California State Board of Pharmacy
1625 N. Market Blvd, N219, Sacramento, CA 95834
Phone: (916) 574-7900
Fax: (916) 574-8618
www.pharmacy.ca.gov

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

LICENSING COMMITTEE REPORT

Stan Weisser, Licensee Member, Chairperson
Lavanza Butler, Licensee Member, Vice-Chairperson
Ryan Brooks, Public Member
Ricardo Sanchez, Public Member
Debbie Veale, Licensee Member
Albert Wong, Licensee Member
Amy Gutierrez, Board President and Acting Chairperson

Report of the committee meetings held on August 22, 2017 and October 27, 2017.

a. Discussion and Consideration of Licensing Requirements of an Advanced Pharmacy Technician (APT)

Attachment 1

Background/Prior Committee Discussion and Action

The Licensing Committee is offering recommendations to the board to establish an advanced pharmacy technician license type. This recommendation comes after two meetings where the committee discussed the concept as well as the framework. As part of the development of the proposal, the committee focused on how such a framework would benefit consumers. The committee believes that the primary benefit in creating this new category of licensure would be to allow a pharmacist to be redirected to provide more direct patient care activities, including increasing pharmacist interaction with consumers while an advanced pharmacy technician is redirected to perform specific duties.

In general, the provisions create a definition of an advanced pharmacy technician to include "an individual licensed by the board who is authorized to perform technician pharmacy tasks as authorized in BPC Section 4115.6…" An APT is also authorized to perform any of the duties of a pharmacy technician.

In addition to the proposed definition, the committee considered the appropriate minimum requirements for licensure. After discussion and consideration at two meetings, the committee is recommending the following general criteria for licensure:

1. Hold an active pharmacy technician license; and
2. Possess certification by a pharmacy technician certifying program (e.g. PTCB or ExCPT); and
3. Obtain a minimum of an AA degree in pharmacy technology, or a bachelor's degree, or completion of a training program approved by the board; and
4. Have 3,000 hours of pharmacy technician experience.

OR

5. Graduate from a school of pharmacy.

Finally, the committee is also offering a recommendation to establish the renewal requirements including:

1. Twenty hours of continuing education, including two hours of education in medication error prevention and two hours of board sponsored law and ethics education.
2. Maintain certification by a pharmacy technician certifying program.

As part of its discussion the committee considered the current marketplace but also anticipated progression in the pharmacy profession, including the expanded roles pharmacists have in providing direct patient care. The committee noted the importance of identifying duties that can be performed by other pharmacy personnel that possess appropriate training and education. Based on articles and position statements, it is clear that nationally there is recognition that pharmacy operations need to change to allow for this direct patient care by pharmacist.

The committee's recommendation takes a similar approach to the advanced practice pharmacist legislation enacted through Senate Bill 493 (Hernandez, Chapter 469, Statutes of 2013). Such an approach allows for more a more robust reassignment of duties that do not require professional judgement, and addresses liability concerns expressed by the committee. Further, this approach is flexible and will allow for an easy response to a dynamic marketplace, allow for appropriate tools for the board to meet its consumer protection mandate, will allow PICs to decide if they will use the proposed authorized duties for ATPs, and will allow pharmacy technicians to continue functioning in their current capacity if they so choose.

<u>For Board Consideration and Action</u>

As stated above, the committee is providing recommendations that would facilitate the creation of an advanced pharmacy technician licensing category. As part of the recommendation, the committee is offering several motions. In addition, the committee is seeking policy guidance from the board:

- Does the board believe it is appropriate to create two separate licensure categories for the advanced pharmacy technician, one focused on the community/ambulatory care pharmacy and a second focused on the inpatient pharmacy?

Committee Recommendation (Motion): Pursue statutory change to add the definition of an advanced pharmacy technician. [Draft language included as part of **Attachment 1,** proposed BPC Section 4038.5**.**]

Committee Recommendation (Motion): Pursue statutory change to add the licensing requirements for an advanced pharmacy technician. [Draft language included as part of **Attachment 1**, proposed BPC Section 4211.]

Committee Recommendation (Motion): Pursue statutory change to establish the renewal requirements for an advanced pharmacy technician. [Draft language included as part of **Attachment 1,** proposed BPC Section 4234.]

b. Discussion and Consideration of the Duties an APT May Perform in a Traditional Community Pharmacy Setting

Attachment 2

Background/Prior Discussion and Action

As part of the development of the APT provisions, the committee discussed the scope of practice of an individual granted licensure as an APT. The committee discussed the duties currently authorized by law for all pharmacy technicians to perform and noted that all such nondiscretionary duties must be completed under the direct supervision and control of a pharmacist.

The committee reviewed a proposal to establish the scope of practice for an APT in the community/ambulatory care pharmacy setting. The committee considered various articles related to the topic, including one regarding accepting verbal prescriptions and prescription transfers as well as the outcomes of a Drake University study regarding a "Tech-Check-Tech" program in community pharmacies.

After discussion and hearing public comments, the committee voted to pursue a statutory change to establish duties that an APT may perform in a community/ambulatory care pharmacy:

1. Verify the accuracy of a typed prescription label and ensure the label accurately reflects the container's contents for a drug order.
2. Accept new orders and seek clarification on prescriptions from a prescriber's office, as specified, including inquiring about the intended purpose or indication for a prescribed medication.
3. Inquire about the intended purpose or indication of the medication from the prescriber's office.
4. Transfer prescriptions.
5. Receive a transferred prescription.
6. Perform the technical task of vaccine administration.
7. Compile patient medication lists.

The committee also discussed how the proposed new duties would impact pharmacy services and the conditions that must be satisfied for an APT to perform such duties. As part of its discussion, the committee discussed how the proposal would benefit consumers and requirements that a community/ambulatory care pharmacy must fulfill to allow for the use of the APT, with the ultimate goal of increased patient access to pharmacists and clinical services.

After discussion and consideration, the committee voted to recommend a statutory change to include that a community/ambulatory care pharmacy using an APT must ensure:

1. ATP duties are specified in the pharmacy's policies and procedures and are completed under the supervision of a pharmacist.
2. The PIC is responsible for the ongoing evaluation of the accuracy of the duties performed by the APT.

3. A pharmacist physically hands the patient or patient's agent the medication and provides patient information.
4. An electronic record that identifies personnel responsible for the preparation and dispensing of the prescription is maintained.

For Board Consideration and Action

As stated above, the committee is providing recommendations that would create the duties of an APT in the community/ambulatory care pharmacy setting as well as the changes to the operations of such a pharmacy. In addition, the committee is seeking policy guidance from the board:

- Specifically relating to the proposed requirements of a pharmacy using APTs, should a pharmacist be required to physically hand and provide patient education on all controlled substances medications or just all new prescriptions (which would include new controlled substances medications)?

Committee Recommendation (Motion): Pursue statutory change to add the duties of an advanced pharmacy technician. [Draft language included as part of **Attachment 2**.]

Committee Recommendation (Motion): Pursue statutory change to establish the conditions that must be met for a community/ambulatory care pharmacy to use an APT. [Draft language included as part of **Attachment 2**.]

A copy of the committee approved statutory language to add BPC Section 4115.6 (a) & (b) included in **Attachment 2**.

c. Discussion and Consideration of the Employment of APTs in a Closed-Door Pharmacy Which Provides Pharmacy Services for Patients of Skilled Nursing and Long-Term Care Facilities

Background

During prior committee meeting discussion, the committee considered the possible role an APT could play in a closed-door pharmacy and how consumers would benefit from such changes. The committee discussed what constitutes a closed-door pharmacy and noted that in a closed-door pharmacy, there is different patient interaction. The committee discussed an example of a patient being discharged from a hospital to a skilled nursing facility, where a pharmacy is providing medications but does not provide patient consultation. The committee noted that patients might benefit from patient consultation upon discharge from a skilled nursing facility.

Recent Committee Discussion

The committee briefly discussed suggested changes related to the APT proposal as it specifically related to a closed-door pharmacy, and if such pharmacies should have separate requirements. The committee ultimately decided that it was not necessary but indicated that the committee will consider patient consultation requirements for patients receiving medications from closed-door pharmacies in the future.

d. Discussion and Consideration of the Employment of APTs in Inpatient Hospital Pharmacies

Committee Discussion
The committee briefly considered the role an APT could play in an inpatient hospital and the resulting benefits to consumers.

The committee deferred much of its discussion to action on a recommendation related to APTs in an inpatient hospital and will await guidance from the board on the possible creation of an APT for the inpatient hospital. In addition, the committee requested submission of possible duties an APT could perform in the setting.

Based upon the direction from the board and submission of possible duties, the committee will resume its discussion during its next committee meeting.

e. Discussion and Consideration of the Current Renewal Requirements for Pharmacy Technicians and Possible Changes Thereto

Attachment 3

Background
In prior meetings, the committee has considered the current renewal requirements for all pharmacy technicians. During its April 2017 meeting, the committee questioned if continuing education should be required as a condition of renewal. As part of its discussion, the committee contemplated if such a requirement would become a hurdle to renewal. The committee was advised by the public that given the availability of courses, many of which can be done online or at no cost, such a requirement would not be a hurdle.

Committee Discussion
The committee briefly considered if inclusion of a continuing education requirement as a condition of renewal for a pharmacy technician license was necessary. The committee decided such a requirement was not necessary.

Attachment 3 includes an excerpt from the April 2017 committee meeting regarding this issue.

f. Licensing Statistics

Attachment 4

Licensing Statistics for July 1, 2017 – September 30, 2017
Attachment 4 includes the licensing statistics for the first quarter of the fiscal year.

During this time the board has received 4,712 applications, including:

- 1,267 intern pharmacists.
- 539 pharmacist exam applications.
- 67 advanced practice pharmacists.
- 1,299 pharmacy technicians.
- 3 nonresident outsourcing facilities.

- 106 temp licenses for various business licenses.

