



LICENSING COMMITTEE REPORT

Stan Weisser, Licensee Member, Chairperson
Lavanza Butler, Licensee Member, Vice-Chairperson
Ryan Brooks, Public Member
Ricardo Sanchez, Public Member
Debbie Veale, Licensee Member
Albert Wong, Licensee Member

1. Call to Order and Establishment of a Quorum

2. Public Comment for Items Not on the Agenda, Matters for Future Meetings

Note: The committee may not discuss or take action on any matter raised during the public comment section that is not included on this agenda, except to decide to place the matter on the agenda of a future meeting. [Government Code Sections 11125 and 11125.7(a)]

3. Discussion and Consideration of Pharmacy Technicians Working in the Community Pharmacy Setting Including:

- a. Changes In Pharmacy Technician Duties
- b. Changes to Create a New License Type of Pharmacy Technician with Expanded Duties, Including Application and Renewal Requirements
- c. Impact of Any Recommended Changes on Prescription Filling and Dispensing in Community Pharmacy Operations, Including Ratios

Attachment 1

Relevant Law

BPC section 4038 defines a pharmacy technician as an individual who assists a pharmacist in a pharmacy in the performance of his or her related duties.

BPC section 4115 specifies that a pharmacy technician can perform packaging, manipulative, repetitive or other nondiscretionary tasks only while assisting and while under the direct supervision and control of a pharmacist.

CCR section 1793.2 specifies the allowable duties that are performed by a pharmacy technician in most pharmacy settings, including:

- Removing the drug or drugs from stock.
- Counting, pouring, or mixing pharmaceuticals.
- Placing the product into a container.
- Affixing the label or labels to the container.
- Packaging and repackaging.

Prior Committee Discussion

For several meetings, the board has discussed different facets of the pharmacy technician program.

In June 2016, the Licensing Committee considered the duties of a pharmacy technician. Subsequently, the committee held a summit focused on the role of pharmacy technicians in various settings. The summit provided the committee with the opportunity to learn about the functions pharmacy technicians perform in various states and practice settings.

The committee focused on how proposed changes would ultimately benefit consumers, including making pharmacists more available to engage in more direct patient care activities.

During the last meeting, the committee reviewed comparisons of pharmacy technician duties in other states. The committee discussed the practical implications of a tech-check-tech model in the community pharmacy setting including questions about the liability to the pharmacist when supervising the activities. Counsel noted that creating a new license type of technicians who check the work of technicians and who have a defined scope of duties, could address this concern as the responsibility would be shared.

The committee also spoke about the need to strengthen the educational requirements if pharmacy technicians are going to perform expanded duties. The committee noted the need to consider the full picture when assessing changes to pharmacy technician duties, as it could impact ratio considerations and most importantly how this could impact patient care. The committee ultimately requested that board staff work with the committee chair to draft a proposal focusing on the community pharmacy setting first.

For Committee Discussion and Consideration

As requested by the committee, attached is a draft proposal for expanding the duties of pharmacy technicians. Consistent with the committee's direction, the proposal was developed with consultation from the committee chair and provides a framework that could be used to implement in the community pharmacy setting. The draft framework includes the following components for consideration:

1. Establishment of an advanced pharmacy technician (APT) licensure and renewal requirements.
2. Identification of the duties authorized to be performed by an APT.
3. Conditions under which an APT may be used in a community pharmacy.

APT Licensure Requirements Overview

1. Posses a California pharmacy technician license
 2. Possess PTCB or ExCPT Certification
 3. Possess a minimum of an AA degree in pharmacy technology
 4. Have completed 3,000 hours of pharmacy technician experience
- OR
5. In lieu of items 1-4, graduate from a school of pharmacy recognized by the board

APT Renewal Requirements Overview

1. Complete 20 hours of CE every two years including 2 hours of education in medication error reduction and 2 hours of board-provided education in law and ethics.
2. Maintain certification.

Application and renewal fees would also be required, but have not been determined.

Overview of APT Duties

1. Verify the accuracy of prescription labels prior to a pharmacist's final review.
2. Verify the accuracy of the prescription contents compared to the description on the label.
3. Accept new and refill prescriptions from a prescriber's office except when professional judgement is required/needed.
4. Transfer prescriptions to another pharmacy.

Overview of Impact to Pharmacy Operations

1. APT duties would be performed under the supervision of a pharmacist as specified in the policies and procedures of the pharmacy.
2. The PIC is responsible for ongoing evaluation of the APT's activities.
3. A pharmacist must provide directly to the patient all new prescriptions and prescriptions for controlled substances.
4. Records of personnel involved in the dispensing process must be maintained.
5. The APT to RPH ratio shall not exceed 1:1.

Information to Support the Proposal

In 2016 an article was published entitled, "Expanded pharmacy technician roles: Accepting verbal prescriptions and communicating prescription transfers" by Timothy P. Frost and Alex J. Adams. The conclusions of the article noted that 17 states currently allow a pharmacy technician to accept verbal prescriptions and/or transfer prescriptions between pharmacies. The authors concluded that overall, with appropriate policies and procedures, delegation of such tasks can be safe and effective, remove undue stress on a pharmacist, and potentially free up pharmacist time for higher-order clinical care.

Further, as the committee has previously been advised, the conclusions of a study conducted in Iowa, "Expanding the Scope of Pharmacies Using Tech-Check-Tech: The Iowa New Model Practice" shows that pharmacists engagement in patient care activities increases when a tech-check-tech model is allowed in a community pharmacy setting, while the rate of dispensing errors remained low.

Attachment 1 includes the draft proposal, a copy of the article, and a copy of the summary document highlighting the outcomes of the Iowa Tech-Check-Tech study.

4. Discussion and Consideration of Pharmacy Technicians Working in a Closed-Door Pharmacy Setting, Which Provide Pharmacy Services for Patients of Skilled Nursing and Long-Term Care Facilities

Although the functions performed by a pharmacy technician in a closed-door pharmacy are

the same as those performed in a community setting, the practice setting itself is different. Most notably, patients do not come into the pharmacy to have their prescriptions filled. Rather, in this type of setting the prescriptions are provided to patients living in a skilled nursing or long-term care facility.

In prior meetings, the committee has heard comments about how this practice setting varies from the traditional pharmacy setting including the high volume of refill prescriptions versus new prescriptions. Comments received included consideration of a tech-check-tech model as well as consideration of a different pharmacist to technician ratio.

During this Meeting

As part of its discussion the committee may wish to consider a possible framework that would allow a pharmacist in a closed door setting to engage in more patient care activities similar to the framework proposed above for the community setting.

5. Future Committee Meeting Dates

Provided below are Licensing Committee meeting dates through 2018:

- September 19, 2017
- January 16, 2018
- April 19, 2018
- June 26, 2018
- September 26, 2018

A summary of the July committee meeting is provided as **Attachment 2**.

Attachment 1

Proposed BPC 4038.5 (Definition)

“Advanced Pharmacy Technician” means an individual licensed by the board who is authorized to perform technical pharmacy tasks as authorized in Section 4115.6.

Proposed 4115.6 (Specified Duties)

- (a) In a community pharmacy, a licensed advanced pharmacy technician may:
- (1) Verify the accuracy of the typed prescription label before the final check by a pharmacist.
 - (2) Verify the accuracy of the filling of a prescription including confirmation that the medication and quantity included on the label is accurately filled on drug orders that previously have been reviewed and approved by a pharmacist.
 - (3) Accept new prescription orders from a prescriber’s office unless the prescription order requires the professional judgement of a pharmacist.
 - (4) Accept refill authorizations from a prescriber’s office unless the prescription order requires the professional judgement of a pharmacist.
 - (5) Transfer a prescription to another pharmacy.
- (b) A community pharmacy may use the services of an advanced pharmacy technician if all the following conditions are met:
- (1) The duties are done under the supervision of a pharmacist and shall be specified in the pharmacy’s policies and procedures.
 - (2) The pharmacist-in-charge is responsible for ongoing evaluation of the accuracy of the duties performed by personnel as authorized in subdivision (a).
 - (3) A pharmacist shall provide all new prescriptions and controlled substances prescriptions directly to the patient or patient’s agent and provide patient information consistent with the provisions of Section 4052 (a) (8).
 - (4) An electronic record that identifies personnel responsible for the preparation and dispensing of the prescription.
 - (5) The ratio of advanced pharmacy technicians performing the duties in subdivision (a) to pharmacist shall not exceed 1:1. This staffing ratio is in addition to the ratio of staff authorized in Section 4115.

