



**California State Board of Pharmacy**

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STATE AND CONSUMER SERVICES AGENCY

DEPARTMENT OF CONSUMER AFFAIRS

GOVERNOR EDMUND G. BROWN JR.

**Licensing Committee Report**

Members:

Greg Lippe, Public Member, Chairperson

Ryan Brooks, Public Member

Rosalyn Hackworth, Public Member

Kenneth Schell, PharmD

Debbie Veale, PharmD

***LICENSING COMMITTEE REPORT AND ACTION***

Report of the Meeting held on March 8, 2011.

**a. FOR INFORMATION: Update on the Board's Psychometric Evaluation of the ExCPT and PTCB Examinations**

Relevant Statutes

Business and Professions Code section 4202 establishes the requirements for licensure as a pharmacy technician. There are several routes to licensure:

- Obtain an associates degree in pharmacy technology
- Completion of a technician training course
- Graduation from a school of pharmacy recognized by the board
- Certification by the Pharmacy Technician Certification board

Business and Professions Code 139 requires a psychometric assessment description of the occupational analysis serving as the basis for the examination and an assessment of the appropriateness of prerequisites for admittance to the examination.

Background

During the April 2009 Board Meeting, the board voted to direct staff to take the necessary steps to secure a vendor to complete the necessary psychometric assessments of the Pharmacy Technician Certification Board (PTCB) and Exam for the Certification of Pharmacy Technicians (ExCPT).

The results of the review would ensure that these applicants who qualify for licensure as a pharmacy technician have passed a validated exam, consistent with the requirements in B&PC 139. Upon completion, the committee will be advised on the findings at which time it may recommend a change to the statutory requirements for licensure detailed in B&PC 4202.

Last year the board was advised that the department's Office of Professional Examination Services (OPES) will conduct these evaluations for the board which should be completed by June 30, 2011.

Committee Discussion:

The committee was advised that board staff recently signed an interagency agreement with the OPES. It will cost approximately \$24,000.

**b. FOR DISCUSSION: Continued Discussion About a Proposal to Specify Continuing Education Credit for Pharmacists in Specific Content Areas**

**Attachment 1**

Relevant Statutes

Business and Professions Code section 4231 requires a pharmacist to earn 30 hours of approved continuing education credit every two years as a condition of renewal.

Business and Professions Code section 4232 specifies that content of courses that will be acceptable including the following:

- Pharmacology
- Biochemistry
- Physiology
- Pharmaceutical chemistry
- Pharmacy Administration
- Pharmacy Jurisprudence
- Public health and communicable diseases
- Professional practice management
- Anatomy
- Histology

Background

At several prior meetings of the board or its committees, there has been general discussion about developing requirements for pharmacists to earn CE in specific subject matter areas. To establish such a requirement would take either a legislative or regulation change.

Prior discussions have included possible mandatory CE in emergency/disaster response, patient consultation, drug abuse or in maintaining control of a pharmacy's drug inventory. Any topic the board determines as appropriate for mandatory CE should have generally broad-based applicability for pharmacists.

At the February 2011 Board Meeting, the board directed that the committee continue its discussion about such a requirement and specified that if the recommendation is approved, authorize staff to investigate implementation.

Committee Discussion

The Committee heard a presentation from two pharmacy directors of California counties' emergency response team and how such a topic would be applicable as an appropriate mandatory CE course. Additional suggested topics also brought to the committee for consideration included the following:

- Emergency/Disaster Response:
- Patient Consultation
- Maintaining Control of a Pharmacy's Drug Inventory
- Patient Consultation
- Ethics

- Drug Abuse
- Defined Content Areas

The committee also heard comments again about content specific course mandates and CE in general.

The committee will continue to review this issue. If appropriate, the committee will also determine if the CE course should mandate how the course is provided (e.g. live, web-based, journal, etc.).

**Attachment 1** contains possible areas for mandatory CE as well as information from the Accreditation Council for Pharmacy Education on continuing education for pharmacists. Also included is a CE comparison chart, developed by the Department of Consumer Affairs.

- c. **FOR DISCUSSION and POSSIBLE ACTION: Discussion About a Request to Modify 16 California Code of Regulations Section 1732.2 Regarding Continuing Education Credit for Pharmacists Gaining Certification by the Board of Pharmacy Specialties.**

## Attachment 2

### Relevant Regulation

CCR 1732.2 allows a pharmacist to petition the board to allow continuing education credit and specifies that coursework meeting the standard of relevance to pharmacy practice that has been approved by specified healing arts board is also acceptable to the board.

### Background

The board voted to pursue amendment to California Code of Regulations Section 1732.2 to grant continuing education credit for various types of pharmacist activities, including attending a board or committee meeting, being certified by the Commission for Certification in Geriatric Pharmacy or for certain activities as a Competency Committee member.

Since that time, the executive officer was advised that there are other certifications that some pharmacists earn that perhaps should be considered as fulfilling portions of the CE requirements for renewal of a pharmacist license. If the board determines it wishes to add these components in the future, it will need to be done as a new rulemaking to section 1732.2.

Following are some additional areas for board consideration that could also be incorporated into this section.

1. Menopause Practitioner Examination - interdisciplinary examination available from NAMS (The North American Menopause Society) ([www.menopause.org](http://www.menopause.org))
2. Board of Pharmacy Specialties (BPS) has recognized six specialty practice areas: note – these certification examinations also require recertification every 7 years (re-certification by examination should also be permitted for credit) ([www.bpsweb.org](http://www.bpsweb.org))
  - **Ambulatory Care Pharmacy** (2011)  
Includes the provision of integrated, accessible healthcare services by pharmacists who are accountable for addressing medication needs, developing sustained partnerships with patients, and participating in the context of family and community.

- **Nuclear Pharmacy** (1978)  
Specialists seek to improve and promote the public's health through the safe and effective use of radioactive drugs for diagnosis and therapy.
- **Nutrition Support Pharmacy** (1988)  
Specialists promote the maintenance and/or restoration of optimal nutritional status, designing and modifying treatment according to the needs of the patient.
- **Oncology Pharmacy** (1996)  
Specialists recommend, design, implement, monitor and modify pharmacotherapeutic plans to optimize outcomes in patients with malignant diseases.
- **Pharmacotherapy** (1988)  
Specialists are responsible for ensuring the safe, appropriate, and economical use of drugs in patient care and frequently serve as a primary source of drug information for other health care organizations.
- **Psychiatric Pharmacy** (1992)  
Specialists address the pharmaceutical care of patients with psychiatric disorders.

**Attachment 2** contains a copy of the proposed regulation language. The 15-day comment period for this proposal concluded on February 21, 2011.

d. **FOR INFORMATION: Update on the Board's Efforts to Implement 16 California Code of Regulations Section 1702, Mandatory Submission of Fingerprints for Pharmacists**

**Attachment 3**

Relevant Regulations

California Code of Regulations 1702 establishes new renewal requirements for pharmacists.

Background

The regulation specifies that as a condition of renewal, a pharmacist must disclose on the renewal form any arrest or conviction, as specified, since the licensee's last renewal; that a pharmacist applicant must pay the actual cost of compliance with the submission of fingerprints; a requirement that the licensee retain proof of compliance, as specified; and that failure to comply with the fingerprint requirement will result in an application for renewal being considered incomplete. This regulation was approved by the Office of Administrative Law and took effect December 7, 2010.

The board was previously advised that because of staff reductions with the Department of Justice, implementation on the electronic fingerprint submissions would be delayed until the necessary program changes could be implemented.

Committee Discussion

The committee was advised that the necessary changes are now in place and that staff would draft letters that will be sent to all affected licensees advising them about the regulation change as well as providing them with the necessary forms. Pharmacists will be advised to retain a copy of their livescan form or other receipt confirming compliance with this provision.

Implementation of the arrest and conviction disclosure requirements was not delayed.

Recent Update

Board staff developed the letter to be sent to affected licensees. This letter is currently undergoing review by the department.

**Attachment 3** contains a copy of the regulation.

e. **FOR DISCUSSION: Discussion Concerning DCA's Focus on Continuing Competency**

**Attachment 4**

Background

Several months ago, DCA Director Stiger indicated that the Department of Consumer Affairs has an initiative underway to promote that all health care boards initiate periodic assessment of continuing competency in their licensed practitioners.

Continuing competency assessment requires periodic evaluation (and perhaps re-testing) of licensed providers to ensure they are maintaining their skills necessary to practice safely.

Committee Discussion

During the meeting, Cindy Kanemoto, representing the DCA discussed different pathways to complete a continuing competency requirement. She stated that the competencies for a profession as well as the board certification requirements must first be identified. Ms. Kanemoto reviewed a five step model including a self evaluation, peer assessment, and a professional development plan. She emphasized that this process is different than just earning CE credit.

Recent Update

During the director's monthly conference call with board presidents and board chairs, Mr. David Swankin, CEO of the Citizen Advocacy Center (CAC) and Dr. Martin Crane, former Chair of the Federation of State Medical Boards (FSMB) provided information on this issue.

**Attachment 4** contains the Proceedings from the Continuing Competency session at the CAC's annual meeting, held in November 2010.

f. **FOR DISCUSSION: Discussion of the Office of Statewide Health Planning and Development's Manpower Assessment and Survey of Licensees**

**Attachment 5**

Background

As part of Senate Bill 139 (Chapter 522, Statutes of 2007) the Office of statewide Health Planning and Development (OSHDP) was directed to establish the California Healthcare Workforce Clearinghouse (Clearinghouse) to serve as the central source for collection, analysis, and distribution of information on the healthcare workforce employment and educational data trends for the state.

Specifically the bill included a provision that OSHPD work with the Employment Development Department's Labor Market Information Division, state licensing boards, and state higher education entities to collect, to the extent available, all of the following data:

- (a) The current supply of health care workers, by specialty.
- (b) The geographical distribution of health care workers, by specialty.
- (c) The diversity of the health care workforce, by specialty, including, but not necessarily limited to, data on race, ethnicity, and languages spoken.
- (d) The current and forecasted demand for health care workers, by specialty.
- (e) The educational capacity to produce trained, certified, and licensed health care workers, by specialty and by geographical distribution, including, but not necessarily limited to, the number of educational slots, the number of enrollments, the attrition rate, and wait time to enter the program of study.

#### Issue

DCA Acting Director Brian Stiger is encouraging all boards to collect the necessary information to assist OSHPD in their charge to, among other items, serve as the repository for comprehensive data and standardize data collection tools and methods.

Many of the boards within the DCA, including our board, do not collect several of the data elements being requested by OSHPD. The Medical Board developed a survey that is designed to collect several elements. The survey is provided to licensees along with their renewal application. It is our understanding that the results will be provided to OSHPD.

#### During the Committee Meeting

Board staff indicated that mandating submission of this information would require either a regulation and/or statutory change. Board staff suggested that the board consider development of a survey that could be accessed from the board's web site. An on-line resource such as Survey Monkey, could serve as an easy collection method that would have minimal impact on board staff.

Cindy Kanemoto, representing the DCA, shared that she has recommended that OSHPD create the survey and also house the data. She stated that the board could provide a link on its Web site to the survey. Ms. Kanemoto advised that the licensees would be directly inputting the information to OSHPD and the board would still have access to the data. She provided that the department is exploring this option as an interim solution until the implementation of the BreEZe system.

**Attachment 5** contains a copy of a fact sheet on the Healthcare Workforce Clearinghouse as well as the draft survey that will be used by the Medical Board.

- g. FOR DISCUSSION: Discussion Regarding the Licensing Committee Presentation by the Emergency Management Services Agency on the Role and Involvement of Pharmacists in Emergency Response in California**

**Attachment 6**

#### Committee Discussion

During the meeting, Patrick Lynch, representing the Emergency Medical Services Authority (EMSA), provided an overview of the Emergency System for the Advance Registration of

Volunteer Health Professionals (ESAR-VHP), a registration system for healthcare professionals to volunteer in the event of a significant disaster or a public health emergency. He discussed that volunteers are verified with the appropriate licensing board, assessed for whether or not they are actively practicing, and are added to the statewide registry. Mr. Lynch stated that during a disaster, state or local officials will determine what kind of health professionals are needed, search the database for available volunteers, and send an alert to selected members via email, telephone and pager.

Mr. Lynch provided that there are currently 515 pharmacists, 105 pharmacist interns, and 18 pharmacy technicians registered in the system.

**Attachment 6** contains a copy of the board's emergency response policy as well as an informational brochure on registering to become an emergency responder.

h. **FOR INFORMATION: Competency Committee Report**

**California Practice Standards and Jurisprudence Examination for Pharmacists (CPJE)**

**Attachment 7**

Effective April 1, 2011, the board instituted a quality assurance review of the California Practice Standards and Jurisprudence Examination for Pharmacists (CPJE). This means that there will be a delay in the release of all CPJE examination scores. This process is done periodically to ensure the reliability of the examination. The board will release scores as soon as possible. Based on historical patterns, the board anticipates results being released approximately August 2011.

The board encourages all qualified applicants to continue to schedule and take the CPJE exam. The greater the number of applicants who take the exam during this review period, the sooner results can be released.

**CPJE Statistics**

CPJE statistics for April 1, 2010, through September 30, 2010, are provided in **Attachment 7**. CPJE statistics for October 1, 2010, through March 31, 2011, will be available for distribution at the board meeting.

**Examination Development**

Both Competency Committee workgroups continue to have meetings in the spring of 2011 to work on examination development. The Competency Committee has ensured the new outline was used to develop examinations administered after April 1, 2011.

Board staff has updated the CPJE Candidate Information Bulletin and board Web site to reflect the new content outline as well as notified candidates eligible to take the CPJE.

**i. FOR INFORMATION: Minutes of the Meeting Held on March 8, 2011**

**Attachment 8**

A summary of the meeting held on March 8, 2011 is provided in **Attachment 8**.

**j. FOR DISCUSSION: Discussion Regarding the Joint Board of Pharmacy/Drug Enforcement Administration Conference on Drug Security for Pharmacies Held in Los Angeles April 12, 2011 in Los Angeles, and Discussion and Possible Approval to Award Continuing Education Credit for Future Joint Conferences in Southern California.**

**Attachment 9**

On April 12, 2011, the DEA and Board cosponsored a one-day conference in Los Angeles titled "Diversion of Controlled Substances, What Every Pharmacist Should Know to Prevent Diversion." The conference was held at the DEA Los Angeles Office in downtown LA. A copy of the agenda is provided in **Attachment 9**.

At the March 30 Board Meeting, the board awarded 5 units of CE credit for those who attended. The board released a subscriber alert after this meeting, with less than two weeks before the conference, the only publicity really done. Nevertheless, the conference had 120 participants who were able to fit, somewhat uncomfortably, within the conference room.

The board developed the following learning criteria for the continuing education credit:

1. Identify CII-V controlled substances commonly abused in the Los Angeles area
2. Know how to access CURES data for your pharmacy's patients
3. Identify ways to keep controlled substances more secure in your pharmacy
4. Identify 3 new parameters for evaluating pharmacist's corresponding responsibility
5. Identify responsibilities of dispensing prescription drugs via the Internet
6. Articulate the dangers of the use, abuse and addiction of controlled substance by teenagers.

There were 71 evaluation responses received, and the comments were generally highly favorable (**Attachment 9** also contains a summary of the surveys):

	1 Needs Work	2	3 Satisfactory	4	5 Great
Overall Conference		1	11	25	11
Topics Timely & Relevant			10	23	39
Facility	2	5	19	22	24
Quality of Speakers		2	12	20	39

The DEA and board staff hope to hold additional sessions in the future in LA. However, the travel restrictions now in place may limit this.

Staff Recommendation for Action:

The board's staff request the board's approval to award 5 hours of CE credit should additional sessions of this conference be provided in the future.

**k. FOR ACTION: Selection of Licensing Committee Meeting Dates for 2011**

We would like to schedule committee meetings through the end of the year. Below are proposed dates for consideration:

June 6, 2011 or June 20 – 24, 2011  
September 6 – 9, 2011 or September 12-16, 2011  
December 5 – 9, 2011

**l. FOR INFORMATION: Licensing Statistics for 2010/11**

**Attachment 10**

**Attachment 10** includes the licensing statistics for third quarter 2010/11.

**m. FOR INFORMATION: Third Quarterly Update of Strategic Plan for the Licensing Committee.**

**Attachment 11**

The third quarterly report on the Licensing Committee's goals is provided at the back of the tab section in **Attachment 11**.

# **Attachment 1**

**SOURCE: Excerpted from -- Accreditation Council for Pharmacy Education, "Accreditation Standards for Continuing Pharmacy Education" Adopted June 20, 2007, Released October 5, 2007, Effective January 1, 2009**

### **Standard 1: Goal and Mission of the CPE Program**

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

#### Guidance

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

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

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

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

CPE activities should be designed according to the appropriate roles and responsibilities of the pharmacists and technicians.

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

## **Standard 2: Educational Needs Assessment**

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

### Guidance

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

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

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

## **Standard 3: Continuing Pharmacy Education Activities**

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

### Guidance:

**Knowledge-based CPE activity:** These CPE activities should be designed primarily for pharmacists and technicians to acquire factual knowledge. This information must be based on evidence as accepted in the literature by the health care professions.

The minimum credit for these activities is 15 minutes or 0.25 contact hour.