As of September 30, 2017, the board has issued 4074 licenses, renewed 15,944 licenses and has 140,066 active licenses, including:

- 6,778 intern pharmacists.
- 45,677 pharmacists.
- 173 advanced practice pharmacists.
- 72,413 pharmacy technicians.
- 6,583 pharmacies.
- 477 hospitals and exempt hospitals.
- 6 nonresident outsourcing facilities.

g. Future Committee Meeting Dates

Provided below are Licensing Committee meeting dates through 2018:

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

A summary of the August committee meeting is provided in **Attachment 5** along with articles and background material provided to and considered by the committee. The draft summary from the October 27, 2017 will be provided during the meeting if available.

Attachment 1

Proposed BPC 4038.5 (Definition)

"Advanced Pharmacy Technician" means an individual licensed by the board who is authorized to perform technical pharmacy tasks as authorized in Section 4115.6. Such an individual may also perform nondiscretionary tasks as specified in Section 4115.

Proposed BCP 4211 (Licensing Requirement)

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

(1) Holds an active pharmacy technician license issued pursuant to this chapter that is in good standing,

(2) Possesses a certification issued by a pharmacy technician certifying program as defined in Section 4202(a)(4).

(3) Has obtained a minimum of an associate's degree in pharmacy technology, obtained a bachelor's degree, or higher or completed a board approved training program.

(4) Has obtained 3,000 hours of experience performing the duties of a licensed pharmacy technician in a pharmacy.

(b) As an alternative to the requirements in subdivision (a), has graduated from a school of pharmacy recognized by the board.

(c) A license issued pursuant to this section shall be valid for two years.

Proposed BPC 4234 (CE/Renewal Requirement)

An advanced pharmacy technician shall complete 20 hours of continuing education each renewal cycle. A licensee must also maintain certification as specified in Section 4211 (a)(2).

Attachment 2

Proposed 4115.6 (Specified Duties)

(a) In a pharmacy as defined in Business and Professions Code Section 4037, a licensed advanced pharmacy technician may perform these technical tasks:
   (1) Verify the accuracy of the typed prescription label and verify the filling of a prescription container by confirming that the medication and quantity reflected on the label accurately reflects the container's contents for drug orders that previously have been reviewed and approved by a pharmacist. A pharmacist is responsible for performing all reviews and verification requiring professional judgement including drug utilization review.
   (2) Accept new or seek clarification about a prescription from a prescriber's office unless the prescription requires the professional judgment of a pharmacist.
   (3) Inquire about the intended purpose or indication for prescribed medication on verbal orders received from a prescriber's office.
   (4) Transfer a prescription to another pharmacy.
   (5) Receive the transfer of a prescription from another pharmacy.
   (6) Provide the technical task of administration of an immunization.
   (7) Compile a medication list by interviewing patient.

(b) A pharmacy as used in subdivision (a) may use the services of an advanced pharmacy technician if all the following conditions are met:
   (1) The duties authorized in subdivision (a) are performed under the supervision of a pharmacist and are specified in the pharmacy's policies and procedures.
   (2) The pharmacist-in-charge is responsible for ongoing evaluation of the performance of personnel as authorized in subdivision (a).
   (3) A pharmacist shall personally provide all new prescription medications directly to the patient or patient's agent, and must provide patient information consistent with the provisions of Section 4052 (a) (8) or other clinical services.
   (4) A pharmacist shall provide other clinical services
   (5) A record is created identifying the personnel responsible for the preparing and dispensing of the prescription medication.

Attachment 3

Excerpt from April 4, 2017 Licensing Committee Meeting Minutes

3. Overview of the Pharmacy Technician Application and Renewal Requirements for Licensure

Chairperson Weisser provided an overview of the pharmacy technician application and renewal requirements. Specifically, Mr. Weisser reminded the committee that the application requirements include the application and fee; fingerprint background check; query from the National Practitioner Data Bank; and a description of the qualifications and supporting documents. Chairperson Weisser reminded the committee that the acceptable qualifications included either completion of a technician training program, certification from a specified program (currently either PTCB or ExCPT) or an associate degree in pharmacy technology. Chairperson Weisser noted that currently only a fee is required for renewal. Chairperson Weisser reminded the committee of two pending regulations that also impact pharmacy technicians, the first regarding changes to the renewal requirement to require a pharmacy technician to self-disclose convictions or disciplinary action. Chairperson Weisser provided a general description of the second pending regulation that relates to application requirements, including updating the application form as well as increasing the requirements for specified pharmacy technician training programs.

The committee noted that one of the pathways to licensure is certification as a pharmacy technician, but under current law, there is no requirement for the certification to be maintained. Members of the committee noted that there should be some sort of mechanism where pharmacy technicians can expand their education and they questioned if continuing education (CE) should be required as a condition of renewal. The committee discussed the possibility of developing a survey to elicit feedback from pharmacy technicians on the issue of continuing education that could be used if public comment during the meeting did not address the issue.

Marian Mobley-Smith, director of strategic alliances, Pharmacy Technician Certification Board (PTCB), was invited to comment on whether states require certification as a condition of the pharmacy technician license. Dr. Mobley-Smith explained that in some states, CE requirements for pharmacy technician licensure renewal mimic PTCB certification requirements. The committee discussed maintenance of a license versus maintaining certification. Dr. Mobley-Smith explained that 20 hours of CE are required for PTCB certification every two years. She said that individual state requirements vary but added that many states align with the current PTCB requirements. Dr. Mobley-Smith estimated that 75 percent to 80 percent of PTCB members maintain their certification. When queried about the number of technicians that maintain their certification as a condition of employment versus a licensing renewal requirement, Ms. Mobley-Smith said she could check to see if PTCB has information but indicated she is aware of at least one large employer that requires maintenance of the certification as a condition of employment.

When queried about the cost impact to individuals wishing to complete continuing educated, she explained that the availability of CE is vast both online and in print, including free and low-cost courses. Dr. Mobley-Smith spoke about the importance of completing continuing education that is related to functions of a pharmacy technician (referred to a “T accredited”). She noted that nationally there are a number of organizations that offer such

accredited CE, and the availability continues to grow. Dr. Mobley explained the route by which someone could seek approval of a CE course that is not otherwise accredited. The committee questioned if PTCB would consider CE as a condition of renewal a hurdle, and the committee was advised that PTCB would not consider it a hurdle given the availability of courses available many of which can be done online at low or no costs. Ms. Herold asked about employer based continuing education and was advised that the PTCB no longer accepts employer based training for purposes of fulfilling the CE requirement as it generally fails to have specified parameters in line with accreditation standards. However Dr. Mobley-Smith noted that this prohibition would not extend to an employer that partners with an accredited provider to provide the CE.

Chairman Weisser inquired about the availability of continuing education courses that may be available for pharmacy technicians that work in either a compounding pharmacy or acute care setting and was advised that there is not the same level of availability for those types of courses. Dr. Mobely-Smith noted that as states grapple with identifying expanded roles for pharmacy technicians, such changes need to be accompanied by commensurate training opportunities so technicians can take advantage of the new and expanded roles. Development of such training opportunities is needed. When queried about types of specialized courses for pharmacy technicians, the committee was advised that such could be in the area of compounding, pharmacy informatics, etc.

The committee heard from Loriann De Martini, California Society of Health-System Pharmacists (CSHP), along with Jeannie Le and Paul Sabitini, pharmacy technician leaders within CSHP. Dr. DeMartini noted that evaluation of pharmacy technician roles is long overdue, noting some of the areas where pharmacy technicians engage in health care including as part of the medication reconciliation process. She noted that there is greater interface with patient care and pharmacy technicians than in the past. The committee inquired if CSHP had comments specific to consideration of continuing education as a condition of renewal for pharmacy technicians. Dr. De Martini explained that CE is offered by CSHP during an annual seminar and noted that the seminar planning committee includes a pharmacy technician member. The committee was advised that as part of the course objectives for CE offered during the annual seminar, presenters need to ensure learning objectives are specified and met for both pharmacists and pharmacy technicians as a condition of the course accreditation. When queried about the cost of such courses, the committee was advised that four-day admittance to the meeting would be $240 and an estimated 20 to 25 hours of CE courses are designated as technician appropriate. The speakers concurred that CE is encouraged among CSHP members and noted that individuals seem to demonstrate a level of confidence once certification is obtained because of the accomplishment of achieving the certification.

Steve Norris advised the committee that pharmacy technicians at his employer are provided access to free continuing education. When queried about how technicians are classified within his organization, the committee was advised that an entry-level pharmacy technician would be similar to a technician in a community pharmacy; a mid–level pharmacy technician would most likely be akin to a technician working in an inpatient setting working with acute patients and other health care providers; and the highest level of technicians perform some administrative work and are required to be certified as a condition of employment.

Attachment 4

Board of Pharmacy Licensing Statistics - Fiscal Year 2017/18

APPLICATIONS

Received	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Designated Representatives (EXC)	45	53	37										135
Designated Representatives Vet (EXV)	2	0	0										2
Designated Representatives-3PL (DRL)	4	9	6										19
Intern Pharmacist (INT)	239	623	405										1267
*Pharmacist (exam applications)	203	168	168										539
Pharmacist (initial licensing applications)	68	202	710										980
Advanced Practice Pharmacist (APH)	33	12	22										67
Pharmacy Technician (TCH)	368	513	418										1299
	* total includes retake exam applications												
Centralized Hospital Packaging (CHP)	0	0	0										0
Clinics (CLN)	4	8	14										26
Clinics Exempt (CLE)	0	0	1										1
Drug Room (DRM)	0	0	0										0
Drug Room -Temp	0	0	0										0
Drug Room Exempt (DRE)	0	0	0										0
Hospitals (HSP)	0	0	5										5
Hospitals - Temp	0	0	6										6
Hospitals Exempt (HPE)	0	1	0										1
Hypodermic Needle and Syringes (HYP)	0	4	0										4
Hypodermic Needle and Syringes Exempt (HYE)	0	0	0										0
Correctional Pharmacy (LCF)	0	1	0										1
Outsourcing Facility (OSF)	0	0	0										0
Outsourcing Facility - Temp	0	0	0										0
Outsourcing Facility Nonresident (NSF)	1	1	1										3
Outsourcing Facility Nonresident - Temp	0	0	0										0
Pharmacy (PHY)	39	41	52										132
Pharmacy - Temp	14	9	29										52
Pharmacy Exempt (PHE)	0	0	0										0
Pharmacy Nonresident (NRP)	16	11	15										42
Pharmacy Nonresident Temp	5	1	7										13
Sterile Compounding (LSC)	2	4	20										26
Sterile Compounding - Temp	0	0	17										17
Sterile Compounding Exempt (LSE)	1	1	0										2
Sterile Compounding Nonresident (NSC)	0	4	1										5
Sterile Compounding Nonresident Temp	0	1	2										3
Surplus Medication Collection Distribution Intermediary (SME)	0	0	0										0
Third-Party Logistics Providers (TPL)	0	0	0										0
Third-Party Logistics Providers - Temp	0	0	0										0
Third-Party Logistics Providers Nonresident (NPL)	0	0	2										2
Third-Party Logistics Providers Nonresident Temp	0	0	1										1
Veterinary Food-Animal Drug Retailer (VET)	0	0	0										0
Veterinary Food-Animal Drug Retailer - Temp	0	0	0										0
Wholesalers (WLS)	6	8	4										18
Wholesalers - Temp	3	4	0										7
Wholesalers Exempt (WLE)	0	0	0										0
Wholesalers Nonresident (OSD)	10	16	4										30
Wholesalers Nonresident - Temp	1	5	1										7
Total	1064	1700	1948	0	0	0	0	0	0	0	0	0	4712

