California State Board of Pharmacy
2720 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833
Phone: (916) 518-3100 Fax: (916) 574-8618
www.pharmacy.ca.gov

Business, Consumer Services and Housing Agency
Department of Consumer Affairs
Gavin Newsom, Governor

MEDICATION ERROR REDUCTION AND WORKFORCE CHAIR REPORT
November 16, 2022

Nicole Thibeau, Licensee Member, Chairperson
Seung Oh, Licensee Member, Vice-Chairperson
Jessica Crowley, Licensee Member
Kula Koenig, Public Member
Jignesh Patel, Licensee Member

I. Call to Order and Establishment of Quorum

II. 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).)

III. Discussion, Consideration and Approval of Draft Minutes from the September 14, 2022, Medication Error Reduction and Workforce Committee

Attachment 1 includes a copy of the draft minutes.

IV. Presentation, Discussion and Consideration of Just Culture

Background

During the September Committee Meeting, members discussed the use of a Just Culture approach to managing patient medication errors and patient safety. Just Culture is not a "non-punitive or blame-free culture" rather it is an approach that focuses on the entire system to evaluate what occurred in an error and what action can be taken to prevent such errors from occurring in the future.

Summary of Prior Discussion

During the last meeting, the Committee discussed the use of Just Culture and its focus on the need for shared accountability for outcomes. Members discussed that the transition takes times and resources but results in a reduction in medication errors and improved patient outcomes.

For Committee Consideration and Discussion

During the meeting members will receive a presentation from Christina Michalek and Matthew Grissinger to provide a presentation on Just Culture.

V. Discussion and Consideration of Possible Future Changes to Title 16, California Code of Regulations Section 1711 Related to Quality Assurance Programs

Relevant Law

California Code of Regulations Section 1711, establishes requirements for each pharmacy to establish or participate in an established quality assurance program that documents and assesses medication errors to determine cause and an appropriate response as part of a mission to improve the quality of pharmacy service and prevent errors.

This section also defines a medication error as any variation from a prescription or drug order not authorized by a prescriber but does not include any variation that is corrected prior to furnishing the drug to the patient or patient's agent or any variation allowed by law. As required by this section an investigation of each medication error shall commence as soon as reasonable possible, but no later than two business days from the date the medication error is discovered.

Background

Originally effective in January 2002, these provisions have remained largely unchanged, with the exception of changes in 2004 and recent amendments in 2021 as part of the implementation of Automated Drug Delivery Systems (ADDS), including provisions to clarify the quality assurance (QA) program related to the uses of ADDS.

Generally, a QA program is intended to advance error prevention by analyzing individually and collectively, investigative, and other pertinent data to address the cause and contributing factors. Required elements include:

1. Date, location, and participants in the QA review.
2. Pertinent data and other information relating to the medication error reviewed and documentation of any patient contact.
3. Findings and determinations generated by the QA review.
4. Recommended changes to pharmacy policy, procedure, systems or processes, if any.

As reported in the media, in survey results, and in public comments received, workforce strains are a contributing factor to medication errors; however, the Committee has received public comment that pharmacy staff are prohibited from including staffing and other workforce issues in QA reporting.

Prior Committee Discussion

As part of the Committee's September 2022 meeting, members considered a number of policy questions related to the Board's current QA program requirements to determine if changes to regulation are necessary to advance error prevention.

Below is a summary of the questions and comments:

1. Should the date the error occurred be required?
   Members indicated that the date or date range should be included if the information can be identified.

2. Should the staff involved in the error be documented?
   Members determined that staff names should be included if the information is collected for non-punitive purposes noting it may be helpful in performing the root cause analysis and identifying if additional training is necessary. Members noted the importance of taking a just culture approach in collecting this information.

3. Should the type of error be required? (e.g., wrong patient, wrong directions, relevant drug information, etc.)
   Members agreed that it is appropriate to require the type of error in the report as such information will help identify trends.

4. Should the volume of workload completed on the date the error occurred be required?
   Members concluded that workload volume and staffing is necessary information to capture especially for evaluation of errors made in community pharmacies. Members noted that to complete a meaningful review, staffing levels need to be considered as part of the review process along with the use of technology. Members also noted that prescriptions filled by a central fill pharmacy should be noted separately.

5. Are there standardized items that should be captured, e.g., prescription volume (new and refill), immunizations provided, MTM, etc.?
   Members concluded that workload volume must be reflected and must also include clinical services.

6. Should the number of staff and classifications on the date of the error be required?
   Members determined that the number of staff and classifications are appropriate for inclusion in the report.

7. Should requirements be updated to require documentation of the actions taken (as well as recommended changes) and the date those actions occurred?
   Members agreed it is important to memorialize the actions taken in response to the error to address contributing factors. Members noted that if the same conclusion continues to be documented with the same outcomes while the errors continue to occur, additional action needs to be taken and noted on the QA form.

8. Should the Board standardize the QA form? **Note**: Staff note that the information varies greatly between pharmacies and at times appears too vague preventing sufficient review of the issue to identify recommended changes in a process.
   Members considered this question and indicated it may be appropriate for the Board to develop a possible template that could be used, but that the Board should not require use of a specific form. The template would provide an example of the minimum information that must be included to assist the pharmacy is reviewing the error. As part of its discussion, members asked how pharmacies identify at-risk behavior and corrective actions taken to address at-risk behavior.

9. Should a threshold be established after which a specified number of medication errors occur (i.e., 12 in a one-month period) that the pharmacy is required to take additional action? (i.e., complete the ISMP self-assessment tool, engage with a consultant that specializes in medication error reduction, etc.)
   Members discussed this concept but noted possible challenges establishing an appropriate measurement that would be meaningful.

10. The current records retention schedule is one year. Should this be extended to allow for assessment of process improvements implemented or should aggregate year end data be required before removal of the QA records?
    Members determined it is appropriate to extend the records retention for QA reports, suggesting between three to five years as an appropriate retention schedule. Members noted that it may be appropriate to aggregate some data prior to the end of the retention period to allow for continuing identification of trends.

Following consideration and discussion, members determined that changes to the Board's current regulations are appropriate.

For Committee Consideration and Discussion

Following the meeting staff developed draft regulation language. During the meeting members will have an opportunity to review the proposed.

As part of its review of the language it may be appropriate for the Committee to consider the following policy questions:

1. Does the committee believe the new proposed requirements established in 1711(e)(2)(A)-(E) are necessary for reporting of incidents involving the use of an ADDS or should such incidents be exempt from including these additional elements of the QA report?
2. As drafted the QA reports retention period is extended to three years. During prior discussion members considered if, prior to destruction, aggregate data should be maintained to allow for trending and assessing for outcomes. Members may wish to provide guidance on the types of aggregate data that should be maintained.

Following consideration of the language, should members believe it is appropriate to amend CCR Section 1711, the following motion could be used to make a recommendation to the Board:

> Recommend to the Board approval of the proposed regulatory text for Section 1711 [as presented/as modified by the committee], direct staff to submit the text to the Director of the Department of Consumer Affairs and the Business, Consumer Services, and Housing Agency for review and if no adverse comments are received, authorize the Executive Officer to take all steps necessary to initiate the rulemaking process, make any non-substantive changes to the package, and set the matter for hearing if requested. If no adverse comments are received during the 45-day comment period and no hearing is requested, authorize the executive officer to take all necessary steps to complete the rulemaking and adopt the proposed regulations at section 1711 as noticed.

A copy of the proposed regulation language is provided in **Attachment 2**.

VI. Discussion and Consideration of Medication Errors and Possible Future Development of Medication Error Reporting Requirements, Including Use of Required Standardized Report

Background

Reporting of medication errors is voluntary. There are different sources for reporting errors including the US Food and Drug Administration's MedWatch Reporting Program and ISMP Medication Errors Reporting Program (MERP).

Prior Committee Discussion

During the September meeting members discussed the issue of medication errors in the community pharmacy settings and that estimates suggest there could be over five million dispensing errors a year in California.

During the meeting members discussed medication error reporting including policy questions. Below are the questions and brief summary of the discussion.

1. Should the Board establish a requirement to report medication errors?
   Some members noted support for such a requirement as it will provide a better understanding of the scope of the issue. Members noted the need for some anonymity if the board pursues a mandatory reporting requirement.

   Public comment indicated that mandatory reporting should include the name of the chain pharmacy. Additional comment agreed that reporting needs to be anonymous.

2. If yes, what would be the appropriate entity to receive such reports?
   Members also considered who would be the appropriate entity to receive such reports, with some members speaking in favor of the Board while others suggesting a third-party organization. Members noted that if a third party was to be used it would be important to understand what the potential costs would be.

   Public comments varied with some indicating that reports should go to a third party while others indicated the reports should be provided to the Board.

3. If yes, should the requirement be limited in duration for purposes of conducting a study similar to the approach taken in New Hampshire?
   Members expressed some hesitation about making the requirement limited in duration.

4. Should the Board establish a standardized medication error reporting form?
   Members suggested development of a standardized form that could be used as a guideline specifying the elements for reporting while providing flexibility and considered the use of technology to facilitate reporting.

Members determined that a mandatory reporting requirement appeared appropriate and requested that staff review the issue and bring forward additional information for members to continue its evaluation of the issue.

For Committee Consideration and Discussion
Described below are approaches taken to implement medication error reporting, two mandatory and one voluntary.

Pennsylvania Patient Safety Authority (PSA) is an independent state agency that collects reports of patient safety events from Pennsylvania healthcare facilities. According to information on its website, Pennsylvania is the only state that requires healthcare facilities to report all incidents of harm (serious events) or potential for harm (incidents). "The PSA analyzes those reports to prevent recurrence either by identifying trends unapparent to a single facility or flagging a single event that has a high likelihood of recurrence and disseminates that information through multiple channels."

Under the provisions of the Pennsylvania law, the PSA developed the Pennsylvania Patient Safety Reporting System (PA-PSRS), a secure, web-based system that permits healthcare facilities to submit reposts as well. The statewide mandatory reporting went into effective in June 2004 for hospitals, ambulatory surgical facilities and birthing centers. Over the years additional facilities have been required to report including nursing homes. Community pharmacies are not required to report.

The reporting system contains strong confidentiality and whistleblower protections, and no information about individual facilities or providers will be made public. Several entities were involved in the development and implementation of the system including the Institute for Safe Medication Practices (ISMP).

ISMP has noted that the automated data interface between the PA-PSRS and the facilities' existing internal error/risk management reporting systems was an important step to facilitate reporting. Staff was also advised that some smaller facilities used the PA-PSRS system as their primary reporting program as they did not have their own program internally.

One of the primary outcomes of the system are quarterly publications. Until the last few years, ISMP reviewed the data sets and published articles.

ISMP Canada's National Incident Data Repository for Community Pharmacies (NIDR) is a collection of reported medication incidents submitted anonymously by community pharmacies for the purpose of improving medication safety. The system was developed in 2008. In 2010, Nova Scotia

was the first jurisdiction to implement a requirement for community pharmacies to anonymously report medication incidents for quality improvement and the submission of data to the NDIR. Since that time additional provinces have implemented similar requirements.

Reporting into this system has contributed to improvements in practice through shared learning, medication safety and quality improvements, as well as informing research and policy including:

Drugs associated with quality-related events reported by community pharmacies in Nova Scotia, Canada, [manuscript published in BMJ Open Quality in May 2020]

Funding for this system is through Health Canada through an agreement with ISMP Canada. In addition, a data processing fee is charged on an annual per-community-pharmacy basis. The data processing fee is $70 per pharmacy, paid annually.

In both examples listed above, reporting is mandatory. This stands in contrast to reporting to Patient Safety Organizations (PSO), which collect and analyze data voluntarily reported by healthcare providers. These provisions were established as part of the Patient Safety and Quality Improvement Act of 2005 which authorized the creation of PSOs to improve quality and safety by reducing the incidents of events that adversely affect patients. The Agency for Healthcare Research and Quality (AHRQ) is responsible for regulation of PSOs. There are currently 100 total PSOs. Voluntary reporting by PSOs to the Network of Patient Safety Databases (NPSD) provides for the aggregation of non-identifiable data from across the county.

Under the provisions of the federal law, there are a number of entities excluded from serving as a PSO including a health insurance issuer, regulatory agencies, entities that carry our inspections or audits for a regulatory agency, and entities that administer a federal, state, local, or tribal patient safety reporting system to which healthcare providers are required to report by law or regulation. PSOs are required to collect and analyze patient safety work product in a standardized matter (referred to as a common format), where possible, to permit valid comparisons of similar cases among similar providers. Community pharmacies have a common format available.

A review of the PSO's operating in California filtered for "retail pharmacy" reveals eight potential PSOs including:

- Alliance for Patient Medication Safety
    - Components of Parent Organizations: National Alliance of State Pharmacy Associations

- Center for Patient Safety
- CEIR and the Institute for Safe Medication Practices PSO
    - Components of Parent Organizations: Emergency Care Research Institute d/b/a ECRI
- Safety Culture Patient Safety Organization
    - Components of Parent Organizations: Walmart
- The Patient Safety Research Foundation, Inc.
    - Components of Parent Organizations: Walgreen Co.
- The PSO Advisory, LLC (Rhode Island)
- Virginia PSO
    - Components of Parent Organizations: Virginia Hospital and Healthcare Association
- Vizient PSO
    - Components of Parent Organizations: Vizient Inc.

