

## Pharmacists Play Critical Role in State's Hospital SARS CoV-2 (COVID) Response: An Inside Look at the Alternate Care Facility (ACF)

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In March 2020, Vanessa Freitag, vice president of operations integration and pharmacy administration for Ascension Wisconsin, was approached by health system leadership to help with the implementation of medication distribution services for a 776-bed alternative care facility (ACF), part of the emergency response efforts for the global pandemic related to coronavirus disease 2019 (COVID-19). The Department of Homeland Security-Federal Emergency Management Agency (FEMA) had pledged to provide the state of Wisconsin Department of Administration (DOA)/Department of Health Services (DHS) the necessary resources to stand up this ACF as a state emergency operations center, to provide medical care to patients in the event of a surge in COVID-19 cases in Wisconsin. The specific designation was a “temporary hospital accommodation” under section 252.02(2), distinct from a licensed care facility, pursuant to an order from the Secretary of DHS. The Army Corps of Engineers was deployed to set up the site within the Exposition Center of the Wisconsin State Fair Park in West Allis. Using the incident command system structure, a number of section chief positions were established to serve as decision makers and ensure delivery on the intended goals. Ascension Wisconsin committed to providing medication management oversight for the ACF, with Freitag acting as the site’s chief pharmacy officer.

Within the first 24 hours of assuming responsibility for this project, a small workgroup of Ascension Wisconsin pharmacists was assembled to develop plans for implementing medication distribution services. The workgroup was given eight days to accomplish this task. This article shows the work that

pharmacists contributed to prepare and facilitate medication management services at Wisconsin’s ACF site, while also serving as a call to action for the further development and standardization of the work completed on this project.

### Initial Strategy

#### Defining Scope, Approach, and Communication Infrastructure

**Confirming scope.** During the planning period, there were multiple changes to the scope of patient criteria for admission to the ACF. The target population was clarified to be low-acuity, COVID-positive patients with an anticipated length of stay of no longer than five days. The intent of the non-licensed ACF was to be a “pressure relief valve” for area hospitals, allowing for improved focus on higher-acuity COVID patients and other non-COVID patients. This step proved to be an essential component of determining the extent of pharmacy services that would be needed at the facility.

The ACF was to be designed using the simplest strategies, to allow for rapid change implementation. The charge was to build a system independent of the technology and automation commonly used in acute care pharmacy management, to allow rapid deployment of services. The extent of the technology within the ACF was a light version of an electronic health record (EHR) platform, with census and progress note documentation functionality; secure text and video on smartphones; and a printer-copy-fax machine. Medication management was accomplished using a paper system due to the limited pharmacy functionality in the scaled-down EHR use.

**Approach.** To meet the imminent deadline for implementing services at the ACF, pharmacist workgroup used a “divide and conquer” strategy to create a feasible

medication services workflow. The workflow was built with the phases of medication use in mind: selection, procurement, storage, preparation, distribution, administration, monitoring, and disposal (Table 1). Pharmacists in the workgroup were each assigned to a phase to begin research, establish options for execution, and propose a model based on the scope of the deliverable and timeline. Considerations included the source of medication supply (facility- or patient-supplied); security (including handling of controlled substances); and workflow integration with other services at the site (i.e. supply distribution, medical care, nursing practice); all while ensuring the workflows maintained an environment of safety and cleanliness to prevent the spread of COVID-19 within the ACF. It was clear that the team needed to expect the unexpected and readily adapt to this rapidly changing environment by thinking outside of the box.

**Stakeholder engagement.** When the project launched, engagement with the chief officers (Medical, Nursing, and Operations) for the ACF occurred through daily meetings and via email and text communications throughout the day, so decisions could be made rapidly. “Point people” within the pharmacy planning team were identified, to communicate and coordinate with each of the external stakeholders involved (i.e. wholesalers, Drug Enforcement Administration (DEA) representatives, state agencies, and other vital partners). The medication management planning team also attended multiple touch-point discussions throughout the day to report on completed task items, as well as barriers that needed escalating. A shared file drive (using G-Suite) was established to house all documents related to the project, including reference documents and working drafts. This allowed stakeholders