APPLICATIONS (continued)

Issued	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Designated Representatives (EXC)	26	18	39										83
Designated Representatives Vet (EXV)	0	0	2										2
Designated Representatives-3PL (DRL)	3	1	2										6
Intern Pharmacist (INT)	238	232	631										1101
Pharmacist (initial licensing applications)	109	228	691										1028
Advanced Practice Pharmacist (APH)	5	23	17										45
Pharmacy Technician (TCH)	616	609	397										1622
Centralized Hospital Packaging (CHP)	0	1	0										1
Clinics (CLN)	2	6	3										11
Clinics Exempt (CLE)	2	1	0										3
Drug Room (DRM)	0	0	0										0
Drug Room-Temp	0	0	0										0
Drug Room Exempt (DRE)	0	0	0										0
Hospitals (HSP)	0	1	0										1
Hospitals - Temp	0	0	0										0
Hospitals Exempt (HPE)	0	2	0										2
Hypodermic Needle and Syringes (HYP)	2	0	1										3
Hypodermic Needle and Syringes Exempt (HYE)	0	0	0										0
Correctional Pharmacy (LCF)	0	0	0										0
Outsourcing Facility (OSF)	0	1	0										1
Outsourcing Facility - Temp	0	0	0										0
Outsourcing Facility Nonresident (NSF)	1	0	3										4
Outsourcing Facility Nonresident - Temp	0	0	0										0
Pharmacy (PHY)	16	16	20										52
Pharmacy - Temp	16	10	10										36
Pharmacy Exempt (PHE)	0	0	0										0
Pharmacy Nonresident (NRP)	6	4	5										15
Pharmacy Nonresident Temp	2	2	1										5
Sterile Compounding (LSC)	1	3	2										6
Sterile Compounding - Temp	1	0	4										5
Sterile Compounding Exempt (LSE)	0	2	0										2
Sterile Compounding Nonresident (NSC)	2	1	0										3
Sterile Compounding Nonresident Temp	0	0	0										0
Surplus Medication Collection Distribution Intermediary (SME)	0	0	0										0
Third-Party Logistics Providers (TPL)	0	0	0										0
Third-Party Logistics Providers-Temp	0	0	0										0
Third-Party Logistics Providers Nonresident (NPL)	1	0	1										2
Third-Party Logistics Providers Nonresident Temp	0	0	0										0
Veterinary Food-Animal Drug Retailer (VET)	0	0	0										0
Veterinary Food-Animal Drug Retailer - Temp	0	0	0										0
Wholesalers (WLS)	5	4	5										14
Wholesalers - Temp	0	1	0										1
Wholesalers Exempt (WLE)	0	0	0										0
Wholesalers Nonresident (OSD)	7	5	3										15
Wholesalers Nonresident - Temp	2	2	1										5
Total	1063	1173	1838	0	0	0	0	0	0	0	0	0	4074

APPLICATIONS (continued)

Pending	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
Designated Representatives (EXC)	307	338	333									
Designated Representatives Vet (EXV)	3	3	1									
Designated Representatives-3PL (DRL)	78	86	92									
Intern Pharmacist (INT)	205	287	341									
Pharmacist (exam applications)	1424	1435	1811									
Pharmacist (eligible exam(Status A))	2261	2107	1257									
Advanced Practice Pharmacist (APH)	148	138	143									
Pharmacy Technician (TCH)	1407	1298	1266									
Centralized Hospital Packaging (CHP)	5	3	3									
Clinics (CLN)	42	43	54									
Clinics Exempt (CLE)	9	8	9									
Drug Room (DRM)	0	0	0									
Drug Room Exempt (DRE)	0	0	0									
Hospitals (HSP)	4	3	8									
Hospitals Exempt (HPE)	1	0	0									
Hypodermic Needle and Syringes (HYP)	7	10	9									
Hypodermic Needle and Syringes Exempt (HYE)	0	0	0									
Correctional Pharmacy (LCF)	1	1	1									
Outsourcing Facility (OSF)	6	5	4									
Outsourcing Facility Nonresident (NSF)	29	29	27									
Pharmacy (PHY)	132	140	162									
Pharmacy Exempt (PHE)	1	1	1									
Pharmacy Nonresident (NRP)	105	103	111									
Sterile Compounding (LSC)	34	35	49									
Sterile Compounding - Exempt (LSE)	8	6	6									
Sterile Compounding Nonresident (NSC)	16	17	18									
Surplus Medication Collection Distribution Intermediary (SME)	0	0	0									
Third-Party Logistics Providers (TPL)	8	8	8									
Third-Party Logistics Providers Nonresident (NPL)	43	42	43									
Veterinary Food-Animal Drug Retailer (VET)	1	1	1									
Wholesalers (WLS)	37	40	38									
Wholesalers Exempt (WLE)	0	0	0									
Wholesalers Nonresident (OSD)	82	90	88									
Total	6404	6277	5884	0	0	0	0	0	0	0	0	0

The number of temporary applications are included in the primary license type.

APPLICATIONS (continued)

Withdrawn	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Designated Representatives (EXC)	0	1	2										3
Designated Representatives Vet (EXV)	0	0	0										0
Designated Representatives-3PL (DRL)	0	1	0										1
Intern Pharmacist (INT)	0	2	0										2
Pharmacist (exam applications)	0	0	2										2
Advanced Practice Pharmacist (APH)	0	0	0										0
Pharmacy Technician (TCH)	8	8	4										20
Centralized Hospital Packaging (CHP)	0	1	0										1
Clinics (CLN)	0	0	0										0
Clinics Exempt (CLE)	0	0	0										0
Drug Room (DRM)	0	0	0										0
Drug Room Exempt (DRE)	0	0	0										0
Hospitals (HSP)	0	0	0										0
Hospitals Exempt (HPE)	0	0	0										0
Hypodermic Needle and Syringes (HYP)	0	1	0										1
Hypodermic Needle and Syringes Exempt (HYE)	0	0	0										0
Correctional Pharmacy (LCF)	0	1	0										1
Outsourcing Facility (OSF)	0	0	0										0
Outsourcing Facility Nonresident (NSF)	0	0	0										0
Pharmacy (PHY)	10	1	1										12
Pharmacy Exempt (PHE)	0	0	0										0
Pharmacy Nonresident (NRP)	2	2	1										5
Sterile Compounding (LSC)	0	0	0										0
Sterile Compounding Exempt (LSE)	0	1	0										1
Sterile Compounding Nonresident (NSC)	0	1	1										2
Surplus Medication Collection Distribution Intermediary (SME)	0	0	0										0
Third-Party Logistics Providers (TPL)	0	0	0										0
Third-Party Logistics Providers Nonresident (NPL)	0	0	0										0
Veterinary Food-Animal Drug Retailer (VET)	0	0	0										0
Wholesalers (WLS)	3	1	0										4
Wholesalers Exempt (WLE)	0	0	0										0
Wholesalers Nonresident (OSD)	0	0	0										0
Total	23	21	11	0	0	0	0	0	0	0	0	0	55

The number of temporary applications withdrawn is reflected in the primary license type.

APPLICATIONS (continued)

Denied	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Designated Representatives (EXC)	0	1	0										1
Designated Representatives Vet (EXV)	0	0	0										0
Designated Representatives-3PL (DRL)	0	0	0										0
Intern Pharmacist (INT)	1	1	1										3
Pharmacist (exam applications)	1	1	2										4
Pharmacist (eligible)	0	0	0										0
Advanced Practice Pharmacist (APH)	0	0	0										0
Pharmacy Technician (TCH)	1	3	2										6
Centralized Hospital Packaging (CHP)	0	0	0										0
Clinics (CLN)	0	0	0										0
Clinics Exempt (CLE)	0	0	0										0
Drug Room (DRM)	0	0	0										0
Drug Room Exempt (DRE)	0	0	0										0
Hospitals (HSP)	0	0	0										0
Hospitals Exempt (HPE)	0	0	0										0
Hypodermic Needle and Syringes (HYP)	0	0	0										0
Hypodermic Needle and Syringes Exempt (HYE)	0	0	0										0
Correctional Pharmacy (LCF)	0	0	0										0
Outsourcing Facility (OSF)	1	0	1										2
Outsourcing Facility Nonresident (NSF)	0	0	0										0
Pharmacy (PHY)	4	0	1										5
Pharmacy Exempt (PHE)	0	0	0										0
Pharmacy Nonresident (NRP)	0	3	0										3
Sterile Compounding (LSC)	1	0	0										1
Sterile Compounding Exempt (LSE)	0	0	0										0
Sterile Compounding Nonresident (NSC)	0	0	0										0
Surplus Medication Collection Distribution Intermediary (SME)	0	0	0										0
Third-Party Logistics Providers (TPL)	0	0	0										0
Third-Party Logistics Providers Nonresident (NPL)	0	0	0										0
Veterinary Food-Animal Drug Retailer (VET)	0	0	0										0
Wholesalers (WLS)	0	0	0										0
Wholesalers Exempt (WLE)	0	0	0										0
Wholesalers Nonresident (OSD)	0	0	0										0
Total	9	9	7	0	0	0	0	0	0	0	0	0	25