Staff note that of the three types of programs listed above, it appears the model used in Canada is most similar to the stated goals of the committee which include aggregated information that can be used for policy decision making as well as providing education to licensees.

Provisions for the Nova Scotia law require the reporting of quality related events (QREs) to a database that contributes to the Canadian Medication Incident Reporting and Prevention System National Incident Data Repository for Community Pharmacies and enables this reporting to be anonymous. Anonymous reporting means that no identifying information about the patient, the reporter, or individual staff members involved is transmitted to the system. QREs include errors that reach the patient as well as those that are intercepted prior to dispensing. The extent to which intercepted errors are reported is based upon the professional judgment of the pharmacy manager in consideration of the nature of the intercepted error, its implications for patient safety and the extent to which it is recurring.

Policy considerations remaining for members include:

1. Identification of the appropriate entity to receive reports, perform analysis to assist the Board in policy making and release reports on trends, educational information, etc.
2. As drafted, the mandatory reporting would begin with community pharmacy. Does the committee believe this is appropriate?
3. As drafted, the reporting timeframe established is seven days. Does the committee believe this is an appropriate timeframe?

Attachment 3 includes the framework for a possible statutory to establish a mandatory reporting requirement.

Should the Committee believe a statutory change is appropriate to establish a mandatory medication error reporting requirement, the following motion could be used to recommend such action to the Board.

> Recommend to the Board pursuit of a statutory proposal to establish a mandatory medication error reporting requirement [consistent with the language as presented/consistent with the language presented and amended by the Committee consistent with its policy discussion]

VII. Discussion and Review of Enforcement Actions Taken and Enforcement Authority Exercised by Other Jurisdictions Related to Workplace Conditions

Background

California is not the only state evaluating the issue of workplace conditions with jurisdictions taking various approaches to address the challenge. As the Committee learned as part of its last meeting some approaches include potential research in workload engineering, adding provisions for anti-retaliatory (whistleblower) protections, and standardizing the CQI process. Some jurisdictions have reporting requirements for unsafe working conditions, some have provisions to ensure sufficient personnel are scheduled to work at all times, some have notification requirements to patient to advise them that the pharmacy is experiencing significant delays or cannot dispense prescriptions in a timely manner.

Jurisdictions are considering changes to provisions of the law to address workplace conditions. As an example, pending legislation in Kansas would have established a legislative joint committee to study pharmacy workplace conditions and the impact of such conditions on patient safety. The measure appears to have died in committee.

Prior Committee Discussion

During the September meeting, members reviewed examples from some state provisions.

Illinois

Under provisions in Illinois, the department may refuse to issue or renew, or may revoke a license, or take other action (including issuing a fine) with regard to any licensee for any one or combination of the following causes:

1. Failing to provide a work environment for all pharmacy personnel that protects the health, safety, and welfare of a patient which includes, but is not limited to, failing to:

a. Employ sufficient personnel to prevent fatigue, distraction, or other conditions that interfere with a pharmacist's ability to practice with competency and safety or creates and environment that jeopardizes patient care.
b. Provide appropriate opportunities for uninterrupted rest periods and meal breaks.
c. Provide adequate time for a pharmacist to complete professional duties and responsibilities, to complete professional duties and responsibilities including, but not limited to:
    i. Drug utilization review
    ii. Immunization
    iii. Counseling
    iv. Verification of the accuracy of a prescription
    v. All other duties and responsibilities of a pharmacist as specified.

2. Introducing or enforcing external factors, such as productivity or production quotas or other programs against pharmacists, student pharmacists or pharmacy technicians, to the extent that they interfere with the ability of those individuals to provide appropriate professional services to the public.

Oklahoma

Oklahoma establishes adequate staffing rules for pharmacists and pharmacies. Specifically, the law provides.

1. Adequate staffing to safely fill prescriptions is the responsibility of the pharmacy, the pharmacy manager, and the pharmacist. If conditions exist that could cause prescriptions to be filled in an unsafe manner, each shall take action to correct the problem.
2. In order to ensure adequate staffing levels a staffing form shall be available in each pharmacy. A copy of the form, when executed, will be given to the immediate supervisor and a copy must remain in the pharmacy for Board inspection. The form shall include at least the following:
    a. Date and time inadequate staffing occurred.
    b. Number of prescriptions filled during the time frame.
    c. Summary of events.
    d. Any comments or suggestions.

    The forms are not sent to the Board.
3. A pharmacist shall complete the staffing report form when:
    a. A pharmacist is concerned about staff due to specified criteria including inadequate number of support person or excessive workload.

4. If the pharmacy manager feels that the situation warrants earlier Board review, the pharmacy manager shall inform the Board.
5. Each pharmacy shall review staffing reports and address any issues listed as well as document any corrective action taken or justification for inaction to assure continual self-improvement.
6. Each pharmacy shall retain completed staffing reports until reviewed and released by the Board. Such reports requiring further review may be held by the Board and may become part of an investigation file.
7. A registrant, including a pharmacy, a pharmacy manager, or a pharmacist, shall not be subject to discipline by the employing pharmacy for completing a staffing report in could faith.

Source: *Okla. Admin. Code § 535:15-3-16*

Oklahoma established an inadequate staffing report that can be submitted to the Board by pharmacy personnel.

Vermont

Under provisions of law in Vermont, the Board may impose disciplinary sanctions against drug outlets in a retail chain; unprofessional conduct has occurred at one or more drug outlet's unprofessional conduct is attributable to corporate policies, practices, systems, or procedures, and sanctions are appropriate to protect the public. Vermont recently filed action against Walgreens alleging several violations include including:

- Violation One: 26 V.S.A. § 2053(a)(1) Introducing or enforcing policies and procedures related to the provision of pharmacy services in a manner that results in deviation from safe practice.
- Violation Two: 26 V.S.A. § 2053(a)(2) Unreasonably preventing or restricting a patient's timely access to patient records or essential pharmacy services.
- Violation Three: 26 V.S.A. § 2053(a)(3) Failing to identify and resolve conditions that interfere with a pharmacist's ability to practice with competency and safety or create an environment that jeopardizes patient care, including by failing to provide mandated rest periods.
- Violation Four: 26 V.S.A. § 2053(a)(4) Repeatedly, habitually, or knowingly failing to provide resources appropriate for a pharmacist of reasonable diligence to safely complete professional duties and responsibilities, including: (A) drug utilization review; (B) immunization; (C) counseling; (D) Verification of the accuracy of a prescription; (E) all other duties and responsibilities of a pharmacist under State and federal laws and regulations.
- Violation Seven: 3 V.S.A. § 129a(b)(1) Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a

client, patient, or customer has occurred. Failure to practice competently includes: (1) performance of unsafe or unacceptable patient or client care.

Virginia

Virginia Law provides that, except in an emergency, a permit holder shall not require a pharmacist to work longer than 12 continuous hours in any workday and shall allow at least six hours of off-time between consecutive shifts. A pharmacist working longer than six continuous hours shall be allowed to take a 30-minute break. Based on an investigation in Virginia, an order was issued against a single CVS store. In this instance the pharmacy license was reprimanded, a fine of $346,250 was assessed for the chain, the pharmacy was placed on an indefinite probation for a period of not less than two years subject to terms and conditions. Under conditions of the order the pharmacy has an appeal right to the order.

Source: 18VAC110-20-110. Pharmacy permits generally.

A copy of the order is included in **Attachment 4**.

For Committee Consideration and Discussion

At the direction of the Committee, staff have prepared statutory language that could be used to include some of additional provisions into California law. As proposed the following sections would be amended.

- BPC 4113.5 Chain Community Pharmacies: Required Staffing
  - Would establish authority for a pharmacist to close a pharmacy if in their opinion staff at the pharmacy is inadequate to safely fill prescriptions or provide other patient care services.
  - Would establish a minimum staffing floor. Further, would require schedule closures for lunch time for all pharmacy staff where staffing of pharmacist hours does not overlap sufficiently

- BPC 4113 Pharmacist in Charge: Notification to the Board
  - Would provide explicit authority for the PIC to have autonomy to make staffing decisions to ensure sufficient personnel.
  - Would establish authority for the PIC to close a pharmacy under specified conditions based on professional judgement may create an unsafe environment for personnel. In the event the PIC is not available, the pharmacist on duty may close the pharmacy.

- BPC 4301 Unprofessional Conduct
  - Would declare as unprofessional conduct actions or conduct that would subvert or tend to subvert the efforts of a pharmacist,

pharmacist-in-charge, pharmacist intern, and pharmacy technician to comply with laws or regulations.
- Would prohibit pharmacies from establishing policies and procedures related to time guarantees to fill prescriptions.

It is recommended that during the meeting members consider the language to determine if the provisions included are appropriate. Should the committee determine amendments to provisions of the law are appropriate, the following motion could be made to offer recommendations to the Board.

> Recommend to the Board pursuit of a statutory proposal to add and amend Business and Professions Code sections [insert sections] consistent with the committee's discussion of the language [as presented/ consistent with the language presented and amended by the Committee consistent with its policy discussion]

Attachment 5 includes a copy of the statutory language.

VIII. Discussion and Consideration of Pharmacist Well-Being Index State Report and National Academy of Medicine National Plan for Health Workforce Well-being

As part of the January 27, 2022, members reviewed the January 2022 Pharmacist Well-being Index (Index) State Report. More recently as part of the June 2022 meeting, members received a presentation on Well-being Index.

During its September meeting, members were advised of a significant increase in the number of California licensees using the Index reflected in the September 2022. The October 2022 report indicates a slight increase in the distress percentage with California now ranked 43.

Attachment 6 includes a copy of the most recent state report.

Also, earlier this month the National Academy of Medicine released the National Plan for Health Workforce Well-being to "drive collective action to strengthen health workforce well-being and restore the health of the nation." The Plan includes seven prior areas including:

1. Create and sustain positive work and learning environments and culture.
2. Invest in measurement, assessment, strategies, and research.
3. Support mental health and reduce stigma.
4. Address compliance, regulatory, and policy barriers for daily work.
5. Engage effective technology tools.
6. Institutionalize well-being as a long-term value.

7. Recruit and retain a diverse and inclusive health workforce.

VII. Future Committee Meeting Dates

- February 1, 2023 (rescheduled from January 24, 2023)
- March 8, 2023
- June 7, 2023

VIII. Adjournment

Attachment 1

California State Board of Pharmacy
2720 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833
Phone: (916) 518-3100 Fax: (916) 574-8618
www.pharmacy.ca.gov

Business, Consumer Services and Housing Agency
Department of Consumer Affairs
Gavin Newsom, Governor

MEDICATION ERROR REDUCTION AND WORKFORCE COMMITTEE
Draft MEETING MINUTES

DATE: September 14, 2022

LOCATION: Pursuant to the provisions of Government Code section 11153, neither a public location nor teleconference locations are provided.

COMMITTEE MEMBERS PRESENT:
Nicole Thibeau, Licensee Member, Chair
Seung Oh, Licensee Member, Vice Chair
Jessi Crowley, Licensee Member
Kula Koenig, Public Member
Jignesh Patel, Licensee Member

STAFF MEMBERS PRESENT:
Anne Sodergren, Executive Officer
Eileen Smiley, DCA Staff Counsel
Debbie Damoth, Executive Specialist Manager

I. Call to Order, Establishment of Quorum, and General Announcements

Chairperson Thibeau called the meeting to order at 10:02 a.m. Chairperson Thibeau reminded everyone present that the Board is a consumer protection agency charged with administering and enforcing Pharmacy Law. Where protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount. The meeting moderator provided instructions on how to participate during the meeting, including the process to provide public comment.

Chairperson Thibeau took roll call. Members present included: Seung Oh, Licensee Member; Jessi Crowley, Licensee Member; Kula Koenig, Public Member; Jig Patel, Licensee Member; and Nicole Thibeau, Licensee Member. A quorum was established.

II. Public Comments on Items Not on the Agenda/Agenda Items for Future Meetings

Members of the public were provided the opportunity to provide comments for items not on the agenda.

A representative of UFCW Western States Council requested the Committee add to a future agenda the required training for pharmacists who administer the Monkeypox (MPX) intradermal vaccine include hands on training and recommended that it be away from workflow duty. The representative requested the training to be consistent across all employers and all healthcare settings.

Members were asked if they wanted to add any items for future agendas. No items for future agendas were discussed.

III. Approval of June 22, 2022, Committee Meeting Minutes

Members of the public were provided the opportunity to provide comment.

Motion: Approve the June 22, 2022, meeting minutes as presented in the meeting materials.

M/S: Oh/Patel

Members of the public were provided the opportunity to provide comment; however, no comments were provided.

Support: 5 Opposed: 0 Abstain: 0 Not Present: 0

Member	Vote
Crowley	Support
Koenig	Support
Oh	Support
Patel	Support
Thibeau	Support

IV. Discussion and Consideration of Possible Future Changes to Title 16, California Code of Regulations Section 1711 Related to Quality Assurance Programs

Chairperson Thibeau advised California Code of Regulations (CCR) section 1711 establishes the requirements for a pharmacy to establish or participate in an established quality assurance (QA) program. Dr. Thibeau noted this program is to document and assess medication errors to determine the cause and an appropriate response to improve the quality of pharmacy service and prevent errors.