Proposed BCP 4211 (Licensing Requirement)

The board may issue an advanced pharmacy technician license to an individual who meets all the following requirements:

- (a)
- (1) Holds an active pharmacy technician license issued pursuant to this chapter that is in good standing,
 - (2) Possesses a certification issued by a pharmacy technician certifying program as specified in board regulation.
 - (3) Has obtained a minimum of an associate’s degree in pharmacy technology.
 - (4) Has obtained 3,000 hours of experience in a pharmacy performing the duties of a licensed pharmacy technician.
- (b) As an alternative to the requirements in subdivision (a), has graduated from a school of pharmacy recognized by the board.
- (c) A license issued pursuant to this section shall be valid for two years, coterminous with the licensee’s pharmacy technician license.

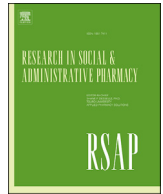
Proposed BPC 4234 (CE/Renewal Requirement)

An advanced pharmacy technician shall complete 20 hours of continuing education each renewal cycle including a minimum of two hours of education in medication error prevention and two hours of board sponsored law and ethics education. A licensee must also maintain certification as specified in Section 4211 (a)(2).

Yet to be determined is the fee.

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Expanded pharmacy technician roles: Accepting verbal prescriptions and communicating prescription transfers

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ABSTRACT

As the role of the clinical pharmacist continues to develop and advance, it is critical to ensure pharmacists can operate in a practice environment and workflow that supports the full deployment of their clinical skills. When pharmacy technician roles are optimized, patient safety can be enhanced and pharmacists may dedicate more time to advanced clinical services. Currently, 17 states allow technicians to accept verbal prescriptions called in by a prescriber or prescriber's agent, or transfer a prescription order from one pharmacy to another. States that allow these activities generally put few legal limitations on them, and instead defer to the professional judgment of the supervising pharmacist whether to delegate these tasks or not. These activities were more likely to be seen in states that require technicians to be registered and certified, and in states that have accountability mechanisms (e.g., discipline authority) in place for technicians. There is little evidence to suggest these tasks cannot be performed safely and accurately by appropriately trained technicians, and the track record of success with these tasks spans four decades in some states. Pharmacists can adopt strong practice policies and procedures to mitigate the risk of harm from verbal orders, such as instituting read-back/spell-back techniques, or requiring the indication for each phoned-in medication, among other strategies. Pharmacists may also exercise discretion in deciding to whom to delegate these tasks. As the legal environment becomes more permissive, we foresee investment in more robust education and training of technicians to cover these activities. Thus, with the adoption of robust practice policies and procedures, delegation of verbal orders and prescription transfers can be safe and effective, remove undue stress on pharmacists, and potentially free up pharmacist time for higher-order clinical care.

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1. Background

As the role of the clinical pharmacist continues to develop and advance, it is critical to ensure pharmacists can operate in a practice environment and workflow that supports the full deployment of their clinical skills. As it stands, pharmacists report high levels of job stress and professional dissatisfaction.¹ In a national survey, pharmacists reported the top stress events they face are “having so much work to do that everything cannot be done well” and “not being staffed with an adequate number of technicians.”¹

Implicit in these responses is the critical role that appropriately trained pharmacy technicians can play in reducing workload and stresses faced by pharmacists. When technician roles are

optimized, patient safety can be enhanced and pharmacists may dedicate more time to advanced clinical services. When technician roles are unnecessarily restricted, there is poor division of labor amongst the pharmacy team and pharmacists spend a substantial fraction of time devoted to non-clinical activities.^{2,3} The legally permitted roles and responsibilities of pharmacy technicians varies greatly country to country and across state lines in the United States (U.S.).⁴ In some respects, the U.S. lags behind other developed nations in the full deployment of the technician workforce. In Denmark, for example, “pharmaconomists” perform the final medication check, answer medication queries, and screen for allergies, among other tasks.⁵

A commonly reported reason for the lack of full deployment of the pharmacy technician workforce is the great variability in their education and training.^{6,7} Less reported is the reciprocal: the variability in legally permissible roles and responsibilities of technicians may suppress investment in more robust education and

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training. For example, why would a technician or employer invest time and money in a skill that is legally prohibited from performing in practice? Similarly, why would a technician training program integrate the teaching of such a skill into its curriculum? This chicken-or-egg scenario leads to robust debates about what the appropriate order of operations should be in terms of expanding technician roles. We personally believe the legal framework for pharmacist delegation should be more permissive than precautionary, and the onus should be on the supervising pharmacist to determine what tasks are appropriate to delegate and to whom. Such a permissive framework can spur investment in education and training that is valued by the individual or the employer.⁸

In that respect, an area in which some have suggested pharmacy technicians could play an increased role relates to a commonly rated pharmacist stressor: being interrupted by phone calls while performing other job duties.⁹ Forty percent of chain pharmacists rated this as a high stress event.¹ Phone calls – like other sources of interruptions and distractions – can divert attention from other activities. Nursing literature has estimated that every interruption can increase the chance of medication error by 12.7%.^{10–12} Two common sources of phone calls that interrupt pharmacy workflow are: 1) verbal prescriptions called in by a prescriber or prescriber's agent; and 2) requests to transfer a prescription order from one pharmacy to another. The National Association of Boards of Pharmacy (NABP) Model State Pharmacy Act and Model Rules recommends allowing certified technicians – but not technician trainees – to transfer prescriptions.¹³ The Model Act expressly recommends prohibiting technician trainees from receiving new oral prescriptions, but it is silent on this task for certified technicians, implying assent.¹³

Allowing technicians to receive and handle these phone calls may serve to reduce interruptions on pharmacists, potentially increasing time for other clinical activities or reducing errors that stem from distractions. Verbal orders such as receiving prescriptions or transferring prescriptions, however, have the potential to be misunderstood or misheard, creating an error cascade that is difficult for the pharmacist to catch during drug utilization review. If handled by individuals who are less familiar with medications than pharmacists or interns, verbal orders may have the potential to introduce new errors into the dispensing process.

The purpose of this manuscript is to describe the potential role for technicians in receiving verbal prescriptions and performing prescription transfers, describe the legal and practice safeguards that may be placed on these activities, and review the existing evidence of the safety of technicians performing these roles. This information will be used as a framework to make recommendations regarding future applications of these tasks.

2. Overview of verbal prescriptions and transferred prescriptions

Verbal communication is one means by which a licensed prescriber may transmit a valid prescription drug order to a pharmacy. Alternatively the prescriber may issue an original signed and written prescription, electronically route it, or fax it to the pharmacy. For a verbal prescription drug order, the prescriber or prescriber's agent must communicate all the information required of a valid prescription drug order except for the signature of the prescriber. Verbal prescriptions may be synchronous or asynchronous (e.g., left as a voicemail). The pharmacist receiving the verbal prescription must promptly reduce it to writing and may process the prescription as any other. Federal law prohibits verbal prescriptions for Schedule II substances, except in rare emergency situations.¹⁴ Unless a state's law is more stringent, federal law permits a verbal prescription as a valid means of ordering a Schedule III through

V controlled substance or any non-controlled medication. Extralegal forces are also in play. For example, the Joint Commission accreditation standards prohibit the use of verbal orders for chemotherapy.¹⁵ Various groups recommend reserving the use of verbal orders to only true emergency situations.¹⁶ Still, many verbal orders are called in for prescriber or patient convenience, though their use has certainly declined with the increased rates of electronic prescribing. For example, one study found a decrease in verbal orders from 22% to 10% of total orders in the 21 months following implementation of an electronic order entry system.¹⁷

A prescription may be transferred from one pharmacy to another up to the maximum refills permitted by the issuing prescriber. There are many reasons why a patient may want to transfer a prescription to a different pharmacy, including convenience. Federal law limits the transferring of a controlled substance to a single, one-time transfer.¹² The transferring pharmacist and the receiving pharmacist must record and document certain pieces of information, and the transferring pharmacist must void the original prescription either on the hard copy or in the electronic record so as not to inadvertently dispense more prescriptions than authorized by the prescriber. Functionally, the act of receiving a transferred prescription is very similar to receiving a new verbal prescription.