RESPOND TO STATUS REQUESTS

A. Email Inquiries	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Pharmacist/Intern Received	844	918	811										2573
Pharmacist/Intern Responded	630	759	608										1997
Pharmacy Technician Received	463	417	187										1067
Pharmacy Technician Responded	620	295	226										1141
Pharmacy Received	187	738	314										1239
Pharmacy Responded	148	420	314										882
Sterile Compounding/Outsourcing Received	160	207	393										760
Sterile Compounding/Outsourcing Responded	40	238	225										503
Wholesale/Clinic/Hypodermic/3PL Received	239	379	376										994
Wholesale/Clinic/Hypodermic/3PL Responded	175	293	250										718
Pharmacist-in-Charge Received	29	186	160										375
Pharmacist-in-Charge Responded	53	141	117										311
Change of Permit Received	476	518	458										1452
Change of Permit Responded	338	346	383										1067
Renewals Received	305	490	504										1299
Renewals Responded	294	378	489										1161

B. Telephone Calls Received	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Pharmacist/Intern	49	38	50										137
Pharmacy	89	88	78										255
Sterile Compounding/Outsourcing	5	35	30										70
Wholesale/Clinic/Hypodermic/3PL	64	89	93										246
Pharmacist-in-Charge	53	97	74										224
Change of Permit	64	42	94										200
Renewals	449	667	765										1881

UPDATE LICENSING RECORDS

A. Change of Pharmacist-in-Charge	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Received	175	156	164										495
Processed	209	190	128										527
Approved	178	193	160										531
Pending	284	249	260										260

B. Change of Desig. Representative-in-Charge	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Received	8	13	9										30
Processed	8	17	9										34
Approved	7	11	12										30
Pending	28	30	28										28

C. Change of Responsible Manager	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Received	4	1	1										6
Processed	3	1	1										5
Approved	2	1	1										4
Pending	7	7	6										6

D. Change of Permits	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Received	152	118	141										411
Processed	225	107	204										536
Approved	122	153	181										456
Pending	942	899	876										876

E. Discontinuance of Business	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Received	23	50	22										95
Processed	18	66	33										117
Approved	25	53	42										120
Pending	120	118	100										100

F. Requests Approved	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Address/Name Changes	1215	1067	836										3118
Off-site Storage		84											84
Transfer of Intern Hours	10	3	1										14
License Verification	163	217	153										533

Revenue Received *

(Revenue available through August 2016)

A. Revenue Received	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Applications													$0
Renewals													$0
Cite and Fine													$0
Probation/Cost Recovery													$0
Request for Information/Lic. Verification													$0
Fingerprint Fee													$0

*CalStars Reports not received at this time. Will provide update at next meeting.

B. Licenses Renewed	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Designated Representatives (EXC)	192	227	200										619
Designated Representatives Vet (EXV)	7	5	0										12
Designated Representatives-3PL (DRL)	17	22	25										64
Pharmacist (RPH)	1508	1749	2021										5,278
Advanced Practice Pharmacist (APH)	3	1	7										11
Pharmacy Technician (TCH)	2443	2434	2776										7,653
Centralized Hospital Packaging (CHP)	2	0	0										2
Clinics (CLN)	91	70	98										259
Clinics Exempt (CLE)	0	0	48										48
Drug Room (DRM)	3	1	1										5
Drug Room Exempt (DRE)	0	0	1										1
Hospitals (HSP)	28	21	21										70
Hospitals Exempt (HPE)	0	1	38										39
Hypodermic Needle and Syringes (HYP)	12	26	19										57
Hypodermic Needle and Syringes Exempt (HYE)	0	0	0										0
Correctional Pharmacy (LCF)	0	0	23										23
Outsourcing Facility (OSF)	0	0	0										0
Outsourcing Facility Nonresident (NSF)	0	0	0										0
Pharmacy (PHY)	222	185	761										1,168
Pharmacy Exempt (PHE)	0	0	66										66
Pharmacy Nonresident (NRP)	23	26	39										88
Sterile Compounding (LSC)	58	41	40										139
Sterile Compounding Exempt (LSE)	0	6	0										6
Sterile Compounding Nonresident (NSC)	6	1	3										10
Surplus Medication Collection Distribution Intermediary (SME)	0	0	1										1
Third-Party Logistics Providers (TPL)	2	1	3										6
Third-Party Logistics Providers Nonresident (NPL)	2	6	5										13
Veterinary Food-Animal Drug Retailer (VET)	1	1	0										2
Wholesalers (WLS)	43	38	45										126
Wholesalers Exempt (WLE)	1	0	7										8
Wholesalers Nonresident (OSD)	52	49	69										170
Total	4716	4911	6317	0	0	0	0	0	0	0	0	0	15944

Current Licensees

	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Designated Representatives (EXC)	2963	2945	2984										2984
Designated Representatives Vet (EXV)	72	72	74										74
Designated Representatives-3PL (DRL)	256	256	258										258
Intern Pharmacist (INT)	6719	6866	6778										6778
Pharmacist (RPH)	44911	45052	45677										45677
Advanced Practice Pharmacist (APH)	140	169	173										173
Pharmacy Technician (TCH)	72579	72568	72413										72413
Centralized Hospital Packaging (CHP)	8	9	9										9
Clinics (CLN)	1100	1099	1097										1097
Clinics Exempt (CLE)	239	238	238										238
Drug Room (DRM)	23	23	23										23
Drug Room Exempt (DRE)	11	11	11										11
Hospitals (HSP)	395	394	392										392
Hospitals Exempt (HPE)	84	85	85										85
Hypodermic Needle and Syringes (HYP)	296	296	292										292
Hypodermic Needle and Syringes Exempt (HYE)	0	0	0										0
Correctional Pharmacy (LCF)	59	59	59										59
Outsourcing Facility (OSF)	1	1	1										1
Outsourcing Facility Nonresident (NSF)	3	3	6										6
Pharmacy (PHY)	6471	6464	6459										6459
Pharmacy Exempt (PHE)	124	124	124										124
Pharmacy Nonresident (NRP)	535	533	534										534
Sterile Compounding (LSC)	765	760	757										757
Sterile Compounding Exempt (LSE)	116	117	117										117
Sterile Compounding Nonresident (NSC)	92	92	89										89
Surplus Medication Collection Distribution Intermediary (SME)	1	1	1										1
Third-Party Logistics Providers (TPL)	23	22	22										22
Third-Party Logistics Providers Nonresident (NPL)	67	62	63										63
Veterinary Food-Animal Drug Retailer (VET)	23	23	23										23
Wholesalers (WLS)	533	533	537										537
Wholesalers Exempt (WLE)	16	16	16										16
Wholesalers Nonresident (OSD)	745	745	754										754
Total	139370	139638	140066	0	0	0	0	0	0	0	0	0	140066

Attachment 5

California State Board of Pharmacy
1625 N. Market Blvd, N219, Sacramento, CA 95834
Phone: (916) 574-7900
Fax: (916) 574-8618
www.pharmacy.ca.gov

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

DATE: August 22, 2017

LOCATION: Department of Consumer Affairs
First Floor Hearing Room
1747 North Market Blvd.
Sacramento, CA 95834

COMMITTEE MEMBERS PRESENT: Stanley Weisser, Licensee Member, Chairperson
Lavanza Butler, Licensee Member, Vice-Chairperson
Ryan Brooks, Public Member
Ricardo Sanchez, Public Member
Debbie Veale, Licensee Member
Albert Wong, Licensee Member

STAFF MEMBERS PRESENT: Virginia Herold, Executive Officer
Anne Sodergren, Assistant Executive Officer
Joshua Room, Deputy Attorney General
Debi Mitchell, Staff Services Manager
Debbie Damoth, Staff Services Manager

1. Call to Order and Establishment of Quorum

Chairperson Weisser called the meeting to order at 9:00 a.m. Roll call was taken with the following members present: Ryan Brooks, Lavanza Butler, Albert Wong, Debbie Veale, and Stan Weisser. A quorum was established. Member Ricardo Sanchez joined the meeting around 9:05.

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

Danny Martinez of the California Pharmacist Association (CPhA) advised the committee of proposed regulations being considered by the California Department of Food and Agriculture (CDFA) related to licensing non-medical personnel to sell and dispense restricted livestock drugs. In 2015 Governor Brown signed SB 27 (Hill) to restrict the use of antimicrobial drugs in livestock product as there was growing concern overuse of antimicrobial drugs contributing to a resistance of antibiotic in animals being

administered the antimicrobial drugs and consumers who consumed those animals. SB 27 provides a properly trained medical personnel such as a veterinary technician or pharmacist can responsibility dispense and prescribe these drugs. The effective date of SB 27 is January 1, 2018, and provides CDFA authority to promulgate regulations. CDFA has released regulations that would allow non-medical personnel such as owners of feed stores and online retailers to dispense restricted livestock drugs without the supervision or oversight of a pharmacist. Mr. Martinez expressed CPhA's concern that the proposed regulations might violate pharmacy law and effect pharmacists' statutory responsibility. Mr. Martinez requested the Licensing Committee add to the next committee meeting agenda discussion on these regulations and possible opposition to the proposed regulations. Chairperson Weisser recommended Mr. Martinez provide the same presentation to the Legislation and Regulation Committee as well.

Chairperson Weisser mentioned working with the California Medical Board to address the issue of putting the purpose of the prescription on the label. Executive Officer Virginia Herold indicated the board asked for this item and patient consultation to be added to a future agenda.