**TABLE 1. Sample Considerations to Define the Medication Use Model**

| <i>Medication Use Phase</i> | <i>Sample Considerations</i>   |
|-----------------------------|--|
| Selection                   | Will the formulary be restricted or open? What will be the process for medications not stocked or available at the ACF?  |
| Procurement                 | Is there a contracted vendor for the ACF for supply ordering? How will account purchasing occur and invoice management? Do accounts need to be established? How will non-formulary medications be obtained? Will controlled substances be ordered by the ACF or only set up to use the patient's own supply?   |
| Storage                     | Is the space for medication storage secure with limited access? Who will have access if a pharmacist is not present? Is the room intended to serve as a medication room or will the space operate as a licensed pharmacy? Will provisions be available to store controlled substances? What controls need to be in place for refrigerated drug storage?  |
| Ordering                    | Will a common medication order set be used or will orders fully open to the physician discretion? Are automatic interchanges/substitutions acceptable? Will we use standing orders for select on-demand medications?   |
| Preparation                 | Will unit dose or bulk dispensing be the primary model? Is a combination of unit dose and bulk medication dispensing be achievable (as patients may be coming with a three-day supply)? Are infusions offered and will sterile compounded products be needed? Coordination with sterile compounding facilities may be necessary if so.   |
| Distribution                | Is a med pass model or on-demand model more acceptable for this situation? Will nursing and physicians have access to the medication room or will it be controlled by licensed pharmacists? How will controlled substances be handled when brought by the patient or dispensed from the medication room to ensure security? The distribution model must limit cross contamination of people and products (as ACF has both COVID-positive and COVID-negative areas within the operational structure). |
| Administration              | Who will be doing the med passing? How will medication administration records be maintained? Will this be manual or electronic? Will patients be allowed to manage their own medications?  |

to make real-time changes, suggestions, and comments to documents, and reduced issues with version control.

## Days 2-8

### Medication Services Development

The team discussed medication safety, including use of patient identifiers, use of wristbands, space assignments for patients (equivalent to room identifiers), and access to emergency medications at the facility given the unique facility care model.

The team reviewed the following options for medication distribution and ultimately chose Option 1.

- **Option 1:** Full satellite med room. This positions inventory and pharmacy labor on-site to prepare and dispense patient-specific medications. It is the most flexible option, because a pharmacist is on-site to help with situations where reconciliation and adjustments are necessary. The repackaging of the patient's own medications into unit-dose packaging would be required, however.
- **Option 2:** Nursing home blister-pack model. This requires a higher level of coordination and multiple distribution models (hospital discharge supplies, and supplies that won't come with the patient).
- **Option 3:** Patient-specific prescriptions, which would facilitate a

process for patient-specific prescription vials with retail pharmacy. Medications would be dispensed in prescription bottles, which might be more complex for nursing staff to manage for a medication pass.

- **Option 4:** Patient-managed medications. Patients would bring their home supply of medications and manage their own medication regimen independently. Based on experience with the patients admitted early on, this option proved to be impractical and/or unsafe.

**Formulary.** Based on other ACF site models around the nation, it was initially proposed that patients admitted to the ACF should be required to have a three-day supply of their outpatient medications provided by their discharging facility for use at the ACF. However, the pharmacists involved in this project recognized that this model would likely not be optimal for hospitals without access to 24-hour pharmacy services or retail pharmacies; therefore, the team developed a medication formulary of just over 100 relatively standard medications. The formulary included one or two drugs in each of the following categories: pain; GI prophylaxis/GI upset/bowel regimens; anticoagulants and antiplatelet agents; fluids and electrolytes; infectious disease;

cardiac health; neurology; mental health; and endocrinology. More than 20 items were deemed appropriate for as-needed medication standing orders, and these products were securely stored in the patient care area. Five formulary controlled substances (HYDROcodone 5mg/Acetaminophen 325mg; OxyCODONE 5mg IR; TraMADol 50mg; LORazepam 0.5mg; and Zolpidem 5mg) were also selected for routine stock. This base formulary was supplemented with a model to procure urgent non-formulary medications for patients, leading to the development of two distinct pathways for medication services at the site: formulary medications and non-formulary medications. The site's medication formulary was approved by the medical staff and work was completed to procure the medications from a pharmaceutical distributor, which required a variance by the Pharmacy Examining Board to allow drug distribution from a wholesaler to an address approved by the board (i.e. a "surge site").<sup>1</sup> To mitigate patient safety concerns and further need to supply patients with non-formulary medications, workflows were developed to leverage existing retail pharmacy workflows within the Ascension health system network to have these medications delivered to the ACF for individual patient use.