3. U.S. state law environmental scan

Currently, 17 U.S. states allow technicians to receive verbal prescriptions in community or institutional settings, and/or transfer prescriptions orders in community or institutional settings (Table 1).¹⁸ Ten states allow technicians to perform both of these tasks, five states allow only the receipt of verbal prescriptions, and two states allow only the transferring of prescription orders between pharmacies.¹⁸

States that allow the receipt of verbal prescriptions and/or transferring of prescription orders were compared to states that do not allow these tasks on certain variables. States that allow these tasks are more likely than states that do not allow these tasks to require either licensure or registration of technicians (88.2% vs. 83.3%, respectively), and are more likely to require that technicians obtain national certification (47.1% vs. 38.9%, respectively). Similarly, states that allow these tasks are more likely than states that do not allow these tasks to have the ability to hold technicians accountable, such as restricting, suspending, or revoking their license (47.1% vs. 33.3%, respectively). Lastly, states that allow these tasks were more likely than states that do not allow these tasks to have all three of these variables present (registration/licensure, certification, accountability capability). Specifically, 47.1% states have all three of these variables allow technicians to take verbal prescriptions and/or transfer prescriptions, compared to 33.3% of the states that do not.¹⁸ The presence of these variables may instill more confidence in the technician workforce that make the delegation of a wider variety of practice activities acceptable, and thus may represent the critical building blocks of expanded technician roles.

We reviewed the state statutes and regulations that permit verbal prescriptions in the aforementioned states. States generally were not too prescriptive in terms of adding legal limitations to when and how this task may be carried out. A few states limited this task to only certified technicians, not trainees. Louisiana was the only state that required the supervising pharmacist to review and initial an oral prescription prior to moving forward with prescription processing; all remaining states allowed the technician to begin data entry, with the pharmacist's review occurring at the traditional drug utilization review step.¹⁹ Wisconsin's law was the most circumscribed in that it permits the acceptance of an oral prescription only if the conversation is recorded, and the

Table 1
Review of state laws.

State	Allow technicians to accept verbal prescriptions	Allow technicians to transfer prescriptions
Arizona		X
Illinois	X	
Iowa	X	
Louisiana	X	X
Massachusetts	X	X
Michigan	X	X
Missouri	X	X
New Hampshire	X	
North Carolina	X	X
North Dakota	X	X
Puerto Rico	X	X
Rhode Island	X	X
South Carolina	X	X
Tennessee	X	X
Utah	X	
Wisconsin	X	
Wyoming		X

pharmacist “listens to and verifies that transcription prior to dispensing” which likely significantly limits use.²⁰

With respect to transferring prescription orders, states also tended to be permissive in statutes and regulations and leave the restrictions to the judgment of the supervising pharmacist. The most common limitation found in law was carving out controlled substances from the prescriptions that technicians could legally transfer between stores. A few states allowed a technician to transfer a prescription as long as the recipient on the other end of the phone was a pharmacist. Arizona had the most narrowly focused law, allowing technicians to perform only an *electronic* transfer between pharmacies owned by the same company and using a common or shared database.²¹ Thus, Arizona technicians are not permitted to verbally communicate a transfer between competitor pharmacies.

4. Existing evidence base with respect to patient safety

In a systematic review on verbal orders, Wakefield et al. found this topic has not been studied in depth and the extant literature is generally anecdotal.²² Paradoxically, Wakefield et al. noted the lone study connecting verbal orders to safety found verbal orders actually decreased the risk of error compared to handwritten orders by a factor of four!^{22,23} We found the paucity of available data to be true in the context of technician acceptance of verbal prescriptions and transferring prescription orders. The identified literature on pharmacy technicians accepting verbal prescriptions was limited to a single study by Friesner and Scott which documents uptake and not commenting on safety or effectiveness; no articles were identified on technicians transferring prescription orders.

Friesner and Scott conducted a survey of technicians registered to practice in North Dakota, a state that allows technicians to accept verbal prescriptions.²⁴ Surveys were mailed to all 456 technicians in the state, and 192 (42.1%) responded in full. Respondents were queried on the extent to which they performed certain tasks, one of which was “taking new prescriptions over the telephone.” Overall, 63% of technician respondents reported taking new verbal prescriptions. Technicians working in community independent pharmacies were much more likely to perform this task than those in inpatient hospitals or large chain community pharmacies. In addition, technicians working in towns with less than 2000 people

were much more likely to perform this task than those working in towns with larger populations. This study was limited in that it did not assess the frequency with which technicians performed this task, and it did not provide any information on the safety – or perceived safety – of technicians perform this task.²⁴

Two case studies were identified related to verbal orders were identified. In Iowa, a pharmacy technician used the verbal prescription route to create forged prescriptions for hydrocodone/acetaminophen.²⁵ In Missouri, a technician misheard a prescription for metolazone 2.5 mg daily as methotrexate 2.5 mg daily, a case in which the patient involved died.²⁶ The prescription was one of eleven that were called into the pharmacy at one time. A state court delivered a \$2 million award against the pharmacy in a negligence suit.²⁶

Perhaps the most interesting finding of our attempted review of evidence was what was not found. Despite 17 states allowing these activities, some for up to four decades, and apparently high uptake of this activity in practice – 63% of technicians in the Friesner and Scott study – we did not find any published studies documenting that these activities lead to widespread safety issues. Of the two cases identified, cases similar to that in Iowa are rendered moot with the reclassification of hydrocodone as a Schedule II substance which can now only be called in emergency situations; while a technician could use the verbal route to forge other controlled substances, this is not exclusive to technicians and can and does unfortunately occur with pharmacists as well. Improvements in state prescription drug monitoring programs can mitigate the risk of this scenario occurring. The Iowa technician had her registration revoked, received a fine, and the board order further suggests that a criminal complaint was filed.²⁵

The case identified in Missouri is tragic and highlights the consequences that can occur in pharmacy practice.²⁶ The mix-up of metolazone and methotrexate is serious. Methotrexate is, however, typically dosed weekly whereas metolazone is typically dosed daily. That such an error could or should have been caught by the pharmacist in the drug utilization review stage may cause some to question the extent to which this error is attributable to the technician receiving the verbal order or the pharmacist who reviewed it for clinical appropriateness.

5. Implications for safety: the role of policies and procedures

Wakefield et al. reviewed common sources of error in the verbal order process.²² Errors could occur on the communicator's end (e.g., misspeaking, confusing patient data, using unapproved communication), or on the receiver's end (e.g., misunderstood sound-alike medications, transcription error, failure to seek clarification, etc.).²² Certainly familiarity with common medications, doses, and uses can mitigate some of the risk on the receiver's end. Pharmacy technicians are increasingly gaining experience with this. For example, studies have recently demonstrated technicians perform accurately at medication reconciliation, often outperforming other health professionals including nurses at this activity.^{27–30} There is undoubtedly transferability of skill set from taking an accurate medication history and accepting a verbal prescription as the former necessitates probing to identify current and past medication names, strength, dosage form, allergies, and other related pieces of information. Practices that have leveraged technicians in medication history roles may be able to use similar training components for these new tasks.

In addition, there are practice policies and procedures that may be adopted to mitigate the potential for harm. Entities such as the Institute for Safe Medication Practice (ISMP) recommend using a prescription pad that prompts the receiver to ask for key pieces of information.^{31–33} Pharmacies may also institute a read-back

technique in which the receiver reads back the order to ensure it was heard accurately, which can include a spelling back of the medication name itself. ISMP goes so far as saying that the read-back technique should be a standard of practice in every setting regardless of who is receiving the verbal order.¹⁶ The receiver may also consider documenting the indication for the medication; this could prevent a metolazone vs. methotrexate mix-up by providing the pharmacist one additional piece of information at the drug utilization review stage that may help ward off errors.³² Pharmacies may also prohibit the use of new or unapproved abbreviations, and confirm doses by reading back the individual digits (e.g., “60 mg: six, zero milligrams”).³³

One issue that remains is the ability of technicians to seek clarification as appropriate in an instance in which the medication that is being called in is not for an appropriate dose, or in the event of a contradiction, among other patient safety issues. Given that most verbal prescriptions are now called in by an agent of the prescriber, clinical conflict resolution is unlikely to occur in real time. If the pharmacist has the right information to catch these issues at the drug utilization review stage, resolution is likely to occur within the same general time duration as if a probing question was asked up front by the pharmacist receiving the verbal order.

6. Conclusion and future direction

Currently 17 states allow technicians to accept verbal prescriptions and/or transfer prescription orders between pharmacies. States that allow these activities generally put few legal limitations on them, and instead defer to the professional judgment of the supervising pharmacist whether to delegate these tasks or not. These activities were more likely to be seen in states that require technicians to be registered and certified, and in states that have accountability mechanisms in place for technicians. Thus, these factors may be seen as critical first steps to enabling advanced pharmacy technician roles. Limiting certain expanded duties to certified technicians is consistent with the NABP Model Act.