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

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

Chairperson Weisser reviewed agenda item noting this discussion is the start of possibly establishing a new licensing category of advanced technician license in the community setting. The committee discussed the options of having two levels of pharmacy technician, or one level which increased responsibility and/or possibly grandfathering in to this advanced level.

Committee members agreed there is a need for a higher level of a pharmacy technician but indicated it is an evolution and process to develop. It was noted that not all pharmacy technicians may want to pursue the advanced pharmacy technician license. The committee identified the problem that is being solved by adding this new licensing category is to allow the pharmacist to be out in front with the patients to increase patient consultation and public protection. The committee noted it also allows pharmacist to interact with the consumers of California. As the industry has involved and changed, pharmacy technicians must keep up with the industry to ensure the public is protected. Committee members also noted that with increased opioid abuse and advanced pharmacy technician is a good idea for consumer protection.

Deputy Attorney General (DAG) Joshua Room added from an enforcement perspective, many diversion cases involve the pharmacy technician license category and one of the reasons it is believed to be this way is because there is not much investment by the licensee in the possession of having a pharmacy technician license. Ms. Herold added that it is the board's hope that this will result in an increase of pharmacist consultation and reinforce the value of the pharmacists' role at the pharmacy. Several committee members discussed the need for pharmacies to hire more pharmacists to allow for patient consultation and to improve the working conditions of the pharmacy.

Chairperson Weisser reviewed relevant statutes and regulations including Business and Professions Code (BPC) sections 4038 defining pharmacy technicians and 4115 specifying tasks a pharmacy technician can complete under the direct supervision and control of a pharmacist. Mr. Weisser reviewed California Code of Regulations (CCR) 1793.2 specifying allowable duties performed by a pharmacy technician in most pharmacy settings including: removing the drug or drugs from stock; counting, pouring, or mixing pharmaceuticals; placing the product into a container; affixing the label or labels to the container; and packaging and repackaging.

Mr. Weisser reviewed the proposed language for BPC 4115.6 outlining proposed specified duties for the advanced pharmacy technician as provided in the meeting materials.

Mr. Weisser asked the committee to consider the conclusions of the Frost article provided in the meeting materials where the author concludes the adoption of robust practice policies and procedures, delegation of verbal orders and prescription transfers can be safe and effective, remove undue stress on the pharmacist and free up pharmacist time for higher order clinical care.

Ms. Veale noted in proposed BPC section 4115.6 (a)(3), this includes all prescriptions including controlled substances. Mr. Weisser noted proposed BPC section 4115.6 (b)(3) provides a pharmacist shall provide all new prescriptions and controlled substances prescriptions directly to the patient or patient's agent.

DAG Room provided clarification to the committee that the board did not need specify who completes the first step of tech-check-tech and that if the language indicates the advanced pharmacy technician completes the second step of tech-check-tech, that is sufficient. Ms. Veale indicated she wanted to ensure the language was clear.

Committee member Wong expressed concern for proposed BPC section 4115.6 (a)(3) as well as an advanced pharmacy technician taking a narcotic order. Chairperson Weisser reminded the committee the advanced pharmacy technician would have additional education required and be more invested in their career as an advanced pharmacy technician. It was the committee's hope that this would assist attracting a higher level of professionalism as well as deterring diversion by pharmacy technicians.

Dr. Wong noted his concernwith the liability on a pharmacist who would not be able to verify if the new order was taken correctly. Counsel Room explained the board would investigate and in such a case where an advanced pharmacy technician is involved, the liability would be shared with the advanced pharmacy technician and pharmacist. Assistant Executive Officer Anne Sodergren added having the purpose of the medication included in the prescription would assist the pharmacist. Mr. Room clarified that the pharmacist will still have responsibility for all the tasks that cannot be delegated as those tasks are inherent in being a pharmacist.

Ms. Veale inquired if the committee was considering adding the purpose of the drug in the prescription label. Both Mr. Weisser and Ms. Herold indicated the board would work with the California Medical Board to determine the appropriate language that satisfied both entities. Counsel Room recommended requiring an inquiry be made about the purpose to the prescriber's office.

Chairperson Weisser reviewed CCR 1793.2 and indicated the committee was not considering any proposed changes for CCR 1793.2. Mr. Weisser opened the discussion for public comment.

Dr. Nasiba Makarem of Cerritos College commented on proposed BPC section 4115.6 (a)(5) inquiring if it should include transfer and receive prescription to another pharmacy. The committee agreed with Dr. Makarem's suggestion. Dr. Makarem recommended the committee consider including allowing an advanced practice pharmacy technicians the task of consultation for over the counter items. The committee provided this was part of the larger patient consultation discussion.

Shane Desselle offered to the committee additional surveys available substantiating the increase commitment of pharmacy technicians to the profession as well as the longevity and higher quality of work life when they have more education, duties and certification. Studies provide that pharmacy technicians who provide these additional services do so at a rate of safety as if performed by a pharmacist. Evidence also suggest even greater efficiency is gained as a result. The committee expressed interest in these studies.

Laura Churns of Albertsons requested the committee consider adding to the duties in proposed BPC 4115.6 to include the advanced pharmacy technician can do the technical task of administering an immunization. Ms. Churns indicated Albertsons is doing this with 38 technicians administering immunizations and have delivered 1,000 shots with zero complaints and incidents since April 2017. The committee expressed interest in this being added to the proposed language.

Members of the public commented on experiences as pharmacy technicians in California and outside of California.

Chairperson Weisser commented that by shifting some of the tasks away from the pharmacist, it is the legal expectation that the pharmacist will hand the medication to the patient and provide an opportunity to the pharmacist to consult. Mr. Weisser continued he didn't understand the resistance of pharmacists to act in a professional, appropriate, and legal way for their patients.

Lorri Walmsley of Walgreens suggested adding the tasks of accept new verbal prescriptions, refills and transfer to the role of a regular pharmacy technician and many other states allow for this and is proven to be safe and effective.

Mr. Weisser and Ms. Butler expressed concerned with a pharmacy technician taking a new prescription order over the phone from a prescriber's office. Mr. Weisser indicated he was more comfortable with an advanced pharmacy technician taking refills or transfers. Dr. Wong stated he wanted the pharmacist to be able to check the work of the pharmacy technician.

Paul Sabatini of UC Davis and Cal Regional in Yuba City requested clarification if the proposed BPC 4115.6 included all control substance levels or just C3-5. The committee clarified as written the proposal allowed for all levels of controlled substances.

Michelle Revis of CPhA inquired who makes the determination if a pharmacist's professional judgement is required in the proposed language BPC 4115.6 (a)(3). Mr. Weisser advised this was written to allow for the advanced pharmacy technician to make the determination at the time of taking the order on the phone or the prescriber's office to request to speak with a pharmacist.

Van Duong recommended having the prescriptions being recorded so there is a mechanism in place to

allow for the pharmacist to check the work. Ms. Duong recommended limiting controlled refills to a pharmacist.

The committee took a break from 10:36 am to 10:53 am.

Dr. Makarem recommend amending proposed BPC 4115.6 (a)(4) be written to allow for an advanced pharmacy technician to accept a refill that has elapsed in the system to a new prescription.

Chairperson Weisser reminded the committee in June 2016, the committee considered the duties of a pharmacy technician. Subsequently, the committee held a summit focused on the role of pharmacy technicians in various settings. The summit provided the committee with the opportunity to learn about the functions pharmacy technicians perform in various states and practice settings. The committee focused on how proposed changes would ultimately benefit consumers, including making pharmacists more available to engage in more direct patient care activities.

During the July 2017 committee meeting, the committee reviewed comparisons of pharmacy technician duties in other states. The committee discussed the practical implications of a tech-check-tech model in the community pharmacy setting including questions about the liability to the pharmacist when supervising the activities. Counsel noted that creating a new license type of technicians who check the work of technicians and who have a defined scope of duties, could address this concern as the responsibility would be shared.

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

Chairperson Weisser began the discussion by reviewing the proposed language to define advanced pharmacy technician.

> **MOTION:** Pursue statutory changes to add the definition of an advanced pharmacy technician by adding BPC section 4038.5 as proposed in the meeting materials.
>
> **Proposed Addition of BPC 4038.5 - Definition**
>
> "Advanced Pharmacy Technician" means an individual licensed by the board who is authorized to perform technical pharmacy tasks as authorized in Section 4115.6.
>
> M/S: Veale/Sanchez
>
> Support: 6 Oppose: 0 Abstain: 0

Chairperson Weisser advised the committee, a draft proposal for developing the duties of an advanced pharmacy technicians was developed with consultation from the committee chair and consistent with the committee's direction to provide a framework that could be used to implement in the community pharmacy setting.

The committee discussed the merits of an advanced pharmacy technician taking the prescription of a controlled substance. The committee discussed the option of requiring the prescription be called in and recorded but it was determined the forgery could still be called in. The committee determined they didn't want to require the prescribers to call in their prescriptions. Many committee members expressed the advanced pharmacy technician must be able to accept prescriptions of controlled substances. Some committee members expressed concern that the pharmacist needs to be able to verify the prescription taken by an advanced pharmacy technician.

Dr. Desselle commented research points to the fact that advanced level pharmacy technicians that have been further educated and certified are more committed and record a higher level of efficacy.

Several members of the public commented on the discussion and expressed desire to postpone the discussion on the duties and review at the holistic level. Chairperson Weisser noted that the board has discussed these topics at multiple meetings and as well as at the pharmacy technician summit and had hoped for more participation during these meetings.

Members of the public commented on concerns about advanced pharmacy technicians taking controlled substances prescriptions and offered as a solution additional training being require for advanced pharmacy technician as well as administering the technical portion of immunizations.