*Above: ACF Constructed at the Milwaukee State Fair Park Exposition Hall.*

Subsequent development of the standard operating procedures (SOPs) quickly followed to outline the procurement, dispensing, and administration of medications within the ACF. Medication services team members with inpatient and retail pharmacy perspectives were involved in the development of these workflows, along with a pharmacy resident who was pursuing an emergency management rotation. The majority of these processes and procedures were designed to use as little technology as possible, with mostly on-paper tools. A paper order set was developed to mirror the site's entire formulary and serve as a tool to facilitate the admissions process of each patient. A template for a medication administration record (MAR) was created. The pharmacist created an individual paper copy for each patient each day, so nursing staff could document medication administrations. Medication safety was also a top priority in the workflow development process, with many of the medication safety recommendations from the Institute for Safe Medication Practices (ISMP) incorporated into these workflows. Many pharmacist-driven protocols commonly found in acute care facilities (e.g., IV to PO, substitutions per formulary) were modified and adopted as SOPs to fit the ACF patient care model. All protocols and SOPs were approved by

the chief medical officer and chief nursing officer for the ACF.

**Workspace.** Within the Exposition Center used for the ACF, the ticket office was designated as the medication room. To streamline workflows, the medication room was divided into stations for each step of the medication distribution process. An intake and decontamination station allowed staff to sterilize items potentially exposed to COVID, such as paperwork and home medication vials. This was followed by a station for reviewing each patient's admission order set and assembly of the paper MAR. The back of the space housed medication shelving and a workspace for assembling each patient's medication envelope for the day. An additional locked room located within the ticket office was used to store the controlled substances kept at the ACF. A clean space for IV medication preparation was also designated in this area. Intravenous admixture (e.g. remdesivir) was done according to USP's immediate-use compounding guidelines; mixtures were prepared in a clean space within the medication room and given a one-hour beyond-use date. This process required intentional communication between the medication room and nursing staff so as not to waste medication doses. After medications were prepared for delivery, runners delivered the medications to

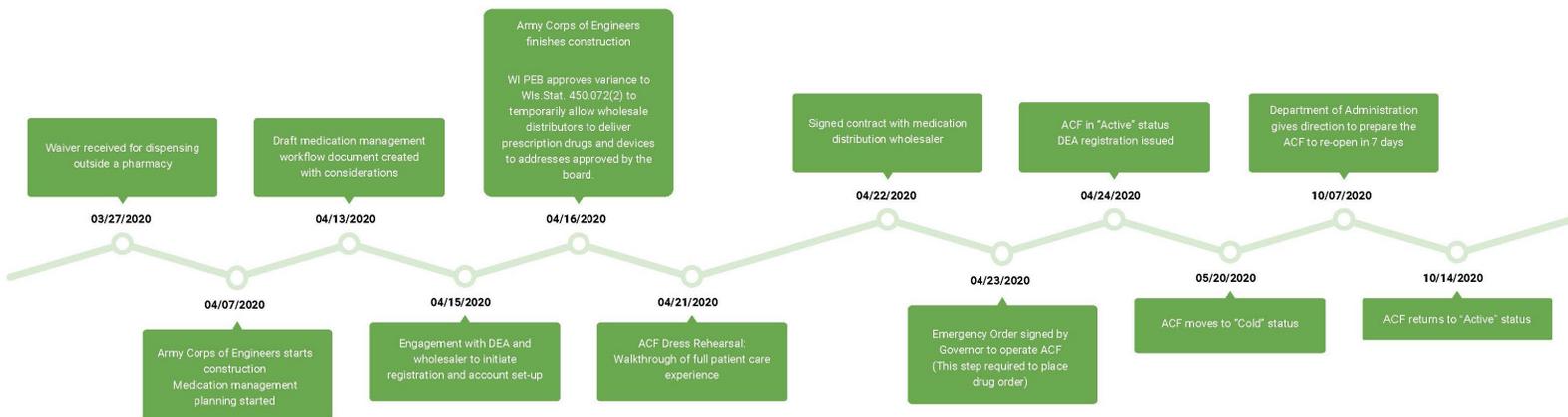
nursing staff using twice-daily medication administration times in patient-specific envelopes to avoid having pharmacists enter the COVID-19-positive patient environment.