As noted previously, the rate of verbal prescriptions has declined, and we envision this will continue as the rate of electronic prescribing continues to grow. Still, these interruptions will continue and creating opportunities to delegate these tasks to technicians will continue to represent an opportunity moving forward. While limited evidence is currently published on these tasks, there is little to suggest appropriately trained technicians cannot perform them safely and accurately, and the track record of success with these tasks spans four decades in some states. The law is, of course, just the minimum standard. Pharmacists are often required to go above and beyond what the law allows in order to provide optimal patient care, and pharmacists can adopt strong practice policies and procedures to mitigate the risk of harm from verbal orders. Such risk reduction strategies include instituting read-back, spell-back techniques, or requiring the indication for each phoned-in medication, among other risk reduction strategies. Pharmacists may also exercise discretion in deciding to whom to delegate these tasks. Pharmacists may be more comfortable with senior technicians who have more experience with medication names, or technicians who have previously conducted medication histories. In addition, extra-legal factors such as Joint Commission accreditation standards also provide checks and balances on the process.

As the legal environment becomes more permissive, we foresee investment in more robust education and training of technicians both in the mechanics of receiving a verbal prescription (e.g., simulated lab with environmental noise) and the understanding of common medication names and doses. Overall, with the adoption of robust practice policies and procedures, delegation of verbal

orders and prescription transfers can be safe and effective, remove undue stress on pharmacists, and potentially free up pharmacist time for higher-order clinical care.

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Conflicts of interest

None.

Disclaimer

The views expressed in this manuscript are those of the authors alone, and do not necessarily reflect those of their respective employers.

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Expanding the Scope of Pharmacies Using Tech-Check-Tech: The Iowa New Practice Model

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Background

- Pharmacy technician advancements in Iowa include
 - Legislation passed in 2007 to allow technician product verification or "Tech-Check-Tech" (TCT) in institutional settings
 - Mandatory technician certification since 2010
- The current community pharmacy practice model poses several barriers to pharmacists' ability to provide MTM services
- According to the 2013 MTM Digest, the top three barriers to MTM services are:
 - Lack of insurance companies paying for MTM services
 - Pharmacists have inadequate time
 - Payment for MTM services is too low
- A 2012 study performed by Kjos and Andreski found that in Iowa the most frequent barriers to MTM services were:
 - Lack of availability of pharmacists' time
 - Insufficient staffing levels
 - High levels of dispensing activities
- In 2009, The New Practice Model Task Force (NPMTF) was established to coordinate efforts in Iowa to redefine the practice of community pharmacy

Objective

- To evaluate the impact on pharmacy practice after implementation of TCT of refill prescriptions in 17 community pharmacies in Iowa.

Methods

- Seventeen community pharmacies in Iowa were recruited to participate in an 18-month demonstration project approved by the state board of pharmacy
 - Phase 1 included 7 pharmacies
 - Phase 2 included 10 pharmacies
- Pharmacies involved in the state association with an interest in practice improvement were recruited
- An application process with standard selection criteria was used for Phase 2
- Technicians completed advanced training on TCT process, prescription dispensing and verification
- Pharmacists completed training on TCT process

Methods (cont.)

- Baseline dispensing errors were determined for 50 refills per day for 15 weekdays for refilled prescriptions
 - Errors were classified as Patient Safety Errors or Administrative Errors based on potential for harm
- Baseline measurements were performed to define the task composition of the pharmacists' workday
 - Pharmacists submitted self-reported time spent in dispensing, patient care, practice development, management and other activities
- The amount of pharmacist provided services were also collected
 - Self-reported services in thirteen categories
 - The reimbursement status of each service
- Pharmacies reported the number of days that TCT was used each month
- Measures were repeated monthly after implementation of TCT
- Pharmacies manually recorded information which was then submitted via an online survey

Results

Table 1- Combined Phase 1 & 2 Pharmacy Demographics

Characteristic	
Ownership	National Chain = 3 Small or Regional Chain = 11 Independent = 3
Location	Urbanized area (population >50,000) = 7 Urban cluster (population 2,500 - <50,000) = 8 Rural (population <2,500) = 2

Table 2- Dispensing Errors

Measure	Baseline	TCT	p-value
PHASE 1			
Prescriptions Checked	5,565	5,950	
Patient Safety Error Rate	0.04%	0.07%	0.808
Administrative Error Rate	0.23%	0.49%	0.443
Total Error Rate	0.27%	0.56%	0.484
PHASE 2			
Prescriptions Checked	7,884	11,274	
Patient Safety Error Rate	0.05%	0.08%	0.452
Administrative Error Rate	0.48%	0.29%	0.202
Total Error Rate	0.53%	0.36%	0.318

Table 3- Pharmacist Workday Composition

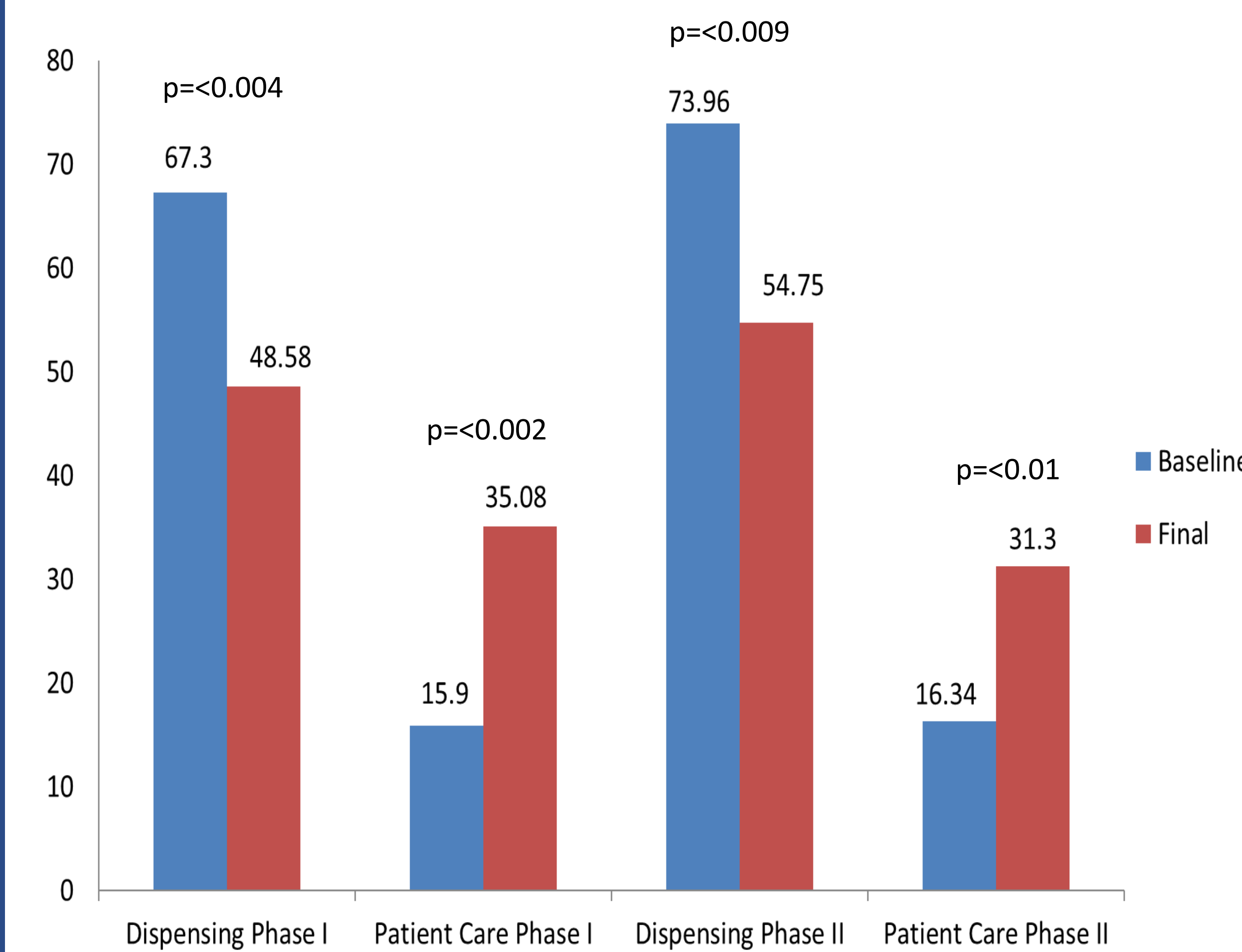
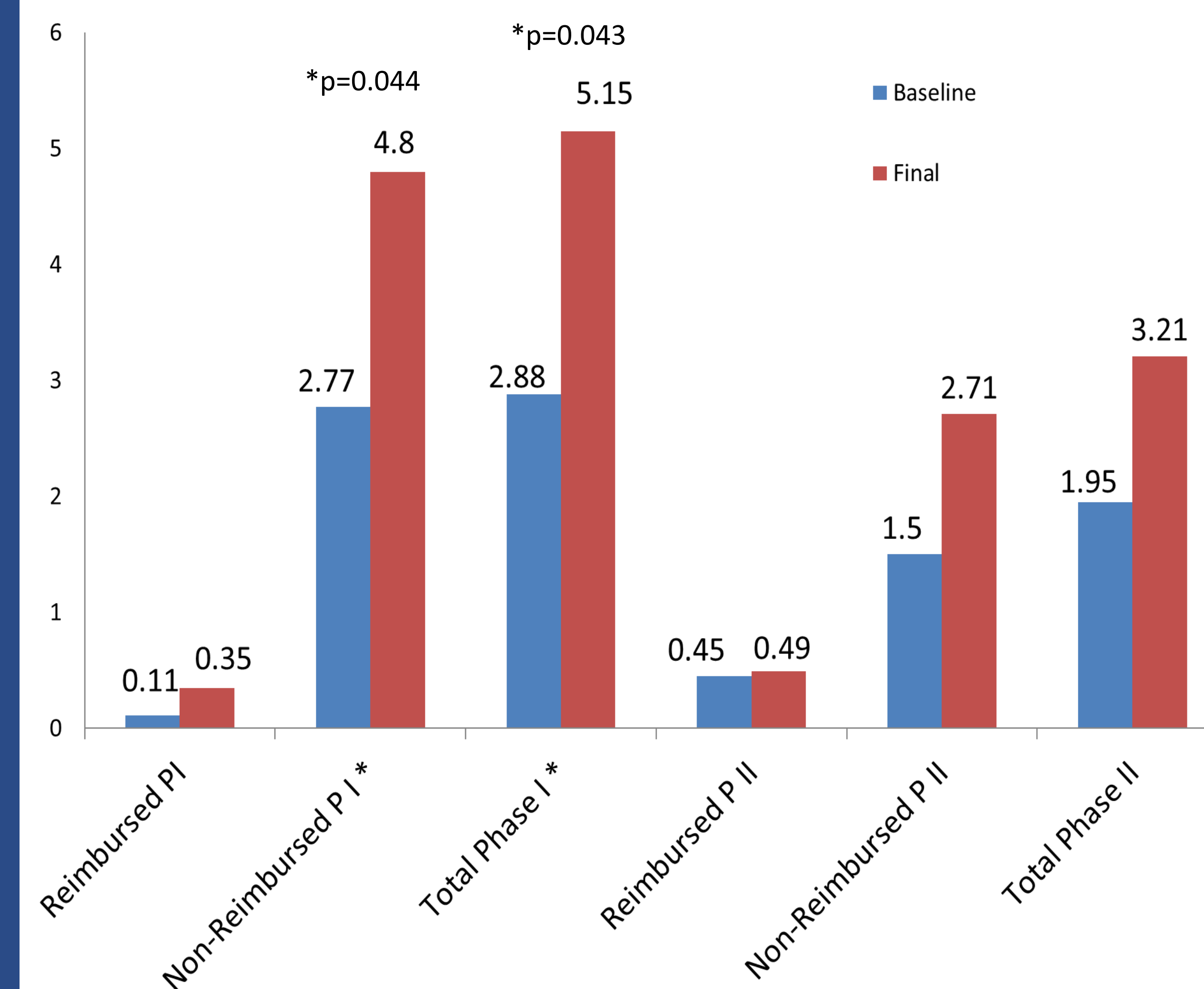


