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

MEDICATION ERROR REDUCTION AND WORKFORCE CHAIR REPORT

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

During the meeting members will review a summary of the Committee's work at its September 14, 202 meeting, as well as updates for discussion and action as necessary.

a. Summary of Presentation and Discussion on Just Culture

Background

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

Summary of Prior Committee Discussion

During the Committee's September 2022 meeting, the Committee discussed the use of Just Culture and its focus on the need for shared accountability for outcomes. Members discussed that the transition takes times and resources but results in a reduction in medication errors and improved patient outcomes.

Summary of Presentation and Discussion

During the meeting members received a presentation from Christina Michalek and Matthew Grissinger on Just Culture. The presentation discussed that Just Culture involved shared accountability for individuals, organizations, and others. Presenters discussed medication errors and system failures impacting errors that may involve several factors including environmental issues, policies, institutional cultural, individual competency, and technology and equipment.

The three fundamental beliefs of Just Culture were discussed including: to err is human; to drift is human; and risk is everywhere. The presentation provided examples of different types of at-risk behaviors.

Members were advised that a culture of coaching involves discussion with the person who made the poor behavioral choice and why the decision was made. It is a two-sided conversation to understand why the error occurred.

Members ask about drift behavior and if preemptive reeducation would assist in prevent such behavior. Members were advised that it was the role of a leader to try to identify drifty before an error occurs and coach when it does occur.

Public comment suggest that the Board consider a requirement or recommendation for the PIC to have a Just Culture certification.

A consumer commented on their experience with a medication error and noted that the pharmacy blamed the consumer for the error saying rather than the pharmacy owning the error.

A copy of the presentation slides is provided in **Attachment 1.**

b. Discussion and Consideration Recommendation to Initiate Rulemaking to Amend Title California Code of Regulations Section 1711 Related to Quality Assurance Programs

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

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

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

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

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

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

Summary of Committee Discussion and Action

As part of the Committee's evaluation of medication errors and workforce issues, it considered if the Board's current QA program requirements are appropriate or if changes to regulation are necessary to advance error prevention. As part of its discussion, members considered several policy questions. The Committee initially reviewed policy questions during its September 2022 meeting and considered follow up questions as part of its November 2022 meeting. Below is a summary of the questions and comments:

September 2022 Summary

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

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

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

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

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

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

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

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

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

Members discussed this concept but noted possible challenges establishing an appropriate measurement that would be meaningful.

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

November 2022 Summary

1. Does the Committee believe the proposed required established in 1711(e)(2)(A)-(E) are necessary for reporting of incidents involving the use of an ADDS or should incidents be exempt from including these additional elements of the QA report?
   Members determined that this information was not needed in a QA report stemming from the use of an ADDS.

2. As drafted the QA reports retention period is three years. During prior discussion members considered if, prior to destruction, aggregate data should be maintained to allow for trending and assessing for outcomes.
   Members agreed with increasing the records retention period. Members spoke in support of establishing a requirement to aggregate data; however, some questioned if that would be feasible. Members discussed possible options but agreed to move forward a recommendation and language.

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

The committee received comments both in support of the motion and opposed to the motion.

Attachment 2 includes a copy of the language.

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

Background

The Pharmacist Well-being Index is a research-validated online tool invented by Mayo Clinic and is designed for pharmacy personnel to measure dimensions of distress and well-being. Pharmacists at risk of high distress are at a:

- 3-fold higher risk of low quality of life
- 8-fold higher risk of burnout
- 2.5-fold higher risk of high fatigue
- 2.5-fold higher risk of intent to leave their current job
- **2-fold higher risk of medication error**

The Board has included information on the Index in its newsletter. The most recent report indicates a slight increase in the distress percent for California respondents.

Also in November 2022, the National Academy of Medicine released the National Plan of Health Workforce Well-being to "drive collective action to strengthen health workforce well-being and restore the health of the nation." The plan highlights priority areas and goals in these areas to better support the health workforce and the health of all communities.

Summary of Committee Discussion and Action

Members discussed the results of the report and requested that the Committee continue to receive updated reports. Members noted a slight increase in the distress percentage for pharmacist licensed in California and noted that some of the actions under consideration by the Committee and work under development by the Communication and Public Education Committee appear to align with some of the information contained in the reports.

Attachment 3 includes a copy of the October 2022 state report.