### Preparing for Go-Live *Process Refinement and Staff Readiness*

After the initial medication use framework had been set up and processes were approaching the go-live date, additional pharmacist help was requested to support workflow optimization and daily operations. At that time, FEMA quickly deployed two additional staff pharmacists from the Department of Veterans Affairs (VA) hospital in Milwaukee. These pharmacists' main duties included creating orientation materials specific to medication management services; reviewing and updating standard operating procedures; inventory maintenance; and short-term staffing of the ACF medication room.

It was immediately recognized that comprehensive training for medication management workflows would be essential to the success of these services. This was especially crucial as the ACF workforce was to be composed of many different pharmacists from a variety of backgrounds, with staff changing on a daily basis. To meet this charge, the VA pharmacists started by evaluating the medication services

**FIGURE 1. ACF Timeline** (top and bottom of page)



workflows and procedures for efficiency, clarity, and simplicity. After a procedure was finalized, a step-by-step video tutorial was created to visually walk pharmacists through the process. The pharmacists also created workflow checklists, a frequently-asked-questions document, and directions for entry for pharmacists reporting to the ACF. This information was also uploaded to the G-Suite platform to provide easily accessible off-site training to future ACF pharmacists.

A clinical review of medications on formulary was also performed specific to the target population's needs, and adjustments to the base formulary were made. Receiving, returning, and reordering of medications was clearly defined in a checklist for future pharmacist use. A medication safety review was then performed, and Institute for Safe Medication Practices initiatives, such as look-alike-sound-alike (LASA) and hazardous labels and tall-man lettering were implemented. Security measures were added to support controlled substance dispensing, including placing a drug storage lock box at the nursing station with shift-to-shift count reconciliation, and perpetual inventory logs. A compilation of clinical resources

pertinent to the treatment of COVID-19 was developed to foster information sharing and strengthen the site-specific knowledge base of pharmacists working at the site.

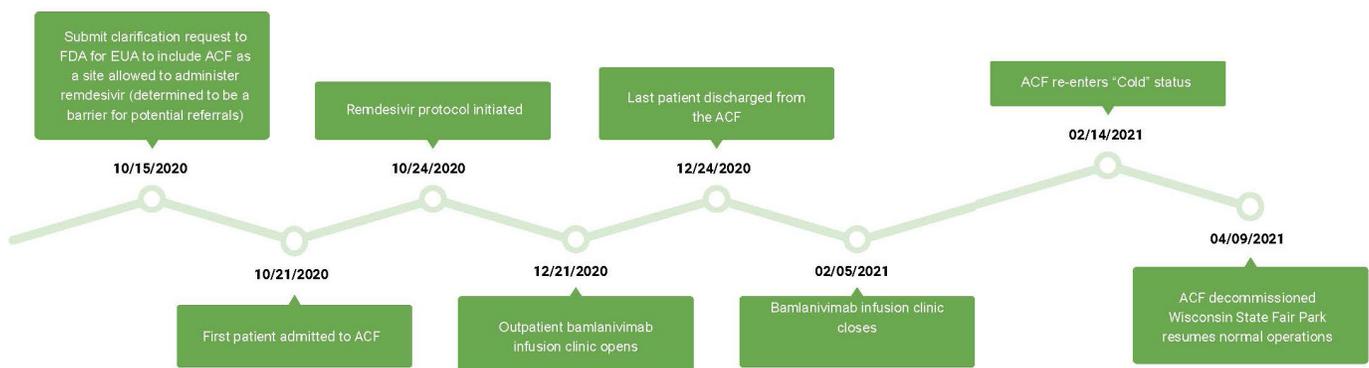
In retrospect, the lesson is clear: To actualize medication use procedures, collaboration between foundational and operational liaisons is crucial. Through hands-on process testing, strategic simplification, and early initiation of training material development, SOPs can be refined to be ready for application to patient care.