Table 4- Patient Care Activities per Pharmacist Hour



Acknowledgements

Financial support from the National Association of Chain Drug Stores, Community Pharmacy Foundation, and McKesson

Table 5- Service Type and Reimbursement

Service Type	Number of Pharmacies Providing Service (Phase 1 & 2 combined)			
	Reimbursed		Non-Reimbursed	
	Baseline	TCT	Baseline	TCT
Prescription Counseling	6	3	17	17
Drug Therapy Problem Identified through Dispensing DUR	3	7	17	17
Drug Information Request	3	2	17	17
Patient Education	2	9	16	17
Immunizations	11	17	4	7
Non-immunizations Injection Administration	7	10	0	6
Patient Testing/Screening	3	4	10	15
MTM Current Medication List/History	6	15	8	14
MTM Medication Reconciliation	6	11	9	12
MTM Patient Follow-Up	5	11	4	14
MTM Patient Interview	4	12	5	13
MTM Provider Consult	5	12	7	16
MTM Other Services	2	6	2	8
TOTAL SERVICES	63	119	116	173
Percent of possible services offered	28.5%	53.8%	52.5%	78.3%

Discussion

- The findings were consistent with those in Phase I
- The rates for dispensing errors remained low with no significant changes from baseline
- The amount of time spent in dispensing and patient care activities changed significantly
- The TCT intervention was successful in repositioning the pharmacist to consistently provide patient care services

Limitations

- Inability to compare error rates due to lack of other published data
- The pharmacist reported workday composition could be affected by social desirability bias

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Attachment 2



**STATE BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
LICENSING COMMITTEE MEETING
MINUTES**

DATE: July 19, 2017

LOCATION: Department of Consumer Affairs
First Floor Hearing Room
1625 North Market Blvd.
Sacramento, CA 95834

COMMITTEE MEMBERS PRESENT: Stanley Weisser, Chairperson
Albert Wong, Licensee Member
Lavanza Butler, Licensee Member
Ricardo Sanchez, Public Member

**COMMITTEE MEMBERS
NOT PRESENT:** Debbie Veale, Vice-Chairperson

STAFF MEMBERS PRESENT: Virginia Herold, Executive Officer
Anne Sodergren, Assistant Executive Officer
Laura Freedman, DCA Staff Counsel
Debi Mitchell, Staff Services Manager I

1. Call to Order and Establishment of Quorum

Chairperson Weisser called the meeting to order at 9:00 a.m. Roll call was taken with the following members present: Lavanza Butler, Albert Wong, and Stan Weisser. Member Ricardo Sanchez joined the meeting around 9:03. A quorum was established.

2. Public Comment for Items Not on the Agenda, Matters for Future Meetings

No public comments were offered.

3. Discussion and Consideration of Retake Waiting Period for North American Pharmacist Licensure Examination (NAPLEX) and California Practice Standards and Jurisprudence Examination for Pharmacists (CPJE)

Chairperson Weisser reviewed relevant statutes applicable to the discussion in Business and Professions Code (BPC) section 4200 establishing requirements for licensure as a pharmacist and subsection (a)(6) further providing that a candidate shall have passed the NAPLEX and the CPJE. BPC section 4200.4 specifies that an applicant who fails the national examination may not retake the examination for at least 90 days or for a period established by regulations adopted by the board in consultation with the Office of Professional Examination Services of the Department.

Chairperson Weisser noted on July 28, 2016, the NABP advised executive officers of changes to the NAPLEX program. Changes included transitioning to a new administration model that included increasing the number of test items, increasing the test administration time and increasing the fee. Additionally, NABP advised that the waiting period for the NAPLEX examination would be decreased to 45 days.

The committee was reminded at the September 2016 Licensing Committee meeting, the committee discussed NABP's change in policy related to the waiting period for candidates who fail the NAPLEX. The committee discussed that while NAPLEX decreased its waiting period to 45 days, California law still requires a 90-day waiting period for the NAPLEX. As part of its discussion, the committee considered whether the proposed change to the waiting period for the NAPLEX is appropriate. The committee discussed that, by statute, any changes to the current waiting period for the NAPLEX would require consultation with Office of Professional Examination Services (OPES). The committee requested that this item be referred back to the committee after consultation with OPES.

Mr. Weisser informed the committee that board staff met with DCA OPES to discuss the rationale for proposed changes from a 90-day waiting period for both the NAPLEX and CPJE. OPES concluded that the 45-day waiting periods are reasonable for both the NAPLEX and CPJE. Further, board staff also consulted with the board's contracted psychometric firm (PSI) responsible for CPJE development and deployment. They reached a similar conclusion to that of board staff and OPES.

The committee was advised based on the conclusions of both OPES and PSI, board staff recommended seeking the necessary changes in statute to reduce the waiting period to 45 days. The committee reviewed draft language based on this recommendation.

Danny Martinez of the California Pharmacist Association (CPhA) commented in support of the motion. Mr. Martinez requested clarification on when the committee would like to see the statute changed. Executive Officer Virginia Herold explained if an author could be found this year, the board would be interested in an immediate change.