Chairperson Thibeau stated the requirements for a QA program have been in place for 20 years and have remained largely unchanged and quite broad. Dr.

Thibeau noted as the Committee continues to evaluate medication errors and workplace issues, the Committee may consider if action was appropriate to address these issues and if a review of the QA program requirements appears appropriate.

Chairperson Thibeau noted as reported both in the media, reports, and in public comments received, workforce strains are a contributing factor to medication errors; however, the Committee has received comments that some staff are prohibited from including staffing and other workforce issues as part of the QA report.

Chairperson Thibeau advised the meeting materials included some policy questions to help guide the discussion.

1. ***Should the date the error occurred be required to be reported?***

   Members reached consensus that the date should be determined to the best of the person's ability as sometimes the date may not be able to be determined.

2. ***Should the staff involved in the error be required to documented?***

   Members agreed it was important to know who was involved for the purpose of determining the root cause of the error and identifying if additional training was needed. Members expressed concern that the names of the people involved would be used for disciplinary or punitive reasons. Members emphasized the use of Just Culture throughout the process.

3. ***Should the QA report include the type of error, for example, patient received the wrong medication, the wrong directions were provided, etc.?***

   Members agreed the type of error should be included and was important to understand the full picture and severity of error as well as allowed for patterns to be identified and may point to a systemic problem.

4. ***Should the volume of workload completed on the date the error occurred be required?***

   Members agreed this should be required with consideration for other factors such as practice setting (e.g., central fill, community, inpatient, long-term care, etc.); if the pharmacist was working alone; robotics used; number of pharmacists/pharmacy technicians working; and point in shift that the error occurred.

5. ***Are there standardized items that should be captured, e.g. prescription volume (new and refill), immunizations provided, MTM, etc.?***

   Members reached consensus that contributing clinical and non-clinical services provided as well as workload should also be included. Members noted a lot of feedback around immunizations and sufficient space needs to be allocated to account for all items.

6. ***Should the number of staff and classification on the date of the error occurred by required?***

   Members agreed it was important to understand why distraction occurs and the root cause.

7. ***Should requirements be updated to require documentation of the actions taken (as well as recommended changes) and the date those actions occurred?***

   Members agreed requirements should be updated to require documentation of actions taken and review patterns in the QA. Ms. Sodergren provided QAs are not always available during inspection due to the retention schedule.

8. ***Should the Board standardize the QA form? Note: Staff note that the information varies greatly between pharmacies and at times appears too vague preventing sufficient review of the issue to identify recommended changes in a process.***

   Members agreed a standardize template would be helpful so long as the form is not required. This would allow companies to modify the form as needed. Members were interested in how at-risk behaviors were identified by pharmacies and what corrective action was taken for those behaviors. Members hoped this would help in catching the near misses and trying to prevent the errors from happening in the future.

9. ***Should a threshold be established after which a specified number of medication errors occur (i.e., 12 in a one-month period) that the pharmacy is required to take additional action? (i.e., complete the ISMP self-assessment tool, engage with a consultant that specializes in medication error reduction, etc.)***

   Members discussed factoring in the type of error and number of errors. Members discussed the complexities of this and that a number may not be the best gauge. Members agreed on the concept have had difficulty identifying how error severity would be accounted.

10. ***The current records retention schedule is one year. Should this be extended to allow for assessment of process improvements implemented or should aggregate year end data be required before removal of the QA records?***

    Members agreed the retention should be extended and suggested at minimum three years and possibly up to five years. Aggregate data would be important but members were unclear how to do it.

Members of the public were provided the opportunity to comment. The Committee heard comments from representatives from UFCW Western States Council, Kaiser, CPhA and CRA/NACDS.

Overall, the Committee heard comments in support of including staff involved; workload/volume including quantitative and qualitative; employer actions taken; standardizing minimum standards for a template/sample QA form with input from patient safety organizations; flexibility in requirements and time allowed to research the error; including ancillary documents involved; increased identifying trends to ensure same type of error isn't happening; increased implementation time; and increasing record retention to five years. The Committee heard comments about the Board not requiring staff involved being documented and not having required elements that may deter people from reporting errors.

Chairperson Thibeau surveyed the Committee after hearing public comment. Members indicated interest in hearing about the role a patient safety organization could play.

Chairperson Thibeau added as it appeared the Committee believed changes may be appropriate, the Committee would continue the discussion at the next meeting. Dr. Thibeau noted with the feedback provided, staff can begin developing a proposal for future consideration by members.

The Committee took a break from 11:12 a.m. to 11:17 a.m. Roll call was taken after break. Members present included Seung Oh, Licensee Member; Jessi Crowley, Licensee Member; Kula Koenig, Public Member; Jig Patel, Licensee Member; and Nicole Thibeau, Licensee Member. A quorum was established.

V. Discussion and Consideration of Medication Errors and Possible Future Development of Medication Error Reporting Requirements, Including Use of Required Standardized Report

Chairperson Thibeau advised the reporting of medications errors was voluntary and there were various sources that accept such reporting. Dr. Thibeau noted the issue of medication errors was not new. A study referenced in the meeting materials from

2003 concluded that dispensing errors were a problem at a national level with about 4 errors per day in a pharmacy filling 250 prescriptions daily.

Chairperson Thibeau provided the New Hampshire State Board of Pharmacy reviewed medication errors received between February 2007 and July 2012 and published its results that included 40 percent of the errors involved dispensing the incorrect medication and 68 percent of the errors occurred when only one pharmacist was on duty. Dr. Thibeau added limitations on the results included that the reporting of errors was not mandatory.

Chairperson Thibeau noted the practice of pharmacy has changed over the years. Dr. Thibeau noted changes include pharmacies that may have integrated technology in the dispensing process and expanded authorization for pharmacists.

Chairperson Thibeau noted more recent information published suggests that about 1.5 percent of all prescriptions in the community setting have a dispensing error. Dr. Thibeau added while that percentage sounds low, given the number of prescriptions dispensed in California, that estimated number of dispensing errors was staggering.

Chairperson Thibeau advised the Committee would discuss the policy questions provided in the meeting materials.

1. ***Should the Board establish a requirement to report medication errors?***

   Some members thought the Board should establish a requirement to report medication errors so that there was data available rather than antidotal information and noted favor toward anonymity for the need for protections for the pharmacies and individuals. Some members thought it would be burdensome.

2. ***If yes, what entity should receive the reports to receive such reports?***

   Some members thought the Board should collect the reports while others thought there could be a better result if a third-party entity (e.g., patient safety organization, ISMP, etc.) collected the information so that the Board could extract the data. A member encouraged the Board to reach out to New Hampshire to review their process.

3. ***If yes, should the requirement be limited in duration for purposes of conducting a study similar to the approach taken in New Hampshire?***

   Members recognized the time and resources that would be required to initiate such a project and were concerned about spending time and resources for a

limited amount of time. Members acknowledged something needed to be done but did not reach a consensus on how to do it.

4. Should the Board establish a standardized medication error reporting form?

Members recommended developing a standardized form to work in conjunction with the QA form. Members agreed the form should be simple.

Members of the public were provided the opportunity to provide comment.

The Committee heard comments from CRA/NACDS, UFCW Western States Council, CPhA and Kaiser.

Public comment was received in support of having data be collected by a patient safety organization provided the Board was required to analyze the data. Public comment was received in support of using existing organizational forms provided elements for CCR 1711 were included noting it would take time to update software system for new requirements. A comment was also made recommending the name of chain pharmacies should be noted to identify repeat issues as well as best practices. Public comment indicated there could be a concern to have to report errors to the regulatory body who could discipline for the errors being reported.

Chairperson Thibeau noted there appeared to be consensus that as a Committee additional requirements may be appropriate regarding the reporting of medication errors. With the Committee's agreement, Chairperson Thibeau will work with staff to develop a possible proposal that could serve as a possible framework for future consideration.

VI. Discussion and Review of Enforcement Actions Taken and Enforcement Authority Exercised by Other Jurisdictions Related to Workplace Conditions

Chairperson Thibeau advised the next item for consideration was enforcement authority exercised by other jurisdictions related to workplace conditions. Dr. Thibeau reminded the Committee at the previous meeting, the Committee heard in Nova Scotia, legal provisions require that pharmacy managers ensure the staffing plan is commensurate with the needs of the patients of the pharmacy and that when staffing issues are related to errors, the Board can require the pharmacy owners and managers to show proof of how they insured that regulatory requirement was met.

Chairperson Thibeau noted there were several jurisdictions within the US that were evaluating this issue. Dr. Thibeau added some actions taken by other jurisdictions included establishing requirements to report unsafe working conditions, having provisions to ensure sufficient personnel are scheduled to work and having

requirements that a pharmacy must notify patients if the pharmacy is experiencing significant delays or cannot dispense prescriptions in a timely manner. Dr. Thibeau added in California, there were provisions establishing when a pharmacist is at lunch, requiring a community chain pharmacy to ensure designated staff are available to assist a pharmacist when requested as well as a new requirement establishing a prohibition on workload quotas.

Chairperson Thibeau referred to the meeting materials that included specific legal requirements for some other states and noted several states include a requirement for the pharmacy to ensure sufficient staffing.

Members were provided the opportunity to comment.

Members spoke in favor of all four states' models highlighting inadequate staffing report forms, limitations on working, and mandatory rest periods. Members suggested taking the highlights from each model and consolidating into one California model. Members spoke in favor of staffing floors as well as pharmacists and pharmacists-in-charge (PIC) being able to make decisions on staffing.

Members of the public were provided the opportunity to comment.

The Committee heard comments from Pizza is Not Working, UFCW Western States Council, and CVS Health. Members heard comments in support of having descriptive language rather than a finite number; support of the PIC to have the staff needed; factor in all services provided when determining staffing; allow the Board to have authority to look at staffing in all capacity where prescriptions are filled; consider staffing as a mitigating factor in disciplinary cases; develop a staffing floor; and discussion on four state models and focus on patient safety.

The CVS Health representative noted the article about CVS Health was not correct.

Chairperson Thibeau concluded there appeared to be consensus that additional authority is appropriate. The Committee was agreeable for Dr. Thibeau to work with staff to develop a possible proposal that could serve as a possible framework for future consideration.

VII. Discussion and Consideration of Just Culture Approach to Managing Patient Medication Errors and Patient Safety

Chairperson Thibeau reported Just Culture as a means of managing patient medication errors and patient safety. The Institute for Safe Medication Practices (ISMP) had good information on Just Culture including how a pharmacy organization could adopt such an approach. Dr. Thibeau noted a Just Culture is not a "non-punitive or blame-free culture", rather it is one focusing on the entire

system to evaluate what occurred in an error and what future action can be taken to prevent such errors in the future.

Chairperson Thibeau had experience with Just Culture through Dr. Thibeau's current employer to both participate in and observe the direct impact of a pharmacy implementing such an approach. Dr. Thibeau explained the process of talking to people involved to determine what happened, what went wrong and determine where the issue was by using a fishbone diagram and asking five "why's" to determine root cause. This process allowed for the errors in systems to be identified.

Members were provided an opportunity to comment.

Some members had experience with Just Culture in their current organizations and believed it was critical to success. Other members didn't use Just Culture at their current organizations but like the concept of going back five steps before the error and assessing systemic errors. The Committee discussed to what extend it would appear in the enforcement mechanism. Ms. Sodergren advised this will be seen where the respondent is providing mitigation (e.g., system changes, training, etc.).

Members of the public were provided the opportunity to comment. A representative from Kaiser commented about a concern that cite and fines were issued for medication errors and is probably stifling the reporting of medication errors.

Chairperson Thibeau noted as there appeared be interest in learning more about Just Culture, Dr. Thibeau will ask staff to arrange for a presentation at a future meeting.

VIII. Discussion and Consideration of Pharmacist Well-Being Index State Report

Chairperson Thibeau referenced the copy of the most recent Pharmacist Well-Being Index. Dr. Thibeau noted there has been an increase in the number of California pharmacists using the index as well as a slight increase in the distress percentage for pharmacists licensed in California. Dr. Thibeau reported the updated pharmacy workplace and well-being reporting, which included data from January 10, 2022, to August 11, 2022, included 14 positive experiences and 159 negative experiences. Dr. Thibeau reported the negative submissions included categories focused on staffing/scheduling, workload/workload expectations, working conditions, pharmacy metrics. Dr. Thibeau noted numerous pharmacists reported verbal or emotional harassment, physical harm, including by patients, and discrimination. Dr. Thibeau added relating this information to the specific well-being index, individuals reported that the factors increased stress, increased burnout, weakened family and personal relationships, and lessened happiness.

Members were provided an opportunity to comment. Members agreed to watch this in the future.

Members of the public were provided an opportunity to comment. A licensed pharmacist in California inquired what the Board intended to do with the results of the survey.

Chairperson Thibeau stated the Committee will continue to monitor these reports and the Communication and Public Education Committee will be developing a campaign to educate the public about pharmacists and the important role they have in patient health.

IX. Future Committee Meeting Dates

Chairperson Thibeau advised the next Committee Meeting was scheduled for November 16, 2022.

X. Adjournment

The meeting adjourned at 12:36 p.m.

