaceuticals, durable and non-durable medical equipment, devices, and supplies (including hazardous substances and investigational products) to be ordered
- B. Place routine orders for pharmaceuticals, durable and nondurable medical equipment, devices, and supplies (including hazardous substances and investigational products) in compliance with legal, regulatory, formulary, budgetary, and contractual requirements
- C. Place emergency orders for pharmaceuticals, durable and non-durable medical equipment, devices, and supplies (including hazardous substances and investigational products) in compliance with legal, regulatory, formulary, budgetary, and contractual requirements
- D. Receive pharmaceuticals, durable and non-durable medical equipment, devices, and supplies (including hazardous substances and investigational products) and verify against specifications on original purchase orders
- E. Place pharmaceuticals, durable and non-durable medical equipment, devices, and supplies (including hazardous substances and investigational products) in inventory under proper storage conditions while incorporating error prevention strategies
- F. Perform non-patient-specific preparation, distribution, and maintenance of pharmaceuticals, durable and non-durable medical equipment, devices, and supplies (including hazardous substances and investigational products) while incorporating error prevention strategies (for example, crash carts, clinic and nursing floor stock, automated dispensing systems)
- G. Remove from inventory expired/discontinued/slow moving/overstocked pharmaceuticals, durable and nondurable medical equipment, devices, and supplies (including hazardous substances and investigational products)
- H. Remove from inventory recalled pharmaceuticals, durable and non-durable medical equipment, devices, and supplies (including hazardous substances and investigational products)
- I. Dispose of or destroy pharmaceuticals or supplies (for example, hazardous substances, investigational products, controlled substances, non-dispensable products)
- J. Communicate changes in product availability (for example, formulary changes, recalls, shortages) to pharmacy staff, patient/patient's representative, physicians, and other healthcare professionals
- K. Implement and monitor policies and procedures to deter theft and/or drug diversion
- L. Maintain a record of controlled substances ordered, received, and removed from inventory
- M. Maintain a record of investigational products ordered, received, and removed from inventory
- N. Perform required inventories and maintain associated records
- O. Maintain record-keeping systems for repackaging, non-patient specific compounding, recalls, and returns of pharmaceuticals, durable and non-durable medical equipment, devices, and

- supplies (including hazardous substances and investigational products)
- P. Compound non-patient specific medications in anticipation of prescription/medication orders
- Q. Perform quality assurance tests on compounded medications (for example, end product testing and validation)
- R. Repackage finished dosage forms for dispensing (for example, unit dose, blister pack, oral syringes)
- S. Participate in quality assurance programs related to pharmaceuticals, durable and non-durable medical equipment, devices, and supplies (including hazardous substances and investigational products)

III. Participating in the Administration and Management of Pharmacy Practice (12% of exam)

- A. Coordinate written, electronic, and oral communications throughout the practice setting (for example, route phone calls, faxes, verbal and written refill authorizations; disseminate policy and procedure changes)
- B. Update and maintain patient information (for example, insurance information, demographics, provider information) in accordance with federal regulations and professional standards (for example, Health Insurance Portability and Accountability Act [HIPAA])
- C. Collect productivity information (for example, the number of prescriptions filled, fill times, payments collected, rejected claim status)
- D. Participate in quality assurance activities (for example, medication error prevention, customer satisfaction surveys, and internal audits of processes)
- E. Generate quality assurance reports (for example, compile or summarize data collected for evaluation or action plan development, root cause analysis)
- F. Implement and monitor the practice setting for compliance with federal regulations and professional standards (for example, Materials Safety Data Sheet [MSDS], Occupational Safety Health Administration [OSHA], Joint Commission on Accreditation of Healthcare Organizations [JCAHO], United States Pharmacopeia [USP])
- G. Implement and monitor policies and procedures for infection control
- H. Implement and monitor policies and procedures for the handling, disposal, and destruction of pharmaceuticals and supplies (for example, hazardous substances, investigational products, controlled substances, non-dispensable products, radiopharmaceuticals)
- I. Perform and record routine sanitation, maintenance, and calibration of equipment (for example, automated dispensing equipment, balances, TPN compounders, and refrigerator/freezer temperatures)
- J. Update, maintain, and use manual or electronic information systems (for example, patient profiles, prescription records, inventory logs, reference materials) in order to perform job related activities
- K. Use and maintain automated and point-of-care dispensing technology
- L. Perform billing and accounting functions for products and services (for example, self-pay, third-party adjudication, pharmaceutical discount cards, medication reimbursement)
- M. Communicate with third-party payors to determine or verify coverage for products and services
- N. Coordinate and/or participate in staff training and continuing education
- O. Perform and/or contribute to employee evaluations and competency assessments
- P. Participate in the establishment, implementation, and monitoring of the practice setting's policies and procedures