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

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

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

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

#### **Standard 4: CPE Activity Objectives**

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

##### Guidance

Objectives must be:

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

DCA Healing Arts Boards Continuing Education/Continuing Competency Requirements

Board	CE Requirement - Obtained from Board Web Sites	Mandatory CE Requirements within the hours required. Obtained from Board Web Sites	CC Requirements	Self Certify	Required Years to Maintain Records	Random Audits
Acupuncture	50 hours every two years	None Identified	None	Yes	4 years	Yes
BBS	36 hours two years preceding renewal	Six Hours of Law and Ethics each renewal period. Otherwise, Spousal/Partner Abuse, Aging and Long Term Care and HIV/AIDs required upon first renewal only.	None	Yes	4 years	Yes
Dental Board (RDA)	25 hours each renewal	Mandatory courses required by the Board for license renewal to include a Board-approved course in Infection Control, a Board-approved course in the California Dental Practice Act and completion of certification in Basic Life Support.	None			
Dental Board (Dentist)	50 hours each renewal	Mandatory courses required by the Board for license renewal to include a Board-approved course in Infection Control, a Board-approved course in the California Dental Practice Act and completion of certification in Basic Life Support.				
Dental Hygiene	25 units each renewal except RDHAP 35 units each renewal	Mandatory courses required by the Board for license renewal to include a Board-approved course in Infection Control, a Board-approved course in the California Dental Practice Act and completion of certification in Basic Life Support.	None	Yes	Three renewal periods	Yes
Medical Board	50 hours every two years preceding renewal	All CME courses must be Category 1-approved. Category 1 means courses that directly relate to one of the following: patient care, community or public health, preventive medicine, quality assurance or improvement, risk management, health facility standards, the legal aspects of clinical medicine, bioethics, professional ethics, or improvement of the physician-patient relationship.	None	Yes		Yes
Naturopathic	60 hours biennially	(1) At least 20 hours shall be in pharmacotherapeutics.	None	Yes		
Occupational Therapy		None Identified	Must complete 24 Professional Development Units (PDUs) during each renewal period. Effective in 2006	Yes	4 years	Yes

DCA Healing Arts Boards Continuing Education/Continuing Competency Requirements

Board	CE Requirement - Obtained from Board Web Sites	Mandatory CE Requirements within the hours required. Obtained from Board Web Sites	CC Requirements	Self Certify	Required Years to Maintain Records	Random Audits
Optometry	40 hours every two year renewal period except TPA must obtain 50 hours.	All optometrists are required to take CE and demonstrate that they met CE requirements upon renewal of their optometric license. However, TPA certified optometrists must obtain 50 hours of CE, 35 of which must be in the diagnosis, treatment and management of ocular disease.	None	Yes		
Osteopathic	150 hours within a three year period	Minimum of sixty hours of the 150 hours must be in AOA Category 1-A or 1-B.	None	Yes	4 years	Yes
Pharmacy	30 hours every two years	None Identified	None	Yes	4 years	Yes
Physical Therapy		For each renewal cycle: Two hours in ethics, laws and regulations, or some combination thereof, and four hours in life support for health care professionals. Such training should be comparable to, or more advanced than, the American Heart Association's Basic Life Support Health Care Provider course.	They provide a chart based on renewal period up to 30 hours required with various pathways to completion - Effective in 2009	Yes	5 years	Yes
Physician Assistants	50 hours every two years or by obtaining certification by the National Commission on Cert. of Physician Assistants. Effective 2010	None Identified		Yes	4 years	Yes
Podiatric Medicine			Each doctor of podiatric medicine is required to complete 50 hours of approved continuing education, including a minimum of 12 hours in subjects related to the lower extremity muscular skeletal system, and one of the continuing competence pathways specified in Business and Professions Code Section 2496(a) through (h), during each two (2) year renewal period. Effective January 1999	Yes	4 years	Yes
Psychology	36 hours each renewal period - They have an	Law and Ethics, Spousal/Partner Abuse and Aging and Long Term Care		Yes	The Board receives reports from the MCEPAA of	The board conducts 100% audit by
Respiratory Care	15 hours every two years	Law and Ethics		Yes	4 years	Yes
Registered Nursing	30 hours each renewal period	None Identified		Yes		

Board	CE Requirement - Obtained from Board Web Sites	Mandatory CE Requirements within the hours required. Obtained from Board Web Sites	CC Requirements	Self Certify	Required Years to Maintain Records	Random Audits
Speech Language/Pathology and Hearing Aid	12 hours of continuing professional development units during each renewal period	None Identified		Yes	2 years	Yes
Veterinary	36 hours each renewal period.	None Identified		Yes	4 years	
Voc Nurse Psych Techs	30 hours each renewal period	None Identified		Yes	4 years	Yes

# **Attachment 2**

## **Title 16. Board of Pharmacy** ***Proposed Modified Language***

**To Amend Section 1732.2. of Article 4 of Division 17 of Title 16 of the California Code of Regulations to read as follows:**

### 1732.2. Board Accredited Continuing Education

(a) Individuals may petition the board to allow continuing education credit hours for specific coursework which is not offered by a provider but meets the standards of Section 1732.3.

(b) Notwithstanding subdivision (a) of this section, coursework which meets the standard of relevance to pharmacy practice and has been approved for continuing education by the Medical Board of California, the California Board of Podiatric Medicine, the California Board of Registered Nursing or the Dental Board of California shall, upon satisfactory completion, be considered approved continuing education for pharmacists.

(c) A pharmacist serving on a designated subcommittee of the board for the purpose of developing the California Practice Standards and Jurisprudence Examination for pharmacists pursuant to section 4200.2 of the Business and Professions Code may annually be awarded up to six hours of continuing education hours for conducting a review of exam test questions. A subcommittee member shall not receive continuing education hours pursuant to this subdivision if that subcommittee member requests reimbursement from the board for time spent conducting a review of exam test questions.

(d) A pharmacist or pharmacy technician who attends a full day board meeting may be awarded up to six hours of continuing education on an annual basis. The board shall designate on its public agenda which day shall be eligible for continuing

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Changes made to the regulatory text noticed on October 8, 2010, are indicated as follows:

Deletions to the regulatory text are indicated by double strike-through, thus: ~~deleted language~~.

Additions to the regulatory text are indicated by a double underline, thus: added language.

education credit. A pharmacist or pharmacy technician requesting continuing education hours pursuant to this subdivision must sign in and out on an attendance sheet at the board meeting that requires the individual to provide his or her first and last name, license number, time of arrival and time of departure from the meeting.

(e) A pharmacist or pharmacy technician who attends a full committee meeting of the board may be awarded up to two hours of continuing education on an annual basis. A maximum of four continuing education hours may be earned each year by attending the full meetings of two different board committees. A pharmacist or pharmacy technician requesting continuing education hours pursuant to this subdivision must sign in and out on an attendance sheet at the committee meeting that requires the individual to provide his or her first and last name, license number, time of arrival and time of departure from the meeting.

~~(f) A pharmacist who completes the Pharmacist Self-Assessment Mechanism (PSAM) administered through the National Association of Boards of Pharmacy, may be awarded up to six hours of continuing education.~~

(f) (e) An individual may be awarded three hours of continuing education for successfully passing the examination administered by the Commission for Certification in Geriatric Pharmacy.

Note: Authority cited: Section 4005, Business and Professions Code.  
Reference: Sections 4200.2, 4202, 4231 and 4232, Business and Professions Code.

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Changes made to the regulatory text noticed on October 8, 2010, are indicated as follows:

Deletions to the regulatory text are indicated by double strike-through, thus: ~~deleted language~~.

Additions to the regulatory text are indicated by a double underline, thus: added language.

# **Attachment 3**

**Order of Adoption**  
**Board of Pharmacy**  
**California Code of Regulations**

**To Add Section 1702 of Division 17 of Title 16 of the California Code of Regulations to read as follows:**

**1702. Pharmacist Renewal Requirements**

(a) A pharmacist applicant for renewal who has not previously submitted fingerprints as a condition of licensure or for whom an electronic record of the licensee's fingerprints does not exist in the Department of Justice's criminal offender record identification database shall successfully complete a state and federal level criminal offender record information search conducted through the Department of Justice by the licensee's or registrant's renewal date that occurs on or after (IOAL insert effective date).

- (1) A pharmacist shall retain for at least three years as evidence of having complied with subdivision (a) either a receipt showing that he or she has electronically transmitted his or her fingerprint images to the Department of Justice or, for those who did not use an electronic fingerprinting system, a receipt evidencing that his or her fingerprints were recorded and submitted to the Board.
- (2) A pharmacist applicant for renewal shall pay, as directed by the Board, the actual cost of compliance with subdivision (a).
- (3) As a condition of petitioning the board for reinstatement of a revoked or surrendered license, or for restoration of a retired license, an applicant shall comply with subdivision (a).

- (4) The board may waive the requirements of this section for licensees who are actively serving in the United States military. The board may not return a license to active status until the licensee has complied with subdivision (a).
- (b) As a condition of renewal, a pharmacist applicant shall disclose on the renewal form whether he or she has been convicted, as defined in Section 490 of the Business and Professions Code, of any violation of the law in this or any other state, the United States, or other country, omitting traffic infractions under \$300 not involving alcohol, dangerous drugs, or controlled substances.
- (c) Failure to provide all of the information required by this section renders an application for renewal incomplete and the board shall not renew the license and shall issue the applicant an inactive pharmacist license. An inactive pharmacist license issued pursuant to this section may only be reactivated after compliance is confirmed for all licensure renewal requirements.

Note: Authority cited: Sections 4001.1, 4005 Business and Professions Code.

Reference: Sections 490, 4036, 4200.5, 4207, 4301, 4301.5, and 4400, Business and Professions Code; and Sections 11105(b)(10), and 11105(e), Penal Code.

  
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VIRGINIA HEROLD  
Executive Officer  
Board of Pharmacy

# **Attachment 4**



## *Assisting public members and the health professional oversight bodies on which they serve*

*This document contains Friday's proceedings from our 2010 annual meeting, held on Thursday and Friday, November 11 – 12, 2010, in Washington, D.C. Although this is not a verbatim transcript of the speakers' remarks and the question and answer sessions, it is a faithful rendition of what occurred.*

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## **CONTINUING COMPETENCE**

### **INTRODUCTION**

Continuing competence is another longstanding priority for CAC. We have been pleased to see recommendations from several prestigious Institute of Medicine committees that advocate more meaningful assessment and demonstration of current competence as a condition of re-licensure and recertification. One such recommendation reads:

All health professions boards should move toward requiring licensed health professionals to demonstrate periodically their ability to deliver patient care, as defined by the five competencies in this report, through direct measure of technical competence, patient assessment, evaluation of patient outcomes and other evidence-based assessment methods.

Other committees have critiqued reliance on mandatory continuing education and recommended significant changes in the way it is delivered. One report we will hear about later this morning is entitled, *Redesigning Continuing Education in the Health Professions*. Part of the justification for this report's recommendations reads:

Licensure and certification processes should reward successful demonstration of maintenance of competence. Additionally, certification should require a minimum standard of practice-based learning to promote the identification and solution of practice-based needs. Licensure should require demonstrated use of learning portfolios with documented needs assessment.

This is not just learning portfolios, but portfolios tailored to an individual's skills, practice and learning needs.

## **Keynote: The Future of Regulation**

### **Mark Lane, Vice President of Professional Standards and Assessment, Federation of State Boards of Physical Therapy**

I'm not going to talk specifically about scope of practice or continued competence, but about regulation in general – what it is, where are we headed, and what can we do about it. Certainly, scope of practice and continuing competence issues play a significant role in the future of regulation.

In order to understand where licensure is heading, we need to understand what licensure is. Here are some things licensure may be:

- **A public policy exercise of the state's police powers.** Is licensure designed to protect the public? Does it protect the public? Or, is it designed to do something entirely different? Is licensure a legalized monopoly to practice a profession? That certainly is an aspect of what licensure is.
- **A system of standards for entry into a profession.**
- **A system of standards for continued practice in the profession.** This raises questions about continued competence.
- **A system for removing impaired or incompetent providers from practice.** How do we identify whom to remove and decide how they should be removed?
- **A legal way to deter entry into a profession.** We may not like it, but licensure does deter entry.
- **A mechanism to protect licensees from competition.** We may not like it, but licensure does do that.
- **A means to gain access to third-party reimbursement.**
- **A means to establish and enhance the prestige of the profession.** We have many professions trying to obtain licensure for status reasons, even when there is no evidence of potential harm to the public.
- **A means to create a market for new academic disciplines.**

There are environmental factors that are influencing the future of regulation:

- **Limited access to healthcare is creating many problems.**
- **Decreasing state budgets which force distorted prioritization by regulators because there aren't the funds to discipline everyone who should be disciplined.**
- **Increasing deficits that force states to cut costs. One way to cut costs is to eliminate licensing boards.**
- **Economic recession, which is helping to drive regulation.**
- **The aging population.**
- **Technology, which changes the ways care is delivered.**

- **Professional associations, which promote their particular agendas and lobby the legislatures.**
- **The public.**
- **National healthcare reform.**

These and other environmental factors compete with each other and regulators are pulled in many different directions. Whoever wins the tug of war will direct the future of regulation.

David Montgomery of the Nebraska Department of Health made a comment I'd like to repeat here:

Our present professional regulatory system is a patchwork resulting from centuries of unsystematic legislation, band-aid fixes, and ad hoc changes. It is marginally effective, but also inefficient, needlessly expensive, inconsistent, and confusing to the public.

Do you agree? Is this true in your experience? If yes, we need to do something about the system. "The best way to predict the future is to invent it," according to Alan Kay, one of the pioneers in computer science. It says we own the future. Our tendency as regulators is to sit back and let things happen to us, but we need to invent the future.

What does it mean to be an inventor? First, we have to change the way we regulate. If we want things to change positively, we can't keep doing the things we have always done. If want things to get worse, we can sit back and let it happen.

If we are inventors as regulators, what qualities do we need to have?

- **Creativity.** Are we thinking outside the box?
- **Open-mindedness.**
- **Ability to listen.**
- **Willingness to change.**
- **Ability to learn from our mistakes.**
- **Proactivity, rather than reactivity.**
- **Perseverance.**
- **Willingness to question assumptions.**
- **Ability to buck the norm, to ask questions.**

We can all demonstrate these qualities of inventors. We can invent a regulatory future. Public members, licensee members and administrators alike need to stir the pot, to ask questions.

We have two choices. One is to continue on the current regulatory path, allowing things to happen to us. The alternative is to change the face of regulation and be inventors of the future.

What will happen if we stay on the current regulatory path?

- **Continuing scope of practice battles,** where it is the public who loses because decisions aren't based on data. They are based on economics and politics and influence.
- **Reactive regulation.** Should we be regulating in reaction to events, creating a hodge-podge of laws that aren't a cohesive guideline to good practice? Our system is currently complaint-based. This shouldn't be the only determinant of good practice. Moreover,

the complaint system waits until the harm has been done. Shouldn't our approach be to promote good practice so we don't have complaints coming in?

- **Discipline-based regulation.** Does punishment change behavior? Does it work in the public interest?
- **Unenforceable and ineffective regulations.** As an example, most jurisdictions have a supervision ratio for physical therapists vs. physical therapy assistants. The ratio varies from jurisdiction to jurisdiction. It doesn't make sense. What if I am supervising two physical therapy assistants and I get sick or go on vacation? Does that mean the patients cannot get treatment? It's all arbitrary and not based on any evidence. The real concern is whether the physical therapist is a good supervisor, not the ratio. Are our regulations really promoting good care and preventing harm, or are they arbitrary?
- **Little assurance of ongoing clinical competence.** We are at the tip of the iceberg in dealing with continued competence. We are just moving from continuing education to thinking about competence. We are far from impacting and demonstrating competence and influencing patient care.
- **Protection and promotion of the profession.** I hear members of licensing boards and professional associations talk about the battles they are fighting with one or more groups. Why are we talking about battles? Shouldn't we be concerned about the patient and creating a system of regulation and service that is in the best interest of the patient? We need to change the dynamic.
- **Regulation based on assumptions vs. evidence.** Oftentimes our regulations inhibit good practice and may contribute to problems with access.
- **Restriction of mobility.**
- **Lack of collaboration between disciplines.**

What might happen if we do not change our regulatory path?

- **Scope of practice decisions would no longer be made by the professions.** The ideal would be an impartial commission that decides based on what would be best for the public.
- **Boards will be deemed ineffective and be eliminated.** They may be combined, stripped of authority, or nationalized.
- **Continued competence will be mandated and it won't necessarily be a good system.**
- **Licensure requirements will be reduced.**
- **There will be a mandated focus on outcomes.**
- **There will be stricter requirements for sunset review.**
- **There will be an increase in public members and fewer licensee members.**
- **There will be forced licensure compacts to improve mobility within the United States and globally.**
- **Elimination of licensure altogether** if we cannot justify what we are going.

What might happen if we change the face of regulation?

- Interdisciplinary scope of practice decisions.
- Proactive rather than reactive regulation.
- Just Culture, which recognizes that people make honest mistakes.
- Education and promotion of quality, as opposed to just trying to prevent bad care.
- Peer Review.
- Continuing Competence.
- Encourage good practice rather than simply punishing bad practice.

Effective regulation does not inhibit good practice. It is evidence-based. It involves collaboration between disciplines for the greater good. It is proactive. Regulators play an active role in promotion of quality and remediation. Effective continued competence measures are in place. Regulation is part of the solution *vis a vis* access to quality healthcare.

How do we get there?

- **Collect the data.** We are doing a bad job now. We should have the capacity to do data analysis of our licensees to find out what the issues are.
- **Collaborate.** Professions and boards need to work together.
- **Change the framework** from a punitive reactive system to a prevention system.
- **Expand our perspective.**
- **Become inventors.**

Our choices are to continue on our current regulatory path, or to change the face of regulation. I suggest that we work together to do the latter. What leadership competencies would allow us to do this?

- External awareness
- Strategic thinking
- Innovation
- Entrepreneurship
- Leading transformation
- Leadership vs. management

Not everyone on a licensing board will have all these skills. That's why you are a team. Here is another quote from David Montgomery:

As part of healthcare reform, a major national conversation is needed over the effectiveness and efficiency of this system, including licensing, private certification, and enforcement. Such a conversation could lead to reforms that would streamline and modernize licensing practices. At present, there is no sign that this will occur.

It is up to us to change the face of regulation. Invention involves creativity, open-mindedness, willingness to change, learning from our mistakes, being active rather than passive, and perseverance. These are the qualities you need to have on your board to be inventors of the future of regulation.

Is your board made up of inventors? Do your board meetings facilitate invention and the creation of a new future, or do they deal only with the agenda?

I challenge you to create an environment where you help create the future of regulation. We can work together to do that. As Margaret Wheatley wrote,

To be responsible inventors and discoverers, we need the courage to let go of the old world, to relinquish most of what we have cherished, to abandon our interpretations of what does and what does not work. We must see the world anew.

That is our challenge as we deal with scope of practice and continued competence. We need to get out of our comfort zones and start changing the regulatory future.

**Comment:** There is a provision in the healthcare reform bill saying if a professional gets recertified every two years, he or she is exempt from some data collection.

**Comment:** In my observation, one of the distinguishing characteristics of effective boards embedded in effective organizations is that there is time set aside for reflective discussion at every board meeting. They challenge the way they do business as a board and the way they do business as an organization. In other words, they exhibit and foster many of the characteristics you mentioned.

## **How Will the Institute of Medicine’s Report “*Redesigning Continuing Education in the Health Professions*” Impact Health Professional Regulatory Boards?**

**Lucinda Maine, Executive Vice President and CEO, American Association of Colleges of Pharmacy**

The work of the IOM Committee on Planning a Continuing Health Care Professional Education Institute needs to be considered together with the work of three other entities. The first of these was research funded by the Macy Foundation. Two key priorities for the Macy Foundation are (1) inter-professional education and (2) maintaining practitioner competence to care for people throughout their professional lifespan. The Macy researchers concluded that the current reliance on continuing education (CE) is insufficient to achieve the second priority. They were particularly concerned about CE in medicine because of what they perceived as commercial biases in its design and delivery. That study group recommended the creation of the IOM committee on which I served and the Macy Foundation provided support.

The Macy Foundation also supported two other pieces of work. One was a study by the Association of American Medical Colleges and the Association of Colleges of Nursing that looked at CE and professional development in those two professions. The fourth piece of work was an economic analysis of the enterprise of CE and continuing professional development.

The IOM committee I served on was charged to review CE of healthcare professionals and to consider specifically a recommendation arising from the first analysis of nursing and medicine to create a national inter-professional continuing education institute to advance the science and the practice of CE.

The committee worked for approximately a year and involved three face-to-face meetings of a very diverse panel. There were two public workshops, extensive literature reviews, and external review of the report and its recommendations.

The committee acknowledged the importance of CE across the lifespan to help professionals stay up-to-date. There was agreement that quality care of the future depends upon the functioning of inter-professional teams. Those teams are going to have different compositions based on practice site and patient needs, but that is the wave of the future. However, we now do uni-rather than multi-professional licensure and certification.

The committee agreed with many others that there are flaws in the way we are currently financing, regulating, conducting and evaluating CE. We agreed that current regulatory requirements are insufficient. There is room for conflicts of interest and bias in the financing CE, but a lot has been done to address this problem.

We talked about the research that is needed to move the enterprise forward. Even though we can draw on the literature on CE and the professions, and we know that the didactic learning method is not optimal for adult learners, we don't know a lot about what more effective models might be, especially for teams of practitioners. We are not currently anywhere near team-based learning at the point of care.

Self-assessment and selecting the right CE program is a very immature science.

The committee embraced continuing professional development as the philosophy and the practice underpinning a better system for keeping our professionals at the cutting edge of their clinical care abilities. The current system is too disaggregated and there is no leverage for change.

We evaluated different scenarios about what could create a better system. One alternative considered was to create a federal agency. Another was a purely private entity composed of professional associations. We considered a coalition involving quality improvement organizations.

Ultimately, we recommended creating a public-private professional development institute that would bring all stakeholders together in support of a nationally coordinated system for professional development. We recommend some initial federal investment, but recognized the need to build a financial model that involves financial support from a variety of sources. The institute would have a board and a structure, but there would also be a variety of councils and ad hoc committees to do the work.