Attachment 2

Proposal to Amend 16 CCR § 1711 as follows:

§ 1711. Quality Assurance Programs.

(a) Each pharmacy shall establish or participate in an established quality assurance program that documents and assesses medication errors to determine cause and an appropriate response as part of a mission to improve the quality of pharmacy service and prevent errors.

(b) For purposes of this section, "medication error" means any variation from a prescription or drug order not authorized by the prescriber, as described in Section 1716. Medication error, as defined in the section, does not include any variation that is corrected prior to furnishing the drug to the patient or patient's agent or any variation allowed by law.

(c)(1) Each quality assurance program shall be managed in accordance with written policies and procedures maintained in the pharmacy in an immediately retrievable form.

(2) When a pharmacist determines that a medication error has occurred, a pharmacist shall as soon as possible:

(A) Communicate to the patient or the patient's agent the fact that a medication error has occurred and the steps required to avoid injury or mitigate the error.

(B) Communicate to the prescriber the fact that a medication error has occurred.

(3) The communication requirement in paragraph (2) of this subdivision shall only apply to medication errors if the drug was administered to or by the patient, or if the medication error resulted in a clinically significant delay in therapy.

(4) If a pharmacist is notified of a prescription error by the patient, the patient's agent, or a prescriber, the pharmacist is not required to communicate with that individual as required in paragraph (2) of this subdivision.

(d) Each pharmacy shall use the findings of its quality assurance program to develop pharmacy systems and workflow processes designed to prevent medication errors. An investigation of each medication error shall commence as soon as is reasonably possible, but no later than 2 business days from the date the medication error is discovered. All medication errors discovered shall be subject to a quality assurance review.

(e) The primary purpose of the quality assurance review shall be to advance error prevention by analyzing, individually and collectively, investigative and other pertinent data collected in response to a medication error to assess the cause and any contributing factors such as system or process failures. A record of the quality assurance review shall be immediately retrievable in the pharmacy. The record shall contain at least the following:

(1) The date, location, and participants in the quality assurance review;

(2) The pertinent data and other information relating to the medication error(s) reviewed and documentation of any patient contact required by subdivision (c)~~,~~ including:

(A) The date and approximate time or date range when the error occurred if known or can be determined. If it cannot be determined, the pharmacy shall note "unknown" in the record.

(B) The names of staff involved in the error.
(C) The use of automation, if any, in the dispensing process.
(D) The type of error that occurred. To ensure standardization of error reporting, the pharmacies' policies and procedures shall include the category the pharmacy uses for identifying the types of errors.
(E) The volume of workload completed by the pharmacy staff on the date of the error including clinical functions. If the date of the error is unknown, the average volume of workload completed daily shall be documented. For errors that occur in a community pharmacy, at a minimum the volume of workload records shall include the number of new prescriptions dispensed, the number of refill prescriptions dispensed, the number of vaccines administered, number of patient consultations given, and any other mandatory activities required by the pharmacy employer. Prescriptions filled at a central fill location and dispensed at the pharmacy must be documented separately from other prescriptions filled at the pharmacy.
(3) The findings and determinations generated by the quality assurance review; and,
(4) Recommend changes to pharmacy policy, procedure, systems, or processes, if any.
The pharmacy shall inform pharmacy personnel of changes to pharmacy policy, procedure, systems, or processes made as a result of recommendations generated in the quality assurance program. Documentation of the steps taken to prevent future errors shall be maintained as part quality assurance report.
(f) The record of the quality assurance review, as provided in subdivision (e) shall be immediately retrievable in the pharmacy for at least ~~one~~ three years from the date the record was created. Any quality assurance record related to the use of a licensed automated drug delivery system must also be submitted to the board within 30 days of completion of the quality assurance review and any facility with an unlicensed automated drug delivery system must report the quality assurance review to the Board at the time of annual renewal of the facility license.
(g) The pharmacy's compliance with this section will be considered by the board as a mitigating factor in the investigation and evaluation of a medication error.
(h) Nothing in this section shall be construed to prevent a pharmacy from contracting or otherwise arranging for the provision of personnel or other resources, by a third party or administrative offices, with such skill or expertise as the pharmacy believes to be necessary to satisfy the requirements of this section.

NOTE: Authority cited: Section 4005, Business and Professions Code; and Section 2 of Chapter 677, Statutes of 2000. Reference: Sections 4125 and 4427.7, Business and Professions Code.

Attachment 3

Proposed addition of Business and Professions Code Section 4113.1 Pharmacy Operations

Any community pharmacy licensed pursuant to this article shall report all medication errors to [Insert Organization]. Reporting shall be submitted no later than 7 days following discovery of the error. Such reports are deemed confidential and are not subject to discovery, subpoena, or disclosure pursuant to Chapter 3.5 (commencing with Section 6250) of Division of Title 1 of the Government Code. The pharmacy shall maintain records demonstrating compliance with this requirement for three years and shall make such records immediately available at the request of an inspector. A medication error report made pursuant to this section shall not be subject to discipline or other enforcement action by the Board based solely on the report; however, if the Board receives other information regarding the medication error, that information may serve as basis for discipline or other enforcement by the Board.

Attachment 4

BEFORE THE VIRGINIA BOARD OF PHARMACY

IN RE: CVS PHARMACY #8302
Permit Number: 0201-004432
Case Number: 203229

ORDER

JURISDICTION AND PROCEDURAL HISTORY

Pursuant to Virginia Code §§ 2.2-4020, 2.2-4024(F), and 54.1-2400(11), a panel of the Virginia Board of Pharmacy ("Board") held a formal administrative hearing on February 7, 2022, in Henrico County, Virginia, to inquire into evidence that CVS Pharmacy #8302 may have violated certain laws and regulations governing its permit to conduct a pharmacy in the Commonwealth of Virginia.

Olivia Basseri, Pharmacist in Charge, appeared as the representative of CVS Pharmacy #8302 at this proceeding. CVS Pharmacy #8302 was also legally represented by the following attorneys from the Washington, D.C., law firm of Baker & Hostetler, LLP: Elizabeth Scully, Esq., Lee Rosebush, Esq., and Marc Wagner, Esq..

NOTICE

By letter dated November 22, 2021, the Board sent a Notice of a Formal Administrative Hearing ("Notice") to CVS Pharmacy #8302 notifying it that a formal administrative hearing would be held on January 11, 2021. The Notice was sent by certified and first class mail to the legal address of record on file with the Board, and a copy of the Notice was also mailed to George Parsells, III, Esquire, counsel for CVS Pharmacy #8302. By letter dated November 31, 2021, the Board notified CVS Pharmacy #8302 that the formal administrative hearing was continued from January 11, 2022, as requested by CVS Pharmacy #8302 through its counsel, and the Board scheduled the hearing for February 7, 2022. Copies of the letter were also mailed to George Parsells, III, Esquire, counsel for CVS Pharmacy #8302, and Brian Johnson, counsel for CVS Pharmacy #8302.

Upon consideration of the evidence, the Board adopts the following Findings of Fact and Conclusions of Law and issues the Order contained herein.

FINDINGS OF FACT

1. On October 7, 2011, the Board issued Permit Number 0201-004432 to CVS Pharmacy #8302 to conduct a pharmacy in the Commonwealth of Virginia. Said permit is scheduled to expire on April 30, 2022. At all times relevant to the allegations herein, said permit was in full force and effect.

2. Multiple pharmacists and pharmacy technicians reported to an Inspector from the Virginia Department of Health Professions ("DHP Inspector") that Respondent is routinely understaffed compared to the workload, despite multiple requests for additional staff to be scheduled. Moreover, in or about January and February 2020, prescription volume increased; yet despite this knowledge Respondent cut pharmacy technician staffing hours. Due to the lack of adequate staffing, multiple pharmacists reported that the facility would be so busy that pharmacy staff would barely be able to take a bathroom break during a 12-hour shift. Other pharmacy staff also reported getting home from a shift and realizing that due to the inadequate staffing, pharmacy staff never had time to use the bathroom during their entire shift.

3. Multiple pharmacy staff attributed medication dispensing errors to Respondent's facility being understaffed. Specifically:

a. Multiple pharmacy technicians reported about one occasion, where a pharmacist dispensed an extra 100 Percocet (oxycodone, C-II) tablets when filling a prescription.

b. A prescription for atorvastatin, a medication used to regulate cholesterol, was dispensed with incorrect instructions to "insert 1 vaginally."

c. On or about April 2020, a pharmacist dispensed Norco (hydrocodone/acetaminophen, C-II) to a patient instead of Percocet, the medication prescribed to this patient.

d. A pharmacist reported that "staffing levels contributed to errors" and that "she herself made a few errors in quantity given to a patient because the pharmacy was so slammed." She further reported other errors where prescriptions were entered under the incorrect patient name.

e. A DHP Inspector reviewed approximately 100 hardcopy prescriptions for the period of November 25, 2019 through January 4, 2020 and 100 hardcopy prescriptions for the period of February 8, 2020 through March 9, 2020, for a total of approximately 200 prescriptions, and discovered a total of 74 medication dispensing errors, for an error rate of approximately 37%. The error types can be described as follows:

i. The prescriptions with the following numbers had errors, which included prescriptions with the incorrect prescriber location, the wrong prescriber, or incomplete directions: 834925, 834923,834905, 834868, 834856, 834855, 834854, 834830, 834804, 834792, 834791, 834790, 834623, 834616, 834587, 834586, 834585, 834575, 834563, 834486, 834328, 834327, 834316, 834282, 834258, 834019, 818606, 834929, 834927, 807304, 807477, 807753, 808132, 816543, 816557, 816582, 816583, 816619, 816784, 816785, 816786, 816792, 816879, 816908, 816907, 816909, and 816916.

ii. The prescriptions with the following numbers had errors that put the patients at risk for harm, which included incomplete directions, incorrect prescriber location, the incorrect refill, or the wrong quantity: 818922, 834869, 834858, 834857, 818915, 834649, 834621, 834438, 834426, 834367, 834319, 818270, 834928, 807986, and 816528.

f. Multiple pharmacy staff reported that the ten phone lines into the pharmacy were "always ringing off the hook" and one reported that patients have reported not being able to get through to the pharmacy over the phone or long wait times.

g. Multiple pharmacy staff attributed "unsafe" and "stressful" work conditions to the lack of adequate staffing and a corporate focus on numerous burdensome metrics that Respondent expected them to meet, such as prescription turnaround time, quotas for calls to patients asking patients if they want refills, offering to contact doctors to switch to more affordable prescriptions, and promoting various programs at the pharmacy. Multiple pharmacy staff reported that these "metrics affect the ability to dispense prescriptions safely." Multiple pharmacy staff reported feeling stressed or overworked, including one pharmacist who was diagnosed with anxiety and took a medical leave of absence, one pharmacy technician who took a leave of absence because of stress, and another pharmacy technician who was placed on anti-anxiety medication because of the stress of working at Respondent's facility.

4. Multiple pharmacists reported being unable to take a 30-minute break when working longer than six continuous hours on a shift. Pharmacists reported that though they were "allowed" by company policy to take a break, they were unable to leave the prescription department because there was little or no pharmacist overlap scheduled and a pharmacist had to be present in the prescription department to verify prescriptions and counsel patients, as needed. One pharmacist reported routinely eating her lunch behind the safe because the facility was too busy to take a designated lunch break.

5. Multiple pharmacists reported routinely staying late on shifts to keep the prescription queue from getting too far behind, working for as many as one to three additional hours per shift.

6. The pharmacist-in-charge and the pharmacist on duty repeatedly requested additional staffing hours to prevent the pharmacy from falling behind on prescription filling and dispensing and concerns for patient safety; however, the district leader, a pharmacist who does not work at Respondent's

facility, repeatedly denied these requests. If the pharmacy staff scheduled hours beyond what was approved by the district leader, the district leader would contact the pharmacist-in-charge and require her to cut hours to stay within the budgeted staffing hours.

7. Between on or about February 8 and March 10, 2020, the pharmacist-in-charge did appear on occasion but never staffed a complete single shift during the four-week period at the Respondent's facility.

8. On or about September 9, 2020, a DHP Inspector conducted an inspection of Respondent's facility and found the following deficiencies:

a. Following the resignation of the former pharmacist-in-charge on or about February 8, 2020, the Board did not receive an application and the associated fee for the incoming pharmacist-in-charge until on or about February 26, 2020, sixteen days later.

b. The emergency key to the prescription department was kept in a stapled bag in the safe located in the manager's office and was not maintained in an envelope with the pharmacist's signature across the seal.

c. The biennial inventory was taken on time, but Respondent failed to document if the biennial inventory was taken before or after receipt or distribution of drugs in a 24-hour pharmacy.

9. In interviews with the investigator and in testimony, pharmacists and pharmacy technicians testified that pharmacists worked extra hours to keep up with the volume of prescriptions for which they were unpaid.

10. A CVS witness testified that they were instituting a revised lunchbreak policy for its employees in the future.

11. A pharmacy technician testified that two CVS representatives visited her during the investigation of CVS #8302. She testified that the CVS representatives were "putting words in my mouth despite how much I was trying to explain myself."