Cindy Hespe of the California Society of Health-Systems Pharmacists (CSHP) representing Loriann DeMartini explained Ms. DeMartini had a concern about the word "and" and residents taking the examinations. Ms. Hespe requested on behalf of Ms. DeMartini if the "and" could be changed to "or." Ms. Herold explained that licensure as a pharmacist requires passage of both the NAPLEX and CPJE. Ms. Herold continued residents usually have six months to become licensed in the state where the residency is

being completed and residency can be started later than July, which is typically when residencies start. The board offers expedited service for applicants in residency. Assistant Executive Officer Anne Sodergren clarified the intent of the language is to allow for an applicant who passes one exam and fails the other exam to wait 45 days to retake the exam that was failed. Ms. Sodergren clarified the exam that was passed does not have to be retaken. Ms. Hespe stated they would support this being enacted this year. Ms. Herold encouraged Ms. Hespe to have the residents notify the board when they apply for residency.

DCA Counsel Laura Freedman reiterated Ms. Sodergren's clarification that failure on either one of the exams would trigger a 45-day waiting period for solely that particular exam.

MOTION: Pursue statutory changes to change the waiting period for both the NAPLEX and CPJE to 45 days by amending BPC sections 4200.4.

Proposed Amendment to B&PC 4200.4

4200.4. An applicant who fails the ~~national examination~~ North American Pharmacist Licensure Examination and the California Practice Standards and Jurisprudence Examination for Pharmacists may not retake the examination for at least ~~90~~ 45 days or for a period established by regulations adopted by the board in consultation with the Office of Professional Examination Services of the ~~d~~Department.

M/S: Sanchez/Wong

Support: 4 Oppose: 0 Abstain: 0

4. Discussion and Consideration of Issuing Board Licenses Including Photos for Individual Licensees

Chairperson Weisser reviewed that the board has encountered instances of unlicensed individuals posing and working as a licensed pharmacist using a name and license number issued to someone else. In such cases the unlicensed individual has provided a fake license to the employer. There are several programs within the DCA that currently issue licenses that include a photo of the individual.

Mr. Weisser noted board staff would appreciate discussion from the committee to determine if it would be appropriate to implement photo licenses for individuals licensed by the board. If agreed upon by the committee and board, implementation could be in place by July of 2018. Staff would recommend a phased approach where newly licensed pharmacists will be issued the photo license upon licensure and current pharmacists will convert to the photo license as part of the renewal process. Mr. Weisser added that he recommended starting with the pharmacists and eventually adding other license types if deemed appropriate.

Committee member Sanchez inquired if this was seen at the pharmacist or pharmacy technician level. Ms. Sodergren confirmed it is seen by the board at the pharmacist level. Ms. Herold added that the paper license provided by the board currently is not very durable. Mr. Sanchez further inquired if there were biometrics such as thumbprint available. Ms. Sodergren indicated she didn't believe so and the samples provided cost at most approximately \$16 per license.

Mr. Sanchez asked if the application could include a clause certifying under the penalty of perjury the licenses can't be duplicated so that if a license was duplicated, it would be a felony. Ms. Herold added there are other ways to have such cases prosecuted. Ms. Freedman added that the issue was with people impersonating the pharmacist who are not necessarily applicants to the board. Ms. Herold added that the current situation of a pharmacist being impersonated is being dealt with by the local police as the person is not a licensee. Committee member Lavanza Butler added it is appropriate to implement the photo license so that the pharmacists can be easily identified. Committee member Albert Wong agreed a new photo is a good idea. Ms. Sodergren added that policy direction provided to board staff allows board staff to report back with options for implementation strategy.

Danny Martinez of CPhA commented in support of the motion. Mr. Martinez requested clarification if this would be included in the new fees. Ms. Sodergren reported it would depend on the implementation strategy.

MOTION: Proceed with photo licenses for licensed pharmacists.

M/S: Butler/Sanchez

Support: 4 Oppose: 0 Abstain: 0

5. Discussion and Consideration of Pharmacy Technician Duties and Possible Changes to Such Duties

Chairperson Weisser provided an overview of the item as well as detailed relevant laws and a pending regulation to add additional requirements for pharmacy technician training courses. Mr. Weisser provided a brief overview of topics discussed at the April 4, 2017, Pharmacy Technician Summit that included: current requirements for pharmacy technicians; pending regulations regarding requirements for pharmacy technician training courses; mechanisms for pharmacy technicians to expand knowledge base; continuing education requirements for pharmacy technicians; overview of possible changes for duties of pharmacy technicians in a community setting to allow for pharmacists to provide more patient care services such as drug utilization review, patient profile review, and patient consultation; possibility of supervising technician with the ability to verify refills filled by a pharmacy technician or verify clerk typist work; increased pharmacy technician standards with an educational component if responsibilities are greater; and Idaho pharmacy technician duties that have expanded to include the authorization of new orders, taking new orders from prescriptions, clarifying prescriptions, immunizing, and extending pharmacy hours to include time when a pharmacist is not present.

Mr. Weisser asked Ms. Sodergren to expand upon the pharmacy technician duties in Idaho. Mr. Weisser noted the Idaho board's former executive officer was present at the meeting. Ms. Sodergren reported as requested by the committee, staff provided in the meeting materials a grid detailing a high-level comparison by state for neighboring and larger states as well as the NABP's survey of pharmacy law. Ms. Sodergren provided to the committee specific areas of pharmacy practice, how the change would impact the operations of the pharmacy, and the resulting benefits to patients receiving care in those settings for direction to board staff by the committee.

Mr. Weisser posed to the committee that the committee may want to consider having, under the supervision of a pharmacist, one pharmacy technician check the work of another pharmacy technician – known as tech-check-tech – in a community setting. Mr. Weisser noted the tech-check-tech is currently used in the hospital setting and has been noted as effective.

Ms. Butler inquired if the pharmacist is responsible for the work done by tech-check-tech as that was her primary concern. Ms. Butler further inquired why the states identified in the meeting materials were selected. Ms. Sodergren explained neighboring states and states that are larger like California in addition to Idaho and two other states were selected for comparison.

Mr. Weisser posed several questions to the committee when considering tech-check-tech: Would this be limited based on the type of prescription, i.e., refill versus new, controlled substance versus noncontrolled, compounded medications? Should the “supervising technician” require special licensure like an advanced practice pharmacist? Should a pharmacist also be responsible for the functions performed by the “supervising technician” or just the PI? If the “supervising technician” is performing the final check, what impact does that have on current ratios, and should the “supervising technician” be included in a ratio? How would this ultimately benefit the patient? Should the pharmacist be required to have patient contact on transactions?

Dr. Wong expressed concern about tech-check-tech and liability of the pharmacist for any mistakes made by a technician in a tech-check-tech program. Mr. Weisser noted the pharmacist has to be relied upon for supervision and oversight before medicine is provided to the consumer. Mr. Sanchez asked if the liability could be shared with a supervising pharmacy technician. Ms. Butler expressed interest in understanding better how tech-check-tech would work in a community pharmacy. Dr. Wong explained with tech-check-tech, the pharmacist would not see the prescription before it was provided to the consumer. The committee expressed concern with this. Mr. Weisser asked where the responsibility would be and how to assist the pharmacist in working more closely with the consumer. Dr. Wong suggested hiring more pharmacists.

Mr. Weisser noted that tech-check-tech was one of many options that could be pursued by the committee. Mr. Weisser indicated his interest was identifying tasks that pharmacists are responsible for by law but do not require a pharmacist’s knowledge so that the pharmacist can be freed up to do drug utilization and patient consultation and to interact with the patient. Dr. Wong expressed more pharmacists are needed but cannot be hired because insurance reimbursements are too low.

Ms. Freedman noted that as the duties and scope of an interim practitioner level for pharmacy technicians develop, the responsibilities would shift to that interim practitioner level for pharmacy technicians in addition to the pharmacist. Dr. Wong was not in agreement of shared responsibility of a pharmacist and pharmacy technician. Ms. Butler was in support of expanded duties for pharmacy technician as she noted there are some duties pharmacists are required to complete but a pharmacy technician could complete. Ms. Butler indicated she is in support of a supervising/lead pharmacy technician but is concerned that a pharmacist is responsible for the pharmacy technicians doing different items under their supervision.

Ms. Sodergren clarified the committee doesn’t seem to be averse to the tech-check-tech model but there is concern as to what safeguards might be developed to assist consumer protection. Adding a secondary

licensure category with increased knowledge, skills and abilities might be one safeguard. Ms. Sodergren suggested board staff make recommendations for a tech-check-tech program based on the concerns of the committee to move forward for consumer protection. Mr. Weisser noted he is interested in vetting the process to ensure consumer protection and liability is attributed to the correct person.