> **MOTION:** Pursue statutory changes to add the duties of an advanced pharmacy technician by adding BPC section 4115.6(a) as proposed in the meeting materials with the additional changes.
>
> **Proposed 4115.6 - Specified Duties**
> (a) In a community pharmacy, a licensed advanced pharmacy technician may:
> (1) Verify the accuracy of the typed prescription label before the final check by a pharmacist.
> (2) Verify the accuracy of the filling of a prescription including confirmation that the medication and quantity included on the label is accurately filled on drug orders that previously have been reviewed and approved by a pharmacist.
> (3) Accept new prescription orders from a prescriber's office unless the prescription order requires the professional judgement of a pharmacist <u>and to require inquiry to be made on the purpose by the advanced pharmacy technician taking the prescription from the prescriber or physician's office.</u>
> (4) Accept refill authorizations from a prescriber's office unless the prescription order requires the professional judgement of a pharmacist.
> (5) Transfer a prescription to another pharmacy.
> <u>(6) Receive a transfer prescription from another pharmacy.</u>
> <u>(7) Technical administration of vaccine.</u>
>
> M/S: Veale/Sanchez
>
> Support: 4 Oppose: 2 Abstain: 0

Chairperson Weisser reviewed the proposed language for BPC 4115.6 (b) regarding specified duties for advanced pharmacy technicians.

Committee members discussed that by adding the option of advanced pharmacy technicians, the advanced pharmacy technician could be an additional resource available to the pharmacists to help free up time for patient consultation. There was concern discussed among members that this won't necessarily help with complaints of inadequate staffing.

Ms. Veale commented she would like BPC section 4115.6 (b)(5) removed as that is the pharmacists' discretion. Mr. Weisser commented he was not comfortable with removing BPC section 4115.6 (b)(5).

Multiple members of the public commented on support to remove BPC section 4115.6 (b)(5) and discussing the ratio issue at a later time. The committee noted that the ratio discussion will need to be added to a future agenda.

> **MOTION:** Pursue statutory changes to add the duties of an advanced pharmacy technician by adding BPC section 4115.6(b)(1)-(4) as proposed in the meeting materials with the removal of 4115.6(b)(5).
>
> **Proposed 4115.6 - Specified Duties**
> (b) A community pharmacy may use the services of an advanced pharmacy technician if all the following conditions are met:
> (1) The duties are done under the supervision of a pharmacist and shall be specified in the pharmacy's policies and procedures.
> (2) The pharmacist-in-charge is responsible for ongoing evaluation of the accuracy of the duties performed by personnel as authorized in subdivision (a).
> (3) A pharmacist shall provide all new prescriptions and controlled substances prescriptions directly to the patient or patient's agent and provide patient information consistent with the provisions of Section 4052 (a) (8).
> (4) An electronic record that identifies personnel responsible for the preparation and dispensing of the prescription.
>
> M/S: Veale/Butler
>
> Support: 6 Oppose: 0 Abstain: 0

Angie Manetti from CRA provided the committee with an update on AB 1589 that it is a 2-year bill and will be subject to the 2-year bill deadline in approximately January/February 2018.

The committee took a break for lunch from 12:12 pm to 12:48 pm.

Chairperson Weisser reviewed the proposed language for BPC 4115.6 (b) regarding licensing requirements for advanced pharmacy technicians.

Ms. Sodergren provided clarification that 3,000 hours was determined to be the equivalent of two years of work as 1,500 hours is the standard equivalent of one year of work used by the board for experience as pharmacist interns and advanced practice pharmacists. The committee discussed the incentive for becoming an advanced pharmacy technician will be driven by the market.

Chairperson Weisser introduced Nasiba Makarem, PharmD and Program Director of Cerritos College to provide the committee with an overview of Cerritos College's pharmacy technician certificate and

associate degree.

Dr. Makarem addressed the committee and provided the committee with Cerritos' two programs. Cerritos offers two routes: the certificate program consisting of 30 units; and the associate degree consisting of 60 units including the general education required for the associate degree.

Chairperson Weisser asked Dr. Makarem to provide an overview of the classes needed for the associate degree at Cerritos College. Dr. Makarem informed the committee the associate degree program included the following three types of classes:

(1) Basic Overview of Pharmacy: pharmacy calculations; pharmacy practice class including laws and regulations; hands on simulated lab where they type prescriptions; soft skills including ethics, resume writing, communication, and medication reconciliation; institutional, long-term, etc.
(2) Technical: sterile compounding; outpatient compounding, over-the-counter (OTC); 2 sets of pharmacology (requires prerequisite of anatomy and physiology or medical terminology)
(3) Clinical: apply their education and train.

Dr. Makarem indicated programs at Santa Ana and Foothill are similar to Cerritos' program. Dr. Makarem provided typically students are encouraged by their employers to pursue additional education.

Chairperson Weisser asked Dr. Makarem if an advanced pharmacy technician could take an order and if there are enough spaces available for earning the associate degree. Dr. Makarem stated she believed an advanced pharmacy technician could take an order and the community colleges are working on increasing programs to allow for more people to obtain their associate degree. Ms. Veale asked Dr. Makarem if the general education portion of the degree was important. Dr. Makarem stated the general education was vital to communication, taking orders and relating to patients.

Angie Manetti of CRA expressed concerns requiring general education for the associate degree for an advanced pharmacy technician as well as access issues for the degree and making multiple pathways available. The committee discussed various options of splitting out the possible pathways for licensure as an advanced pharmacy technician.

> **MOTION:** Pursue statutory changes to add the licensing requirements of an advanced pharmacy technician by adding BPC section 4211 as proposed in the meeting materials.
>
> **Proposed BCP 4211 (Licensing Requirement)**
> The board may issue an advanced pharmacy technician license to an individual who meets all the following requirements:
> (a) (1) Holds an active pharmacy technician license issued pursuant to this chapter that is in good standing,
> (2) Possesses a certification issued by a pharmacy technician certifying program as specified in board regulation.
> (3) Has obtained a minimum of an associate's degree in pharmacy technology.
> (4) Has obtained 3,000 hours of experience in a pharmacy performing the duties of a licensed pharmacy technician.
> (b) As an alternative to the requirements in subdivision (a), has graduated from a school of pharmacy recognized by the board.

(c) A license issued pursuant to this section shall be valid for two years, coterminous with the licensee's pharmacy technician license.

M/S: Wong/Butler

Support: 4 Oppose: 2 Abstain: 0

Chairperson Weisser reviewed the proposed language for BPC 4234 regarding continuing education renewal requirements for advanced pharmacy technicians.

MOTION: Pursue statutory changes to add the continuing education and renewal requirements of an advanced pharmacy technician by adding BPC section 4234 as proposed in the meeting materials.

Proposed BPC 4234 (CE/Renewal Requirement)
An advanced pharmacy technician shall complete 20 hours of continuing education each renewal cycle including a minimum of two hours of education in medication error prevention and two hours of board sponsored law and ethics education. A licensee must also maintain certification as specified in Section 4211 (a)(2).

M/S: Wong/Sanchez

Support: 6 Oppose: 0 Abstain: 0

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

Chairperson Weisser provided an overview of the long-term care facility environment to the committee and explained the purpose of the discussion is to see what pharmacy technicians can do in a closed-door pharmacy setting to assist the pharmacists in providing additional patient care.

DAG Room clarified closed-door pharmacies are issued community pharmacy permits by the board and do not have a separate license type. Ms. Sodergren clarified that in a closed-door pharmacy there is different patient interaction and this discussion provides the committee the opportunity to determine if there are different requirements required for the closed-door pharmacies.

Mr. Weisser provided an example of a patient discharged from the hospital to a skilled nursing facility who is served by a closed-door pharmacy and posed to the committee who is providing the patient with their required patient consultation. Mr. Weisser noted that the closed-door pharmacy typically contracts with the skilled nursing facility and thereby does not provide patient consultation. The patient at a skilled nursing facility is considered the patient of the facility and not that of the closed-door pharmacy.

Art Whitney commented on his experience in the long-term care environment where the pharmacy is the contracted pharmacy for that facility. Based on federal and state rules, the closed-door pharmacy provides services to that facility but not the patient as the patient is a patient of the skilled nursing facility. Mr. Whitney clarified that the closed-door pharmacy provides pharmacy services to the facility with certain requirements by state and federal laws throughout the patient's stay and at discharge. By

contract, closed-door pharmacies do not participate in the non-institutionalized pharmacy population. Mr. Weisser expressed his concern for the patient discharged from a skilled nursing facility.

DAG Room asked if a pharmacy technician would be able to provide assistance to the pharmacist. Mr. Weisser explained there is a lot of work when a patient is added at a closed-door pharmacy. Mr. Whitney confirmed the amount of work is higher for each patient than in a retail community pharmacy setting. Ms. Duong commented it might help patient care if there are additional people to help in meeting time requirements for late admits to the skilled nursing facility.

Gary Lauren of the County of San Mateo noted that long-term care requires additional work and ratios need to be reviewed. Mr. Lauren commented the ratio should be like that of a hospital or institution.

Mr. Weisser expressed his concern if there is information available at the point of discharge for patients serviced by closed-door pharmacies after being discharged from skilled nursing facilities. If closed-door pharmacies could have advanced pharmacy technicians, the patient might benefit in this scenario for possible patient consultation.

Ms. Herold mention the committee didn't address what happens to the pharmacy technician license if an advanced pharmacy technician license is obtained. DAG Room recommended treating it like an intern license where it is a requirement to apply for licensure and the license is cancelled. DAG Room commented BPC 4112 (c) is omitted by implication.

5. Future Committee Meeting Dates

The committee reviewed the remaining meeting dates for 2017 including a date to be determined in September 19, 2017, and October 23, 2017. The dates for 2018 are as follows:

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

The meeting adjourned at 2:42 pm.