*Adapted from the Pharmacy Technician Certification Board's *Content Outline*, 2006; www.ptcb.org

Appendix II. Standards for Commercial Support adapted from Accreditation Council for Continuing Medical Education, 2004

All continuing pharmacy education (CPE) programs should provide for an in-depth presentation with fair and full disclosure and equitable balance. Appropriate topics and learning activities shall be distinguished from topics and learning activities which are promotional or appear to be intended for the purpose of endorsing either a specific commercial drug or other commercial product (as contrasted with the generic product/drug entity and its contents or the general therapeutic area it addresses), or a specific commercial service (as contrasted with the general service area and/or the aspects or problems of professional practice it addresses).

Guideline 1: Independence

- a. A CPE provider must ensure that the following decisions were made free of the control of a commercial interest. A "commercial interest" is defined as any proprietary entity producing health care goods or services, with the exemption of non-profit or government organizations and non-health care related companies.
 - 1) Identification of CPE needs;
 - 2) Determination of educational objectives;
 - 3) Selection and presentation of content;
 - 4) Selection of all persons and organizations that will be in a position to control the content of the CPE;
 - 5) Selection of educational methods;
 - 6) Evaluation of the activity.
- b. A commercial interest cannot take the role of non-accredited partner in a cosponsorship relationship.

Guideline 2: Resolution of Personal Conflicts of Interest

- a. The provider must be able to show that everyone who is in a position to control the content of an education activity has disclosed to the provider all relevant financial relationships with any commercial interest. The ACPE defines "relevant financial relationships" as financial relationships in any amount occurring within the past 12 months that create a conflict of interest.
- b. An individual who refuses to disclose relevant financial relationships will be disqualified from being a planning committee member, a teacher, or an author of CPE, and cannot have control of, or responsibility for, the development, management, presentation or evaluation of the CPE activity.
- c. The provider must have implemented a mechanism to identify and resolve all conflicts of interest prior to the education activity being delivered to learners.

Guideline 3: Appropriate Use of Commercial Support

- a. The provider must make all decisions regarding the disposition and disbursement of commercial support.

- b. A provider cannot be required by a commercial interest to accept advice or services concerning teachers, authors, or participants or other education matters, including content, from a commercial interest as conditions of contributing funds or services.
- c. All commercial support associated with a CPE activity must be given with the full knowledge and approval of the provider.

Written agreement documenting terms of support

- d. The terms, conditions, and purposes of the commercial support must be documented in a written agreement between the commercial supporter that includes the provider and its educational partner(s). The agreement must include the provider, even if the support is given directly to the provider's educational partner or cosponsor.
- e. The written agreement must specify the commercial interest that is the source of commercial support.
- f. Both the commercial supporter and the provider must sign the written agreement between the commercial supporter and the provider.

Expenditures for an individual providing CPE

- g. The provider must have written policies and procedures governing honoraria and reimbursement of out-of-pocket expenses for planners, teachers and authors.
- h. The provider, the cosponsor, or designated educational partner must pay directly any teacher or author honoraria or reimbursement of out-of-pocket expenses in compliance with the provider's written policies and procedures.
- i. No other payment shall be given to the director of the activity, planning committee members, teachers or authors, cosponsor, or any others involved with the supported activity.
- j. If teachers or authors are listed on the agenda as facilitating or conducting a presentation or session, but participate in the remainder of an educational event as a learner, their expenses can be reimbursed and honoraria can be paid for their teacher or author role only.

Expenditures for learners

- k. Social events or meals at CPE activities cannot compete with or take precedence over the educational events.
- l. The provider may not use commercial support to pay for travel, lodging, honoraria, or personal expenses for non-teacher or non-author participants of a CPE activity. The provider may use commercial support to pay for travel, lodging, honoraria, or personal expenses for bona fide employees and volunteers of the provider, cosponsor or educational partner.

Accountability

- m. The provider must be able to produce accurate documentation detailing the receipt and expenditure of the commercial support.