Dr. Wong voiced concern of looking at how more pharmacists can be hired and insurance reimbursements increased. Mr. Weisser suggested based on current ratios, benefits of the pharmacists are being realized and he would like the pharmacist to be freed up to interact with the patient more.

Ms. Herold added if a specialty pharmacy technician is established and patient consultation is the focus where the pharmacist works directly with the patient, the medication errors can be caught at this level. Ms. Herold indicated that building in the pharmacist interaction at the end of the process will benefit the consumer and ensure drug utilization is completed.

Mark Johnston, former Idaho Board of Pharmacy director currently working for CVS Health representing them today and NABP Executive Committee commented to the committee. Mr. Weisser asked Mr. Johnston to speak in the capacity of former director of the Idaho Board of Pharmacy. Mr. Johnston explained tech-check-tech in Idaho is just the check of the pills in the bottle. He continued in Iowa, Drake University did a study on tech-check-tech and found technicians had a lower error rate of 0.36 percent compared to 0.53 percent error rate for pharmacists. In Idaho, the pharmacy technician is held responsible for errors as done in Canada for twenty years. Mr. Johnston added if this requirement is added, it can be an option for the pharmacist, but not required.

Mr. Weisser clarified that in California the clerk can complete data entry for the prescription but in Idaho only registered technicians can type the label. Mr. Johnston clarified Idaho allows tech-check-tech for new prescriptions, refill prescriptions and controlled substance prescriptions but not compounded prescriptions. In Idaho, the pharmacist checks the prescription when received and again before the prescription is picked up by the consumers. Additionally, Idaho provides for a pharmacy technician to check medicine from a machine. Other states also allow pharmacy technicians to check automation at a low rate.

Paige Talley from the California Council for the Advancement of Pharmacy (CCAP) requested clarification on the type of practice settings. Mr. Weisser clarified that the focus is on community setting. Ms. Talley reported CCAP is in support of more education, certification and mandatory continuing education for pharmacy technicians.

Cindy Hespe representing CSHP commented on CSHP's support of tech-check-tech. She added policies and procedures might be a good requirement as required in the hospital setting. Ms. Hespe inquired if the inspectors look on the self-assessment forms to know how many hospital settings are doing tech-check-tech. Mr. Weisser reiterated this discussion is for the community pharmacy setting. Ms. Herold mentioned she knew of two hospitals but the board doesn't track this information. Ms. Herold knew of one related error but indicated errors wouldn't be reported to the board unless there was a financial settlement.

Lindsay McDonald from the National Health Career Association and provider of ExCPT certification program for pharmacy technicians inquired about the implementation of pending regulations on

pharmacy technician training courses. Ms. Freedman referred to the agenda item. Ms. Sodergren directed Ms. McDonald to the rulemaking process and offered to speak with her after the meeting.

The committee took a break.

A pharmacist member of the public commented in a low-volume pharmacy, tech-check-tech is helpful. When there is an overlap of pharmacists, typically the second pharmacist does technician work. In a high-volume pharmacy, a machine is used but is typically maintained by a pharmacist. The pharmacist was concerned Idaho might not be a fair comparison where New York and Florida might be a better comparison. Accountability for pharmacy technicians will help them to be better. If technicians can pull for another technician that would assist in processing.

John Roth, CEO for California Pharmacists Association (CPhA), commented the board may want to look at the process used for SB 493. Mr. Roth continued to request clarification if the definition of tech-check-tech is the same throughout the nation. He also commented on the drawbacks of the Iowa study as the freeing up of the pharmacists' time didn't change the workflow of the pharmacist. Mr. Roth recommended the board ensure that tech-check-tech is the method that would be used in community pharmacies.

Lorri Walmsley on behalf of Walgreens commented on the Drake study presented at the Iowa Association reporting the error rates remained low as the pilot went through the process, and the amount of dispensing and patient care activities for pharmacists changed significantly and pharmacists were able to offer more clinical services. Walgreens is participating in a pilot study in Iowa and a few stores in Wisconsin.

Dr. Wong stated he is worried that tech-check-tech would result in the workload of the pharmacist being increased but patient care not being increased. Ms. Walmsley indicated that is not what she believed the study indicated. Ms. Butler recalled these states do not have the volume of California.

Mr. Weisser asked the committee their thoughts on continuing education for pharmacy technicians. Ms. Butler indicated she thought it was a good thing. Mr. Weisser also commented it helped to sift through those pharmacy technicians who are committed versus those who aren't committed. Dr. Wong agreed the more educated the pharmacy technician is, the better the consumer is served. Mr. Sanchez agreed more education would better the profession.

Chairperson Weisser requested staff prepare and bring more information forward to the next committee meeting to review the data that staff has found regarding the duties and the scope as well as the sensitivity of the issues brought up by the committee members (responsibility), certification and recertification, CE and how the board will enforce. Staff will check in with Chairperson Weisser to ensure the information gathered is following the committee's direction and the committee agreed.

6. Discussion and Consideration of Pharmacy Technician Ratios in California

Chairperson Weisser provided an overview of the relevant laws regarding pharmacy technician ratios of pharmacist to pharmacy technicians.

Ms. Butler stated she supported an increase in the pharmacy technician ratio to possibly 1:2 but that there should be a limit to the ratio of pharmacists to pharmacy technicians. Dr. Wong agreed there should be an increase in the ratio.

Mr. Weisser asked the committee how they envisioned the increase in ratios fitting in with a change of duties for the pharmacy technician. Ms. Butler and Dr. Wong expressed an interest of a motion in increasing the ratio of pharmacist to pharmacy technician to 1:2.

MOTION: Increase the pharmacist to pharmacy technician ratio to 1:2.

M/S: Butler/Wong

Mr. Weisser recommended further discussing the issue and determining how the committee would like the duties of the pharmacy technician to change before changing the ratio. Ms. Butler and Dr. Wong agreed to withdraw their motion.

Angie Manetti on behalf of the California Retailers Association (CRA) commented in support the need for an increase in the ratios. She reported many of CRA's members have realized an 80 percent increase in prescriptions from 1997 to 2015 and look forward to increased dialogue as the dialogue hasn't occurred since 2001 when then the ratios were changed. Mr. Weisser stated he also received a letter from Mary Staples of the CRA and looks forward to her input at the next meeting.

Mark Johnston of CVS Health and NABP stated in his capacity representing NABP that the NABP Pharmacy Survey of Pharmacy Law is a very static document that is updated annually and only as good as each board is at updating their respective laws. Mr. Johnston commented that after the publication many states changed their ratios. He added the survey also doesn't show trends that are happening such as elimination of ratios. Mr. Johnston expressed support in the discussion.

7. Discussion and Consideration of Application and Renewal Requirements for Pharmacy Technicians

Mr. Weisser reviewed relevant law detailing requirements for becoming licensed as a pharmacy technician. He continued reviewing pending regulations regarding pharmacy technician application requirements. Mr. Weisser reviewed the committee's previous discussion that certification as one of the pathways to licensure does not require maintaining the certification. The committee also previously noted if continuing education should be a requirement of renewal for pharmacy technicians. Mr. Weisser provided most states require licensure or registration while some states also require the maintenance of certification and/or continuing education.

Dr. Wong commented he would like to see more education to qualify for licensure and increase the requirement because of the increase of responsibility. Additionally, this would prevent people entering the field for the purpose of diversion and would elevate the field.

Ms. Butler stated that if duties and ratios are to be expanded, the committee should also look what the continuing education would want to require.

Mr. Sanchez asked if other programs were successful in increasing hours. Ms. Sodergren reported that the Pharmacy Technician Certification Board (PTCB) and ExCPT which are pathways to licensure has 20 hours of continuing education required to maintain certification. The board currently only requires payment of a renewal fee. Other states have determined that 20 hours of continuing education is sufficient and appropriate. Additionally, the committee found at the pharmacy technician summit there is value in continuing education and it is not a barrier to renewal as there are many free continuing education courses and many employers make them available as well.

Dr. Wong recommend making one of the courses be drug and alcohol abuse. Ms. Butler stated she would not have a problem with it.

Mr. Weisser asked Ms. McDonald of the National Health Career Association provider of ExCPT certification program what continuing education is required by ExCPT. Ms. McDonald informed the committee that 1 hour of law is required and 1 hour of drug safety is required in addition to the 18 hours of continuing education required every two years. Ms. Butler thought this was a good. Dr. Wong stated he wanted more specific education of drug and alcohol abuse.