12. A second pharmacy technician testified that she felt threatened and scared because CVS sent an email stating that employees had to sign the email, which stated the employee was not going to give a statement to the Board of Pharmacy, and the employee was not going to speak to the Board of Pharmacy. At that time, the pharmacy technician had already spoken to the Board of Pharmacy.

13. A former pharmacist-in-charge of CVS #8302 testified that she told the CVS district manager that "someone was going to die with these working conditions."

14. A pharmacist who worked at CVS #8302 testified that "you go so fast, you just get it done and you are going to hurt somebody. It is just a given. And as a pharmacist, that's your worst fear. Corporate will survive if they kill somebody but is a pharmacist going to?"

15. An expert witness for CVS #8302 testified that medication errors are never "okay".

CONCLUSIONS OF LAW

1. Finding of Fact Number 2, 3(a), 3(g) and 3(e)(ii) constitute violations of Virginia Code § 54.1-3316(1) and (13).

2. Finding of Fact Number 3(b), 3(c), 3(d), and 3(e)(i) constitute violations of Virginia Code § 54.1-3316(1).

3. Finding of Fact Number 3(f) constitutes a violation of Virginia Code § 54.1-3316(13).

4. Finding of Fact Number 4 and 5 constitute violations of Virginia Code § 54.1-3316(7) and 18 VAC 110-20-110(B) of the Regulations Governing the Practice of Pharmacy ("Regulations").

5. Finding of Fact Number 6 constitutes a violation of Virginia Code § 54.1-3316(2) and 18 VAC 110-20-25(10) and 18 VAC 110-20-110(C) of the Regulations.

6. Finding of Fact Number 7 constitutes a violation of Virginia Code § 54.1-3316(2) and 18 VAC 110-20-25(10) and 18 VAC 110-20-110(G) of the Regulations.

7. Finding of Fact Number 8(a) constitutes a violation of Virginia Code § 54.1-3316(2) and 18 VAC 110-20-25(10) and 18 VAC 110-20-110(H) of the Regulations.

8. Finding of Fact Number 8(b) constitutes a violation of Virginia Code § 54.1-3316(2) and 18 VAC 110-20-25(10) and 18 VAC 110-20-190(B)(1) of the Regulations.

9. Finding of Fact Number 8(c) constitutes a violation of Virginia Code § 54.1-3316(2) and 18 VAC 110-20-25(10) and 18 VAC 110-20-240(A)(4) of the Regulations.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, the Virginia Board of Pharmacy hereby ORDERS as follows:

1. CVS Pharmacy #8302 is REPRIMANDED.

2. CVS Pharmacy #8302 is assessed a MONETARY PENALTY of $346,250.00. This penalty shall be paid to the Board by certified check or money order made payable to the Treasurer of Virginia within 60 days from the date of entry of this Order. Failure to pay the full monetary penalty by the due date may cause the matter to be sent for collection and constitutes grounds for an administrative proceeding and further discipline.

3. CVS Pharmacy #8302 is placed on INDEFINITE PROBATION for a period of not less than two years subject to the following terms and conditions:

a. The period of probation shall begin on the date that this Order is entered and shall remain in effect until the Board has notified CVS Pharmacy #8302 in writing that it is released from probation.

b. CVS Pharmacy #8302 shall be subject to quarterly unannounced inspections by an inspector of the Department of Health Professions. The inspections shall be conducted during normal business hours and shall include a review of prescription records and an audit of pharmacy errors. CVS Pharmacy #8302 shall be responsible for the payment of an inspection fee to be paid to the Board within 30 days of each inspection. Any fee not paid in a timely manner will be sent for collection. In the event that any inspection reveals a possible violation of the laws or regulations pertaining to the practice of pharmacy in Virginia or the Virginia Drug Control Act (Virginia Code §§ 54.1-3400 *et seq.*), the Board may notice CVS Pharmacy #8302 to appear for an administrative proceeding.

c. CVS Pharmacy #8302 shall submit quarterly "Self Reports" which include a reporting of hours worked each week by pharmacists and pharmacy technicians and the number of prescriptions dispensed weekly. Self Reports shall be submitted on a quarterly basis to the Board, with the first report due no later than 60 days from the date of entry of the Order and subsequent reports due the last day of the March, June, September, and December until CVS Pharmacy #8302 is notified, in writing, that the reporting requirement is ended.

4. CVS Pharmacy #8302 shall bear any costs associated with the terms and conditions of this Order.

5. CVS Pharmacy #8302 shall comply with all laws and regulations governing the practice of pharmacy in the Commonwealth of Virginia. Any violation of the foregoing terms and conditions of this Order or any statute or regulation governing the practice of pharmacy shall constitute grounds for further disciplinary action.

6. This Order shall remain in effect until the Board has notified CVS Pharmacy #8302 in writing that it is released from all terms and conditions.

7. The Executive Director of the Board is authorized to issue a letter acknowledging satisfactory completion of the foregoing conditions or to refer the matter to a Special Conference Committee for review of CVS Pharmacy #8302's compliance with the foregoing conditions.

Pursuant to Virginia Code § 54.1-2400.2, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

FOR THE BOARD

Caroline D. Juran
Executive Director
Virginia Board of Pharmacy

ENTERED AND MAILED ON:
3/17/2022

NOTICE OF RIGHT TO APPEAL

As provided by Rule 2A:2 of the Supreme Court of Virginia, CVS Pharmacy #8302 has 30 days from the date it is served with this Order in which to appeal this decision by filing a Notice of Appeal with Caroline Juran, Executive Director, Board of Pharmacy, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233. The service date shall be defined as the date CVS Pharmacy #8302 actually received this decision or the date it was mailed to CVS Pharmacy #8302, whichever occurred first. In the event this decision is served upon it by mail, three days are added to that period.

Attachment 5

Proposed Amendment to BPC 4113.5.

(a) A community pharmacy shall not require a pharmacist employee to engage in the practice of pharmacy at any time the pharmacy is open to the public, unless either another employee of the pharmacy or, if the pharmacy is located within another establishment, an employee of the establishment within which the pharmacy is located, is made available to assist the pharmacist at all times.

(b) This section shall not apply to any of the following:

(1) A hospital pharmacy, as defined in Section 4029 or 4056.

(2) A pharmacy located in a hospital facility, including, but not limited to, a building where outpatient services are provided in accordance with the hospital's license.

(3) A pharmacy owned or operated by a federal, state, local, or tribal government entity, including, but not limited to, a correctional pharmacy, a University of California pharmacy, or a pharmacy operated by the State Department of State Hospitals.

(4) A pharmacy owned by a person or persons who, collectively, control the majority of the beneficial interest in no more than four pharmacies in California.

(5) A pharmacy entirely owned and operated by a health care service plan that exclusively contracts with no more than two medical groups in the state to provide, or arrange for the provision of, professional medical services to the enrollees of the plan.

(6) A pharmacy that permits patients to receive medications at a drive-through window when both of the following conditions are met:

(A) A pharmacist is working during the times when patients may receive medication only at the drive-through window.

(B) The pharmacist's employer does not require the pharmacist to retrieve items for sale to patients if the items are located outside the pharmacy. These items include, but are not limited to, items for which a prescription is not required.

(7) Any other pharmacy from which controlled substances, dangerous drugs, or dangerous devices are not furnished, sold, or dispensed at retail.

(c) A violation of subdivision (a) is not subject to subdivision (a) of Section 4321.

(d) The board shall not take action against a pharmacy for a violation of this section if both of the following apply:

(1) Another employee is unavailable to assist the pharmacist due to reasonably unanticipated circumstances, including, but not limited to, illness, injury, family emergency, or the employee's termination or resignation.

(2) The pharmacy takes all reasonable action to make another employee available to assist the pharmacist.

(e) The pharmacist on duty may close a pharmacy if, in their opinion, the staffing at the pharmacy is inadequate to safely fill or dispense prescriptions or provide other patient care services in a safe manner without fear of retaliation.

(f) A pharmacy is always staffed with at least one clerk or pharmacy technician fully dedicated to performing pharmacy related services. Where staffing of pharmacist hours does not overlap sufficiently, scheduled closures for lunch time for all pharmacy staff shall be established and publicly posted and included on the outgoing phone message.

(g) This section shall not be construed to permit an employee who is not licensed under this chapter to engage in any act for which a license is required under this chapter.

Proposal to Amend BPC 4113.

(a) Every pharmacy shall designate a pharmacist-in-charge and, within 30 days thereof, shall notify the board in writing of the identity and license number of that pharmacist and the date he or she was designated.

(b) The proposed pharmacist-in-charge shall be subject to approval by the board. The board shall not issue or renew a pharmacy license without identification of an approved pharmacist-in-charge for the pharmacy.

(c) The pharmacist-in-charge shall be responsible for a pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy. The pharmacist-in-charge shall have autonomy to make staffing decisions to ensure sufficient personnel are present in the pharmacy to prevent fatigue, distraction or other conditions that may interfere with a pharmacist's ability to practice competently and safely.

(d) The pharmacist-in-charge shall have the authority to close a pharmacy if workplace hazards, such as unsanitary conditions, temperatures deviate from appropriate drug storage conditions, or other conditions based on their professional judgement may create an unsafe environment for personnel or pharmacy staff. In the event the pharmacist-in-charge is not available, the pharmacist on duty, after a reasonable attempt to reach the pharmacist-in-charge, may close the pharmacy to the reasons previously cited.

(e) Every pharmacy shall notify the board in writing, on a form designed by the board, within 30 days of the date when a pharmacist-in-charge ceases to act as the pharmacist-in-charge, and shall on the same form propose another pharmacist to take over as the pharmacist-in-charge. The proposed replacement pharmacist-in-charge shall be subject to approval by the board. If disapproved, the pharmacy shall propose another replacement within 15 days of the date of disapproval and shall continue to name proposed replacements until a pharmacist-in-charge is approved by the board.

(f) If a pharmacy is unable, in the exercise of reasonable diligence, to identify within 30 days a permanent replacement pharmacist-in-charge to propose to the board on the notification form, the pharmacy may instead provide on that form the name of any pharmacist who is an employee, officer, or administrator of the pharmacy or the entity that owns the pharmacy and who is actively involved in the management of the pharmacy on a daily basis, to act as the interim pharmacist-in-charge for a period not to exceed 120 days. The pharmacy, or the entity that owns the pharmacy, shall be prepared during normal business hours to provide a representative of the board with the name of the interim pharmacist-in-charge with documentation of the active involvement of the interim pharmacist-in-charge in the daily management of the pharmacy, and with documentation of the pharmacy's good faith efforts prior to naming the interim pharmacist-in-charge to obtain a permanent pharmacist-in-charge. By no later than 120 days following the identification of the interim pharmacist-in-charge, the pharmacy shall propose to the board the name of a pharmacist to serve as the permanent pharmacist-in-charge. The proposed permanent pharmacist-in-charge shall be subject to approval by the board. If disapproved, the pharmacy shall propose another replacement within 15 days of the date of disapproval, and shall continue to name proposed replacements until a pharmacist-in-charge is approved by the board.

Proposal to Amend BPC 4301.

The board shall take action against any holder of a license who is guilty of unprofessional conduct or whose license has been issued by mistake. Unprofessional conduct includes, but is not limited to, any of the following:

(a) Procurement of a license by fraud or misrepresentation.

(b) Incompetence.

(c) Gross negligence.

(d) The clearly excessive furnishing of controlled substances in violation of subdivision (a) of Section 11153 of the Health and Safety Code.

(e) The clearly excessive furnishing of controlled substances in violation of subdivision (a) of Section 11153.5 of the Health and Safety Code. Factors to be considered in determining whether the furnishing of controlled substances is

clearly excessive shall include, but not be limited to, the amount of controlled substances furnished, the previous ordering pattern of the customer (including size and frequency of orders), the type and size of the customer, and where and to whom the customer distributes its product.

(f) The commission of any act involving moral turpitude, dishonesty, fraud, deceit, or corruption, whether the act is committed in the course of relations as a licensee or otherwise, and whether the act is a felony or misdemeanor or not.

(g) Knowingly making or signing any certificate or other document that falsely represents the existence or nonexistence of a state of facts.

(h) The administering to oneself, of any controlled substance, or the use of any dangerous drug or of alcoholic beverages to the extent or in a manner as to be dangerous or injurious to oneself, to a person holding a license under this chapter, or to any other person or to the public, or to the extent that the use impairs the ability of the person to conduct with safety to the public the practice authorized by the license.

(i) Except as otherwise authorized by law, knowingly selling, furnishing, giving away, or administering, or offering to sell, furnish, give away, or administer, any controlled substance to an addict.

(j) The violation of any of the statutes of this state, of any other state, or of the United States regulating controlled substances and dangerous drugs.

(k) The conviction of more than one misdemeanor or any felony involving the use, consumption, or self-administration of any dangerous drug or alcoholic beverage, or any combination of those substances.

(l) The conviction of a crime substantially related to the qualifications, functions, and duties of a licensee under this chapter. The record of conviction of a violation of Chapter 13 (commencing with Section 801) of Title 21 of the United States Code regulating controlled substances or of a violation of the statutes of this state regulating controlled substances or dangerous drugs shall be conclusive evidence of unprofessional conduct. In all other cases, the record of conviction shall be conclusive evidence only of the fact that the conviction occurred. The board may inquire into the circumstances surrounding the commission of the crime, in order to fix the degree of discipline or, in the case of a conviction not involving controlled substances or dangerous drugs, to determine if the conviction is of an offense substantially related to the qualifications, functions, and duties of a licensee under this chapter. A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this provision. The board may take action when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw his or her plea

of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

(m) The cash compromise of a charge of violation of Chapter 13 (commencing with Section 801) of Title 21 of the United States Code regulating controlled substances or of Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code relating to the Medi-Cal program.