So, our first recommendation was that the Secretary of HHS should commission a planning committee to develop a plan for a public-private continuing professional development institute. This recommendation was made a couple of months before the passage of national healthcare reform, which calls for the creation of multiple offices, agencies and commissions. Our IOM recommendation is likely to take a back seat, but the National Health Workforce Commission called for in the Affordable Care Act could potentially address some of the recommendations in the IOM report.

The institute should help advance what we know about continuing professional development, help to guide and influence regulation across jurisdictions, and professions, address issues associated with financing CE and continuing professional development. The original Macy Foundation report recommending an institute documented the financing of medical CE, but there is little data for other professions. There is also a need for research into the science of CE and professional development.

The goals of the institute include creating a stronger scientific foundation for CE and continuing professional development. This means collecting and analyzing data, or creating a framework for other organizations to conduct data collection, analysis and measurement. Research is needed to identify meaningful measures of practice performance and quality. Electronic health records may facilitate the meaningful measurement of quality in ways we haven't be able to do before.

The committee believed that the institute could help inform regulation nationally, even if regulation continues to be state-based. In pharmacy, there is already a National Association of Boards of Pharmacy and a model pharmacy practice act.

How would continuing professional development be funded? Perhaps employers and practitioners themselves will need to bear more of the expense. Responsibility should be shared by all of the stakeholders.

One of the principal rationales for a national public-private institute is that we are committed to changing the model of patient care to an inter-professional model. Educators have a responsibility to educate future clinicians to work effectively in teams. Early in 2011, pharmacy, medicine, nursing, dentistry and public health will release a set of core competencies for inter-professional education involving these disciplines.

It may be productive to host an annual symposium, perhaps with a partner such as CAC, to synthesize the learning across professionals and energize and advance the enterprise. This would benefit of licensing boards and certifying bodies by assembling a collection of best practices that accelerate learning and improve the delivery of education, the regulation of practice, and the delivery of patient care.

**Questioner:** I am a public member in the state of Pennsylvania. I am surprised you said there is little research into educational methods other than didactic. Looking at how people on the cutting edge are trained now, some of the techniques are simulation, partial-task training, human patient simulators, gaming, triage scenarios for trauma, virtual reality, joystick-controlled learning, smart phone applications that offer just-in-time training, scenario-based cases, team ratings, video replay, cognitive task analysis, mentoring, and rotating skill stations.

**Maine:** We talked about everyone of those except the smart phone application, but not in any level of detail. The general consensus was that there is good evidence that there are a variety of different approaches. According to the Department of Education, blended learning appears to be the most effective – i.e., some didactic and some active learning via the tools you mention. Also, online learning appears to be more effective than the traditional model of sitting in a lecture hall and being lectured to. A complicating factor is that many entities that provide active learning are not approved by state regulatory boards so wouldn't satisfy regulatory requirements.

**Questioner:** There are continuing professional development activities underway within some specialty societies. This is the driver of continuing professional development within the medical professions. There has been a lot of attention paid to the various modalities of CE and other professional development and measurement activities that are part of maintenance of competence. This will undoubtedly be the primary way physicians will demonstrate to licensing authorities and others that they are maintaining their professional competence.

**Maine:** Maintenance of certification in medicine was on the table as an extremely important model. The problem is that only about three percent of pharmacists are board-certified, so we can't use maintenance of certification the way medicine is using it, and that is true in other disciplines also.

**Questioner:** Professional development must take place in the practice setting and not in a lecture hall. Mandatory CE is a big source of resort and cruise business in the US. Boards are asking people for contact hours, with little attention to the content of those hours. Did the committee address the role of licensing boards as the demand structures to drive the desired change?

**Maine:** It was clearly understood that state mandates for CE units are the leading driver of practitioner behavior today. Most licensed professionals have those requirements. Nobody knows what would happen if they went away and nobody is recommending that the requirements and the regulatory oversight go away. But, we did talk about the probability that workplace learning is the most effective model.

**Questioner:** Please elaborate on the topic of funding by private sources, particularly with respect to pharmaceutical companies, which I think are pernicious when I see their ads on television. What circumstances would make it okay for pharmaceutical companies to be funding CE?

**Maine:** I agree. There is a difference between marketing activities, which are regulated by the FDA (including all the pernicious advertising on TV) and continuing education grant support. I administered CE

earlier in my career and AACP offers CE credits at our annual meetings. I think the point made by the economist on the IOM committee was that there is absolutely potential for wrongdoing and ample evidence of it occurring, but if the accreditation framework for the providers of CE and the regulatory framework for the consumers of the CE have adequate safeguards, then wrongdoing shouldn't occur. The situation has improved and many providers have left the business. There has been some creative thinking, for example, finding ways to demonstrate that what is learned in CE is applied to patient care.

**Comment:** I am the current President of the National Board for the Certification of Hospice and Palliative Care Nurses and the President of the Alliance of Hospice and Palliative Nursing. My comment goes to the recommendation related to inter-professional models. We are very proud that the American Academy of Hospice and Palliative Physicians and the Hospice and Palliative Nurses Association have a combined conference every year. The conference includes social workers, physicians, registered nurses, administrators, nursing assistants, and advanced practice nurses. They not only attend, they are also presenters. All the professions benefit from the presentations and the networking that goes on.

**Maine:** The Society of Critical Care Medicine is another organization that is moving in that same direction. We need to foster this kind of collaboration and to find ways to make the documentation of CE as inter-disciplinary and user-friendly as possible.

**Comment:** I am a public member of a medical board and a public member of the Accreditation Council for Continuing Medical Education (ACCME). As a sociologist, I am very skeptical about pharmaceutical companies and am suspicious of the research they fund. However, one of the things that ACCME has done is to require in its accreditation standards at least a symbolic separation between pharmaceutical company funding and what is actually taught in CE courses and the faculty who does the teaching. ACCME is also working with nursing organizations to permit both physicians and nurses to earn CE credit for some of the same courses. The proposed institute seems a great way to encourage more of this kind of collaboration.

**Comment:** I am with the Wyoming State Board of Nursing. We have been struggling with competence for initial licensure for entry-level nurses. We approve education programs and approve many online programs because of the rural nature of the state. Our requirement for practical clinical experience for initial licensure has provoked a lot of political pushback against online programs. We rely heavily on the National Council of State Boards of Nursing's research, which shows that practical experience with a preceptor in an educational setting must supplement online learning.

## **Continuing Competence Initiatives by Licensing Board Associations**

### **Martin Crane, Immediate Past Chair, Federation of State Medical Boards Board of Directors**

The goal of the maintenance of licensure initiative at the Federation of State Medical Boards (FSMB) is to assure the continued competence of licensed physicians. This effort has moved forward in a deliberate and thoughtful fashion for about six or seven years.

Maintenance of licensure is a sea change in the licensure and license renewal process for physicians. It will mean that, as a condition of licensure renewal, physicians must demonstrate participation in a continuous professional development program of life-long learning that is objective, practice-relevant, and results in demonstrable practice improvement over time. It is the kind of change that the Institute of Medicine (IOM) has been recommending.

Why do it? Because state medical boards are mandated to protect the public and guarantee that licensed physicians are competent. It is implied authority in every medical practice act. For physicians, it is a commitment to their patients. For the public, it is an assurance that they have access to the highest quality care. I believe it will give the public confidence in a self-regulatory system and the medical profession. We are preparing to launch the initiative in a few states in the near future and expect full implementation in five to ten years.

Assuring that physicians maintain their competence throughout their careers is an absolute expectation by the public. Most surveys show that the public already believes that physicians are periodically evaluated for competence and quality of care.

The initial licensing process takes into account education, training, experience, examination, and other factors. The re-licensure process to date has been mainly administrative. I agree with the previous speaker that mandatory continuing education leaves a lot to be desired, at least the continuing education system we have now.

There is definitely a cultural and paradigm shift underway in medicine and some other professions away from the reactive, complaint-driven approach to a proactive approach of prevention and improvement. This is not about finding bad apples. It is about making good practitioners better by encouraging continuing professional development.

We paid attention to the IOM reports (*To Err is Human*, *The Quality Chasm*, etc.), the Pew Commission recommendations, the patient safety and error reduction movements and recognized that the accountability of the regulatory system was being challenged. We did not want to be part of the problem and felt that we could change and be part of the solution.

We created a special committee, which included representatives of the public, the IOM and other stakeholders in addition to medicine. The core statement of this effort is that medical boards have an obligation to the public to ensure the ongoing competence of physicians seeking license renewal. This is the same as their obligation to assess people seeking initial licensure.

An important point about the recommendations coming from the committee is that current competence needs to be demonstrated within the scope of one's daily professional practice. We began with the core competencies of the Accreditation Council for Graduate Medical Education (ACGME), which encompass most of the practice of medicine and pay attention to system-based and team approaches to practice. This is a non-punitive, non-burdensome system for physicians and does not create undue expectations by the public.

The guiding principle is lifelong learning to facilitate improvement in practice. State boards establish the requirements, but they don't have the resources and funding to do everything, so they will collaborate with other organizations, such as assessment certification organizations and third-party attestations, just as the CE process does now. The system should not compromise care nor create barriers to physician practice. It needs to balance transparency and privacy.

We created an advisory group in 2009 to look at the impact FSMB has on boards, on the public, on physicians, to review the FSMB's reports, to predict the challenges in the future, and to decide whether the maintenance of licensure initiative is a value-added endeavor. The advisory group represented regulators, licensees, legislators, assessment certification bodies, and the public. It endorsed the concept that licensees must participate in a professional development program based on the ACGME competencies.

There are three components to implementation: Objective self-assessment of knowledge and skills; performance improvement plans, measurement of the resulting improvements. Licensees may choose from several options to satisfy these three requirements.

One option is to maintain specialty certification, which itself requires continuing professional development and continuous practice improvement. About seventy percent of physicians are board-certified. That leaves at least thirty percent who cannot maintain their licenses through that route.

There are also physicians who are grandfathered by their specialty certification boards, which means they are exempt from maintenance of certification requirements. Depending on the specialty, anywhere from 29 – 40 percent of physicians are grandfathered. There are also physicians who choose not to re-certify – 29 percent of generalists.

So, more than half physicians cannot participate in maintenance of certification as a surrogate for maintenance of licensure.

The system needs to be verifiable and satisfy the public that the profession means business. It needs to cover physicians who are in non-clinical roles because they may want to re-enter practice in the future.

In April, FSMB approved a framework for maintenance of licensure and a template for state board implementation. This will be exposed for public comment, submitted to the board in February and to the FSMB delegate assembly in April 2011.

The startup plan allows boards to build on programs they already have, so long as they are consistent with continuing professional development and lifelong learning, and do not rely exclusively on CE. We anticipate that the program will evolve with time. Self-assessment will drive educational opportunities and improvement plans will drive practice changes. We will start with a renewal cycle of 5-10 years

Challenges remain. One is that we are still developing programs like this in silos. We still don't fully know how we will deal with non-clinically active physicians.

We don't want to push out physicians who are at the end of their careers. Reciprocity and portability among states is important. Remediation programs must be created for those whose self-assessment identifies deficiencies.

FSMB is happy to share what we are doing as a model for other professions.

### **William Rafferty, Immediate Past President, Association of Regulatory Boards of Optometry**

I am here on behalf of the Association of Regulatory Boards of Optometry (ARBO), but I am presenting as myself today because I don't know whether my board would support everything I say.

Regulatory boards are charged with responsibility for ensuring the competence of licensees. Currently continuing education is the modality optometry uses. I think we all know that is insufficient.

ARBO formulated a plan based on common sense, which looks a lot like what the FSMB is doing. It is a work in progress. Our continuing education program (COPE) categorizes continuing education into subject areas and creates a framework states can use. It includes an accreditation process and a tracking system for every optometrist in the country. We also have a national mobility program providing a national uniform high standard for mobility. It has not been adopted by many states.

We have been working on competency since the 1960s, when we developed our CE system. Recently, we have had conferences on the topic. In 2009 we conducted a survey, which asked whether general board certification and continued competence are the same. Seventy-three percent of respondents said they are not the same. We asked whether there is a need for track education programs with post-assessment. Most respondents thought so. We asked them to name the highest priority for regulatory boards at this time. More than 50 percent said continued competence. This gave us the momentum to pass a resolution supporting the development of an improved system for demonstrating continued competency for the benefit of the public. In 2010, we presented the outline of our competency program to the membership. It was fairly well received.

Yesterday, our board considered increasing the number of CE hours and adding a test at the end. I said I thought that would be doing more of the same and expecting a different outcome. That approach would still not identify the practitioner's weaknesses and it would not demonstrate the practitioner's competence to the public. I believe those are the two objectives we must try to accomplish. Hopefully, we will modify our approach in North Carolina.

People ask why bother to have a continuing competence program? Healthcare consumers have a right to expect their practitioner is competent. Our maintenance of licensure concept was not designed for third parties; it is designed to protect the public. However, we recognize that in some professions, competence will be demonstrated through certification and in others through licensure.

Our plan uses the competency, accreditation, and tracking programs I mentioned earlier. It involves self-assessment. It involves putting a framework around both continuing education and continuing professional development to address the results of self-assessment. It includes a post-assessment component to monitor what happens in step two and identify changes that affect practice performance. We want to see long-term changes in practice.

The self-assessment is computer-based. It can be self-or testing center-administered. It is not a test, but a self-assessment module. It directs education and remediation to an individual's weaknesses, not their strengths. Practitioners will be provided feedback about strengths and weaknesses.

The curriculum attempts to establish a dynamic, well-rounded, long-term learning process. Because optometry is a specialized area, it is possible to break down the learning process according to sections of the eye. There can be required areas and elective areas and general requirements related to ethics and medical errors, and so on.

Continuing professional development includes accredited and non-accredited learning activities, self-assessment programs, structural learning, degree programs, chart review, teaching, research, and so on. The post-assessment component is designed to determine the effectiveness of the educational and professional development activities. We are thinking of a five-year framework for pre- and post-assessment.

This program could fit well in most states without statutory modifications. It is designed for boards that want to enhance their current programs. The program is feasible for ARBO because it builds on existing programs, such as the data tracking.

**Questioner:** Please talk a bit about the concepts of "legally defensible and psychometrically sound." These are often raised as stumbling blocks in the way of continued competence programs.

**Crane:** The American Board of Medical Specialties first called its program "maintenance of competence." Early on, they learned that they would not be indemnified if they gave someone a certificate of competence, so they changed the name to maintenance of certification. FSMB researched this and learned that we are indemnified and can use the word competence. The legal concerns you raise vary from jurisdiction to jurisdiction.

**Rafferty:** Our plan is to start small, with two or three states, to see what problems we run into. We are fortunate to have an exceptional psychometrically sound testing agency, which will be used for self-assessment and post-assessment, so it will be legally defensible.

**Questioner:** The Accreditation Council for Pharmacy Education accredits providers of continuing education. Quality improvement in CE is part of our strategic plan. Dr. Crane, you mentioned that non-clinically active physicians and physicians with inactive licenses will have to comply. Please explain how that will work.

You also referred to maintenance of competence programs in other countries, which have moved toward a continuing professional development model. In pharmacy, most of these countries have a split register. They have different requirements for maintenance of licensure for pharmacists who are clinically active and those who are not. Please comment on this, given the objective of having a competency system that relates to what practitioners do on a daily basis.

**Crane:** There is a difference between having an active license and being an active physician. Anyone with an active license has to go through an administrative renewal process currently. Some of the licensees are not in clinical practice. They may be in administrative roles. There is a movement to create an administrative license, which would not authorize an individual to practice, but would enable him or her to be a medical director of an HMO or hospital.

Those with inactive licenses must now demonstrate something to a medical board in order to gain an active license. In the future, anyone who decides to re-enter practice will have to satisfy the maintenance of licensure requirements.

We were sure from the start that what we were talking about was an individual's current daily practice. We are now looking into the idea of "mapping a practice," as is currently done in hospitals. Most of medicine is now practiced outside hospitals.

**Questioner:** Do you have a system worked out for monitoring compliance with your program?

**Rafferty:** The program could be voluntary initially, but we are hoping state boards will adopt the program for re-licensure. In North Carolina, we monitor 100 percent of CE compliance currently, and could monitor a new program the same way.

**Crane:** Currently, medical boards randomly monitor CMEs. So, we don't really know much about compliance right now. We thought we would start with an attestation system because boards don't have the resources to monitor. Ultimately, in order to be credible, the system has to be verifiable. I am hoping that we will incentivize participation with changes in the reimbursement process.

# **Attachment 5**

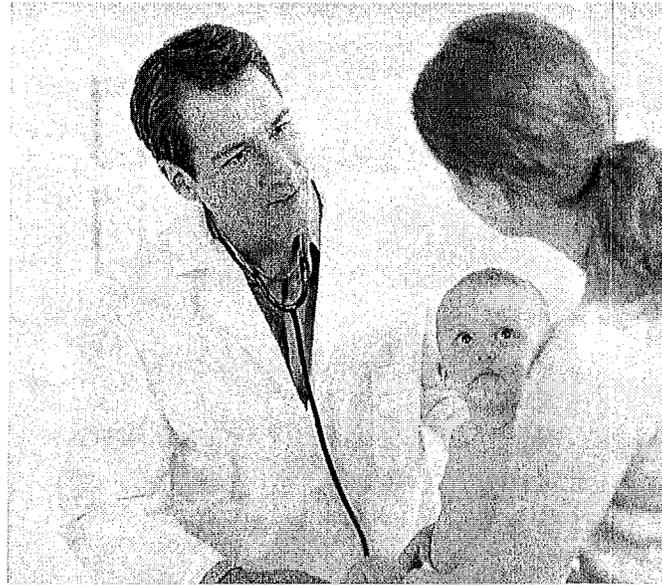
## CLEARINGHOUSE

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[www.oshpd.ca.gov/hwdd](http://www.oshpd.ca.gov/hwdd)



October 7, 2010

## Factsheet



**WANT  
DATA?**

oshpd

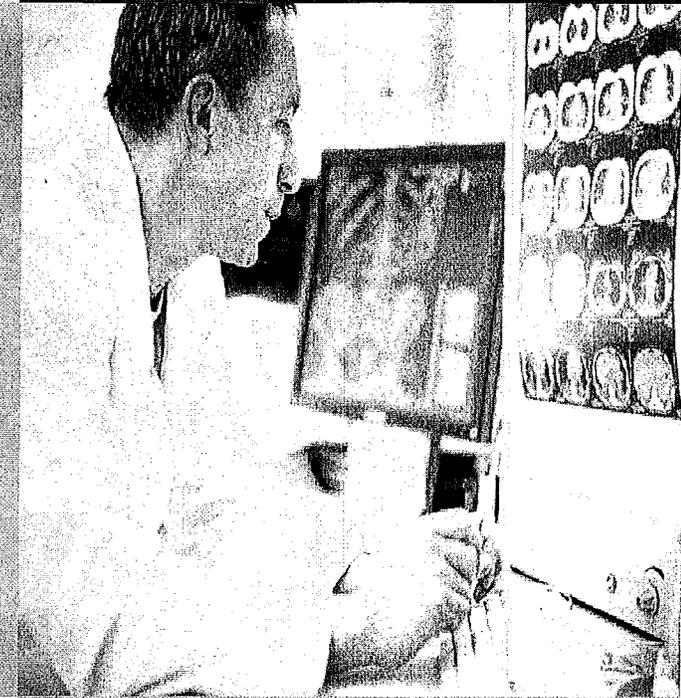
## WHAT IS HEALTHCARE WORKFORCE AND FACULTY DATA?