PLAN A

ASSOCIATE IN ARTS GENERAL EDUCATION
AA DEGREE REQUIREMENTS 2016 – 2017

Cerritos College
Counseling & Guidance

- **PLAN A is designed primarily for those students interested in preparing for a vocational career upon graduation. PLAN A may also be used by university transfer students and for students in vocational majors who may possibly wish to transfer in the future. However, some courses listed in PLAN A are not transferable to the four-year universities. Therefore, students following PLAN A should see a counselor for guidance in selecting the general education plan that will best suit their educational and career goals.**
- **A minimum of 60 degree applicable units must be completed with a 2.0 grade point average to qualify for the AA degree. The 60 units is to include a minimum of 18 units of specific courses for a major, a minimum of 18 units of identified general education courses and requirements, any units taken to meet the proficiency requirements, and electives as needed.**
- **Students planning to transfer to a California State University (CSU) or University of California (UC) campus need additional specific general education units beyond the 18 units required for this plan. Depending on the student's transfer plans, the additional units should be selected from either PLAN B (CSU General Education Certification) or PLAN C (Intersegmental General Education Transfer Curriculum). When selecting their courses, students are advised to check that the courses they select for PLAN A will count in the appropriate transfer general education category for PLAN B or PLAN C.**
- **Associate in Arts (AA-T) and Associate in Science (AS-T) for Transfer majors are required to fully complete Plan B or Plan C.**
- **Note: Courses denoted with one asterisk (*) appear in more than one category but may be used to satisfy only one category. Courses denoted with two asterisks (**) do not meet the general education requirements listed in PLAN B or PLAN C.**
- **Courses marked with a CL are cross-listed with another course. See individual cross-listed course descriptions in the Cerritos College catalog. Cross-listed courses may only receive credit once.**

PROFICIENCY REQUIREMENTS

1) Mathematics

a. Earn a score on the College Level Math test sufficient for placement in a course above the level of MATH 80, or Math 80B

b. Complete MATH 80 or MATH 80B with a grade of "Pass" or "C" or higher, or

c. See your counselor for other options

2) Reading

a. Complete the Reading Proficiency Test at a level above READ 54

b. Complete READ 54 or READ 97 with a grade of "Pass" or "C" or higher, or

c. See your counselor for other options

3) Writing

a. Complete ENGL 100 with grade of " Pass" or "C" or higher

4) Health & Wellness

a. Completion with a grade of Pass or "C" or higher of at least one unit of a course from the approved department list below:

Athletics	200L, 201LA, 201LB, 201LC, 202L, 203LA, 203LB, 203LC, 204L, 205LA, 205LB, 205LC, 205LD, 206L, 207LA, 207LB, 207LC, 208L, 209LA, 209LB, 209LC, 210L, 211LA, 211LB, 211LC, 212L, 213LA, 213LB, 213LC, 214L, 215LA, 215LB, 215LC, 216L, 217LA, 217LB, 217LC, 218L, 219LA, 219LB, 219LC, 220L, 221LA, 221LB, 221LC, 221LD, 222L, 223LA, 223LB, 223LC, 223LD, 224L, 225LA, 225LB, 225LC, 225LD, 226L, 227LA, 227LB, 227LC, 228L, 229LA, 229LB, 229LC, 230L, 231LA, 231LB, 231LC, 232L, 233LA, 233LB, 233LC, 234L, 235LA, 235LB, 235LC, 235LD, 236L, 237LA, 237LB, 237LC
Kinesiology	100, 102, 104, 106, 108, 120, 121, 122, 123, 130, 131, 132, 133, 134, 200, 202, 203, 206, 207, 210
Physical Education Activities	100, 101,102, 103, 104, 105, 107, 108, 110, 111, 112, 116, 118, 119, 124, 126, 130, 132, 134, 136, 138, 139, 140, 141, 145, 147, 149, 151, 152, 155,156, 157, 161, 163, 165, 166, 167, 169, 170, 172, 176, 177, 178, 179, 181, 184, 185, 186, 188, 189, 191, 192, 194, 240, 245, 246, 249, 261, 263, 265, 266, 267, 272, 274, 276, 278, 281, 282, 284, 285, 288, 289, 291, 292 Other courses that will meet the requirement include Dance 105, 106A, 106B, 107, 108A, 108B, 108C, 109, 110, 112, 120, 121, 122, 123, 124, 125, 130A, 130B, 133, 134, 135, 136, 140, 141, 142, 143, 144, 150, 151.

b. Complete HED 100, 101, 103, or 200; HO 100, or 152; CDEC 161; or WS 103

c. Complete an Allied Health program (DA, DH, RN PTA, Pharm Tech, MA)

d. For other options, see your counselor.

A. NATURAL SCIENCES Select at least three units from either Physical Sciences or Biological Sciences:	NEEDED	IN PROGRESS	COMPLETED
1) PHYSICAL SCIENCES			
Astronomy 102, 103, 104, 105L (LAB), 106			
Chemistry 100 (LAB), 110 (LAB), 111 (LAB), 112 (LAB)			
Earth Science 101, 102 (LAB), 104, 104L(LAB),106, 110 (LAB)			
Energy 110			
Geography 101, 101L (LAB) , 103			
Geology 101 (LAB), 102, 102L (LAB), 201 (LAB), 204, 207 (LAB), 208, 209			
Physical Science 100, 112 (lab)			
Physics **50 (LAB), 100 (LAB), 101 (LAB), 102 (LAB), 201 (LAB), 202 (LAB), 203 (LAB)			
2) BIOLOGICAL SCIENCES			
Anatomy & Physiology 120 (LAB), 150 (LAB), 151 (LAB), 200 (LAB) , 201 (LAB)			
Anthropology **110, 115, 115L (LAB)			
Biology 105, 110 (LAB), 115 (LAB), 120 (LAB), 200 (LAB), 201 (LAB)			
Botany 120 (LAB)			
Microbiology 200 (LAB)			
Psychology 241			
Zoology 120 (LAB)			

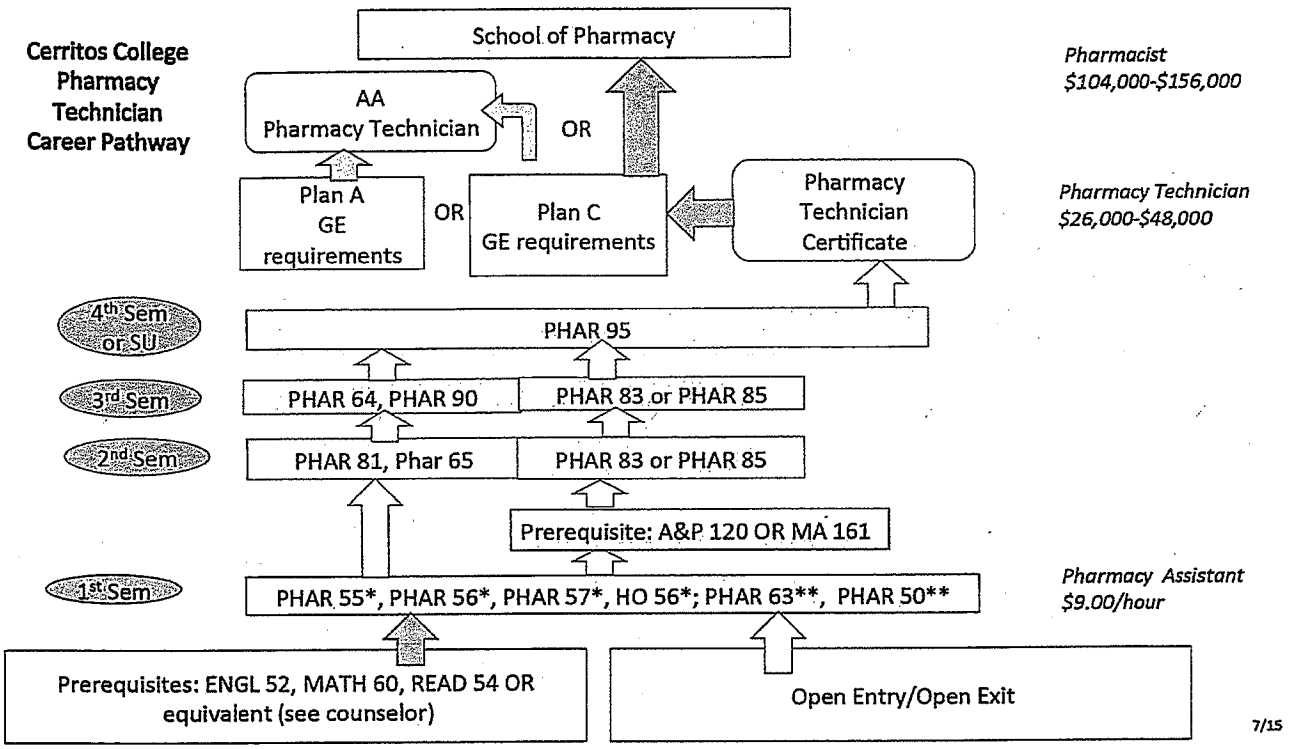
B. SOCIAL AND BEHAVIORAL SCIENCES Select at least **three units** from either American History or American Government. Courses listed under the Social and Behavioral Science category below may be selected to Meet the 18-unit general education requirement. *Note: Completion of a U.S. history or government course which fulfills the California State University requirement taken at any accredited institution my be used in lieu of the course requirement*	NEEDED	IN PROGRESS	COMPLETED
1) AMERICAN HISTORY			
History 101,102, 103			
2) AMERICAN GOVERNMENT			
Political Science 101, 201			
3) SOCIAL AND BEHAVIORAL SCIENCE			
Administration of Justice101			
American Sign Language 220			
Anthropology 100, 120, 170, 200, 201, 202, 203, CL205			
Business Administration CL**208			
Child Development 110			
Child Development/Early Childhood**113			
Counseling**150, 200			
Economics101, CL102, 201, 201M, 202, 202M, 204			
Environmental Policy 200			
Finance 125			
Geography102, 105, 140			
History110, 120, CL204, 210, 220, 221, 230, 235, 241, 242, 245, 246, 250, 255, 260, 265, **270, 275			
Journalism 100			
Kinesiology CL108, 211			
Political Science 110, 210, 220, 230, 240, 250, 260			
Psychology 101, 150, 251, 261, 271			
Sociology101, 110, 120, 201, CL202, 205, 210, 215, **225, 230, 250			
Speech 110			
Speech Language Pathology **105			
Women's Studies 101, CL108, CL202, CL204, CL205, CL206, CL**208			
C. HUMANITIES Select at least three units from either the Fine Arts or Humanities:			
1) FINE ARTS			
Architecture **110, 112			
Art 100, 101, 102, 103, 104, 105A, 105B, 106, 107, *CL108, *CL109, 110, 113, 116, 120, 130A, 150, **186, **192, 193			
Dance 100, 101			
Film 159			
Humanities *CL108, *CL109			
Music100, 101, 102, 103, 104, 104B, 105, 180			
Photography 100, 160			
Theatre 101, 102, 103, 104, **110, 150, RTV/TH151, RTV 152			
2) HUMANITIES			
American Sign Language 110, 111, 210, 211			
Art *CL108, *CL109			
Chinese 101, 102, 201, 202,260			
English 102, 106, 221A, 221B, 222, 223, 224, 225, 226, 227, 228, 230A, 230B, 232, 233, 234,			
235, 236, 237, 238, 239, 245, 246A, 246B, 248A, 248B			
French 101, 102, 201, 202, 203, 281, 282, 283, CL285			
German 101, 102, 201, 202			
Humanities 100, *CL108, *CL109			
Japanese 101, 102, 201, 202			
Philosophy 100, 102, 104, 105, 107, 108, 109, 130, 140, 200, 201, 203, 204, 205, 206			
Photography 150			
Sign Language 101, 102, 201			
Spanish 101, 102, 111, 112, 201, 202, 206, 210, 245, CL285			
Speech 140, **145			
Women's Studies 102, CL109			
D. LANGUAGE AND RATIONALITY Select at least three units from English Composition and three units from Communication & Analytical Thinking			
1) ENGLISH COMPOSITION			
English 100			
2) COMMUNICATION AND ANALYTICAL THINKING			
Business Communication**148			
Computer & Information Sciences **101, **102, **103			
Engineering Design Technology**131			
Mathematics **80, **80B, 110A, 110B, 112, 114, 115, 116, 140, 155, 160,170, 190, 220, 250			
Philosophy 103, 106, **160			
Psychology 103, 210			
English 101, 103			
Reading 200			
Speech **60, 100, 120, 130, 132, 150, 235			
Speech Language Pathology**220			
E. If needed, select an additional course from the general education courses listed above or a course from PLAN B or PLAN C so that the earned general education units total at least 18.			