(n) The revocation, suspension, or other discipline by another state of a license to practice pharmacy, operate a pharmacy, or do any other act for which a license is required by this chapter that would be grounds for revocation, suspension, or other discipline under this chapter. Any disciplinary action taken by the board pursuant to this section shall be coterminous with action taken by another state, except that the term of any discipline taken by the board may exceed that of another state, consistent with the board's enforcement guidelines. The evidence of discipline by another state is conclusive proof of unprofessional conduct.

(o) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate any provision or term of this chapter or of the applicable federal and state laws and regulations governing pharmacy, including regulations established by the board or by any other state or federal regulatory agency.

(p) Actions or conduct that would have warranted denial of a license.

(q) Engaging in any conduct that subverts or attempts to subvert an investigation of the board.

(r) The selling, trading, transferring, or furnishing of drugs obtained pursuant to Section 256b of Title 42 of the United States Code to any person a licensee knows or reasonably should have known, not to be a patient of a covered entity, as defined in paragraph (4) of subsection (a) of Section 256b of Title 42 of the United States Code.

(s) The clearly excessive furnishing of dangerous drugs by a wholesaler to a pharmacy that primarily or solely dispenses prescription drugs to patients of long-term care facilities. Factors to be considered in determining whether the furnishing of dangerous drugs is clearly excessive shall include, but not be limited to, the amount of dangerous drugs furnished to a pharmacy that primarily or solely dispenses prescription drugs to patients of long-term care facilities, the previous ordering pattern of the pharmacy, and the general patient population to whom the pharmacy distributes the dangerous drugs. That a wholesaler has established, and employs, a tracking system that complies with the requirements of subdivision (b) of Section 4164 shall be considered in determining whether there has been a violation of this subdivision. This provision shall not be interpreted to require a wholesaler to obtain personal medical information or be authorized to permit a wholesaler to have access to personal medical

information except as otherwise authorized by Section 56 and following of the Civil Code. For purposes of this section, "long-term care facility" has the same meaning given the term in Section 1418 of the Health and Safety Code.

(t) The acquisition of a nonprescription diabetes test device from a person that the licensee knew or should have known was not the nonprescription diabetes test device's manufacturer or the manufacturer's authorized distributor as identified in Section 4160.5.

(u) The submission of a reimbursement claim for a nonprescription diabetes test device to a pharmaceutical benefit manager, health insurer, government agency, or other third-party payor when the licensee knew or reasonably should have known that the diabetes test device was not purchased either directly from the manufacturer or from the nonprescription diabetes test device manufacturer's authorized distributors as identified in Section 4160.5.

(v) Actions or conduct that would subvert or tend to subvert the efforts of a pharmacist to comply with laws and regulations, or exercise professional judgement, including creating or allowing conditions that may interfere with a pharmacist's ability to practice with competency and safety or creating or allowing an environment that may jeopardize patient care.

(w) Actions or conduct that would subvert or tend to subvert the efforts of a pharmacist-in-charge to comply with laws and regulations, exercise professional judgement, or make determinations about adequate staffing levels to safely fill prescriptions of the pharmacy or provide other patient care services in a safe and competent manner.

(x) Actions or conduct that would subvert or tend to subvert the efforts of a pharmacist intern or and pharmacy technician to comply with laws or regulations.

(y) Establishing policies and procedures related to time guarantees to fill prescriptions within a specified time unless such guarantees are required by law or to meet contractual requirements.

Attachment 6

APhA

WELL-BEING index

Well-being Index For Pharmacy Personnel

State Report For State Boards of Pharmacy

NABP District Eight States

OCTOBER 2022

pharmacist.com

For Every Pharmacist. For All of Pharmacy.

Well-being Index Resources Accessed

July 2019 to October 2022 and January 2022 to October 2022

WELL-BEING index
https://app.mywellbeingindex.org/signup
Invitation Code: APhA

Well-being Index for Pharmacy Personnel *Resources Accessed*

When individuals complete their WBI, they are directed to resources under 9 categories.

Since its launch, the assessors using the WBI for Pharmacy Personnel accessed resources under Stress & Resiliency the most often. In 2022 to date, the same category of resources was also the most accessed. A breakdown of resources accessed follows in the next slide.

The frequency of categories accessed, can be used to inform planning for resources and programming developed/offered by state associations and state boards of pharmacy.

Well-being Index for Pharmacy Personnel

Resources Accessed – Percentage of All Views

Resource Categories	July 2019 through October 2022	January 2022 through October 2022
Stress & Resiliency	34%	32%
Relationships & Work-life Balance	16%	17%
Emotional Concerns	14%	15%
Career Development	12%	15%
Fatigue	8%	6%
Suicidal Thoughts	*8%*	*3%*
Health Behavior	*5%*	*9%*
Money / Financial	2%	2%
Alcohol / Substance Use	1%	1%

The only difference in rank order

WELL-BEING index
https://app.mywellbeingindex.org/signup
Invitation Code: APhA

DISTRESS PERCENT CHANGES

National and District

October 2022 versus September 2022

WELL-BEING index
https://app.mywellbeingindex.org/signup
Invitation Code: APhA

Changes in Distress Levels

As of October 2022

State	Change in Distress % September 2022 vs October 2022	Distress % October 2022	State Rank for Distress Percent October2022
Largest Increase in Distress Percent			
Wyoming	+3.33%	20.00%	51
Arkansas	+2.63%	30.58%	18
South Dakota	+1.47%	26.47%	47
Maine	+1.02%	19.05%	52
Alaska	+0.50%	31.17%	35
Largest Decrease in Distress Percent			
Puerto Rico	-2.14%	42.86%	7
Tennessee	-1.02%	29.77%	41
Utah	-0.68%	29.85%	40
Idaho	-0.55%	33.06%	31
Florida	-0.47%	34.34%	22
NATIONAL	-0.06%	31.99%	----

WELL-BEING index
https://app.mywellbeingindex.org/signup
Invitation Code: APhA

Changes in Distress Levels – District Eight

As of October 2022

	Change in Distress % Sep 2022 vs Oct 2022	Distress % Oct 2022	Distress % State Rank Oct 2022	Change in Distress % Aug 2022 vs Sep 2022	Distress % State Rank Sep 2022	Distress % State Rank Aug 2022	Distress % State Rank Jul 2022	Distress % State Rank Jun 2022	Distress % State Rank May 2022	Distress % State Rank Apr 2022	Distress % State Rank Jan 2022	Distress % State Rank Dec 2021	Distress % State Rank Apr 2021	Distress % State Rank May 2020	Distress % State Rank Apr 2020
Arizona	**0.23%**	**39.67%**	**12**	0.05%	12	12	12	13	13	13	13	14	13	16	17
California	**0.08%**	**29.45%**	**43**	0.38%	44	45	45	45	44	44	41	40	38	35	35
Colorado	**0.12%**	**31.53%**	**34**	-0.22%	34	34	34	35	30	28	27(T)	25	23	14	19
Hawaii	**-0.42%**	**38.04%**	**15**	-0.43%	14	13	13	12	12	10	8	7	6	2	2
Nevada	**No Change**	**59.74%**	**1**	-0.26%	1	1	1	1	1	1	1	1	1	18	11
New Mexico	**-0.41%**	**29.17%**	**44**	No Change	43	43	43	43	42	3	36	42	44	39	39
Utah	**-0.68%**	**29.85%**	**40**	0.53%	39	40 (T)	42	42	41	39	38	37	32	27	31

T=Tied in rank with another state.
Note: Some historic data from 2020/2021/2022 has been removed to allow space for current month. Refer to previous months' reports or contact ashaughnessy@aphanet.org for data.

DISTRESS PERCENT MONTHLY REPORTS
State-Specific
September 2022 versus October 2022

WELL-BEING index
https://app.mywellbeingindex.org/signup
Invitation Code: APhA

WELL-BEING INDEX FOR PHARMACY PERSONNEL

STATE DISTRESS PERCENT*

OCTOBER 2022

As of October 6, 2022, the Arizona distress percent was 39.67% (ranked 12/52) with 193 assessors.

SEPTEMBER 2022

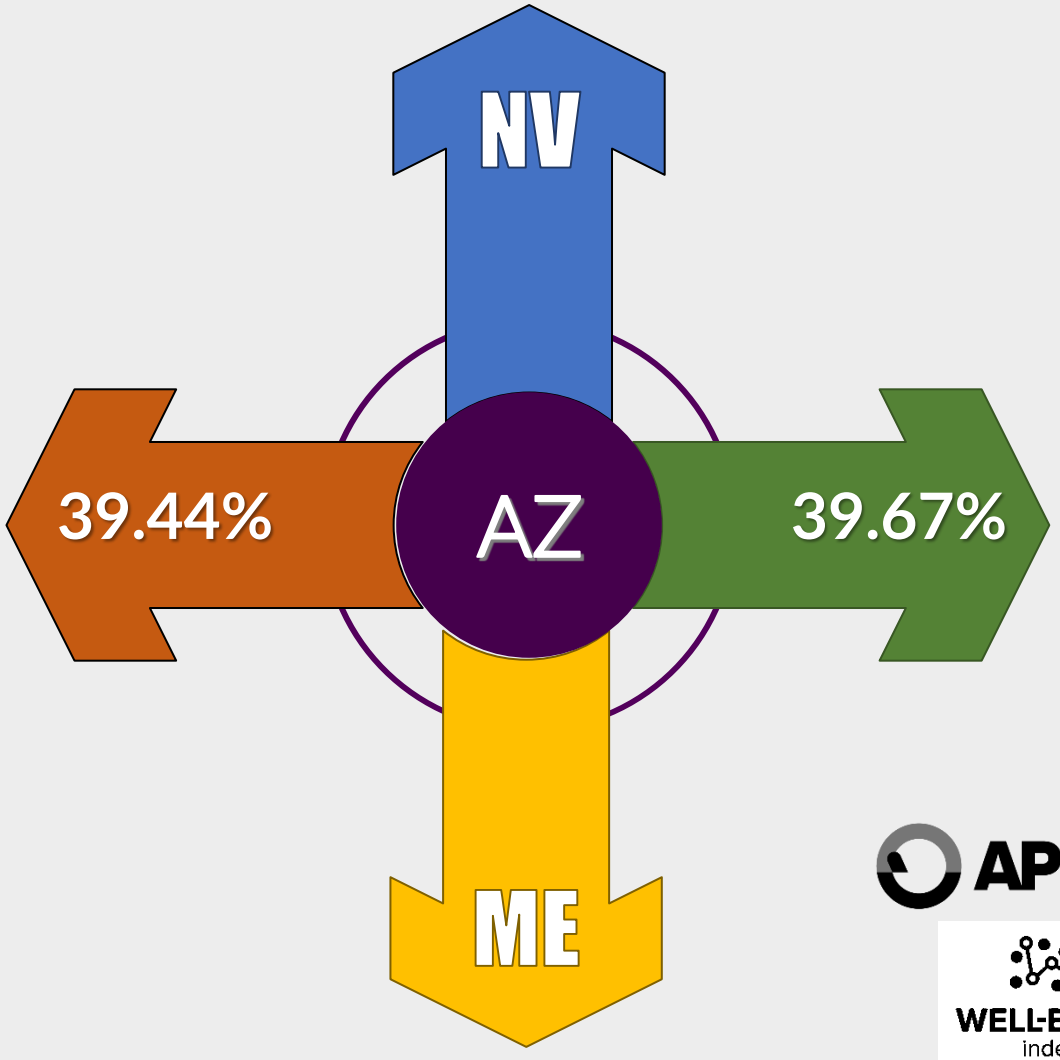
As of September 6, 2022, the Arizona distress percent was 39.44% (ranked 12/52) with 192 assessors.

STATE COMPARISON

As of October 6, 2022

Nevada is the highest at 59.74% (n=33)

Maine has the lowest 19.05% (n=26)



APhA

WELL-BEING index
https://app.mywellbeingindex.org/signup
Invitation Code: APhA

Distress Percent is the percentage of individuals with Well-Being Index (WBI) score ≥5.It measures the percent of individuals that are at a high level of distress.

WELL-BEING INDEX FOR PHARMACY PERSONNEL

STATE DISTRESS PERCENT*

OCTOBER 2022

As of October 6, 2022, the California distress percent was 29.45% (ranked 43/52) with 766 assessors.