### Ready When Needed

While the facility was ready to accept patients by April 24, 2020, area hospitals had pivoted to internally manage patient surges through patient transfers and critical bed management. As a result, the ACF did not receive immediate requests for admissions, which subsequently placed the ACF into cold status (hibernation) from May 20, 2020 to October 14, 2020 (Figure 1). During this hibernation period, all medications were returned to the wholesaler and the facility was locked down. The fall of 2020 saw an additional surge in

hospital admissions due to COVID-19 that greatly exceeded the spring surge and strained area healthcare systems. The order to re-activate the ACF came on October 7, 2020, proposing a return to active status on October 14, 2020.<sup>2</sup> This prompted the pharmacy leadership team to once again prepare the ACF for medication distribution services and work with FEMA to contract with the VA to provide pharmacist staffing. Initially, one pharmacist was scheduled per day to cover from 7:00 AM to 7:00 PM, with the intent to complete the morning medication pass and other activities from 7:00 AM to 11:00 AM, break from 11:00 AM to 3:00 PM, then complete the evening med pass from 3:00 PM to 7:00 PM. During the time block from 7:00 AM to 7:00 PM, these pharmacists were on call in case of overnight admissions. By 3:00 PM each day, the pharmacy administrator would receive a notification about how many admissions were planned for the next day and communicate this information to the staffing pharmacists.

The first patient was admitted to the ACF on October 21, 2020. The admission process for the first patients was a bit



**TABLE 2. Patient Requirements for Admission at the ACF**

| <i>Initial</i>   | <i>Final</i>   |
|--|--|
| Currently hospitalized for at least 24 hours   | <ul style="list-style-type: none"> <li>• Same day transfers for patients currently hospitalized</li> </ul> <b>OR</b> <ul style="list-style-type: none"> <li>• ED for at least 4 hours (pending physician-to-physician review)</li> </ul>                             |
| Patients age between 18 and 70   | Patients 18 and older  |
| Orders for IV fluid hydration and limited antibiotics  | Orders for IV fluid hydration, limited antibiotics, and remdesivir   |
| From Floor: oxygen requirement of NC O2 4 Litres per Minute (LPM) or less to maintain pulse ox of greater than 90% | <ul style="list-style-type: none"> <li>• From ED: oxygen requirement of NC O2 16 LPM or less to maintain pulse ox of greater than 90%</li> <li>• From Floor: oxygen requirement of Optiflow 50 LPM/50% FiO2 or less to maintain pulse ox greater than 90%</li> </ul> |
| Transferring facility must transfer at least 3 days of medication with patient                                     | <ul style="list-style-type: none"> <li>• Transferring facility should transfer any non-formulary medication with patient</li> <li>• Patients own medications acceptable</li> </ul>   |

cumbersome and ended up taking longer than anticipated. This led to several adjustments to workflow processes.

One of the first changes was streamlining the process for medication reconciliation to ensure patient safety and pharmacy efficiency. Initially, pharmacists were relying on medication lists sent from the admitting hospital as the source of all medication records. This was quickly found to be insufficient and inefficient. As the ACF evolved, the pharmacy team started to reach out to the transferring hospital ahead of time to obtain accurate medication lists, anticipate gaps in medication stock, gather times of last medication administration, and proactively address problems prior to the patient transfer. In the end, the ideal model became a pharmacist-to-pharmacist discussion between the transferring facility and the ACF about the patient's medication list prior to transfer.

A unique aspect of the ACF was that physicians and nursing staff changed daily. Pharmacists at the ACF, on the other hand, were scheduled in week-long blocks, which allowed for process consistency and smoother handoffs of care coordination and medication management. Since pharmacists were proactively reaching out to the transferring facility to perform detailed medication reconciliations prior to admission, the care team quickly determined that pharmacists were best equipped to prepare the medication order template for each patient to be reviewed by the ordering physician. Upon patient arrival to the ACF,

the pharmacist would present the reconciled order form to the physician for clinical assessment and modification if necessary, along with the physician signature. This form was then returned to the pharmacist to begin compiling the patient's medication pass envelope. This drastically improved workflow, decreased medication delays, and improved provider satisfaction.