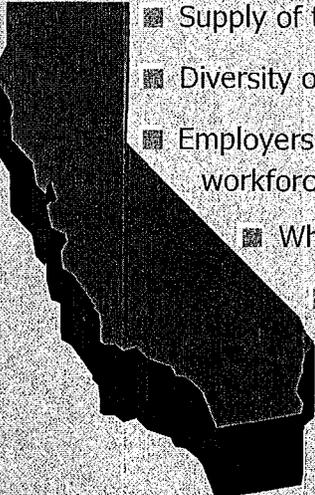


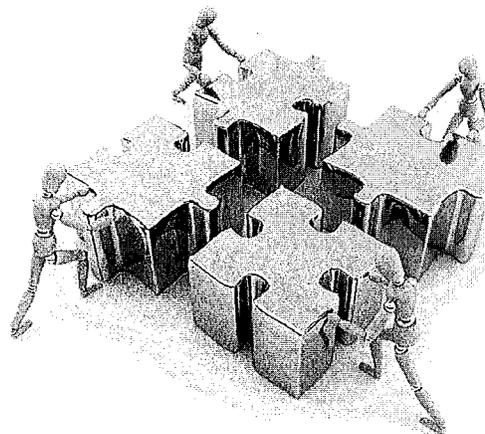
## WHO ARE THE STATUTORY DATA PROVIDERS?

- Employment Development Department's Labor Market Information Division
- 22 health licensing authorities
- University of California Office of the President
- California State University Chancellor's Office
- California Community Colleges Chancellor's Office
- Office of Statewide Health Planning and Development

## WHAT ARE THE BENEFITS?



- 
- Supply of the workforce
  - Diversity of the workforce
  - Employers' current and projected workforce demand
  - Where they are working
  - Educational capacity to train workers
  - Student enrollment and graduates



- Centralize comprehensive data
- Conduct trend analysis and reporting
- Standardize data collection tools and methods
- Improve workforce recruitment and retention
- Disseminate data easily
- Develop policy and planning strategies
- Address workforce shortages

Complete in Black or Blue Ink  
Shade Circles Like This ●

Mail-In Physician Survey

Return to MBC

# MAIL-IN PHYSICIAN RENEWAL SURVEY

Date Survey Completed MM/DD/YYYY

License Type/Number: str005 int006str007  
Expiration Date: dte014

Are you retired?  Yes  No If yes, skip to #9.

## 1. ACTIVITIES IN MEDICINE

Mandatory: Fill in one circle on each line.

Hours	None	1-9	10-19	20-29	30-39	40+
Patient Care	<input type="radio"/>					
Telemedicine	<input type="radio"/>					
Administration	<input type="radio"/>					
Research	<input type="radio"/>					
Teaching	<input type="radio"/>					
Other	<input type="radio"/>					

## 2. PRACTICE LOCATIONS

Mandatory: If you have hours for Patient Care, enter the primary and secondary practice location(s).

Primary practice location (U.S. Only)		Secondary practice location (U.S. Only)	
Zip Code	County Code	Zip Code	County Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

### CODES (CA County / Out of State)

01 Alameda	11 Glenn	21 Marin	31 Placer	41 San Mateo	53 Trinity
02 Alpine	12 Humboldt	22 Mariposa	32 Plumas	42 Santa Barbara	54 Tulare
03 Amador	13 Imperial	23 Mendocino	33 Riverside	43 Santa Clara	55 Tuolumne
04 Butte	14 Inyo	24 Merced	34 Sacramento	46 Sierra	56 Ventura
05 Calaveras	15 Kern	25 Modoc	35 San Benito	47 Siskiyou	57 Yolo
06 Colusa	16 Kings	26 Mono	36 San Bernardino	48 Solano	58 Yuba
07 Contra Costa	17 Lake	27 Monterey	37 San Diego	49 Sonoma	
08 Del Norte	18 Lassen	28 Napa	38 San Francisco	50 Stanislaus	98 Out of State
09 El Dorado	19 Los Angeles	29 Nevada	39 San Joaquin	51 Sutter	
10 Fresno	20 Madera	30 Orange	40 San Luis Obispo	52 Tehama	

## 3. CURRENT TRAINING STATUS

Mandatory:  Residency  Fellow  Not in Training

## 4. MEDICAL PRACTICE/SPECIALTY AND BOARD CERTIFICATIONS

Mandatory: Mark all of your specialty classifications in your primary (P) and secondary (S) practice areas. Also, mark any Board Certifications (BD) that you have.

P	S	BD Certification	P	S	BD Certification
<input type="radio"/>	<input type="radio"/>	Addiction Psychiatry	<input type="radio"/>	<input type="radio"/>	General Practice
<input type="radio"/>	<input type="radio"/>	Adolescent Medicine	<input type="radio"/>	<input type="radio"/>	Geriatric Medicine
<input type="radio"/>	<input type="radio"/>	Advanced Heart Failure and Transplant Cardiology	<input type="radio"/>	<input type="radio"/>	Geriatric Psychiatry
<input type="radio"/>	<input type="radio"/>	Aerospace Medicine	<input type="radio"/>	<input type="radio"/>	Gynecologic Oncology
<input type="radio"/>	<input type="radio"/>	Allergy and Immunology	<input type="radio"/>	<input type="radio"/>	Hematology
<input type="radio"/>	<input type="radio"/>	Anatomic Pathology and Clinical Pathology	<input type="radio"/>	<input type="radio"/>	Hospice and Palliative Medicine
<input type="radio"/>	<input type="radio"/>	Anesthesiology	<input type="radio"/>	<input type="radio"/>	Infectious Disease
<input type="radio"/>	<input type="radio"/>	Blood Banking/Transfusion Medicine	<input type="radio"/>	<input type="radio"/>	Internal Medicine
<input type="radio"/>	<input type="radio"/>	Cardiovascular Disease	<input type="radio"/>	<input type="radio"/>	Interventional Cardiology
<input type="radio"/>	<input type="radio"/>	Child Abuse Pediatrics	<input type="radio"/>	<input type="radio"/>	Maternal and Fetal Medicine
<input type="radio"/>	<input type="radio"/>	Child and Adolescent Psychiatry	<input type="radio"/>	<input type="radio"/>	Medical Biochemical Genetics
<input type="radio"/>	<input type="radio"/>	Clinical and Laboratory Dermatological Immunology	<input type="radio"/>	<input type="radio"/>	Medical Genetics
<input type="radio"/>	<input type="radio"/>	Clinical Biochemical Genetics	<input type="radio"/>	<input type="radio"/>	Medical Oncology
<input type="radio"/>	<input type="radio"/>	Clinical Cardiac Electrophysiology	<input type="radio"/>	<input type="radio"/>	Medical Toxicology
<input type="radio"/>	<input type="radio"/>	Clinical Cytogenetics	<input type="radio"/>	<input type="radio"/>	Molecular Genetic Pathology
<input type="radio"/>	<input type="radio"/>	Clinical Genetics (MD)	<input type="radio"/>	<input type="radio"/>	Neonatal-Perinatal Medicine
<input type="radio"/>	<input type="radio"/>	Clinical Molecular Genetics	<input type="radio"/>	<input type="radio"/>	Nephrology
<input type="radio"/>	<input type="radio"/>	Clinical Neurophysiology	<input type="radio"/>	<input type="radio"/>	Neurodevelopmental Disabilities
<input type="radio"/>	<input type="radio"/>	Colon and Rectal Surgery	<input type="radio"/>	<input type="radio"/>	Neurological Surgery
<input type="radio"/>	<input type="radio"/>	Complementary and Alternative Medicine	<input type="radio"/>	<input type="radio"/>	Neurology with Special Qualification in Child Neurology
<input type="radio"/>	<input type="radio"/>	Congenital Cardiac Surgery	<input type="radio"/>	<input type="radio"/>	Neurology
<input type="radio"/>	<input type="radio"/>	Cosmetic Surgery	<input type="radio"/>	<input type="radio"/>	Neuromuscular Medicine
<input type="radio"/>	<input type="radio"/>	Critical Care Medicine	<input type="radio"/>	<input type="radio"/>	Neuropathology
<input type="radio"/>	<input type="radio"/>	Cytopathology	<input type="radio"/>	<input type="radio"/>	Neuroradiology
<input type="radio"/>	<input type="radio"/>	Dermatology	<input type="radio"/>	<input type="radio"/>	Neurotology
<input type="radio"/>	<input type="radio"/>	Dermatopathology	<input type="radio"/>	<input type="radio"/>	Nuclear Medicine
<input type="radio"/>	<input type="radio"/>	Developmental-Behavioral Pediatrics	<input type="radio"/>	<input type="radio"/>	Nuclear Radiology
<input type="radio"/>	<input type="radio"/>	Diagnostic Radiology	<input type="radio"/>	<input type="radio"/>	Obstetrics and Gynecology
<input type="radio"/>	<input type="radio"/>	Emergency Medicine	<input type="radio"/>	<input type="radio"/>	Occupational Medicine
<input type="radio"/>	<input type="radio"/>	Endocrinology, Diabetes and Metabolism	<input type="radio"/>	<input type="radio"/>	Ophthalmology
<input type="radio"/>	<input type="radio"/>	Facial, Plastic and Reconstructive Surgery	<input type="radio"/>	<input type="radio"/>	Orthopaedic Sports Medicine
<input type="radio"/>	<input type="radio"/>	Family Medicine	<input type="radio"/>	<input type="radio"/>	Orthopaedic Surgery
<input type="radio"/>	<input type="radio"/>	Forensic Psychiatry	<input type="radio"/>	<input type="radio"/>	Otolaryngology
<input type="radio"/>	<input type="radio"/>	Gastroenterology	<input type="radio"/>	<input type="radio"/>	Pain Medicine
<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Pathology - Anatomic



# **Attachment 6**

# Disaster Response Policy Statement

Advance planning and preparation for disaster and emergency response are important activities for individuals, as well as all Board licensees. The Board has begun working on such preparedness with the federal and state government, and to this end, in October 2006, the Board adopted the following policy statement.

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

The Board encourages its licensees to volunteer and become involved in local, state, and national emergency and disaster preparedness efforts. City or county health departments, fire departments, or other first responders can provide information on local opportunities. The Emergency Preparedness Office of the California Department of Health Services is a lead agency overseeing emergency preparedness and response in California, particularly regarding health system response, drug distribution and dispensing, and/or immunization and prophylaxis in the event of an emergency. At the federal level, lead contact agencies include the Department of Health and Human Services, the Centers for Disease Control, and/or the Department of Homeland Security and its Federal Emergency Management Agency (FEMA). Potential volunteers are encouraged to register and get information at [www.medicalvolunteer.ca.gov](http://www.medicalvolunteer.ca.gov) (California) and [www.medicalreservecorps.gov](http://www.medicalreservecorps.gov) (federal).

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

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

Furthermore, during a declared disaster or emergency affecting residents of California, the Board hopes that persons outside of California will assist the residents of California. To facilitate such assistance, in the event of a declared California disaster or emergency, the Board expects to use its powers under the California Business and Professions Code, including section 900 and section 4062, subdivision (b) thereof, to allow any pharmacists, intern pharmacists, or pharmacy technicians, who are not licensed in California but who are licensed in good standing in another state, including those presently serving military or civilian duty, to provide emergency pharmacy services in California. The Board also expects to allow nonresident pharmacies or wholesalers that are not licensed in California but that are licensed in good standing in another state to ship medications to pharmacies, health professionals or other wholesalers in California.

Finally, the Board also expects to allow use of temporary facilities to facilitate drug distribution during a declared disaster or state of emergency. The Board expects that its licensees will similarly respond outside of the state to disasters or emergencies affecting populations outside California, and will pursue whatever steps may be necessary to encourage that sort of licensee response.

<sup>1</sup>Expanded powers in the event of a disaster are also granted to the Governor and/or other chief executives or governing bodies within California by the California Emergency Services Act [Cal. Gov. Code, §§ 8550-8668] and the California Disaster Assistance Act [Cal. Gov. Code, §§ 8680-8690.7], among others. Section 8571 of the Government Code, for instance, permits the Governor to suspend any regulatory statute during a state of war or emergency where strict compliance therewith would prevent, hinder, or delay mitigation.

<sup>2</sup>See also the Interstate Civil Defense and Disaster Compact [Cal. Gov. Code, §§ 177-178], the Emergency Management Assistance Compact [Cal. Gov. Code, §§ 179-179.5], and the California Disaster and Civil Defense Master Mutual Aid Agreement [executed 1950], regarding cooperation among the states.

## Volunteer Questions and Answers:

**Q: Is there protection for liability and workers compensation for volunteer health professionals?**

**A: Volunteers deployed through Disaster Healthcare Volunteers will be registered in their local county as Disaster Service Workers, a program providing these protections.**

**Q: Do I need to have prior disaster experience?**

**A: No! All volunteers are welcome.**

**Q: I'm retired. Can I still volunteer?**

**A: Yes! Just be sure to indicate your license status when you register.**

**Q: What other issues should I consider?**

**A: Care for your family if you respond. Emergency response can be physically and emotionally difficult; personal medical conditions may need to be evaluated. You may have work or other commitments that would prevent you from responding to an activation. Missions may be up to ten days in duration.**

## Who Should Register?

- Audiologists and Audiology Aides
- Certified Nurse Assistants
- Chiropractors
- Clinical Laboratory Scientists
- Medical Laboratory Technologists
- Clinical Nurse Specialists
- Cytotechnologists
- Dentists
- Diagnostic Radiologic Technologists
- EMT-Is and EMT-Paramedics
- Hemodialysis Technicians
- Home Health Aides
- Licensed Clinical Social Workers
- Licensed Midwives
- Licensed Vocational Nurses
- Marriage and Family Therapists
- Nuclear Medicine Technologists
- Nurse Anesthetists
- Nurse Midwives
- Nurse Midwife Furnishers
- Nurse Practitioner Furnishers
- Nurse Practitioners
- Occupational Therapists
- Occupational Therapy Assistants
- Optometrists
- Osteopathic Physicians and Surgeons
- Pharmacists
- Pharmacy Technicians
- Phlebotomists
- Physical Therapists
- Physical Therapist Assistants
- Physicians and Surgeons
- Physician Assistants
- Podiatrists
- Psychiatric Mental Health Nurses
- Psychiatric Technicians
- Psychologists
- Public Health Microbiologists
- Public Health Nurses
- Registered Associate Social Workers
- Registered Dental Assistants
- Registered Dental Hygienists
- Registered Nurses
- Registered Veterinary Technicians
- Respiratory Care Practitioners
- Speech-Language Pathologists
- Speech-Language Pathology Aides
- Veterinarians

*Managed by the California Emergency Medical Services Authority,  
in partnership with the California Department of Public Health.  
Funds are provided by the United States  
Department of Health and Human Services.*

California Emergency Medical Services Authority

1930 9th Street • Sacramento, CA 95811

Phone: 916-322-4336 • Fax: 916-323-4898

Email: [healthcarevolunteers@ems.ca.gov](mailto:healthcarevolunteers@ems.ca.gov)

Web: <http://www.emsa.ca.gov>

# WHEN DISASTER STRIKES, YOU CAN MAKE THE DIFFERENCE



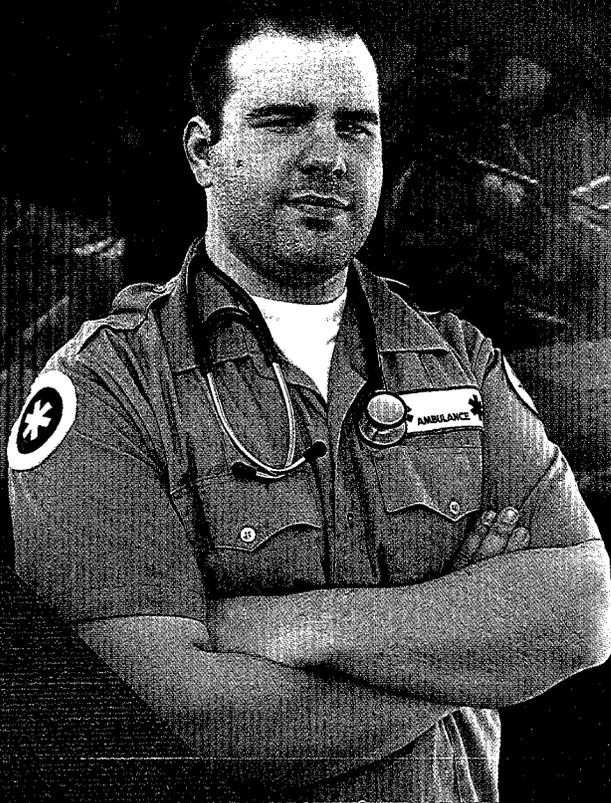
## REGISTER TODAY

[WWW.HEALTHCAREVOLUNTEERS.CA.GOV](http://WWW.HEALTHCAREVOLUNTEERS.CA.GOV)

[WWW.HEALTHCAREVOLUNTEERS.CA.GOV](http://WWW.HEALTHCAREVOLUNTEERS.CA.GOV)

## Who are “Disaster Healthcare Volunteers?”

Disaster Healthcare Volunteers are professionals like you who want to volunteer during an emergency or disaster. When you register on our secure web-based registry, you will indicate your volunteer preferences and enter information about your skills. The registry will automatically notify you in the case of a disaster and track your deployment.



## What role will I have in a large-scale disaster or emergency?

Your role will be to practice your profession or skill as either an individual called up at the time of a disaster, or as part of an organized response team. Volunteers may participate in several ways, including:

- As an individual called upon during extreme emergencies for your county
- As part of a community-based Medical Reserve Corps;
- As a member of a State of California Medical Assistance Team.

Every attempt will be made to match your skills, competencies and license or registration level with your responsibilities during a disaster. However, there might be situations in which you will be asked to assist with activities that are less challenging than your normal work duties.

## How do I register?

Visit the Disaster Healthcare Volunteers' site at: **WWW.HEALTHCAREVOLUNTEERS.CA.GOV**, click the “Register Now” button and you're on your way!

## How does the “Disaster Healthcare Volunteers” program work?

Once you have registered to become a Disaster Healthcare Volunteer, your professional license will be verified electronically with your licensing board by the Emergency Medical Services Authority. This information will become a part of the secure Disaster Healthcare Volunteer Statewide Registry.

During a disaster, state or local (county) officials will determine what kind of health professionals are needed, search the database for available volunteers, and send an alert to selected members via e-mail, telephone and pager.

If you receive an alert in the event of a disaster, you will have the chance to accept or decline the volunteer request. If you accept, you will receive specific instructions on where and when to report, and what is needed for the incident. There is no obligation to participate during an activation.

## Why register now, before a disaster?

Registering now allows verification of your license and credentials, promotes training opportunities, and helps disaster managers understand how many volunteers might be available. This will help us match your skills with the needs required in each emergency situation.

**Registering now makes it easier to help when disaster strikes!**

## REGISTERING IS EASY!

Visit the Disaster Healthcare Volunteers' site at: **WWW.HEALTHCAREVOLUNTEERS.CA.GOV**, click the “Register Now” button and you're on your way!