SEPTEMBER 2022

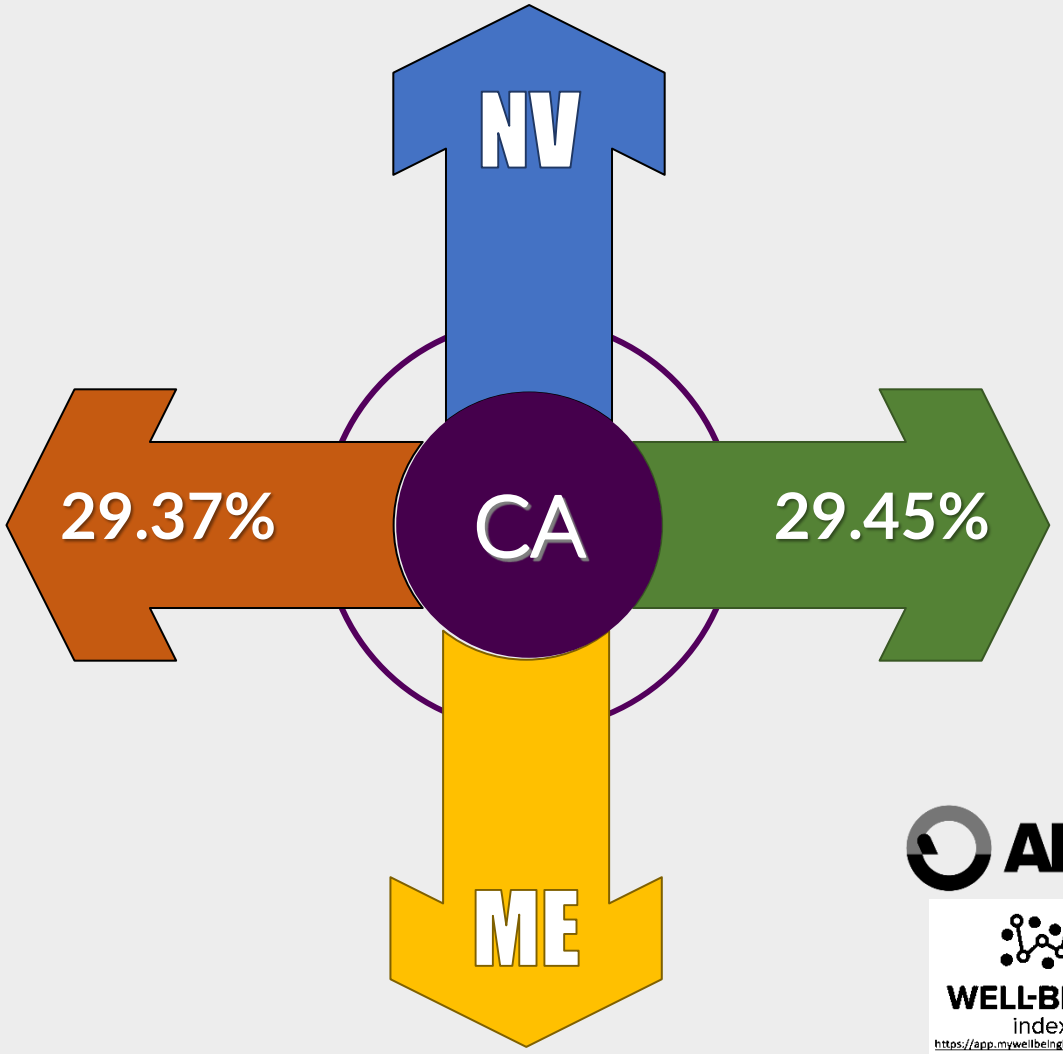
As of September 6, 2022, the California distress percent was 29.37% (ranked 44/52) with 756 assessors.

STATE COMPARISON

As of October 6, 2022

Nevada is the highest at 59.74% (n=33)

Maine has the lowest 19.05% (n=26)



APhA

WELL-BEING index
https://app.mywellbeingindex.org/signup
Invitation Code: APhA

Distress Percent is the percentage of individuals with a Well-Being Index (WBI) score ≥5. It measures the percent of individuals that are at a high level of distress.

WELL-BEING INDEX FOR PHARMACY PERSONNEL

STATE DISTRESS PERCENT*

OCTOBER 2022

As of October 6, 2022, the Colorado distress percent was 31.53% (ranked 34/52) with 209 assessors.

SEPTEMBER 2022

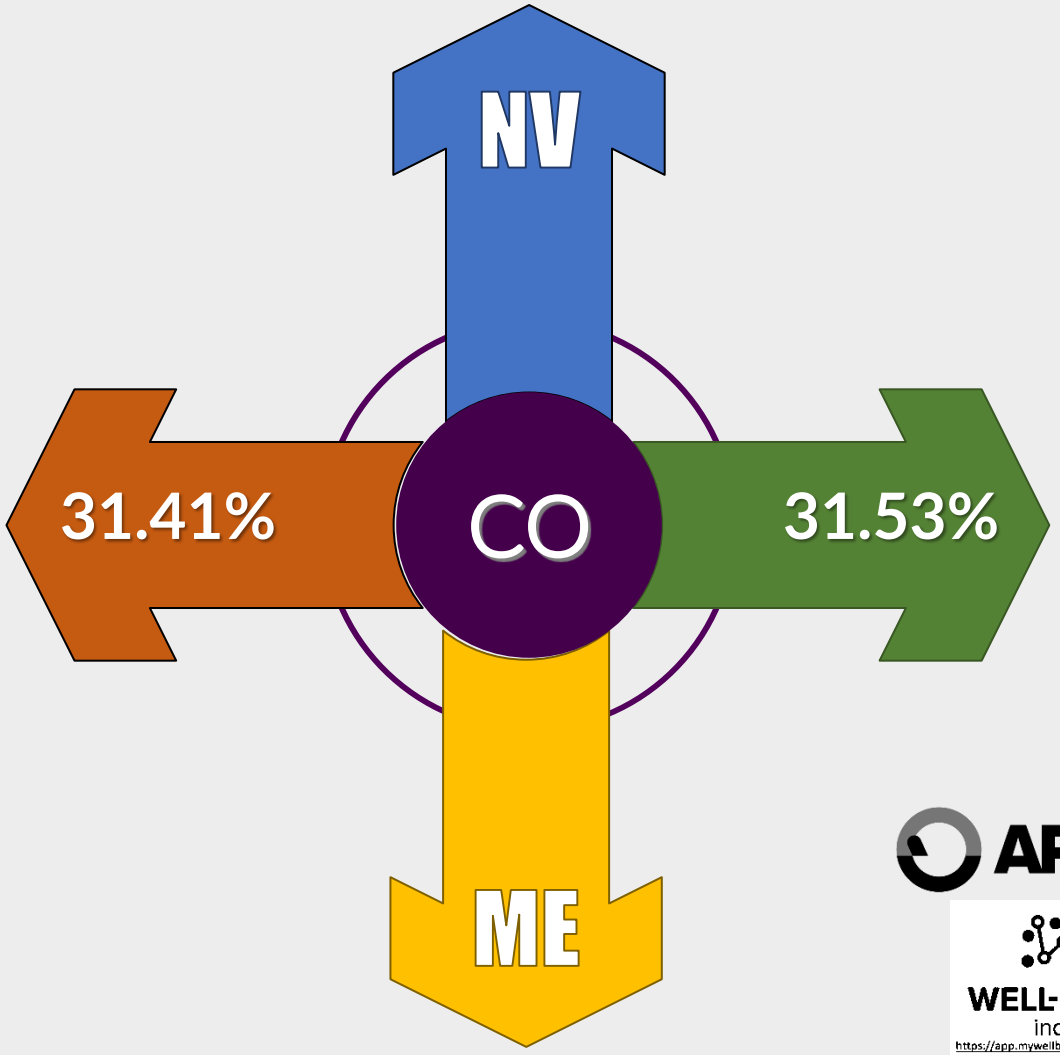
As of September 6, 2022, the Colorado distress percent was 31.41% (ranked 34/52) with 205 assessors.

STATE COMPARISON

As of October 6, 2022

Nevada is the highest at 59.74% (n=33)

Maine has the lowest 19.05% (n=26)



APhA

WELL-BEING index
https://app.mywellbeingindex.org/signup
Invitation Code: APhA

Distress Percent is the percentage of individuals with a Well-Being Index (WBI) score ≥5. It measures the percent of individuals that are at a high level of distress.

WELL-BEING INDEX FOR PHARMACY PERSONNEL
STATE DISTRESS PERCENT*

OCTOBER 2022

As of October 6, 2022, the Hawaii distress percent was 38.04% (ranked 15/52) with 29 assessors.

SEPTEMBER 2022

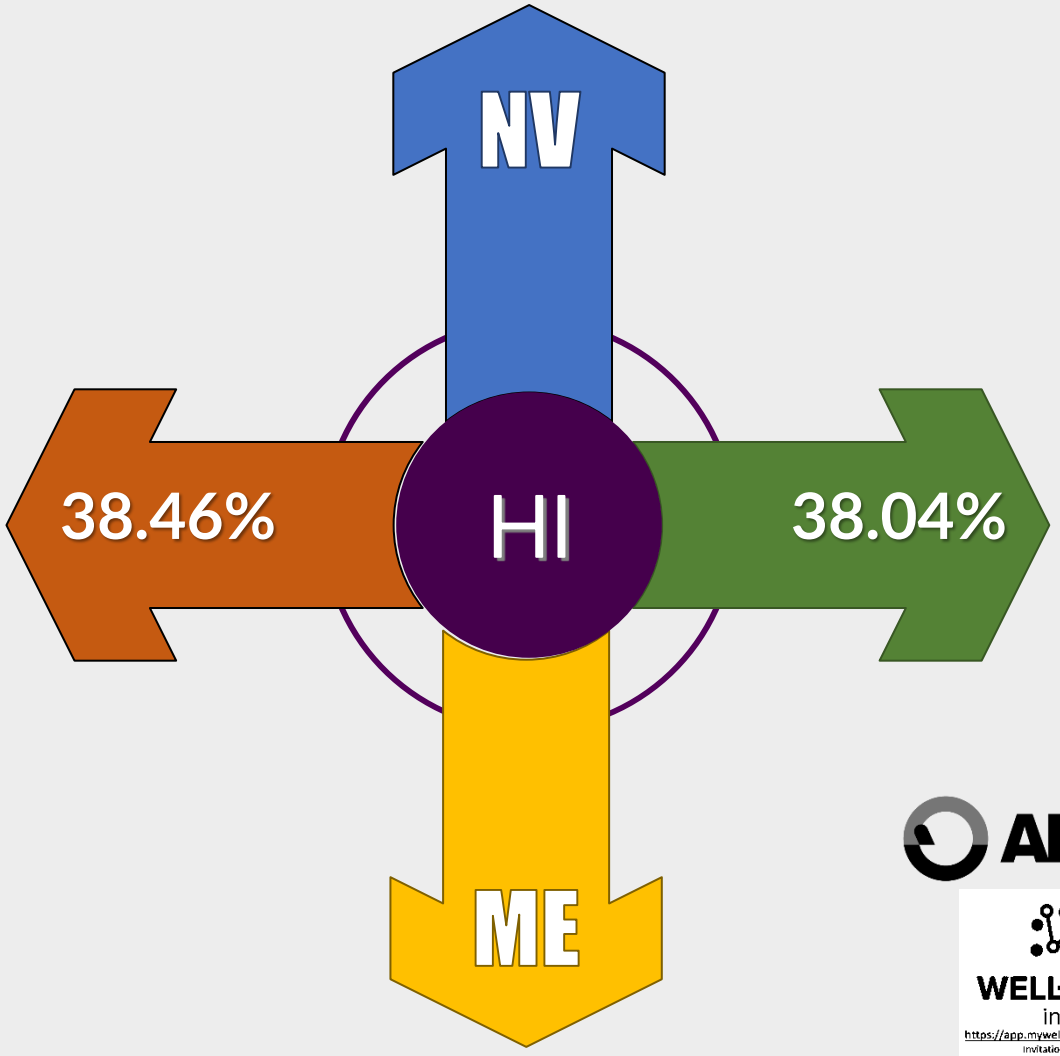
As of September 6, 2022, the Hawaii distress percent was 38.46% (ranked 14/52) with 29 assessors.

STATE COMPARISON

As of October 6, 2022

Nevada is the highest at 59.74% (n=33)

Maine has the lowest 19.05% (n=26)



APhA

WELL-BEING index
https://app.mywellbeingindex.org/signup
Invitation Code: APhA

Distress Percent is the percentage of individuals with a Well-Being Index (WBI) score ≥5. It measures the percent of individuals that are at a high level of distress.

WELL-BEING INDEX FOR PHARMACY PERSONNEL
STATE DISTRESS PERCENT*

OCTOBER 2022

As of October 6, 2022, the Nevada distress percent was 59.74% (ranked the highest at 1/52) with 33 assessors.