Note: The proceeding graduation requirements apply to students who were in attendance during the 2016-17 school year and thereafter. Student who enrolled prior to Fall 2016 and who have maintained continuous attendance at Cerritos College have the option of meeting the current requirements or those in effect at the time continuous attendance began.

Cerritos College

www.cerritos.edu/pharmacy-technology/

Pharmacy Technician



7/15

For detailed course description, please refer to the current General Catalog:
www.cerritos.edu/catalog

Interested enrolling at Cerritos College?

Please refer to the step-by-step enrollment process:
www.cerritos.edu/futurestudents

Want to apply to get your certificate?

1. Make sure you meet the requirements for certificate.
   a. Determine which form to fill out and download the form at:
      www.cerritos.edu/admissions-and-records/online-forms/
      i. Petition for Certificate: Petition to graduate with a Certificate of Achievement
      ii. Petition for Degree: Petition to graduate with an Associate in Arts
2. Fill out the appropriate form and meet with a counselor.
   a. Make an appointment by calling (562) 860-2451, ext. 2231or use Online Counseling at:
      www.cerritos.edu/counseling/online-orientation.htm

Cerritos College

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Pharmacy Technology - AS

Pharmacy Technology Associate of Science Degree

To earn an Associate Degree with a specialization in Pharmacy Technology, students must complete the required courses plus the general breadth requirements (minimum total = 60 units).

In addition, students complete the required courses under the pharmacy technology certificate to prepare them for licensing exam and for entry-level employment as a pharmacy technician.

REQUIRED COURSES: Complete the following courses with a grade of C or higher:		Units
PHT060	Pharmacy Systems I	3
PHT062	Pharmacology I	3
PHT064	Pharmacy Calculations	3
PHT070	Pharmacy Systems II	3
PHT071	Pharmacology II	3
PHT072	Pharmacy Clinical Experience (240 hours)	5
PHT074	Pharmacy Seminar	2
Pre-Requisite Courses		
BIOL155	Introductory Anatomy and Physiology**or Higher**	
Math 090	Elementary Algebra **or Higher**	
English 015	Preparation for College Writing **or Higher**	
	Total Units	21 - 25

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San Bernardino, CA 92410
909-384-4400

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

Timothy P. Frost [a], Alex J. Adams [b, *]

[a] The University of Toledo, College of Pharmacy, 2801 W Bancroft, Toledo, OH, 43606, United States
[b] Idaho State Board of Pharmacy, 4537 N Molly Way, Meridian, ID, 83646, United States

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ABSTRACT

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

1. Background

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

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

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

* Corresponding author.
E-mail address: alexadamsrph@gmail.com (A.J. Adams).

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1551-7411/

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

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

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

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

2. Overview of verbal prescriptions and transferred prescriptions

Verbal communication is one means by which a licensed prescriber may transmit a valid prescription drug order to a pharmacy. Alternatively the prescriber may issue an original signed and written prescription, electronically route it, or fax it to the pharmacy. For a verbal prescription drug order, the prescriber or prescriber's agent must communicate all the information required of a valid prescription drug order except for the signature of the prescriber. Verbal prescriptions may be synchronous or asynchronous (e.g., left as a voicemail). The pharmacist receiving the verbal prescription must promptly reduce it to writing and may process the prescription as any other. Federal law prohibits verbal prescriptions for Schedule II substances, except in rare emergency situations.[14] Unless a state's law is more stringent, federal law permits a verbal prescription as a valid means of ordering a Schedule III through V controlled substance or any non-controlled medication. Extra-legal forces are also in play. For example, the Joint Commission accreditation standards prohibit the use of verbal orders for chemotherapy.[15] Various groups recommend reserving the use of verbal orders to only true emergency situations.[16] Still, many verbal orders are called in for prescriber or patient convenience, though their use has certainly declined with the increased rates of electronic prescribing. For example, one study found a decrease in verbal orders from 22% to 10% of total orders in the 21 months following implementation of an electronic order entry system.[17]

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

3. U.S. state law environmental scan

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

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

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

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Table 1
Review of state laws.

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

pharmacist "listens to and verifies that transcription prior to dispensing" which likely significantly limits use.[20]

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

4. Existing evidence base with respect to patient safety

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

Friesner and Scott conducted a survey of technicians registered to practice in North Dakota, a state that allows technicians to accept verbal prescriptions.[24] Surveys were mailed to all 456 technicians in the state, and 192 (42.1%) responded in full. Respondents were queried on the extent to which they performed certain tasks, one of which was "taking new prescriptions over the telephone." Overall, 63% of technician respondents reported taking new verbal prescriptions. Technicians working in community independent pharmacies were much more likely to perform this task that those in inpatient hospitals or large chain community pharmacies. In addition, technicians working in towns with less than 2000 people were much more likely to perform this task than those working in towns with larger populations. This study was limited in that it did not assess the frequency with which technicians performed this task, and it did not provide any information on the safety – or perceived safety – of technicians perform this task.[24]

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

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

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

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

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

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

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

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

6. Conclusion and future direction

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

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

As the legal environment becomes more permissive, we foresee investment in more robust education and training of technicians both in the mechanics of receiving a verbal prescription (e.g., simulated lab with environmental noise) and the understanding of common medication names and doses. Overall, with the adoption of robust practice policies and procedures, delegation of verbal orders and prescription transfers can be safe and effective, remove undue stress on pharmacists, and potentially free up pharmacist time for higher-order clinical care.

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Conflicts of interest

None.

Disclaimer

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

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

Michael Andreski, RPh, MBA, PhD[1] Megan Myers, Pharm D[2] Anthony Pudlo, PharmD, MBA, BCACP[2] Kate Gainer, PharmD[2]

[2] Drake University College of Pharmacy and Health Sciences, [2] Iowa Pharmacy Association

Background

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

Objective

- To evaluate the impact on pharmacy practice after implementation of TCT of refill prescriptions in17 community pharmacies in Iowa.

Methods

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

Methods (cont.)

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

Results

Table 1- Combined Phase 1 & 2 Pharmacy Demographics

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

Table 2- Dispensing Errors

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

Table 3- Pharmacist Workday Composition

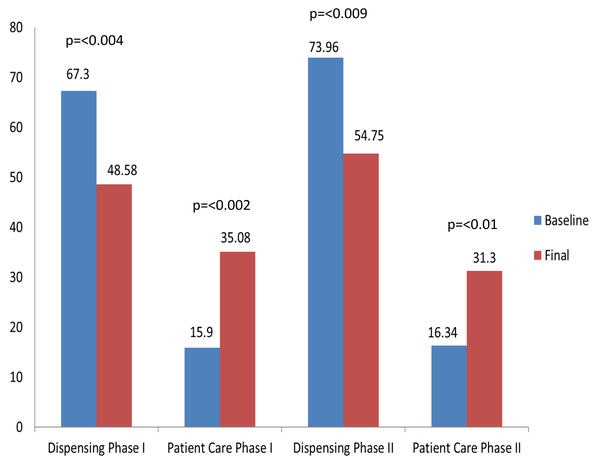

Table 4- Patient Care Activities per Pharmacist Hour

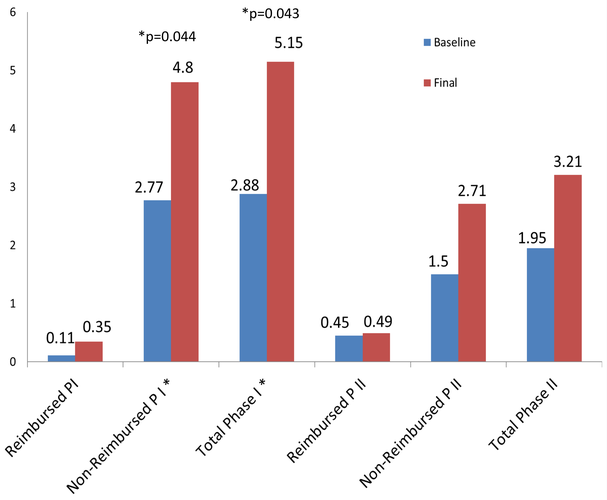

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Table 5- Service Type and Reimbursement

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

Discussion

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

Limitations

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

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