Initial exclusion criteria for the ACF included a negative COVID test; skilled nursing care, nursing home, or assisted living residents; weight over 350 pounds; catheterization requiring assistance; complex wound care; continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BiPAP); dialysis; Clinical Institute Withdrawal Assessment for Alcohol (CIWA) score greater than 8; acute mental health issues or drug/alcohol addiction; pregnancy; incarceration or in police custody; severely immunocompromised or contact precautions for acute diarrheal illness, know active Methicillin-Resistant Staphylococcus aureus (MRSA), Clostridium difficile, tuberculosis, Extensively Drug-Resistant Organism (XDRO), Multidrug-Resistant Organism (MDRO), or known Candida auris colonization or infection; or investigational drug regimens. These criteria were established to ensure staff was able to manage patients safely in the unique ACF environment, but were modified as appropriate (such as eliminating a previous age limit).

It was recognized early on that the initial acceptance criteria needed to be

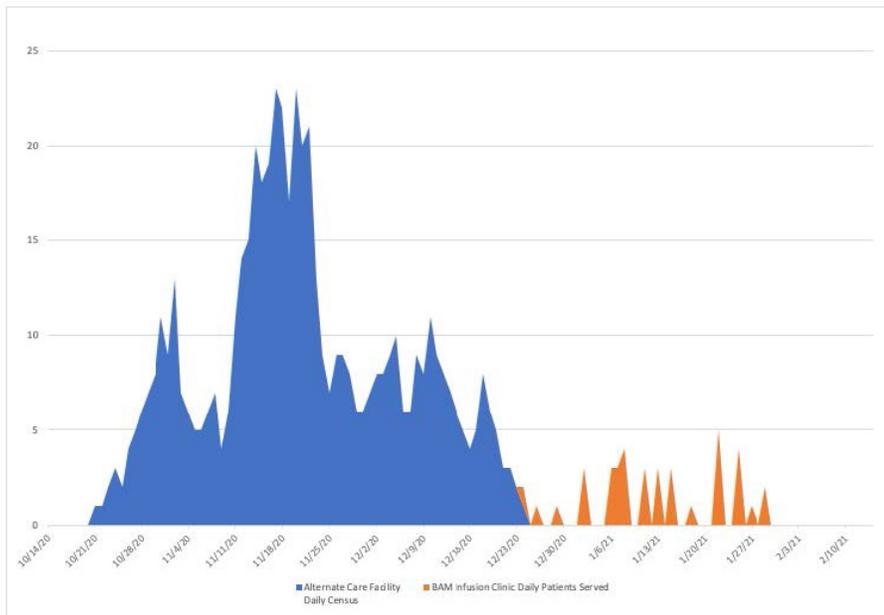
modified as well to be more inclusive of the COVID patients who were presenting to Wisconsin hospitals (Table 2). This relied on pharmacists, respiratory therapists, and other clinical staff at the ACF for feedback and subsequent integration of these modified criteria. The most prominent modification involved the Wisconsin DOA and DHS submitting a waiver on behalf of the ACF to administer remdesivir. The ACF was the first non-licensed facility in the nation to be granted Food and Drug Administration (FDA) emergency use authorization (EUA) to use remdesivir outside of inpatient acute-care hospitals. This paved the way for other states' COVID response sites, with Wisconsin leading the way. The acceptance criteria were refined using an iterative process with regional health-system chief executive officers, CMOs, CNOs, and care management leaders. Changes were done incrementally to support the state's evolving needs. In the end, the ACF was also able to provide bamlanivumab infusions for the final seven weeks of operations (Figure 1).

## Lessons Learned

### Staffing

What began as a one-pharmacist operation organically grew into three separate eight-hour pharmacist shifts per day to accommodate an increasing census in a manual medication distribution model. Original staffing models were not sufficient to account for the significant inefficiencies caused by the lack of many of the technological conveniences that acute care facilities are accustomed to. As time went on, the team found that two overlapping pharmacist shifts were ideal to support the ACF care model: one pharmacist to focus on patient intake and medication reconciliation, while the other pharmacist focused on the medication distribution process. At times of very low census, downtime was spent managing medication inventory, coordinating patients' own medication delivery and returns, and performing quality assurance on documentation and records. During the first observed surge at the facility and highest peak of patient admissions, one pharmacist worked an 18-hour day. An on-call system could have been considered for potential unplanned peaks in admissions, but this was never explored. While the intent was

**FIGURE 2. Patient Census**



to extend the staffing model to include pharmacy technicians, a high reliance on pharmacist credentials to support the clinical staff at the ACF led to using additional pharmacists as cross-coverage instead. Staffing was a combination of FEMA-identified VA pharmacists, ACF-contracted temp agency pharmacists, and Ascension-employed pharmacists.