SEPTEMBER 2022

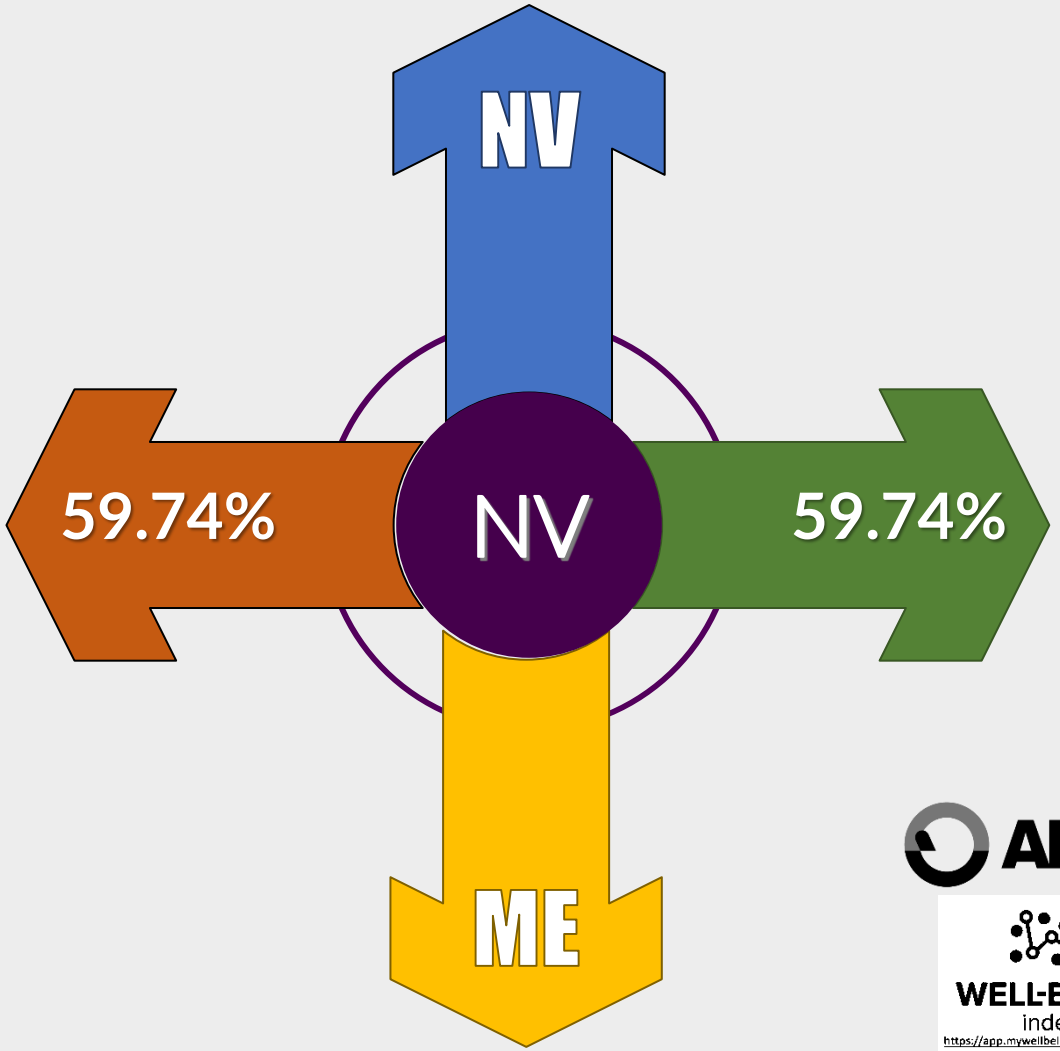
As of September 6, 2022, the Nevada distress percent was 59.74% (ranked the highest at 1/52) with 33 assessors.

STATE COMPARISON

As of October 6, 2022

Nevada is the highest at 59.74% (n=33)

Maine has the lowest 19.05% (n=26)



APhA

WELL-BEING index
https://app.mywellbeingindex.org/signup
Invitation Code: APhA

Distress Percent is the percentage of individuals with a Well-Being Index (WBI) score ≥5. It measures the percent of individuals that are at a high level of distress.

WELL-BEING INDEX FOR PHARMACY PERSONNEL
STATE DISTRESS PERCENT*

OCTOBER 2022

As of October 6. 2022, the New Mexico distress percent was 29.17% (ranked 44/52) with 51 assessors.

SEPTEMBER 2022

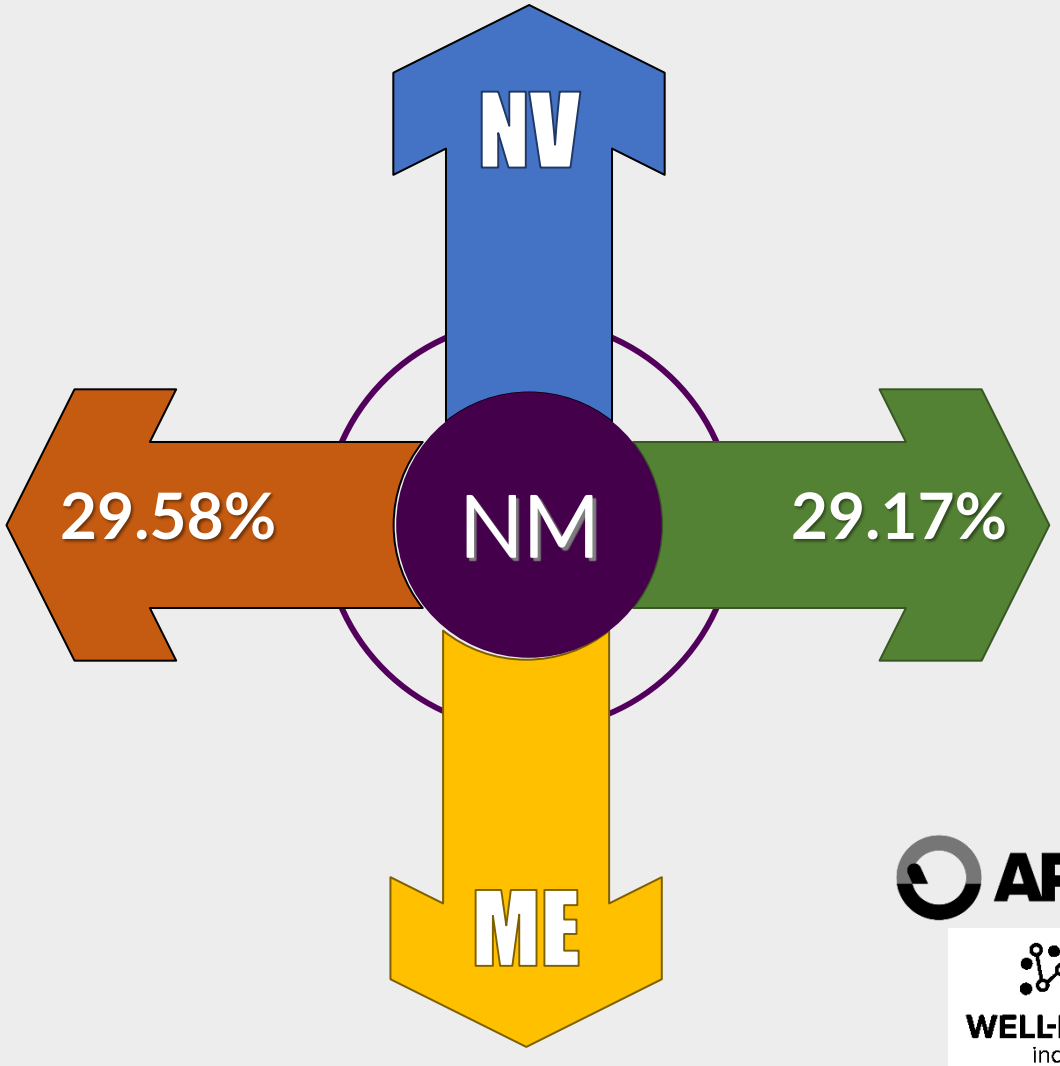
As of September 6. 2022, the New Mexico distress percent was 29.58% (ranked 43/52) with 50 assessors.

STATE COMPARISON

As of October 6, 2022

Nevada is the highest at 59.74% (n=33)

Maine has the lowest 19.05% (n=26)



APhA

WELL-BEING index
https://app.mywellbeingindex.org/signup
Invitation Code: APhA

Distress Percent is the percentage of individuals with a Well-Being Index (WBI) score ≥5. It measures the percent of individuals that are at a high level of distress.

WELL-BEING INDEX FOR PHARMACY PERSONNEL
STATE DISTRESS PERCENT*

OCTOBER 2022

As of October 6, 2022, the Utah distress percent was 29.85% (ranked at 40/52) with 74 assessors.

SEPTEMBER 2022

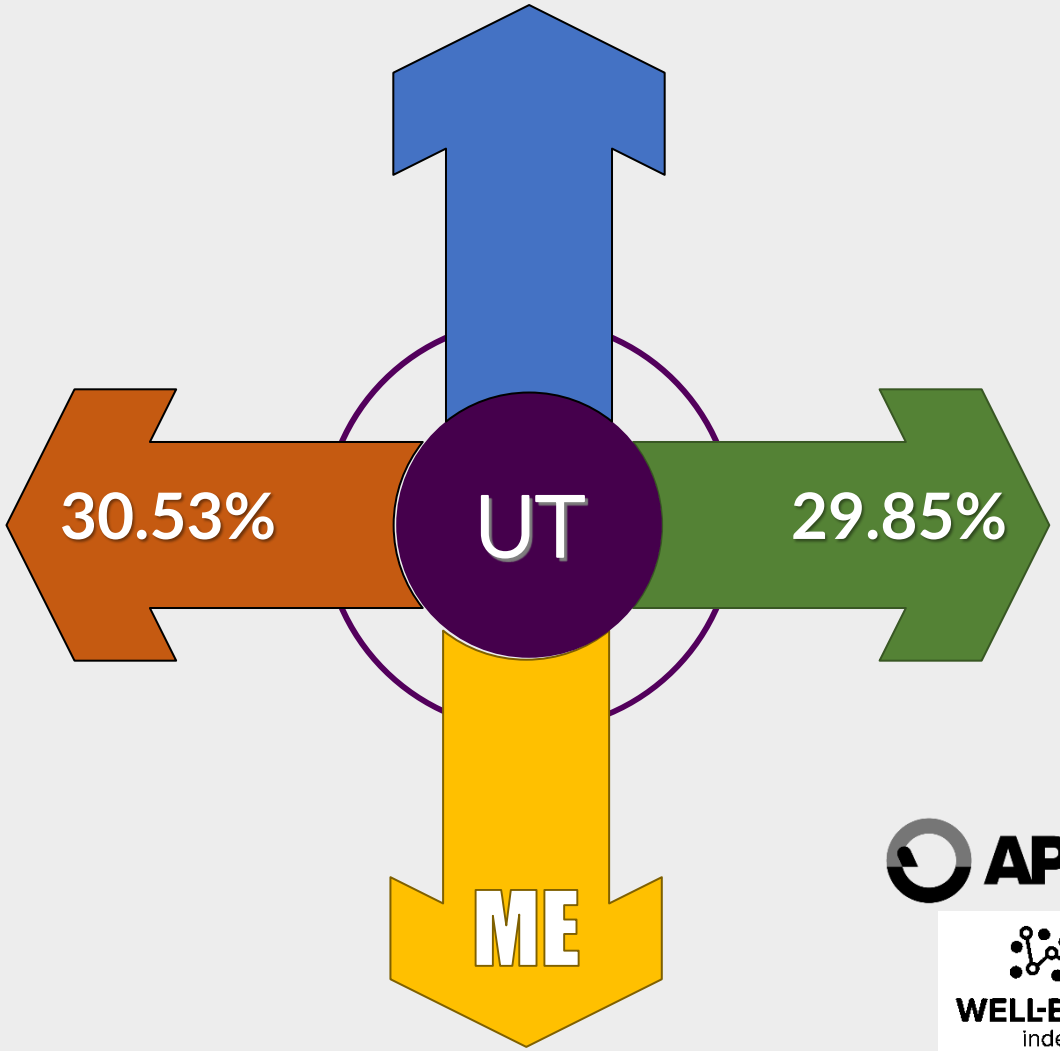
As of September 6, 2022, the Utah distress percent was 30.53% (ranked tied at 39/52) with 71 assessors.

STATE COMPARISON

As of October 6, 2022

Nevada is the highest at 59.74% (n=33)

Maine has the lowest 19.05% (n=26)



APhA

WELL-BEING index
https://app.mywellbeingindex.org/signup
Invitation Code: APhA

Distress Percent is the percentage of individuals with a Well-Being Index (WBI) score ≥5. It measures the percent of individuals that are at a high level of distress.

Well-being Resources Promo Slides*

For Your Use in State Social Media and Periodicals

**Please do not change the content of these promotional slides*

WELL-BEING index

Burnout is real.

Take advantage of APhA's online screening tool, invented by the Mayo Clinic, to evaluate your fatigue, depression, burnout, anxiety, and stress and assess your well-being.
It takes less than 5 minutes to answer 9 short questions.
It's 100% anonymous, free, and you do not need to be an APhA member.
Resources are available once you submit your assessment.

Well-being Index for Pharmacists, Student Pharmacists, & Pharmacy Technicians

https://app.mywellbeingindex.org/signup

Invitation Code: APhA

Or Scan

APhA

You're committed to pharmacy.
We're committed to your well-being.
www.pharmacist.com/wellbeing

PHARMACY WORKPLACE & WELL-BEING REPORTING

Your experiences – positive and negative – tell a powerful story!

Your experience can be the spark that helps change and enhance the pharmacy workplace, pharmacy personnel well-being, and patient safety.

Submit your experience report to
Pharmacy Workplace and Well-being Reporting.
www.pharmacist.com/pwwr

Your report is confidential, anonymous, and protected by the Alliance for Patient Medication Safety - a recognized national patient safety organization.

Share the PWWR link with your colleagues!