**IN TIMES OF DISASTER, CALIFORNIA NEEDS YOU!  
BECOME A DISASTER HEALTHCARE VOLUNTEER  
REGISTER TODAY AT WWW.HEALTHCAREVOLUNTEERS.CA.GOV**



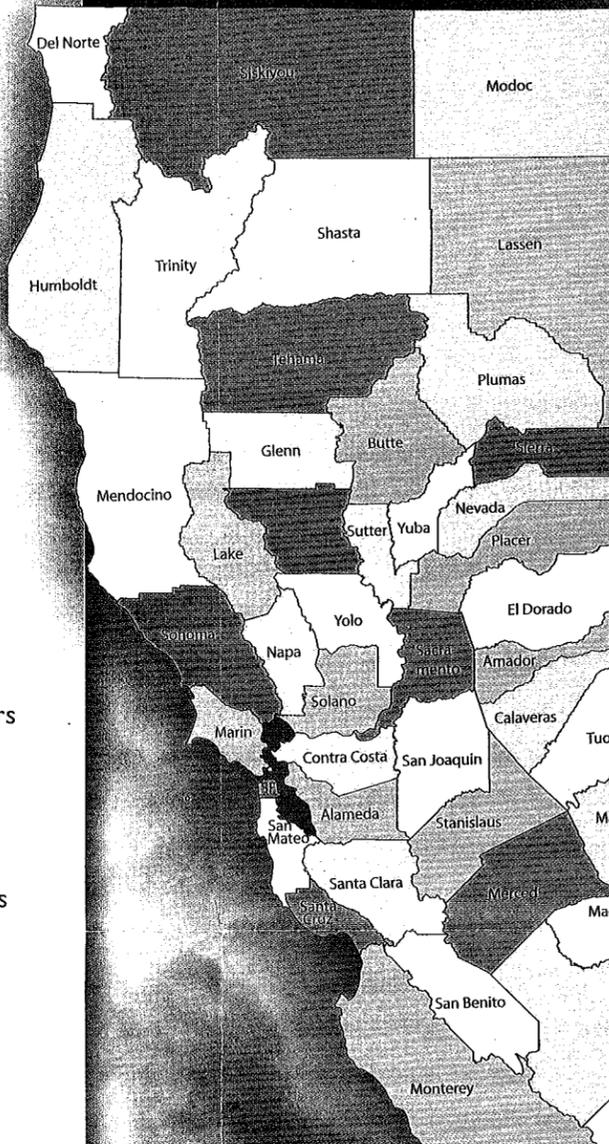
# BECOME A DISASTER HEALTHCARE VOLUNTEER

REGISTER TODAY AT [WWW.HEALTHCAREVOLUNTEERS.CA.GOV](http://WWW.HEALTHCAREVOLUNTEERS.CA.GOV)



## Who Should Register?

- Audiologists and Audiology Aides
- Certified Nurse Assistants
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- Clinical Laboratory Scientists
- Medical Laboratory Technologists
- Clinical Nurse Specialists
- Cytotechnologists
- Dentists
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- EMT-Is and EMT-Paramedics
- Hemodialysis Technicians
- Home Health Aides
- Licensed Clinical Social Workers
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- Physicians and Surgeons
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- Podiatrists
- Psychiatric Mental Health Nurses
- Psychiatric Technicians
- Psychologists
- Public Health Microbiologists
- Public Health Nurses
- Registered Associate Social Workers
- Registered Dental Assistants
- Registered Dental Hygienists
- Registered Nurses
- Registered Veterinary Technicians
- Respiratory Care Practitioners
- Speech-Language Pathologists
- Speech-Language Pathology Aides
- Veterinarians



## Your Healthcare Expertise Makes the Difference.

All healthcare professionals are needed to volunteer for public service in the event of a significant disaster or a public health emergency. You can make a difference during times of disaster by helping people, animals and your community.



# REGISTER TODAY

[WWW.HEALTHCAREVOLUNTEERS.CA.GOV](http://WWW.HEALTHCAREVOLUNTEERS.CA.GOV)

# **Attachment 7**

**California State Board of Pharmacy  
CPJE Statistics 4/1/10 – 9/30/10**

The charts below display data for all candidates who took the CPJE examination between 4/1/10 – 9/30/10, inclusive.

The board also displays NAPLEX scores associated with any candidate who took the CPJE during this six-month period and was reported to the board, regardless of when the NAPLEX may have been taken (it could have occurred outside the six-month reporting period noted above). Typically, the board reports CPJE performance data at six-month intervals.

**Overall Pass Rates**

**CPJE**

		Frequency	Percent
Valid	F	235	17.7
	P	1095	82.3
	Total	1330	100.0

**NAPLEX**

		Frequency	Percent
Valid	F	61	4.7
	P	1227	95.3
	Total	1288	100.0

**Location of School**

**CPJE**

			JPE		JPE Total	NAPLEX		NAPLEX Total
			Fail	Pass		Fail	Pass	
School	California	Count	62	679	741	17	718	735
		% within school	8.4	91.6	100.0	2.3	97.7	100.0
	Other US	Count	112	333	445	18	396	414
		% within school	25.2	74.8	100.0	4.3	95.7	100.0
	Foreign	Count	61	77	138	26	107	133
		% within school	44.2	55.8	100.0	19.5	80.5	100.0
	Unclassified	Count	0	6	6	0	6	6
		% within school	0	100.0	100.0	0	100.0	100.0
Total		Count	235	1095	1330	61	1227	1288
		% within school	17.7	82.3	100.0	4.7	95.3	100.0

**Gender**

			JPE pass fail status		JPE Total	NAPLEX pass fail status		NAPLEX Total
			Fail	Pass		Fail	Pass	
gender	F	Count	146	764	910	38	845	883
		% within gender	16.0	84.0	100.0	4.3	95.7	100.0
	M	Count	89	331	420	23	382	405
		% within gender	21.2	78.8	100.0	5.7	94.3	100.0
Total		Count	235	1095	1330	61	1227	1288
		% within gender	17.7	82.3	100.0	4.7	95.3	100.0

**Degree**

			JPE pass fail status		JPE Total	NAPLEX pass fail status		NAPLEX Total
			Fail	Pass		Fail	Pass	
degree	BS Pharm	Count	67	94	161	30	124	154
		% within degree	41.6	58.4	100.0	19.5	80.5	100.0
	Pharm D.	Count	168	1001	1169	31	1103	1134
		% within degree	14.4	85.6	100.0	2.7	97.3	100.0
Total		Count	235	1095	1330	61	1227	1288
		% within degree	17.7	82.3	100.0	4.7	95.3	100.0

**California Schools**

			JPE pass fail status		JPE Total	NAPLEX pass fail status		NAPLEX Total
			Fail	Pass		Fail	Pass	
school	UCSF	Count	8	100	108	0	107	107
		% within school	7.4	92.6	100.0	0	100.0	100.0
	UOP	Count	19	167	186	5	180	185
		% within school	10.2	89.8	100.0	2.7	97.3	100.0
	USC	Count	8	156	164	2	162	164
		% within school	4.9	95.1	100.0	1.2	98.8	100.0
	Western	Count	11	104	115	6	108	114
		% within school	9.6	90.4	100.0	5.3	94.7	100.0
	Loma Linda	Count	7	45	52	2	49	51
		% within school	13.5	86.5	100.0	3.9	96.1	100.0
	UCSD	Count	6	41	47	0	46	46
		% within school	12.8	87.2	100.0	0	100.0	100.0
	Touro U	Count	3	66	69	2	66	68
		% within school	4.3	95.7	100.0	2.9	97.1	100.0
Total		Count	62	679	741	17	718	735
		% within school	8.4	91.6	100.0	2.3	97.7	100.0

### US Schools of Pharmacy

	JPE pass fail status		Total
	F	P	
Auburn	0	3	3
U of AZ	1	6	7
U of AR	0	3	3
UCSF	8	100	108
U of Pacific	19	167	186
USC	8	156	164
U of CO	1	5	6
U of Conn	1	5	6
Howard DC	0	2	2
FL A&M	2	2	4
U of FL	3	9	12
Mercer	0	1	1
U of GA	0	3	3
Idaho SU	1	2	3
U of IL Chi	4	11	15
Butler U	1	2	3
Purdue	1	9	10
Drake	2	4	6
U of IA	0	3	3
U of KS	0	2	2
U of KY	0	2	2
NE LA U	1	1	2
Xavier	3	2	5
U of MD	4	5	9
MA Col Pharm	10	18	28
NE-MA	1	9	10
Ferris	0	1	1
U of MI	1	4	5
Wayne SU	0	2	2
U of MN	2	5	7
St. Louis Col of PH	0	2	2
UMKC	0	3	3
U of MT	1	3	4
Creighton	1	7	8
U of NE	0	4	4
Rutgers	0	2	2

	JPE pass fail status		Total
	F	P	
U of NM	0	4	4
Western	11	104	115
Midwestern U	2	14	16
Chicago			
A&M Schwartz	1	5	6
St. Johns	2	2	4
SUNY-Buff	2	3	5
Union U	0	1	1
UNC	2	5	7
ND SU	0	1	1
OH Nrthrn U	1	3	4
OH State U	2	6	8
U of Cinn	2	3	5
U of Toledo	1	1	2
SW OK State	1	2	3
U of OK	0	3	3
OR State U	1	6	7
Duquesne	0	2	2
Phi C of Pharm	1	2	3
Temple	4	7	11
U of Pitt	0	1	1
U of RI	3	1	4
U of SC	1	1	2
TX SO U	1	1	2
U of Hous	1	2	3
U of TX	1	4	5
U of UT	2	1	3
Med C of VA	1	1	2
U of WA	2	13	15
WA State U	0	5	5
U of WI-Mad	0	6	6
U of WY	0	1	1
Campbell U	1	0	1
Nova Southeastern	6	9	15
Wilkes University	1	0	1
Bernard J Dunn	2	2	4

	JPE pass fail status		Total
	F	P	
Midwestern AZ	6	8	14
Nevada College of Pharm	7	38	45
Loma Linda U	7	45	52
UCSD	6	41	47
MA School of Pharm - Worcester	1	3	4
Palm Beach Atlantic University	1	5	6
Lake Erie Col	0	5	5
Touro U	3	66	69
U of Charleston	3	2	5

	JPE pass fail status		Total
	F	P	
U of Appalachia	2	4	6
South U School of Pharm	0	1	1
Hampton U (VA)	1	0	1
Pac U of Or	6	6	12
Wingate U	0	1	1
Unclassified	0	6	6
Other/FG	61	77	138
	235	1095	1330

**Country**

	JPE pass fail status		Total
	F	P	
Armenia	0	1	1
Bulgaria	1	1	2
Brazil	0	1	1
Canada	0	1	1
Switzerland	1	0	1
China	0	1	1
E&W Germany	0	1	1
Egypt	8	11	19
United Kingdom	1	2	3
Israel/West Bank/Gaza Strip	0	1	1
India	16	18	34
Iraq	0	1	1
Iran	2	2	4
Italy	1	1	2
Japan	1	0	1
Jordan	2	1	3
S. Korea	2	4	6
Lebanon	0	4	4
Nigeria/New Guinea	1	1	2
Philippines	16	16	32
Romania	0	1	1
Sweden	0	1	1
Serbia	1	0	1
USSR	0	1	1
Syria	0	1	1
Turkmenistan	0	1	1
Taiwan	2	0	2
Ukraine	1	0	1
USA	178	1020	1198
Uzbekistan	1	0	1
Yugoslavia	0	1	1
South Africa	0	1	1
<b>Total</b>	<b>235</b>	<b>1095</b>	<b>1330</b>

# **Attachment 8**



**California State Board of Pharmacy**

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STATE AND CONSUMER SERVICES AGENCY

DEPARTMENT OF CONSUMER AFFAIRS

GOVERNOR EDMUND G. BROWN JR.

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

**DATE:** March 8, 2011

**LOCATION:** Department of Consumer Affairs  
First Floor Hearing Room  
1625 N. Market Boulevard  
Sacramento, CA 95834

**COMMITTEE MEMBERS  
PRESENT:**

Deborah Veale, RPh

**COMMITTEE MEMBERS  
NOT PRESENT:**

Greg Lippe, Public Member, Chair  
Ryan Brooks, Public Member  
Rosalyn Hackworth, Public Member  
Kenneth Schell, PharmD

**STAFF  
PRESENT:**

Virginia Herold, Executive Officer  
Anne Sodergren, Assistant Executive Officer  
Robert Ratcliff, Supervising Inspector  
Kristy Schieldge, DCA Staff Counsel  
Debbie Anderson, Licensing Manager  
Tessa Miller, Staff Analyst

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**Call to Order**

Acting Chair Deborah Veale called the meeting to order at 9:36 a.m.

Ms. Veale advised that due to scheduling conflicts for the other members of the committee, the meeting will be conducted by a subcommittee of the committee.

## **1. Update on the Board's Psychometric Evaluation for the ExCPT and PTCB Examinations**

Assistant Executive Officer Anne Sodergren provided that Business and Professions Code (B&PC) section 139 requires a psychometric assessment description of the occupational analysis serving as the basis for the examination and an assessment of the appropriateness of prerequisites for admittance to the examination.

Ms. Sodergren stated that during the April 2009 Board Meeting, the board voted to direct staff to take the necessary steps to secure a vendor to complete the necessary psychometric assessments of the Pharmacy Technician Certification Board (PTCB) and Exam for the Certification of Pharmacy Technicians (ExCPT).

Ms. Sodergren provided that the results of the review would ensure that the applicants who qualify for licensure as a pharmacy technician have passed a validated exam, consistent with the requirements in B&PC 139. She indicated that upon completion, the committee will be advised on the findings at which time it may recommend a change to the statutory requirements for licensure detailed in B&PC 4202.

Ms. Sodergren provided that after obstacles in securing a contract to complete the assessment, the board was advised last year that the department's Office of Professional Examination Services (OPES) will conduct these evaluations for the board which should be completed in June 30, 2011.

Ms. Sodergren provided that board staff recently signed an interagency agreement with the OPES.

### Public Comment

Michael Negrete asked whether an assessment of the job description will be conducted.

Ms. Sodergren provided that the department will be doing this for the board. She stated that the review will include an evaluation on the process of how an exam is developed and whether this process conforms with B&PC 139.

There was no additional discussion or public comment.

## **2. Discussion About a Proposal to Specify Continuing Education Credit for Pharmacists in Specific Content Areas**

Ms. Veale discussed that at several prior meetings of the board or its committees, there has been general discussion about developing requirements for pharmacists to earn continuing education (CE) in specific subject matter areas.

Ms. Veale provided that at the February 2011 Board Meeting, the board directed that the committee continue its discussion about such a requirement.

Ms. Veale reviewed suggested content areas including the following:

- a. Emergency/Disaster Response:
- b. Patient Consultation
- c. Maintaining Control of a Pharmacy's Drug Inventory
- d. Patient Consultation
- e. Ethics
- f. Drug Abuse
- g. Defined Content Areas

### Presentation

Mark Chew representing the Orange County Health Care Agency and Glen Tao from the County of Los Angeles Department of Public Health provided a presentation to the subcommittee regarding the role of pharmacists in emergency response.

Dr. Chew provided an overview of emergency disasters in California and the role that pharmacists can play in the response to these situations. He reviewed the three primary hazards in California: (1) earthquakes, (2) floods, and (3) wildfires and stated that pharmacists are ideally positioned to aid in these situations as they possess basic skill sets and are accessible to the public.

Dr. Chew discussed that to better prepare pharmacists for this role, pharmacists should earn continuing education in emergency response.

Dr. Tao reviewed arguments in favor of mandatory emergency response preparedness CE courses including the following:

- Courses will reach 100 percent of registered pharmacists
- May help to increase the number of Disaster Healthcare Volunteers
- Consistent with the board's Disaster Response Policy Statement
- Will keep pharmacists aware of basic emergency preparedness principles even during long periods of non-emergencies
- Pharmacies have greater public access than physician offices and clinics
- The pharmacy profession is an existing resource of skill sets that can be tapped in times of emergency

Ms. Veale asked the presenters to elaborate on suggested content for CE in this area.

Dr. Tao discussed that the first course could focus on the board's policy statement on this issue to inform licensees that they can provide emergency response services.

Dr. Chew discussed other potential CE course topics including planning, personal preparedness, and how to prepare a pharmacy to be a dispensing site for mass dispensing and vaccinations.

## Public Comment

Dana Grau, representing the California Department of Public Health (CDPH), stated that there was a lack of understanding amongst pharmacists during the H1N1 epidemic. He discussed that CE in this area will provide a better understanding and comfort for pharmacists to assist and provide services.

Ms. Veale asked whether pharmacists have indicated any resistance in providing emergency services and the applicability of earning CE in this area.

Dr. Chew stated that he has received some input and concern from pharmacists expressing skepticism that they will actually be impacted by a local disaster. He discussed the benefit of having plans prepared in the event there is a local emergency or disaster.

Patrick Lynch discussed the benefit of showing pharmacists how they fit into the state system and how they can assist during a disaster. He suggested that pharmacists develop a home plan, a family plan, and a continuation of business plan.

Ms. Veale asked whether there is currently CE available on this subject.

Dr. Chew provided that there are some Web sites that provide emergency preparedness CE. He suggested that pharmacy schools also be encouraged to provide CE in this area.

Ms. Herold provided comment on the board's policy statement on this issue. She reviewed that the board needs to determine whether basic knowledge in this area is in the best interest of the public. Ms. Herold discussed that it is challenging to train volunteers during a disaster, and pre-disaster training is thus preferred.

Ms. Veale expressed concern regarding whether a three hour training would be sufficient.

Mike Negrete discussed that using "emergency" instead of "disaster" may make this issue more applicable. He provided comment in support of an introductory course on emergency preparedness including the development of a family plan. Dr. Negrete discussed that during an emergency, pharmacists will need to ensure that their families are safe before responding for service to the public.

Jon Roth, CEO of the California Pharmacists Association (CPHA), discussed that there should be a demonstrated deficiency that would warrant mandated CE in this area. He stated that CPHA has a policy in opposition to mandated CE. Mr. Roth discussed the extent to which CE will actually correct a deficiency. He encouraged the board to establish a process to evaluate and determine deficiencies for proposed mandated CE subjects in the future.

Ms. Herold discussed that the board needs to evaluate the value of CE. She provided that 20 percent of licensees audited for CE requirements are deficient and can not provide proof of completing CE which was required to renew their license and for which the pharmacist certified they had completed.

Supervising Inspector Robert Ratcliff stated that the goal of requiring CE is to protect the public. He discussed that the public is not protected if no one is equipped to respond to an emergency.

Hamdi Saramah, suggested that licensees earn certification in emergency response. He discussed that this certification would be similar to flu shot certification. Mr. Saramah provided that pharmacies can advertise that they are certified in this area and certified pharmacists can take a leadership role during an emergency response.

Discussion continued. It was emphasized that the committee and the board must first decide whether to move forward with mandated CE and then identify specific content.

Dr. Ratcliff discussed that the board currently allows licensees to earn 20 hours of CE every two years for attending meetings of the board. He expressed concern and stated that this hour allowance seems excessive and may not be appropriate.

Nr. Negrete agreed with the concern raised by Dr. Ratcliff. He also provided comment regarding "live" CE and encouraged the board to consider Standard 7 regarding active learning activity as established by the Accreditation Council for Pharmacy Education (ACPE).

Ms. Herold referenced a handout provided to the subcommittee listing mandatory CE requirements by other states. She stated that the list identifies requirements for "live" CE as well.

Mr. Roth encouraged that the board also review the CE requirements established by other healing arts boards, such as the Dental Board.

Ms. Veale provided that CE regarding drug abuse or in maintaining control of a pharmacy's drug inventory has also been proposed as a topic for mandatory CE.

Mr. Roth asked whether the board imposes CE in a particular area on pharmacies or pharmacists-in-charge who are found to be in violation of pharmacy law.

Ms. Herold indicated that the board does require CE as part of disciplinary action.

Dr. Ratcliff provided that the board's cite and fine program can also mandate up to 6 hours of CE as well.

Dr. Chew suggested that that the board recommend topics for seminars hosted by pharmacy associations.

Dr. Negrete discussed that some CE topics may be more applicable and beneficial for pharmacists-in-charge (PIC). He asked whether consideration has been given to require specific topics for PICs.