Attachment 1

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Just Culture: The Role of Accountability in Pharmacy

Matthew Grissinger, RPh, FISMP, FASCP
Director, Education
Institute for Safe Medication Practices

Christina Michalek, RPh, FASHP
Director, Membership and PSO Services
Institute for Safe Medication Practices

Objectives

1. Introduce concept of a Just Culture
2. Differentiate between human error, at-risk behavior, and reckless behavior
3. Examine why at-risk behaviors occur
4. Identify how to manage the three behaviors

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Just Culture

- System design
- Behavioral choices
- Learning environment
- Share accountability
  - **Individuals**
  - **Organizations**
  - **Others…..**

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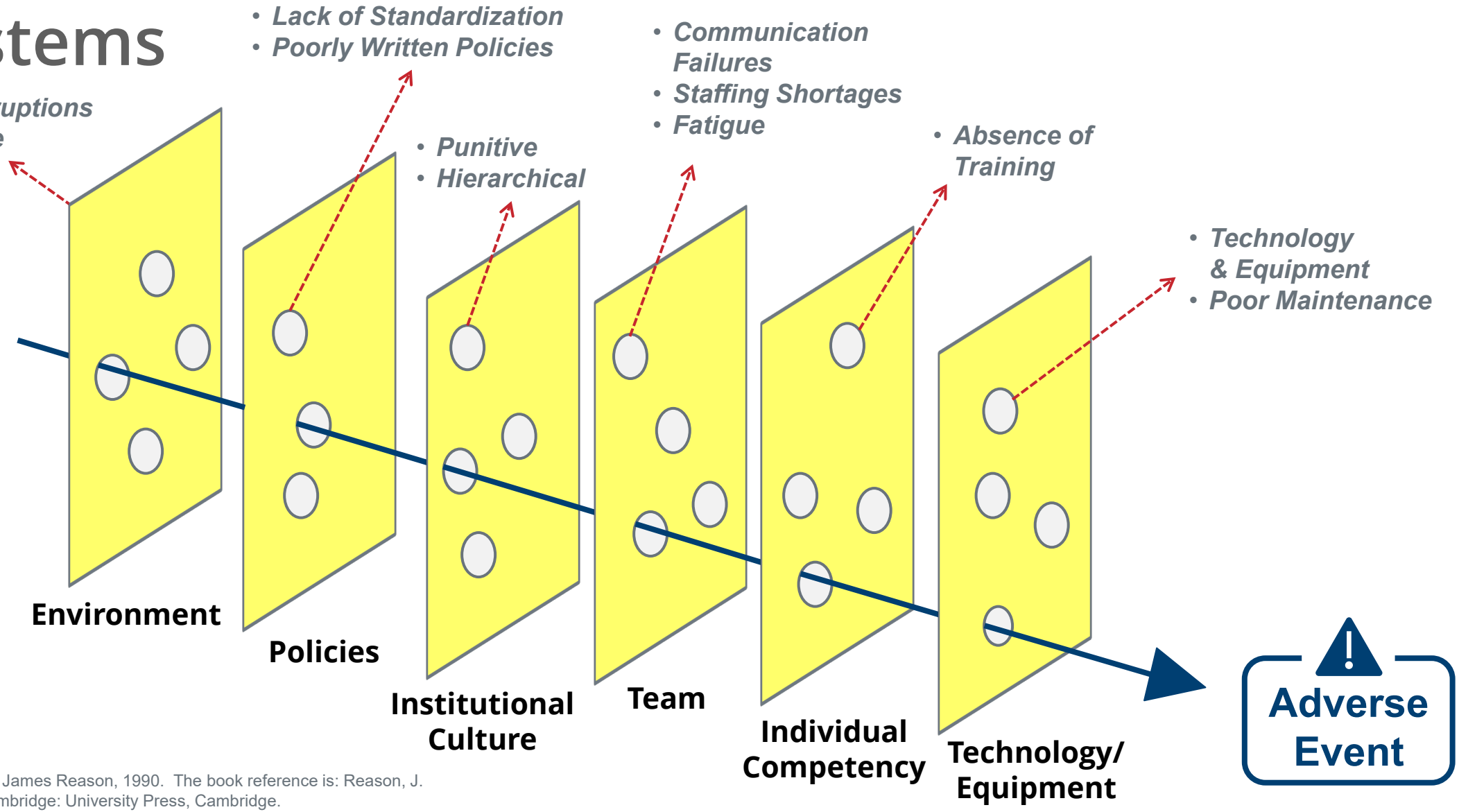
Latent and Active Failures

- Medication errors are rarely caused by a single element or the fault of a single practitioner
- Catastrophic events are most often the result of the combined effects of latent failures in the system and active failures by individuals

Latent Failures (Blunt End)

- **Latent failures (blunt end errors) -** adverse consequences which lie hidden in a system
- Become evident when combined with other factors to cause or contribute to an error
- "Accidents waiting to happen"
- Often originate where organizational policies, procedures, and resource allocation decisions are made

Systems



"Swiss Cheese" Model – James Reason, 1990. The book reference is: Reason, J. (1990) Human Error. Cambridge: University Press, Cambridge.