Guideline 4: Appropriate Management of Associated Commercial Promotion

- a. Arrangements for commercial exhibits or advertisements cannot influence planning or interfere with the presentation, nor can they be a condition of the provision of commercial support for CPE activities.
- b. Product-promotion material or product-specific advertisement of any type is prohibited in or during CPE activities. The juxtaposition of editorial and advertising material on the same products or subjects must be avoided. Live (staffed exhibits, presentations) or enduring (printed or electronic advertisements) promotional activities must be kept separate from CPE.
 - For **print**, advertisements and promotional materials will not be interleaved within the pages of the CPE content. Advertisements and promotional materials may face the first or last pages of printed CPE content as long as these materials are not related to the CPE content they face **and** are not paid for by the commercial supporters of the CPE activity
 - For **computer based**, advertisements and promotional materials will not be visible on the screen at the same time as the CPE content and not interleaved between computer 'windows' or screens of the CPE content
 - For **audio and video recording**, advertisements and promotional materials will not be included within the CPE. There will be no 'commercial breaks.'
 - For **live, face-to-face CPE**, advertisements and promotional materials cannot be displayed or distributed in the educational space immediately before, during, or after a CPE activity. Providers cannot allow representatives of Commercial Interests to engage in sales or promotional activities while in the space or place of the CPE activity.
- c. Educational materials that are part of a CPE activity, such as slides, abstracts and handouts, cannot contain any advertising, trade name or a product-group message.
- d. Print or electronic information distributed about the non-CPE elements of a CPE activity that are not directly related to the transfer of education to the learner, such as schedules and content descriptions, may include product promotion material or product-specific advertisement.
- e. A provider cannot use a commercial interest as the agent providing a CPE activity to learners, e.g., distribution of self-study CPE activities or arranging for electronic access to CPE activities.

Guideline 5: Content and Format without Commercial Bias

- a. The content or format of a CPE activity or its related materials must promote improvements or quality in healthcare and not a specific proprietary business interest of a commercial interest.

- b. Presentations must give a balanced view of therapeutic options. Use of generic names will contribute to this impartiality. If the CPE educational material or content includes trade names, where available trade names from several companies should be used, not just trade names from a single company.

Guideline 6: Disclosures Relevant to Potential Commercial Bias

Relevant financial relationships of those with control over CPE content

- a. An individual must disclose to learners any relevant financial relationship(s), to include the following information:
 - The name of the individual;
 - The name of the commercial interest(s);
 - The nature of the relationship the person has with each commercial interest.
- b. For an individual with no relevant financial relationship(s) the learners must be informed that no relevant financial relationship(s) exist.

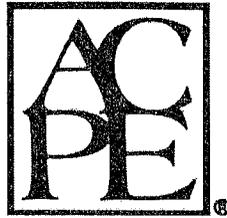
Commercial support for the CPE activity.

- c. The source of all support from commercial interests must be disclosed to learners. When commercial support is 'in-kind' the nature of the support must be disclosed to learners.
- d. 'Disclosure' must never include the use of a trade name or a product-group message.

Timing of disclosure

- e. A provider must disclose the above information to learners prior to the beginning of the educational activity.

NOTE: These Guidelines have been adopted by ACPE from the Accreditation Council for Continuing Medical Education with permission (October 2006).



GLOSSARY

Accreditation

A voluntary process in which an institution, organization or agency submits to an in-depth analysis to determine its capacity to provide quality continuing pharmacy education in accord with standards.

Acquired Immune Deficiency Syndrome (AIDS) Therapy Related

CPE activities which address therapeutic, legal, social, ethical, or psychological issues related to the understanding and treatment of patients with AIDS.

Active learning

A process whereby pharmacists and/or pharmacy technicians are actively engaged in the learning process, rather than "passively" absorbing lectures. Active learning involves reading, writing, discussion, and engagement in solving problems, analysis, synthesis, and evaluation. Faculty usually takes a more guiding role.

Activity

An educational event which is based upon identified needs, has a purpose or objectives, and is evaluated to assure the needs are met. An activity is designed to support the continuing professional development of pharmacists and/or pharmacy technicians to maintain and enhance their competence. Each CPE activity should promote problem-solving and critical thinking while being applicable to the practice of pharmacy as defined by the current *Definition of Continuing Pharmacy Education* (Appendix I). The CPE activities should be designed according to the appropriate roles and responsibilities of the pharmacists and/or pharmacy technician.

Accredited Provider - An institution, organization or agency that has been recognized by the Accreditation Council for Pharmacy Education, in accord with its policy and procedures, as having demonstrated compliance with the standards which are indicative of the Provider's capability to develop and deliver quality continuing pharmacy education.

Assessment

The Latin root *'assidere'* means to sit beside. In an educational context it is the process of observing learning, such as describing, collecting, recording, scoring, and interpreting information about a pharmacist's and technician's learning. Assessments are used to determine achievement of objectives.