Ms. Herold stated that most PICs want to be well trained. She discussed that the self assessment is a tool to assist with the operation of a pharmacy.

Philip Swanger, representing California Society of Health-System Pharmacists (CSHP), indicated that if the board wants to focus on content specific CE each year, CSHP would be open to incorporating these areas in preparation for its Annual Seminar.

Ms. Veale reviewed other suggested topics for CE including patient consultation, ethics, and drug abuse.

Mr. Grau suggested that the board consider dividing the CE hour requirement into certain categories rather than mandating specific topics. He stated that this will allow flexibility for licensees.

Ms. Veale discussed that this will add another level of validation for board staff during the CE audit process.

Ms. Shellans suggested that licensees can self certify on the renewal form that they earned the required amount of CE hours in each category.

Ms. Herold advised that a citation and fine will be issued to a licensee who is unable to produce proof of completing the required CE when audited by the board.

Ms. Shellans shared that the most common CE subjects across all boards are ethics and substance abuse. She discussed that these subjects are significant to public safety and serve both a remedial and preventive purpose.

Dr. Negrete suggested that a sunset date be established for required topics.

Ms. Herold provided that there was a previous CPR CE requirement that has expired.

There was no additional discussion or public comment.

### **3. Request to Modify 16 California Code of Regulations Section 1732.2**

Ms. Herold provided that currently undergoing promulgation by the board as a regulation are proposed modifications to 16 California Code of Regulations Section 1732.2 regarding approval of specific continuing education credit for various types of pharmacist activities, including attending a board or committee meeting, being certified by the Commission for Certification in Geriatric Pharmacy or for certain activities as a Competency Committee member.

Ms. Herold provided that the executive officer was advised after the completion of the 15-day comment period that there are other certifications that some pharmacists earn that perhaps should be considered as fulfilling portions of the CE requirements for renewal of a pharmacist license. She highlighted the following suggestions by Professor Katherine Besinque, PharmD:

1. Menopause Practitioner Examination- interdisciplinary examination available from NAMS (The North American Menopause Society) ([www.menopause.org](http://www.menopause.org))
2. Board of Pharmacy Specialties (BPS) has recognized six specialty practice areas: note –these certification examinations also require recertification every 7 years (re-certification by examination should also be permitted for credit) ([www.bpsweb.org](http://www.bpsweb.org))
  - [Ambulatory Care Pharmacy](#) (2011)  
Includes the provision of integrated, accessible healthcare services by pharmacists who are accountable for addressing medication needs, developing sustained partnerships with patients, and participating in the context of family and community.
  - [Nuclear Pharmacy](#) (1978)  
Specialists seek to improve and promote the public's health through the safe and effective use of radioactive drugs for diagnosis and therapy.
  - [Nutrition Support Pharmacy](#) (1988)  
Specialists promote the maintenance and/or restoration of optimal nutritional status, designing and modifying treatment according to the needs of the patient.
  - [Oncology Pharmacy](#) (1996)  
Specialists recommend, design, implement, monitor and modify pharmacotherapeutic plans to optimize outcomes in patients with malignant diseases.
  - [Pharmacotherapy](#) (1988)  
Specialists are responsible for ensuring the safe, appropriate, and economical use of drugs in patient care and frequently serve as a primary source of drug information for other health care organizations.
  - [Psychiatric Pharmacy](#) (1992)  
Specialists address the pharmaceutical care of patients with psychiatric disorders.

Ms. Herold indicated that Dr. Besinque also suggests that:

- as new board specialties are added to BPS they be added to the list.
- re-certification by examination be include as well (re-certification by CE does not need to be included)

Ms. Herold advised that if the board determines it wishes to add these components in the future, this will need to be done as a new rulemaking to section 1732.2.

Ms. Veale discussed that she received CE after completing a college course and passing the exam.

## Public Comment

Mike Negrete clarified that these items are competency assessments, not courses.

Ms. Herold provided that this item will be further discussed at the May 2011 Board Meeting.

There was no additional discussion or public comment.

#### **4. Update on the Board's Efforts to Implement 16 California Code of Regulations Section 1702, Mandatory Submission of Fingerprints for Pharmacists**

Ms. Veale provided that the board was previously advised that because of staff reductions with the Department of Justice, implementation on the electronic fingerprint submissions would be delayed until the necessary program changes could be implemented. She indicated that as the necessary changes are now in place, staff is developing letters that will be sent to all affected licensees advising them about the regulation change as well as providing them with the necessary forms. Ms. Veale stated that it is anticipated that this information will be mailed this in April 2011. She provided that pharmacists will be advised to retain a copy of their livescan form or other receipt confirming compliance with this provision.

Ms. Veale provided that implementation of the arrest and conviction disclosure requirements was not delayed.

No public comment was provided.

#### **5. Discussion Concerning DCA's Focus on Continuing Competency**

Ms. Herold provided that in addition the California Protection Enforcement Initiative (CPEI), the DCA also has an initiative underway to promote that all health care boards initiate periodic assessment of continuing competency in their licensed practitioners.

Ms. Herold provided that continuing competency assessment requires periodic evaluation (and perhaps re-testing) of licensed providers to ensure they are maintaining their skills necessary to practice safely.

Ms. Herold provided that the DCA has encouraged the board to pursue this issue. She referenced to the document prepared last year at the Consumer Advocacy Council's annual meeting provided in the meeting materials.

Cindy Kanemoto, representing the DCA Licensing for Job Creation, discussed the department's efforts to provide the healing arts boards with information in order to

implement a model in this area. She discussed that the healing art's boards will be invited to a conference call to discuss a recommendation to replace continuing education with a continuing competency model.

Ms. Kanemoto discussed the efforts by other states in this area including Washington, Michigan, and Florida. She discussed a comparison chart of the CE requirements for all of California's health care boards. Ms. Kanemoto offered to provide a copy of this chart to the board.

Ms. Kanemoto discussed different pathways to complete a continuing competency requirement. She stated that the competencies for a profession as well as the board certification requirements must first be identified. Ms. Kanemoto reviewed a five step model including a self evaluation, peer assessment, and a professional development plan. She emphasized that this process is different than just earning CE credit.

Ms. Veale sought clarification regarding the management of such a system.

Ms. Kanemoto reviewed that, dependant on the model, associations or accrediting bodies may maintain the records and ensure that the correct CE is completed.

Ms. Herold provided that this would require statutory modification. She discussed that the board would be delegating part of its authority away if an association was involved in this process.

Ms. Shellans provided comment regarding how other agencies have implemented similar processes. She discussed that this usually revolves around CE for education, requalification of the license, and peer review.

### Public Comment

Dr. Negrete sought clarification regarding the peer review process.

Ms. Shellans discussed that the accrediting body establishes requirements for this process and a procedure manual for the training of peer reviewers. She stated that peer reviewers assess the licensee's performance on patient cases and compile a report that is submitted to a committee of the accrediting agency. Ms. Shellans indicated that negative reports are actionable by the board.

Dr. Ratcliff discussed that competency assessments are not currently required for all professions in healthcare including physician assistants and physicians who have been exempted. He stated that this may cause concern for various pharmacy associations.

Ms. Kanemoto discussed that the CAC has suggested that boards consider how hospitals recertify their staff and evaluate whether this is a mechanism to qualify competency.

Ms. Herold discussed that the majority of pharmacists do not work in a hospital setting. Ms. Veale discussed that there is regular review of competency in a variety of settings and by employers.

Mark Chew discussed that he regularly evaluated pharmacy staff while serving as a pharmacy director. He stated that he was also evaluated for the same competency.

Ms. Kanemoto advised that the conference call to further discuss this issue should be scheduled within the next month.

There was no additional discussion or public comment.

The subcommittee recessed for a break at 11:11 a.m.

The subcommittee reconvened at 11:27 a.m.

## **6. Office of Statewide Health Planning and Development's Manpower Assessment and Survey of Licensees**

Ms. Sodergren provided that as part of Senate Bill 139 (Chapter 522, Statutes of 2007) the Office of statewide Health Planning and Development (OSHPD) was directed to establish the California Healthcare Workforce Clearinghouse (Clearinghouse) to serve as the central source for collection, analysis, and distribution of information on the healthcare workforce employment and educational data trends for the state.

Ms. Sodergren reviewed that the bill included a provision that OSHPD work with the Employment Development Department's Labor Market Information Division, state licensing boards, and state higher education entities to collect, to the extent available, all of the following data:

- a. The current supply of health care workers, by specialty.
- b. The geographical distribution of health care workers, by specialty.
- c. The diversity of the health care workforce, by specialty, including, but not necessarily limited to, data on race, ethnicity, and languages spoken.
- d. The current and forecasted demand for health care workers, by specialty.
- e. The educational capacity to produce trained, certified, and licensed health care workers, by specialty and by geographical distribution, including, but not necessarily limited to, the number of educational slots, the number of enrollments, the attrition rate, and wait time to enter the program of study.

Ms. Sodergren discussed that many of the boards within the DCA, including the Board of Pharmacy, do not collect several of the data elements being requested by OSHPD.

Ms. Sodergren reviewed a model developed by the Medical Board including a survey that is designed to collect several elements. She stated that the survey is provided to

licensees along with their renewal application. Ms. Herold indicated that she is unsure whether participation in this survey is mandated or is voluntary.

Ms. Sodergren provided that Acting Director Brian Stiger is encouraging all boards to collect the necessary information to assist OSHPD in their charge to, among other items, serve as the repository for comprehensive data and standardize data collection tools and methods.

Ms. Sodergren provided that as mandating submission of this information would require either a regulation and/or statutory change, board staff recommends that the board consider development of a survey that could be accessed from the board's Web site. She discussed that an on-line resource such as Survey Monkey, could serve as an easy collection method that would have minimal impact on board staff. Ms. Sodergren clarified that the survey would be completed on a voluntary basis.

Cindy Kanemoto, representing the DCA Licensing for Job Creation, provided that a memorandum of understanding or an agreement may be necessary if information is being provided to OSHPD. She clarified that participation in the Medical Board's survey is required.

Ms. Kanemoto discussed that she is recommending that OSHPD create the survey and also house the data. She stated that the board could provide a link on its Web site to the survey. Ms. Kanemoto advised that the licensees would be directly inputting the information to OSHPD and the board would still have access to the data. She provided that the department is exploring this option as an interim solution until the implementation of the BreEZe system.

Ms. Kanemoto discussed that each survey will be targeted towards the specific licensing types of each board.

#### Public Comment

Phillip Swanger, representing California Society of Health-System Pharmacists (CSHP), asked whether any data would be released to the public.

Ms. Sodergren discussed that if released, the data would be released by OSHPD.

Ms. Shellans discussed that the board does not collect certain information regarding its licensees as there is no mandate and there are legal and privacy concerns regarding certain information that is not necessary for licensure.

Ms. Veale provided comment in support of pursuing the survey as a voluntary option.

There was no additional discussion or public comment.

## **7. Presentation by the Emergency Management Services Agency on the Role and Involvement of Pharmacists in Emergency Response in California**

Patrick Lynch, representing the Emergency Medical Services Authority (EMSA), provided an overview of the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP), a registration system for healthcare professionals to volunteer in the event of a significant disaster or a public health emergency. He discussed that volunteers are verified with the appropriate licensing board, assessed for whether or not they are actively practicing, and are added to the statewide registry. Mr. Lynch stated that during a disaster, state or local officials will determine what kind of health professionals are needed, search the database for available volunteers, and send an alert to selected members via email, telephone and pager.

Mr. Lynch provided that there are currently 515 pharmacists, 105 pharmacist interns, and 18 pharmacy technicians registered in the system.

Ms. Veale provided that she is registered in the system.

Ms. Herold offered to distribute brochures in the board's office.

Ms. Sodergren suggested that brochures also be provided to the department.

Mr. Lynch stated that he would like to work with the board to establish a link to the ESAR-VHP on the board's Web site. He also proposed that information regarding the system be provided on renewal notices.

Ms. Herold provided that the board compiled a list of emergency compounders during the H1N1 epidemic.

No public comment was provided.

## **8. Competency Committee Report**

Ms. Veale provided that both Competency Committee workgroups have meetings scheduled in the spring of 2011 to work on examination development. She stated that the Competency Committee will ensure the new outline will be used to develop examinations administered after April 1, 2011.

No public comment was provided.

## **9. Licensing Statistics**

Ms. Sodergren provided an overview of the statistics for licensing workload beginning in July 2010. She stated that as of March 1, 2011, the board has received over 11,300 applications for licensure; almost 6,800 are seeking licensure as a pharmacy technician. Ms. Sodergren discussed that there has been a significant increase in pharmacy technician applicants over the last few years. She stated that the board has issued over 9,800 new licenses and processed about 1,270 change applications (e.g. change in pharmacist-in-charge, change of permits, etc.) Ms. Sodergren reviewed that the board has about 4,900 applications pending, a portion of these applications are awaiting receipt of deficient items and almost 800 are eligible pharmacist exam applicants that have not taken the exam.

Ms. Sodergren provided that a three year comparison will be provided to the board at the July 2011 Board Meeting.

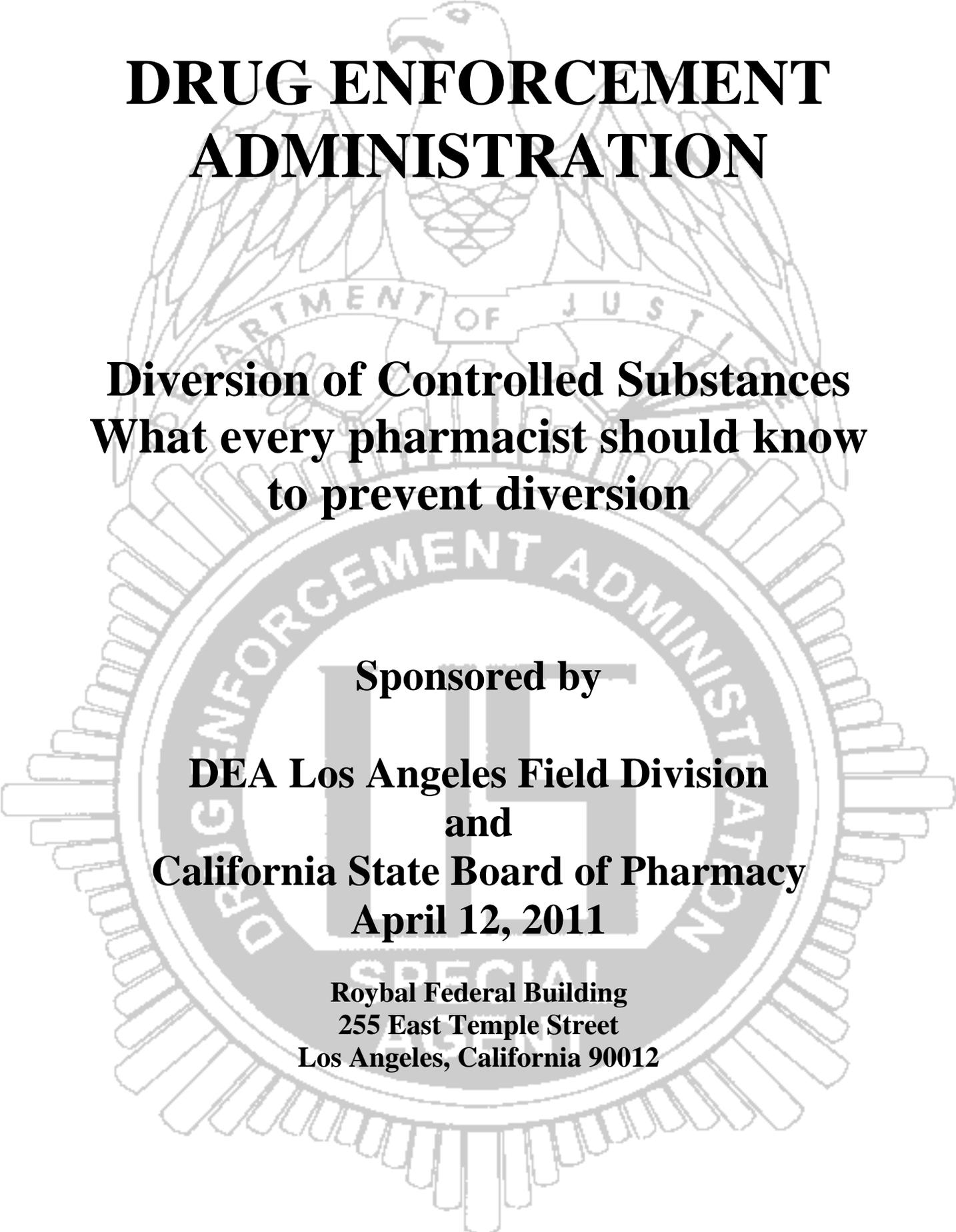
No public comment was provided.

## **10. Public Comment for Items Not on the Agenda**

No public comment was provided.

The meeting was adjourned at 11:59 a.m.

# **Attachment 9**

The background of the slide features a large, faint watermark of the official seal of the Drug Enforcement Administration (DEA). The seal is circular with a scalloped outer edge. Inside the circle, there is a central shield with a scale of justice and a sword. Above the shield is an eagle with its wings spread. The words "DEPARTMENT OF JUSTICE" are written in a banner above the eagle, and "DRUG ENFORCEMENT ADMINISTRATION" is written in a banner below the shield. The word "SPECIAL" is partially visible at the bottom of the seal.

# **DRUG ENFORCEMENT ADMINISTRATION**

**Diversion of Controlled Substances  
What every pharmacist should know  
to prevent diversion**

**Sponsored by**

**DEA Los Angeles Field Division  
and  
California State Board of Pharmacy  
April 12, 2011**

**Roybal Federal Building  
255 East Temple Street  
Los Angeles, California 90012**

## AGENDA

April 12, 2011



- 9:30 am Welcome/Orientation  
*DEA Special Agent in Charge Timothy Landrum*  
*California Board of Pharmacy Executive Officer Virginia Herold*  
*DEA Diversion Program Manager Mike Lewis*
- 10:00 am Drug Trafficking /Trends in Los Angeles  
*DEA Diversion Program Manager Mike Lewis*
- 11:00 am Break
- 11:15 am Controlled Substances Utilization Review and Evaluation System -- CURES  
Records, Inquiries and Reports  
*CURES staff*
- 12:30 pm Lunch
- 2:00 pm Pharmaceutical Supply Chain Thefts  
Reporting and Prevention  
*Judi Nurse*
- 3:00 pm Break
- 3:15 pm Board actions against Internet Prescribing  
*Virginia Herold*
- 3:30 pm Questions to Panel  
*D/I's, Board Investigators*
- 4:00 pm Adjournment

# EVALUATION RESULTS - April 12, 2011 presentation

Diversion of Controlled Substances - What Every Pharmacist Should Know to Prevent Diversion  
(71 participants responded)

	1 needs work	2	3 satisfactory	4	5 great
<b>Overall Conference</b>		1	11	25	35
<b>Topics Timely and Relevant</b>			10	23	39
<b>Facility</b>	2	5	19	22	24
<b>Quality of Speakers</b>		2	12	20	39
<b>(totals)</b>	2	8	52	90	137

## Specific comments:

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Very informative. The changes that have impacted pharmacy in terms of threats over the past 10 years. Good content from DEA - thanks for the statistics. BOP stats backed up DEA stats nicely. CURES - did not seem any progress since the presentation of 2 years ago. Very good session and well worth the time.

---

Medical Board and the LA AG's Office should have participated. We have to have a better system of identifying and sanctioning errant prescribers (DEA - MED Board).

---

I liked the presentation regarding the different fraud schemes and how pharmacies should enforce strict internal controls.

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Participant name badges. Pre-test / post-test. Longer question session. More comments from Lee Worth!

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Would be helpful to have print-out of powerpoint. More time for questions.