### **Common Medications**

Remdesivir (if criteria were met), albuterol, dexamethasone, and enoxaparin became inventory staples at the ACF for treating COVID patients. Cough suppressants and guaifenesin were common medications requested for as-needed use and eventually moved to floor stock. Emergency or rapid-response was supported by 24-hour on-site paramedics contracted through an ambulance service, thus eliminating the need for emergency crash carts. A surprising yet understandable need that arose at the ACF was for pharmacologic agents for sleep induction and sleep maintenance, because patient beds were in an area with overhead fluorescent lights that remained partially on at all times.

### **Scope of Services**

As the acuity of patients and the demand for ACF admissions increased, the scope of medication management services did as well. What started as plans to perform only an admission

medication reconciliation expanded to daily reconciliation with pharmacist participation in care management and discharge rounds, which were held virtually. In addition to medication reconciliation, daily clinical functions included warfarin and remdesivir lab monitoring. Acceptance criteria changed from requiring inpatient status for admission to allowing direct admittance from an emergency department (ED), which became the most common admission type for the ACF. The medication reconciliation process for a direct admission from an ED often required more time spent on medication reconciliation, as a hospital pharmacist was not typically involved in these patients' care prior to transfer to the ACF.

### **Communication**

Pharmacist-to-pharmacist handoff was crucial at the ACF. Work done by the Pharmacy Society of Wisconsin (PSW) to connect pharmacy leaders from health systems and hospitals throughout Wisconsin proved to be a tremendous resource. A dedicated page within the PSW website shared the ACF formulary, admission criteria, and floor-stock medications, as well as routine conference calls for process refinement and information sharing, which expedited patient handoff between care sites. Prior to or at the time of admission, a pharmacist from the referring facility and an ACF pharmacist would confer on the

following:

- Date and time of last known dose of medications given at the referring facility
- Which medications would be transferred with the patient
- Whether the patient would be a candidate for remdesivir, dexamethasone, and/or anticoagulation, and whether these were already started at the referring facility

A complete MAR was then faxed from the referring pharmacist to the ACF to prepare for reconciliation against the formulary. Collaborating with social services and adding a standing placeholder at rounds increased the frequency with which patients discharged with their own home medications. Working closely with the interprofessional care teams was key to effectively serving the COVID-19-positive patients admitted to the ACF.

A total of 170 patients were served by Wisconsin's ACF (Figure 2). As more COVID-19 treatments became available, the ACF saw less demand for acute care services and more demand for outpatient infusion therapy. Having a medication management program that could quickly flex to the changing demand of the public health crisis was important for success.

## **Leader Reflection and Future Applicability**

Developing medication management services for Wisconsin's ACF served as a learning experience for the entire team, especially considering the time constraints. The core medication-use processes set the foundation to build these medication distribution services. The team needed quick action, rapid decision making, and strong collaboration. It was essential that pharmacists were willing to be flexible, to change course when the situation demanded it.

While our project leader was able to reach out to other ACF medication services leaders in other parts of the country, the models and takeaways at each site varied greatly, making it difficult to generalize or adopt a one-size-fits-all model. However, having examples of real operations at other ACF sites did influence some of the decisions and direction for the Wisconsin ACF. Various toolkits and quick reference

guides offered a starting point, but the level of detail needed to bring those processes live, on a tight timeline, was the real challenge. As of this writing, the likelihood of needing to establish another ACF for a global pandemic seems remote, but there would be value in having a toolkit and resources prepared for the implementation of standardized medication services, should other public health emergencies or natural disasters arise in the future. This document could serve as another resource for pharmacy leaders. In fact, the most valuable resource for the ACF medication distribution process success was the contributing pharmacists. Without each pharmacist's contributions and dedication, this ACF site would have not have had the bandwidth to assist state health systems in combating the COVID-19 pandemic.

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