Case study or scenario

A description of a situation that requires problem-solving and/or investigation by the learner, e.g. application of learned material to provide a solution to the problem.

Combined Programs

An activity that consists of both live and enduring (home study) components where every learner is required to participate in both components.

Commercial Bias

A personal judgment in favor of a specific proprietary business interest of a commercial interest.

Commercial Interest

Any proprietary entity producing health care goods or services, with the exemption of non-profit or government organizations and non-health care related companies. The ACPE does not consider providers of clinical service directly to patients to be commercial interests.

Commercial Support

Financial, or in-kind, contributions given by a commercial interest, which is used to pay all or part of the costs of a CPE activity.

Conflict of Interest

When an individual's interests are aligned with those of a commercial interest the interests of the individual are in 'conflict' with the interests of the public. ACPE considers financial relationships to create actual conflicts of interest in CPE when individuals have both a financial relationship with a commercial interest and the opportunity to affect the content of CPE about the products or services of that commercial interest.

Contact Hour

A unit of measure of educational credit which is equivalent to approximately 60 minutes of participation in an organized learning experience.

Continuing Education Unit (CEU)

An educational credit unit of measure where 0.1 CEU is equivalent to one contact hour.

Continuing Pharmacy Education (CPE)

Continuing education for the profession of pharmacy is a structured educational activity designed or intended to support the continuing development of pharmacists and/or pharmacy technicians to maintain and enhance their competence. Continuing pharmacy education (CPE) should promote problem-solving and critical thinking and be applicable to the practice of pharmacy.

Continuing Professional Development

The lifelong process of active participation in learning activities that assists in developing and maintaining continuing competence, enhancing their professional practice, and supporting achievement of their career goals.

Cosponsorship

An accredited provider works with another organization for the purpose of developing a continuing pharmacy education activity.

Curricular-based

CPE activities that are designed to be building blocks of knowledge, skills and attitudes for a specific disease state, task, etc.

Disease State Management/Drug therapy

Covers CPE activities that address disease states, drugs and/or drug therapy related to disease states.

Enduring Materials (Home Study)

Enduring materials are home study activities that are printed, recorded or computer assisted instructional materials that do not provide for direct interaction between faculty and participants.

Evidence-based medicine

The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. (Centre for Evidence-Based Medicine)

Faculty

A person(s) who guides and delivers or writes the content of a CPE activity.

Financial Relationships

Financial relationships are those relationships in which the individual benefits by receiving a salary, royalty, intellectual property rights, consulting fee, honoraria, ownership interest (e.g. stocks, stock options or other ownership interest, excluding diversified mutual funds), or other financial benefit. Financial benefits are usually associated with roles such as employment, management position, independent contractor (including contracted research), consulting, speaking and teaching, membership on advisory committees or review panels, board membership, and other activities from which remuneration is received, or expected.

Formative Evaluation

An evaluation process in which outcomes data and analysis are used to modify (form or reform) an activity with an eye to improving it before the activity is completed or repeated.

Goal

A concise written statement of what the provider intends to achieve for pharmacy and/or pharmacy technician education at a certain point in the future. The CPE goal should address how a provider will assist pharmacists and/or pharmacy technicians to maintain and enhance their professional competencies to practice in various settings.

Law

CPE activities which address federal, state, or local laws and/or regulations affecting the practice of pharmacy.

Live Programs

CPE activities that provide for direct interaction between faculty and participants and may include lectures, symposia, live teleconferences, workshops, etc.

Mission

A statement that is consistent with the program goals and specifically indicate the provider's short-term intent in conducting CPE activities including the intended audience and scope of activities.

Needs assessment

Identification of educational needs of the pharmacists and/or pharmacy technician that serve as the basis for planning CPE activities.

Non-commercialism

Continuing pharmacy education activities that provide an in-depth presentation with fair, full disclosure as well as objectivity and balanced. Appropriate topics and learning activities shall be distinguished from those topics and learning activities that are promotional or appear to be intended for the purpose of endorsing either a specific commercial drug or other commercial product (as contrasted with the generic product/drug entity and its contents or the general therapeutic area that it addresses), or a specific commercial service (as contrasted with the general service area and/or the aspects or problems of professional practice that it addresses).

Objectives

Statements that describe what the pharmacists and/or pharmacy technician can expect to know or do after completion of the CPE activity. Objectives are preferably written in behavioral terminology and should suggest outcome measures for a program's success or effectiveness.

Outcome

The end result of a learning activity measured by evaluation or change in practice.