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Very good presentation.

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Have pre-access to the powerpoint presentation. Have more educational seminars in Southern CA. Create educational program for high school. DEA needs to be in front screen for educational purpose.

---

Overall presentation was very informative.

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Need larger space. Very informative on a timely topic. Would like to see more workshops provided.

---

Excellent content, a lot of useful info. Transcripts of presentations would be helpful.

---

Informative. Live performance gave "stories" to provide practical examples of what types of abuse and diversions are occurring currently and what type of people that have history of these abuses. Up-to-date info.

---

Would like more info for County Public Health Depts that store mass quantities of meds for emergencies.

---

Very good information. Would be good to hear early on in practice. I know when I first started working, I was definitely naive to this and I filled a fake Rx. We did catch him though because he came back and said I didn't fill enough. Would have liked better explanation of CURES - speakers not quite as good.

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Conference room is too small to accommodate all participants. Long line to get into the building.

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Would like more programs if possible in Orange County.

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Everything was good. We need more classes like this. I still need 15 more continued education credits for my pharmacy technician certification.

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Room hot - poor ventilation. Very uncomfortable.

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Offer program to all local CPhA chapters. Please post DEA and BOP slide sets on BOP web page.

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The breaks were too long. Too much to cover - cut breaks much shorter. Very enjoyable, need more publicity. I only accidentally heard about the program.

---

Promote moral standard of pharmacist fulfilling - corresponding responsibility of dispensing controlled drugs.

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Need handouts. Could have used this 5 years ago!

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Did not like the location where CE conference was held. Like the topic and its application.

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Perhaps topic on consequences of diversion of drugs (sanctions / criminal convictions).

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Room not conducive - hard to see slides due to setup. Too cold in morning. Would have been nice to have handouts -- are we able to get those slides? When people have questions -- presenter should "repeat" the question.

---

Use different color on your powerpoint presentation. It is hard to see red print on a purple background. Thank you so much for all the info. Please have more of these sessions.

---

Fire escapes -- LOCKED EMERGENCY ONLY? No way to walk stairs. How to escape 2nd floor? Excellent presentation.

---

Great workshop - very informative. Hope to see more meetings like this one. Next topic: please include e-Rx on controlled substances.

---

Suggest a larger conference room. Also suggest a different location - some hospitals will donate the use of their conference room free, or low cost parking. Overall, program speakers were very good.

---

Slides by Judi Nurse and Valerie Sakamura: print on powerpoint slides too small. Red font on dark blue background makes it hard to read as there is reduced contrast. Recommend yellow font instead of red font. Misspellings on powerpoint slides need correcting.

---

Red highlighting on Judi Nurse presentation is unreadable in back of room. Get bigger room next time. Have Judi use microphone. Have all presenters sit 50' from screen and make sure they can read slides. Thanks.

---

Room too small for turnout. Hard to read Judi's slides. Location not too convenient.

---

Would be helpful to have powerpoint slides printed out. Please do use the microphones. The powerpoint slides were too cluttered, print too small to read, color of font against background too hard to read. Some speakers offered practical suggestions/applications for RPh - that was helpful.

---

CURES section was not as informative as the other lectures. Best section was the one discussing how pharmacies and pharmacists deal with diversion. Internet pharmacy presentation - informative.

---

---

Very enjoyable. I wish there was time for networking.

---

Great topics. Judy did a good job.

---

Was hard to hear some speakers and see powerpoint. Cold too.

---

Good to help educate everyone of the magnitude of the problem.

---

Judi Nurse: learn to use microphone. PowerPoint suggestions: Do not use blue background. Do not use red letters. Black letters and white background make easier to see. Do not use small font. Our eyes are old and need bigger letters to see.

---

Perhaps a syllabus of the program. To save paper, you could have it on the website for download. It's too much information to write down and a lot of the points were not touched upon by the speakers. I'm glad the CURES reps were there, however, they weren't around in the afternoon.

---

Handouts for powerpoint presentations would be good or at least a website where we can print them out prior to or after the program. Don't use red letters on blue slide - hard to read; maybe you can underline instead. Otherwise a great presentation.

---

Need to have speakers using microphone. Slides are hard to read. Have copies of slides as handouts.

---

I liked Michael Lewis' presentation. It was very interesting and eye-opening. I did not like the CURES presentation. It was very choppy and it didn't flow well.

---

A very interesting and necessary presentation. Please keep updating material and having these presentations! More about what the DEA is looking for. What are things that are an issue? What should pharmacies be documenting?

---

Would like a copy of slides printed out to take back to work and discuss with my associates. Like to have a listing of who to call with specific questions or problems. Procedure to follow if you are presented with a "group" of people that you believe to be attempting to procure medications by questionable means (diversion).

---

Like hearing of responsibility of RPhs. Contact info / who to call for questions. Opportunities for improvement: Quality of sound / difficult to identify addiction and responsibility of RPh. Referrals to health insurance / PBM if fraud/abuse suspected. P.S. I'd be happy to speak! I work for Aetna F/A Unit.

---

Can you also include situations in long-term care facilities and board-n-care and intermediate care facilities? I work for a pharmacy catering to ICF patients who are under the care of an LVN and the LVN or RN are ordering refills of their meds. For controlled drugs III-V refills are called in by LVN of the ICF, not MD's office - is this a violation of the board?

---

Recommendations to make specific discussion regarding long-term care pharmacies and its regulations in details. More emphasis on "authorized" prescriber having different RNs/LVNs giving orders, either via phone or fax. Thank you!

---

# **Attachment 10**

Board of Pharmacy Licensing Statistics - Fiscal Year 2010/11

	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN*	FYTD
<b>APPLICATIONS</b>													
Received													
Pharmacist (exam applications)	137	102	132	152	118	101	84	94	114				1034
Pharmacist (initial licensing applications)	203	343	169	184	87	68	25	136	66				1281
Intern pharmacist	50	472	381	341	41	52	94	68	125				1624
Pharmacy technician	776	955	870	930	776	886	831	759	1110				7893
Pharmacy	19	28	28	22	27	23	20	20	32				219
Pharmacy - Temp	10	5	10	25	15	9	8	2	7				91
Sterile Compounding	5	4	4	8	9	3	4	5	3				45
Sterile Compounding - Temp	0	0	0	0	5	2	0	0	0				7
Clinics	4	2	8	8	0	3	8	7	6				46
Hospitals	6	0	0	17	10	1	2	0	3				39
Hospitals - Temp	0	0	0	0	0	0	0	0	0				0
Nonresident Pharmacy	4	8	5	8	4	9	7	3	3				51
Nonresident Pharmacy - Temp	0	0	0	2	0	1	2	0	1				6
Licensed Correctional Facility	0	0	0	0	0	0	0	0	0				0
Hypodermic Needle and Syringes	2	2	3	1	1	1	1	2	0				13
Nonresident Wholesalers	10	11	9	7	10	13	6	10	8				84
Nonresident Wholesalers - Temp	0	0	2	3	0	1	1	0	1				8
Wholesalers	7	9	6	3	9	3	4	4	6				51
Wholesalers - Temp	0	1	0	0	0	0	0	0	1				2
Veterinary Food-Animal Drug Retailer	0	0	0	0	0	0	0	0	0				0
Veterinary Food-Animal Drug Retailer - Temp	0	0	0	0	0	0	0	0	0				0
Designated Representatives	36	42	39	49	25	32	43	32	48				346
Total	1269	1984	1666	1760	1137	1208	1140	1142	1534	0	0	0	12840

Board of Pharmacy Licensing Statistics - Fiscal Year 2010/11

	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN*	FYTD
<b>Issued</b>													
Pharmacist	179	471	77	267	85	90	13	124	68				1374
Intern pharmacist	72	310	544	333	65	53	80	50	72				1579
Pharmacy technician	752	932	794	789	778	1042	383	858	741				7069
Pharmacy	21	18	23	17	28	26	25	26	14				198
Pharmacy - Temp	0	0	0	0	0	0	0	0	0				0
Sterile Compounding	3	1	1	3	3	10	3	2	2				28
Sterile Compounding - Temp	0	0	0	0	0	0	0	0	0				0
Clinics	9	6	3	1	3	5	7	4	16				54
Hospitals	1	2	0	3	7	10	10	3	0				36
Hospitals - Temp	0	0	0	0	0	0	0	0	0				0
Nonresident Pharmacy	4	0	10	6	4	6	4	8	7				49
Nonresident Pharmacy - Temp	0	0	0	0	0	0	0	0	0				0
Licensed Correctional Facility	0	0	0	0	0	0	1	0	0				1
Hypodermic Needle and Syringes	2	0	2	2	1	1	0	2	0				10
Nonresident Wholesalers	4	3	4	7	14	6	3	12	9				62
Nonresident Wholesalers - Temp	0	0	0	0	0	0	0	0	0				0
Wholesalers	4	6	6	0	6	4	0	8	8				42
Wholesalers - Temp	0	0	0	0	0	0	0	0	0				0
Veterinary Food-Animal Drug Retailer	0	0	0	0	0	0	0	0	0				0
Veterinary Food-Animal Drug Retailer - Temp	0	0	0	0	0	0	0	0	0				0
Designated Representatives	16	29	41	44	35	17	48	29	27				286
<b>Total</b>	<b>1067</b>	<b>1778</b>	<b>1505</b>	<b>1472</b>	<b>1029</b>	<b>1270</b>	<b>577</b>	<b>1126</b>	<b>964</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>10788</b>
<b>Pending</b>													
Pharmacist Examination	725	566	622	605	498	487	384	356	358				605
Pharmacist Examination Eligible	1043	1043	979	799	825	760	744	629	677				799
Intern pharmacist	270	441	274	276	243	241	134	151	200				276
Pharmacy technician	2505	2550	2697	2693	2751	2465	2698	2585	2841				2693
Pharmacy	75	81	85	90	86	80	65	58	68				90
Sterile Compounding	24	26	26	29	34	28	21	22	22				29
Clinics	29	26	23	28	26	24	26	28	19				28
Hospitals	8	8	6	13	23	13	4	4	4				13
Nonresident Pharmacy	43	51	40	44	44	46	47	42	38				44
Licensed Correctional Facility	0	0	0	0	0	0	0	0	0				0
Hypodermic Needle and Syringes	12	15	12	11	11	11	9	8	8				11
Nonresident Wholesalers	78	86	74	72	69	76	68	66	67				72
Wholesalers	48	49	47	48	52	52	51	48	45				48
Veterinary Food-Animal Drug Retailer	0	0	0	0	0	0	0	0	0				0
Designated Representatives	188	197	180	175	163	181	153	158	181				175
<b>Total</b>	<b>5048</b>	<b>5139</b>	<b>5065</b>	<b>4883</b>	<b>4825</b>	<b>4464</b>	<b>4404</b>	<b>4155</b>	<b>4528</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>4883</b>

Board of Pharmacy Licensing Statistics - Fiscal Year 2010/11

	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN*	FYTD
<b>Change of Pharmacist-in-Charge***</b>													
Received	104	128	102	154	108	106	84	82	115				983
Processed	118	132	99	136	123	90	60	76	160				994
Pending	389	385	388	381	366	463	487	493	448				381
<b>Change of Exemptee-in-Charge***</b>													
Received	8	9	6	12	8	12	13	6	8				82
Processed	4	0	7	0	0	0	0	9	7				27
Pending	108	117	116	128	136	148	161	158	159				128
<b>Change of Permits</b>													
Received	48	69	54	43	59	53	67	46	59				498
Processed	4	44	15	39	38	159	74	44	102				519
Pending	222	247	286	303	324	218	211	213	170				303
<b>Discontinuance of Business***</b>													
Received	20	21	10	24	17	78	n/a	1	26				197
Processed	0	0	28	1	0	78	0	2	0				109
Pending	135	156	138	162	179	179	179	178	204				162
<b>Renewals Received</b>													
Pharmacist	1572	1339	3322	2317	1052	1696	1455	980					13733
Pharmacy technician	2958	2262	4676	2504	1875	2595	2219	1727					20816
Pharmacy	407	298	633	960	226	692	329	456					4001
Sterile Compounding	26	17	76	39	23	30	13	18					242
Clinics	106	68	145	91	47	80	92	84					713
Nonresident Pharmacy	31	20	70	18	18	27	21	23					228
Licensed Correctional Facility	0	0	27	17	2	0	0	0					46
Hypodermic Needle and Syringes	17	10	50	28	23	33	18	17					196
Nonresident Wholesalers	56	43	86	35	43	33	39	28					363
Wholesalers	73	27	91	27	37	42	31	24					352
Veterinary Food-Animal Drug Retailer	2	1	5	1	3	4	2	1					19
Designated Representative	155	113	416	179	170	255	184	226					1698
<b>Total</b>	<b>5403</b>	<b>4198</b>	<b>9597</b>	<b>6216</b>	<b>3519</b>	<b>5487</b>	<b>4403</b>	<b>3584</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>42407</b>

# **Attachment 11**

# LICENSING COMMITTEE

Goal 2: Ensure the qualifications of licensees.

Outcome: Qualified licensees

Objective 2.1	Issue licenses within three working days of a completed application by June 30, 2011.								
Measure:	Percentage of licenses issued within three work days.								
Tasks:	1. Review 100 percent of all applications within 7 work days of receipt.								
		<b># of Apps. Received:</b>				<b>Average Days to Process:</b>			
		Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4
	Pharmacist (exam applications)	371	371	292		35	10	25	
	Pharmacist (initial licensing)	715	339	227		4	4	5	
	Pharmacy Intern	903	434	287		9	5	7	
	Pharmacy Technician	2,601	2,592	2,700		28	48	44	
	Pharmacies	81	100	77		16	29	8	
	Non-Resident Pharmacy	17	21	13		28	31	34	
	Wholesaler	22	15	14		25	31	31	
	Veterinary Drug Retailers	0	0	0		0	0	0	
	Designated Representative	117	106	123		24	31	35	
	Out-of-state distributors	30	30	24		24	35	35	
	Clinics	14	11	21		16	26	6	
	Hypodermic Needle & Syringe Distributors	7	3	3		13	20	18	
	Sterile Compounding	13	20	12		12	37	8	
	Change of Permit	171	155	172		45	71	70	
Pharmacist in Charge	334	368	281		19	57	23		
Designated Representative in Charge	23	32	7		45	57	70		
Discontinuance of Business	51	102	27		66	68	N/A		

2. Process 100 percent of all deficiency documents within five work days of receipt.

	Average Days to process deficiency:			
	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Pharmacist (exam applications)	5	3	6	
Pharmacist (initial licensing)	7	3	6	
Pharmacy Intern	7	3	4	
Pharmacy Technician	14	15	16	
Pharmacies	8	12	4	
Non-Resident Pharmacy	4	11	9	
Wholesaler	4	11	9	
Veterinary Drug Retailers	4	0	0	
Designated Representative	4	11	9	
Out-of-state distributors	4	11	9	
Clinics	8	12	4	
Hypodermic Needle & Syringe	4	11	9	

3. Make a licensing decision within three work days after all deficiencies are corrected.

	Average Days to Determine to Deny/Issue License:			
	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Pharmacist (exam applications)	2	2	2	
Pharmacist (initial licensing)	2	2	2	
Pharmacy Intern	2	2	2	
Pharmacy Technician	3	3	3	
Pharmacies	3	5	5	
Non-Resident Pharmacy	5	5	9	
Wholesaler	5	5	6	
Veterinary Drug Retailers	0	0	0	
Designated Representative	2	5	4	
Out-of-state distributors	5	5	6	
Clinics	3	5	5	
Hypodermic Needle & Syringe	2	2	4	

4. Issue professional and occupational licenses to those individuals and firms that meet minimum requirements.

	<b>Licenses Issued:</b>			
	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Pharmacist	272	442	205	
Pharmacy Intern	926	451	202	
Pharmacy Technician	2,478	2,609	1,982	
Pharmacies	65	91	79	
Non-Resident Pharmacy	14	16	19	
Wholesaler	16	10	16	
Veterinary Drug Retailers	0	0	0	
Designated Representative	86	96	104	
Out-of-state distributors	11	27	24	
Clinics	18	9	27	
Hypodermic Needle & Syringe	4	4	2	
Sterile Compounding	5	16	7	

5. Withdrawn licenses to applicants not meeting board requirements.

	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Pharmacy Technician	81	125	287	
Pharmacies	2	0	3	
Non-Resident Pharmacy	5	0	2	
Clinics	3	0	1	
Sterile Compounding	0	1	0	
Designated Representative	12	11	24	
Hypodermic Needle & Syringe	3	0	2	
Out-of-state distributors	19	0	11	
Wholesaler	5	2	5	
Veterinary Drug Retailers	0	0	0	
Registered Pharmacist	155	212	540	
Intern Pharmacist	1	1	121	

6. Deny applications to those who do not meet California standards.

	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Pharmacist	2	3	1	
Intern Pharmacist	0	2	1	
Pharmacy Technician	21	23	26	
Pharmacies	0	2	1	
Non-Resident Pharmacy	1	0	0	
Clinics	0	0	0	
Sterile Compounding	0	0	0	
Designated Representative	0	0	2	
Hypodermic Needle & Syringe	0	0	0	
Out-of-state distributors	0	1	0	
Wholesaler	0	0	0	

7. Responding to e-mail status requests and inquiries to designated e-mail addresses.

	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Pharmacist/Pharmacist Intern	645	565	1280	
Pharmacy Technicians	498	856	1413	
Site licenses (pharmacy, clinics)	1,284	469	669	
Site licenses (wholesalers, nonresident pharmacies)	925	1,000	946	
Pharmacist in Charge	219	96	207	
Renewals	269	310	305	

8. Responding to telephone status request and inquiries.

	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Pharmacist/Pharmacist Intern	82	*	*	
Pharmacy Technicians	*	*	*	
Site licenses (pharmacy, clinics)	369	256	373	
Site licenses (wholesalers, nonresident pharmacies)	221	114	153	
Pharmacist in Charge	49	52	51	
Renewals	1,138	1,329	1,415	

\* Voicemail status requests have been suspended to allow staff time to focus on processing applications and issuing licenses

Objective 2.2	Cashier 100 percent of all revenue received within two working days of receipt by June 30, 2011.								
Measure:	Percentage of revenue cashiered application within 2 working days.								
Tasks:	<b>Revenue Received:</b>				<b>Average Days to Process:</b>				
	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	
	Applications	\$676,974	\$571,998	\$325,928		3	2.5	4	
	Renewals	\$2,912,806	\$2,198,366	\$1,298,458		3	2.5	2.5	
	Cite and Fine	\$325,040	\$324,735	\$278,805		4	3	3	
	Probation/ Cost Recovery	\$30,869	\$73,511	\$254,909		4	3	3	
	Request for Information/ License Verification	\$5,005	\$7,470	\$4,390		3	2.5	3	
	Fingerprint Fee	\$17,432	\$17,039	\$16,575		3	3	3	
* 2nd quarter reflects October and November 2010 data available at the time of report development.									