Mr. Weisser requested staff incorporate continuing education required for certification and one to two units in drug and alcohol abuse. Ms. Butler indicated she wouldn't have a problem with it. Mr. Sanchez felt more continuing education is required and would like to see if continuing education helped to bring back drug abuse. Dr. Wong suggested one unit of alcohol abuse and one unit of drug abuse.

Ms. Sodergren asked if the committee would like to incorporate the law and ethics required of pharmacists. Ms. Herold recommended looking at the duties and identifying what will re-instill training. Ms. Butler agreed.

A representative of Cerritos College reported to the committee that Cerritos College is set by the state at 30-33 units – two semesters and summer for certificate. An associate degree requires approximately 75 units. The representative stated their students were higher quality. Many go on to pursue their pharmacist degree or work as a pharmacy technician in a hospital setting. At the request of Mr. Weisser, the representative indicated there is an interest in advanced practice pharmacy technician.

8. Update on Development of Mandatory Board Provided Law and Ethics Continuing Education Courses

Chairperson Weisser provided an overview of the new regulation requiring board provided continuing education for pharmacists effective July 1, 2017. Mr. Weisser reported board staff routinely provide continuing education on pharmacy law in person but can be scalable using other deployment options, including webinars. The department's training unit uses an interactive web based platform for training, and board staff is exploring that option. Based on discussions with the department, board staff believes the course could be available by March 1, 2018.

Ms. Sodergren inquired if the webinar model is acceptable by the committee. Ms. Herold reported the board provides other training and would like direction if this training is acceptable, for example, training on being a pharmacist-in-charge (PIC), corresponding responsibility, and joint DEA/Board opioid abuse prevention training. Mr. Weisser was agreeable to this. Ms. Herold indicated it would be helpful to determine if the board is favorable to this policy and then seek legal clarification. Counsel Freedman

indicated she thought this would be acceptable but would need to research and verify. Mr. Weisser asked Ms. Freedman to bring her direction to the next meeting. Ms. Butler participated in the PIC and corresponding responsibility training and would like to include this as acceptable.

Dr. Wong inquired if the joint DEA/Board training was being provided throughout the state. Ms. Herold indicated one was provided in San Diego with scheduled events in Sacramento and Los Angeles. The board is working to secure training in the Bay area. Ms. Herold stated the board is looking to have a session in Chico. Dr. Wong would like to see the training available for no cost and work with the licensees. Mr. Sanchez is in favor of training.

The committee took a lunch break.

9. Discussion and Consideration on Pharmacist Consultation in Various Pharmacy Settings

Chairperson Weisser provided an overview of relevant law regarding pharmacist consultation and automated drug delivery system (ADDS).

Mr. Weisser reminded the committee of previous committee discussion at the April 2017 Licensing Committee Pharmacy Technician Summit, where the committee discussed changes in duties performed by pharmacy technicians in various settings. The committee discussed whether expanding pharmacy technician duties to include more responsibilities while under the supervision of a pharmacist would allow pharmacists to provide more patient care services, including drug utilization review, patient profile review and patient consultation.

As part of the discussion, the committee considered various settings, including traditional community pharmacy, mail order and closed door pharmacy, inpatient, and other specialty pharmacy settings. The committee reviewed a summary of the workflow in Iowa's tech-check-tech pilot, where the pharmacist is involved at the first level interaction with the patient performing the data and review prior to printing the label, and providing the final consultation.

The committee reviewed the pharmacist involvement for call-in prescriptions in Idaho. It was explained that in Idaho, the pharmacist would be at the DUR and PU1 station verifying the data entry. In regard to patient consultation there is a toll-free number that patients may call.

Mail order pharmacies were discussed, and staff suggested the need to broaden consultation requirements for mail order pharmacies, noting that consumer complaints surrounding mail order pharmacies involve allegations of delays in therapies because the patient is unable to reach a pharmacist.

The committee heard that medication reconciliation is performed in the mail order pharmacy setting by the pharmacy benefit managers (PBMs), who have access to patient records and would highlight if there was duplication in therapy. Mr. Weisser expressed concern that some pharmacists rely on the PBMs.

Mr. Weisser queried the committee on their thoughts on patient consultation. Ms. Sodergren relayed to the committee that inspectors often find patient consultation is provided but there is low quality of the patient consultation. Mr. Weisser expressed concern of the requirements of the patient consultations.

Dr. Wong suggested working with the doctors to ensure the patients get the information they need. The committee discussed the option of adding the purpose of the drug on the prescription label to enhance patient consultations to prevent future medication errors.

Ms. Herold indicated the board may work with the Medical Board of California to have the indication on the labels. The committee was in consensus to work with the Medical Board of California on this.

Mr. Weisser queried the committee their thoughts on where the pharmacists should be in the workflow of a pharmacist. Dr. Wong commented the pharmacist should be the person to hand the medication to the consumer. Ms. Butler commented that pharmacist should be at the beginning and end of the process. Mr. Sanchez agreed.

Mr. Weisser inquired of the committee if the mail order pharmacy requirements for patient consultations is sufficient. Mr. Weisser is concerned that the pharmacist is removed from the scenario. Mr. Weisser asked the committee if the board wants to mandate how the patient consultation is required. Ms. Butler agreed the board should mandate the requirements of the patient consultation by mail order pharmacies and other specialty pharmacy settings.

Mr. Weisser inquired of the committee members if the ADDS requirements sufficiently ensure patient consultation. Mr. Sanchez asked if quality of the consultation when the pharmacist can't see the individual varied. Ms. Butler agreed the consultation should take place, a pharmacist should be available if a new medication is dispensed, and it would be better for the pharmacist to see the patient. Mr. Weisser suggested at minimum a video screen to see the patient. Dr. Wong stated it is good to have this but there is a cost associated. The committee would like the machine physically located by the pharmacy and at minimum a video consultation.

Mr. Weisser inquired if the committee felt patients discharged from the hospital are receiving enough information from either a pharmacist or nurse upon discharge. Mr. Sanchez had a good experience. Mr. Weisser asked if CSHP had any comments. Cindy Hespe of CSHP reported they are working on the transition of care of patients at the various stages in obtaining medication in the pharmacy, being admitted/discharged from the hospital, admitted/discharged from the nursing home, etc., to ensure patient safety.

Mr. Weisser requested staff return with recommendations based on the committee's discussion so the committee may revisit the issues at the next meeting.

Paige Talley from CCAP reported to the committee various groups have a transitions of care team. Mr. Weisser expressed concern on a transition from skilled nursing homes back to patients' homes when medications may have changed, and who is providing the consultation.

10. Licensing Discussion and Consideration of the Centers for Disease Control's Newly Released Guide for Pharmacist to Establish Collaborative Practice Agreements

Chairperson Weisser told the committee the Centers for Disease Control and Prevention (CDC) recently

released a guide entitled “Advancing Team-Based Care Through Collaborative Practice Agreements -- A Resource and Implementation Guide for Adding Pharmacists to the Care Team.” The CDC has also developed additional resources to promote the use of collaborative practice agreements and team based care.

Danny Martinez from CPhA reported to the committee that through the National Alliance of State Pharmacy Associations, CPhA helped developed this publication and wanted to let the committee know they are working on incorporating CPAs into the APP program.

11. Licensing Statistics

Chairperson Weisser provided an overview of the licensing statistics including receipt of 256 applications for the new Advanced Practice Pharmacists license. In fiscal year 2016/2017, the board has received 17,504 applications, including:

- 2,462 intern pharmacists.
- 3,332 pharmacist exam applications.
- 256 advanced practice pharmacists.
- 6,262 pharmacy technicians.
- 7 outsourcing facilities.
- 33 nonresident outsourcing facilities.

As of June 30, 2017, the board has issued 11,784 licenses, renewed 64,206 licenses and has 139,164 active licenses, including:

- 6,584 intern pharmacists.
- 44,864 pharmacists.
- 130 advanced practice pharmacists.
- 72,562 pharmacy technicians.
- 6,663 pharmacies.
- 514 hospitals and exempt hospitals.
- 2 nonresident outsourcing facilities.

Ms. Herold introduced Licensing Manager Debi Mitchell as one of the managers of the licensing units. The committee commended the board staff for the work they do processing applications and renewals.

DCA Counsel Laura Freedman clarified for agenda item No. 8 that board-provided continuing education training would meet the requirements for the law and ethics continuation training effective July 1, 2017.

12. Future Committee Meeting Dates for 2018

The committee reviewed the remaining meeting dates for 2017 including a date to be determined in August 21, 2017, and September 19, 2017. The dates for 2018 are as follows:

- January 16, 2018
- April 19, 2018
- June 26, 2018
- September 26, 2018

The meeting adjourned.

DRAFT