Patient Safety

The prevention of healthcare errors, and the elimination or mitigation of patient injury caused by healthcare errors (An unintended healthcare outcome caused by a defect in the delivery of care to a patient.) Healthcare errors may be errors of commission (doing the wrong thing), omission (not doing the right thing), or execution (doing the right thing incorrectly). Errors may be made by any member of the healthcare team in any healthcare setting. (definitions approved by the National Patient Safety Foundation® Board July 2003)

Pharmacy Technician

An individual working in a pharmacy who, under the supervision of a licensed pharmacist, assists in pharmacy activities that do not require the professional judgment of a pharmacist. (<http://www.acpe-accredit.org/pdf/whitePaper.pdf>)

Program

The overall CPE activities of an accredited provider.

Relevant Financial Relationships

ACPE focuses on financial relationships with commercial interest in the 12 month period preceding the time that the individual is being asked to assume a role controlling content of the CPE activity.

Self Assessment or Self Study

A comprehensive review and assessment process of the provider's CPE program to document accomplishments, assess areas for improvement and outline a plan for making those improvements.

Summative Evaluation

An evaluation process in which outcomes data and analysis are used to show the degree to which goals are attained at the conclusion of an activity.

Target Audience

Group of individuals for which an educational activity has been designed (e.g. pharmacists, technicians, or both).

Universal Program Number (UPN)

A Universal Program Number is an identification number that is assigned to each CPE activity developed and sponsored, or cosponsored, by an ACPE-accredited provider. This number is developed by appending to the ACPE provider identification number (e.g. 197), the cosponsor designation number (000 for no cosponsor, 999 for all non-ACPE-accredited cosponsors), the year of CPE activity development (e.g., 07), the sequential number of the CPE activity from among the new CPE activities developed during that year (e.g., 001), and the topic and format designators (see below).

Cosponsor Designators:

- 000 - no cosponsoring organization
- 999 - cosponsoring with a non-ACPE-accredited organization

Format Designators:

- L - Live activities
- H - Home study and other enduring activities
- C - Activities that contain both live and home study and enduring components

Topic Designators - activities are related to:

- 01 - Disease State Management/Drug therapy
- 02 - AIDS therapy
- 03 - Law (related to pharmacy practice)
- 04 - General Pharmacy
- 05 - Patient Safety

Target audience designator

- P - Pharmacist
- T - Pharmacy Technician

If a CPE activity's target audience is exclusively for *pharmacists* the designation "P" will be used as follows:

- 01-P Disease State Management/Drug therapy
- 02-P AIDS therapy
- 03-P Law (related to pharmacy practice)
- 04-P General Pharmacy
- 05-P Patient Safety: The prevention of healthcare errors, and the elimination or mitigation of patient injury caused by healthcare errors (An unintended healthcare outcome caused by a defect in the delivery of care to a patient.) Healthcare errors may be errors of commission (doing the wrong thing), omission (not doing the right thing), or execution (doing the right thing incorrectly). Errors may be made by any member of the healthcare team in any healthcare setting. (definitions approved by the National Patient Safety Foundation® Board July 2003)

If a CPE activity's target audience is exclusively for *pharmacy technicians* the designation "T" will be used as follows:

- 01-T Disease State Management/Drug therapy
- 02-T AIDS therapy
- 03-T Law (related to pharmacy practice)
- 04-T General Pharmacy

- 05-T Patient Safety: The prevention of healthcare errors, and the elimination or mitigation of patient injury caused by healthcare errors (An unintended healthcare outcome caused by a defect in the delivery of care to a patient). Healthcare errors may be errors of commission (doing the wrong thing), omission (not doing the right thing), or execution (doing the right thing incorrectly). Errors may be made by any member of the healthcare team in any healthcare setting. (definitions approved by the National Patient Safety Foundation® Board July 2003)

Note: If the CPE activity is intended for both pharmacists and pharmacy technicians, that activity will have the same Universal Program Number with respect to the provider identification number, cosponsor designation, year of release, sequence number and format; however, the topic designator in the number will be specific to each audience, either a "P" or "T." For example:

197-000-06-001-L05-P (program number to be used for pharmacists)

197-000-06-001-L05-T (program number to be used for pharmacy technicians)

Memorandum

To: Licensing Committee

Date: December 6, 2007

From: Board of Pharmacy

Subject: Competency Committee Report

FOR INFORMATION

Since the last Licensing Committee Meeting, the Competency Committee workgroups have each held one meeting. At both meetings, the committee continued to work on exam development. Members were also advised of the board's approval of the proposal to strengthen the penalty against applicants who compromise the board's examination.

The most recent quality assurance ended on November 9, 2007.