Objective 2.3	Update 100 percent of all information changes to licensing records within five working days by June 30, 2011.																																																					
Measure:	Percentage of licensing records changes within five working days.																																																					
Tasks:	<table border="1" data-bbox="370 289 1523 573"> <thead> <tr> <th data-bbox="370 289 743 331"></th> <th colspan="4" data-bbox="743 289 1141 331">Requests Received:</th> <th colspan="4" data-bbox="1141 289 1523 331">Average Days to Process:</th> </tr> <tr> <th data-bbox="370 331 743 373"></th> <th data-bbox="743 331 857 373">Qtr 1</th> <th data-bbox="857 331 954 373">Qtr 2</th> <th data-bbox="954 331 1052 373">Qtr 3</th> <th data-bbox="1052 331 1141 373">Qtr 4</th> <th data-bbox="1141 331 1239 373">Qtr 1</th> <th data-bbox="1239 331 1336 373">Qtr 2</th> <th data-bbox="1336 331 1433 373">Qtr 3</th> <th data-bbox="1433 331 1523 373">Qtr 4</th> </tr> </thead> <tbody> <tr> <td data-bbox="370 373 743 415">Address/Name Changes</td> <td data-bbox="743 373 857 415">3,120</td> <td data-bbox="857 373 954 415">2,606</td> <td data-bbox="954 373 1052 415">2,640</td> <td data-bbox="1052 373 1141 415"></td> <td data-bbox="1141 373 1239 415">5</td> <td data-bbox="1239 373 1336 415">3</td> <td data-bbox="1336 373 1433 415">8</td> <td data-bbox="1433 373 1523 415"></td> </tr> <tr> <td data-bbox="370 415 743 489">Off-site Storage Applications (approved)</td> <td data-bbox="743 415 857 489">24</td> <td data-bbox="857 415 954 489">26</td> <td data-bbox="954 415 1052 489">20</td> <td data-bbox="1052 415 1141 489"></td> <td data-bbox="1141 415 1239 489">20</td> <td data-bbox="1239 415 1336 489">25</td> <td data-bbox="1336 415 1433 489">27</td> <td data-bbox="1433 415 1523 489"></td> </tr> <tr> <td data-bbox="370 489 743 573">Transfer of Intern Hours to Other States</td> <td data-bbox="743 489 857 573">34</td> <td data-bbox="857 489 954 573">17</td> <td data-bbox="954 489 1052 573">24</td> <td data-bbox="1052 489 1141 573"></td> <td data-bbox="1141 489 1239 573">30</td> <td data-bbox="1239 489 1336 573">30</td> <td data-bbox="1336 489 1433 573">30</td> <td data-bbox="1433 489 1523 573"></td> </tr> </tbody> </table>										Requests Received:				Average Days to Process:					Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Address/Name Changes	3,120	2,606	2,640		5	3	8		Off-site Storage Applications (approved)	24	26	20		20	25	27		Transfer of Intern Hours to Other States	34	17	24		30	30	30	
	Requests Received:				Average Days to Process:																																																	
	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4																																														
Address/Name Changes	3,120	2,606	2,640		5	3	8																																															
Off-site Storage Applications (approved)	24	26	20		20	25	27																																															
Transfer of Intern Hours to Other States	34	17	24		30	30	30																																															

Objective 2.4	Implement at least 25 changes to improve licensing decisions by June 30, 2011.
Measure:	Number of implemented changes.
Tasks:	<ol style="list-style-type: none"> <li data-bbox="370 220 1490 283">1. <b>Determine why 26 states do not allow the use of a CA license as the basis for transfer of pharmacist license to that state.</b>  <i>Jan. 2007: Survey of some states indicate misunderstanding of why California cannot accept NAPLEX scores earned before January 1, 2004. Educational efforts, on a state by state basis, initiated.</i>   <i>March 2007: Pennsylvania agrees to accept California NAPLEX scores.</i>  <i>May 2007: At National Association of Boards of Pharmacy meeting several states agree to reconsider their position against accepting California scores.</i> </li> <li data-bbox="370 514 1490 661">2. <b>Evaluate the drug distribution system of clinics and their appropriate licensure.</b>  <i>1st Qtr 09/10: Continued to advise clinics and their advocates about the barrier the Capen decision places on surgicenters/clinics from obtaining a board clinic permit. A legislative solution is needed.</i>   <i>3rd Qtr 09/10: Board hears presentation by Fort Sutter Surgery Center discussing the issue.</i> </li> <li data-bbox="370 703 1490 1029">3. <b>Work with the Department of Corrections on the licensure of pharmacies in prisons.</b>  <i>June 2007: Meet with the Department of Corrections Receiver to discuss possible regulatory structures for drug dispensing and distribution within correctional facilities.</i>   <i>Oct. 2008: Board staff meet with Department of Corrections staff to develop regulatory structure for prisons.</i>   <i>Dec. 2008: Met with receiver for correctional facilities to discuss regulatory structure.</i>  <i>1st Qtr 10/11: Governor includes provisions for pharmacy services in prisons.</i>  <i>3rd Qtr 10/11: Legislation introduced to include some changes.</i> </li> <li data-bbox="370 1039 1490 1690">4. <b>Work with local and state officials on emergency preparedness and planning for pandemics and disasters. Planning to include the storage and distribution of drugs to assure patient access and safety.</b>  <i>2nd Qtr 09/10: Board votes that in declared emergencies where a board meeting cannot quickly be scheduled, a subcommittee of three members can make decisions for patient safety under provisions of Business and Professions Code section 4062 and the board's emergency response policy.</i>   <i>4th Qtr 09/10: Licensing continued reviewing requests from CDPH seeking clarification on board disaster response policy.</i>   <i>2nd Qtr 10/11: Discussion of the California Hospital Association's repopulation after hospital evacuation guidelines and checklist at Licensing Committee Meeting.</i>   <i>3rd Qtr 10/11: Board discussed its role in repopulation of hospitals in working with the CDPH to inspect the pharmacy to validate that there are appropriate safeguards to ensure the safety of the drugs. Licensing Committee hosts a presentation on emergency preparedness during quarterly meeting. Committee discusses need for possible mandatory CE in this area.</i> </li> <li data-bbox="370 1701 1490 1795">5. <b>Evaluate the need to issue a provisional license to pharmacy technician trainees.</b>  <i>Dec. 2010: Update on the board's psychometric evaluation for the ExCPT and PTCEB at the Licensing Committee.</i> </li> </ol>

**6. Evaluate use of a second pharmacy technician certification examination (ExCPT) as a possible qualifying route for registration of technicians.**

**Sep. 2006:** *Committee hears presentation on ExCPT exam approved for certification of technicians by five states. Committee directs staff to evaluate exam for possible use in California.*

**Dec. 2006:** *DCA recruiting for Chief of Examination Resources Office; review postponed. Additional methods to accomplish review considered.*

**March 2007:** *DCA recruiting for Chief of Examination Resources Office; review postponed. Additional methods to accomplish review considered.*

**May 2007:** *Board seeks private contractor to evaluate both ExCPT and PTCB exams for job validity.*

**Sep. 2007:** *Board required to check with other state agencies to ensure that state-employed PhD psychometricians are not able to perform this review before the board can contract for services. Committee recommends delay until CSHP and CPhA complete their review of pharmacy technician training and knowledge.*

**Oct. 2007:** *Board postpones work on this topic until CSHP and CPhA complete their review.*

**March 2009:** *Board executive staff meet with the executive director of the ExCPT exam.*

**April 2009:** *Board directs staff to secure a psychometric review of both the PTCB and ExCPT exams, in wake of AB 418 being stalled in the legislature.*

**2nd Qtr 09/10:** *Board initiates discussions with DCA regarding use of their Ph.D to evaluate the validation studies.*

**2nd Qtr 10/11:** *DCA psychometric expert initiates review of PTCB and ExCPT exams.*

**3rd Qtr 10/11:** *Board staff reports interagency agreement has been signed with OPES. The DCA psychometric expert has begun its review of the PTCB and ExCPT examinations.*

**7. Review requirements for qualifications of pharmacy technicians with stakeholders**

**4th Qtr 07/08:** *Future work on the training of technicians will occur as joint activities of the pharmacist associations.*

*Legislation to require an exam and continuing education for pharmacy technicians is dropped (AB 1947)*

*Board participates in CSHP sponsored stake holder meeting.*

**2nd Qtr 08/09:** *Executive officer participates in a meeting with CPhA and CSHP to provide technical advice on proposed legislation to be introduced next year. Attend CSHP sponsored stakeholder meeting.*

**3rd Qtr 08/09:** *Senate Bill 418 introduced to add new requirements for technicians. SB 418 is later dropped for the year.*

8. Implement the Department of Consumer Affairs Applicant Tracking System to facilitate implementation of I-Licensing system, allowing online renewal of licenses by 2008.  
**Note:** I-Licensing system has been cancelled and the BreEZe system will take its place.
- July 2006: Executive officer becomes executive sponsor of program.*
- Nov. 2006: Board completes system identification of parameters for each licensing program.*
- Dec. 2006 - Jan. 2007: Preparatory work and pilots completed; board staff initiates transfer to ATS system as sole platform for applicant tracking for all licensing programs.*
- 3rd Qtr 08/09: Request for Proposal for I-Licensing system modified to contain revised parameters. Staff changes in the Office of Information Services cause additional delay in moving the project forward. ATS project implemented.*
- 2nd Qtr 09/10: Board advised of new initiative to facilitate online applicant submission and renewal.*
- 4th Qtr 09/10: Board analyst temporarily assigned to assist on BreEZe project.*
- 1st Qtr 10/11: Assistant Executive Officer chairs forms design workgroup to consolidate forms for all boards (reducing programming costs). Executive staff continue on BreEZe execution steering committee.*
- 2nd Qtr 10/11: Board analyst continues to work with the department on the BreEZe project.*
- 3rd Qtr 10/11: Executive staff and analyst continue to work with DCA on implementation issue.*
9. Participate with California's Schools of Pharmacy in reviewing basic level experiences required of intern pharmacists, in accordance with new ACPE standards.
- 3rd Qtr 06/07: Board attends 3 day-long working sessions convened by California's schools of pharmacy to develop list of skills students should possess by end of basic intern level experience (about 300 hours).*
- Oct. 2007: Board considers basic internship competencies developed under the program and develops letter of support.*
- Oct. 2008: California Pharmacy Council meets to discuss Intern requirements.*
- Dec. 2009: Licensing Committee again discusses the requirements given that other states are no longer transferring intern hours.*
- 3rd Qtr 10/11: Executive staff continue to serve on executive steering committee.*

**10. Implement new test administration requirements for the CPJE.**

*March 2007: Board advised about new exam vendor for CPJE effective June 1, 2007. Board notifies all CPJE eligible candidates of pending change, advises California schools of pharmacy graduating students and applicants in general.*

*June 2007: Shift to new exam vendor, PSI, takes place. New Candidates Guide is printed and distributed. Some transition issues to new vendor exist and are being worked on.*

*4th Qtr 09/10: Board approves new job content outline submitted by the Competency Committee as a result of the job analysis with an effective date of 4/1/2011.*

*2nd Qtr 07/08: Transition efforts to PSI continue.*

*3rd Qtr 07/08: New security procedures put in place and corresponding revisions to the Candidates' Guide are published and released.*

*1st Qtr 09/10: Competency Committee develops occupational analysis survey.*

*2nd Qtr 09/10: Competency Committee develops new content online for CPJE.*

*3rd Qtr 09/10: Board approves new job content outline submitted by the Competency Committee as a result of the job analysis with an effective date of 4/1/2011.*

*2nd Qtr 10/11: Documents advising applicants of new exam structure developed and released.*

*3rd Qtr 10/11: Board staff updated CPJE Candidate Information Bulletin and Web site for new Content Outline effective April 1, 2011.*

*4th Qtr 10/11: New CPJE Content Outline implemented.*

**11. Participate in ACPE reviews of California Schools of Pharmacy.**

*Oct. 2007: Board participates in review of California Northstate College of Pharmacy.*

*Jan. 2008: Board participates in review of UCSF.*

*March 2008: Board participates in review of Touro.*

*3rd Qtr 08/09: Board participates in three ACPE reviews of the schools of pharmacy at USC, Touro and California Northstate.*

*3rd Qtr 09/10: Board participates in ACPE review of the school of pharmacy at UOP.*

**12. Initiate review of Veterinary Food Animal Drug Retailer Designated Representative training.**

*Sept. 2007: Licensing Committee initiates review of training requirements for Designated Representatives and notes problems with unavailability 40-hour course specified in board regulations.*

*Oct. 2007: Board evaluates options for training of designated representatives.*

*Sept. 2008: Licensing Committee hears testimony regarding program.*

*June 2009: Evaluation of designated representative training scheduled for September.*

- 13. Convene Committee to evaluate drug distribution within hospitals.**  
*2nd Qtr 08/09: Executive Officer presents information at CSHP Seminar on failure of the recall system to remove Heparin from nearly 20% of California hospitals months after recall.*  
*3rd Qtr 08/09: Board establishes subcommittee to initiate review.*  
*March 2009: First meeting convened.*  
*June 2009: Second meeting convened in San Francisco.*  
*Sept. 2009: Third meeting convened in Sacramento.*  
*Dec. 2009: Work of Hospital Subcommittee nearly completed. Board to review parameters for recalls at January 2010 meeting.*  
*2nd Qtr 09/10: Document finalized.*
- 14. Improve reporting of and accounting for intern hours.**  
*4th Qtr 08/09: Licensing Committee discusses how intern hours are reported to the board and specifics of where intern hours can be earned.*
- 15. Participate in initiatives to increase the number of pharmacists in California to meet demand.**  
*4th Qtr 08/09: Board executive staff attend forums aimed at ensuring continual growth in the number of pharmacists and pharmacy technicians in California.*
- 16. Assess the operations of specialty pharmacy services.**  
*4th Qtr 08/09: Board initiates review of refill pharmacies.*  
*2nd Qtr 10/11: Board considers request from PETNET Solutions for a waiver of security requirements for pharmacies to permit after hours maintenance of equipment without a pharmacist present. The board lacks the authority to waive California pharmacy law in the manner requested.*
- 17. Encourage use of technology where it benefits the public.**  
*June 2009: Presentation to Licensing Committee of new robotic technology to compound drugs in hospitals.*  
*Oct. 2009: Automation equipment demonstrated to Board that would facilitate unit dose packaging in hospitals and allow for barcoding.*  
*Jan. 2010: Demonstration to Board of patient medication instructions in various languages accessible by emerging software available to pharmacies.*
- 18. Secure the implementation of e-prescribing in California by the earliest possible date.**  
*4th Qtr 08/09: Licensing Committee sees presentation on e-prescribing pilot programs sponsored by the California HealthCare Foundation and CalPERS.*  
*2nd Qtr 10/11: Board hears presentation by CalERx on the status of e-prescribing in California.*  
*Executive Officer provides presentations on e-prescribing at annual CalERx meeting.*  
*Board establishes an ad hoc task force to develop a guidance document on the e-prescribing of controlled substances.*  
*3rd Qtr 10/11: Guidance document prepared and reviewed by board.*  
*4th Qtr 10/11: Medical Board to review the section for prescribers.*

- 19. Ensure the public receives necessary pharmaceuticals in emergency response activities to the H1N1 pandemic.**
- 4th Qtr 08/09: Board assists the California Department of Public Health in responding to distribution of Tamiflu and Relenza. Pharmacy law requirements regarding labeling and dispensing not waived as standard and necessary pharmacists care could still be provided.*
- 2nd Qtr 09/10: Board continues to work with Department of Public Health on H1N1 distribution issues.*
- 20. Automate fingerprint background results with the Department of Justice.**
- 2nd Qtr 09/10: Began working with the DCA to implement automation of background results for applicants to be automatically imported into the board's Applicant Tracking System (ATS).*
- 3rd Qtr 09/10: Continued working with the DCA on developing programming specifics in order to go live on February 17, 2010. Board staff develops the procedures.*
- 4th Qtr 09/10: Final revision to the procedures, trained staff, and assigned job task to staff. Board staff continues to manage automated process and resolve issues.*
- 21. Evaluate pharmacy technician, pharmacist, and intern pharmacist application process to identify areas for improvement and to modify the application requirements to require "Self-Query" reports from the National Practitioners Data Bank – Healthcare Integrity and Protections Data Bank (NPDB-HIPDB).**
- 3rd Qtr 09/10: Staff reached out to pharmacy technician programs to advise them of statutory changes to the application fee. Staff revised pharmacy technician application after reviewing most common deficiencies for legal review.*
- 4th Qtr 09/10: Staff reached out to pharmacy technician programs educating them on the most common application deficiencies.*
- 1st Qtr 10/11: Staff finalized the draft pharmacy technician, pharmacist, and intern pharmacist application. Legal approved the draft pharmacy technician and intern pharmacist application.*
- 2nd Qtr 10/11: Legal approved the pharmacist application. Proposal to initial a regulation change to update the pharmacy technician application at the Licensing Committee meeting. Licensing Committee made recommendations for board to pursue the changes to the pharmacy technician application. Licensing Committee made recommendations for board to pursue the changes to require "Self-Query" reports from the National Practitioners Data Bank – Healthcare Integrity and Protections Data Bank (NPDB-HIPDB) for the pharmacy technician, pharmacist, and intern pharmacist application for licensure. At the recommendation of the Licensing Committee, the board authorized the Executive Officer to take all steps necessary to initiate a rulemaking update to the pharmacy technician application form and NPDB/HIPDB self-query report.*

**3rd Qtr 10/11:** Regulation change noticed to require self-query report with technician application.  
The board approved to initiate a rulemaking file to add 1727.2 and to amend 1728 related to requiring an intern pharmacist and pharmacist applicant to submit a Self-Query from the NPDB-HIPDB.  
The board approved to modify the Pharmacy Technician Application and direct staff to take all steps necessary to complete the rulemaking process.

**22. Implement Fingerprint Requirement for Pharmacist Renewal.**

**4th Qtr 09/10:** Regulation approved by Office of Administrative Law (effective date of regulation is December 7, 2010).  
Department drafted programming changes to accommodate requirement.  
Board staff tested changes in a testing environment.

**2nd Qtr 10/11:** Obtained FBI approval through DOJ for job title on Live Scan for licensed pharmacists.  
Board staff working with the department to implement importing automated fingerprint response into ATS.  
Implementation delayed due to hiring freeze and approval by FBI of new category for reprinted pharmacists.

**3rd Qtr 10/11:** Staff added to the board's Web site the pharmacist renewal fingerprinting requirements for those licensed prior to 2001. Included on the Web site is the Live Scan form and instructions required for renewal. Staff developed the letter notifying pharmacist licensees that have been identified as to comply with this renewal requirement and forwarded to Legal for review and approval. Board staff continues to work with the DCA on programming requirements to facilitate implementation.

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|  | <p>23. Evaluate licensing requirements for businesses seeking licensure that are under common ownership.<br/> <i>4th Qtr 09/10: Board staff developed standards for common ownership requirements.</i></p> <p>24. Evaluate Continuing Education Requirement for Pharmacists<br/> <i>2nd Qtr 10/11: Board discussed a proposal to specify continuing education credit for pharmacists in specific content areas and forwarded to Licensing Committee.</i><br/> <i>Licensing Committee discussed multiple specific areas for optional continuing education. The committee decided to amend the regulation 16CCR 1732.2. to allow for continuing education hours for various specified activities.</i><br/> <i>Regulation 16CCR 1732.2. was noticed for public comment on Nov. 22, 2010.</i><br/> <i>3rd Qtr 10/11: Board approved based on Licensing Committee recommendation to pursue specific content areas for continuing education and authorized staff to investigate implementation.</i><br/> <i>Subcommittee of the Licensing Committee discussed possible course content and methods of requiring continuing education.</i></p> <p>25. Improve pharmacy technician application forms to reduce deficiencies and require HIPDB.<br/> <i>1st Qtr 10/11: Identify changes and initiate rulemaking process to adopt changes to application forms.</i><br/> <i>2nd Qtr 10/11: Additional enhancements identified, and returned to board for approval.</i><br/> <i>3rd Qtr 10/11: Regulation change initiated to require new application form.</i><br/> <i>Board adopts changes to implement via promulgation of regulations.</i></p> <p>26. Require a self query HIPDB report as a condition for applying for a pharmacists intern and pharmacist license and as part of the application process to take the CPJE.<br/> <i>1st Qtr 10/11: Board approves concept and staff readies regulation changes to implement.</i></p> |
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