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Active Failures (Sharp End)

- Actions made by practitioners that contribute to error
- "Sharp End" errors
- Effects are felt almost immediately
  - **Slips, lapses**
  - **Behavioral choice**
    - Decisions, choices made by individual
    - Failure in judgement

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Three Fundamental Beliefs in a Just Culture

To err is human

To drift is human

Risk is everywhere

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Human Behaviors in a Just Culture

Human error—inadvertent action; inadvertently doing other than what was intended or what should have been done

At-risk behavior—behavioral choice that increases risk where risk is not recognized, or is mistakenly believed to be justified or insignificant

Reckless behavior—behavioral choice to consciously disregard a substantial and unjustifiable risk

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Behaviors and Responses

Behavior	Choose Behavior?	See the Risk?	Response?
Human Error			
At Risk Behavior			
Reckless Behavior			

To Err is Human: Is Zero Error Possible?

- An inadvertent mistake, cognitive slip or lapse that causes an outcome other than intended
- Ubiquitous and inevitable
- **Not** a behavioral choice
- No one is immune

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Behaviors and Responses

Behavior	Choose Behavior?	See the Risk?	Response?
Human Error	**NO**	**NO**	**CONSOLE Review System**
At Risk Behavior			
Reckless Behavior			

Alleviate grief, sorrow, or disappointment – providing comfort and solace

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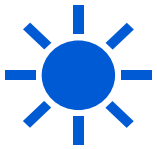
Factors That Degrade Human Performance

Each human error has preceding cause

Light

Noise



Climate

Humidity

Mental Distractions

Physical Distractions

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At Risk Behavior

- Risk is not recognized or recognized and believed to be justified
- Fading perception of risk as we become more comfortable with the task
- Desire to accomplish more

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At-Risk Behaviors: Drift

A behavioral choice

- Ubiquitous and inevitable
- No one is immune
- Lose situational awareness
- Why are people not following policies?

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At-Risk Behaviors

Behavior choice driven by the perception of consequences

— Rewards for taking shortcuts

- **Immediate, strong, positive**

— Slowly become routine

— Becomes the norm

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Examples of At-Risk Behaviors

- Processing illegible orders
- Technology work-arounds
- Preparing more than one patient's medications at once
- Not using 2 patient identifiers
- Not counselling patients
- Incomplete handoff during shift change

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Behaviors and Responses

Behavior	Choose Behavior?	See the Risk?	Response?
Human Error	**NO**	**NO**	**CONSOLE Review System**
At Risk Behavior	**YES**	**YES/NO**	**COACH Review System**
Reckless Behavior			

Teach and supervise, to act as a trainer, to give instruction

Managing At-Risk Behaviors

Coach

- Change perceptions of risk

Change Systems

- Change systems that are causing behaviors

Address Rewards

- Change the consequences

Modify Barriers

- Reduce barriers that prevent compliance
- Add barriers to prevent noncompliance

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Reckless Behaviors

Conscious disregard of a substantial and unjustifiable risk

- Examples
  - **Harm does not have to result, just the risk of harm**
  - **Today's at-risk behaviors may be tomorrow's reckless behaviors**
- Management of Reckless Behavior
  - **Possible disciplinary action**
  - **What was the intent of the behavioral choice?**

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Case Study

Determine the Behavior in a Just Culture

You choose to drive at 50 mph over the speed limit in the dark on a crowded street with no headlights	Reckless Behavior
You choose to drive at 10 mph over the speed limit	At-Risk Behavior
You inadvertently drive at 10 mph over the speed limit	Human Error

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Human Error, At-risk, Reckless?

CBS/AP / *January 24, 2013, 1:29 PM*

N.Y. hospital patients potentially exposed to HIV, hepatitis through reused insulin pens

insulin pens / FLICKR/HEATHER AITKEN

- **Human Error:** Staff picked up the wrong pen for administration to a patient
- **At-risk behavior:** Insulin pens not always labeled per patient; staff unaware that the pen could not be used on a second patient after changing the needle
- **Reckless behavior:** A clinic physician instructs the staff to reuse the insulin pens even though is known to be against OSHA and CDC Guidance because it will save the clinic money

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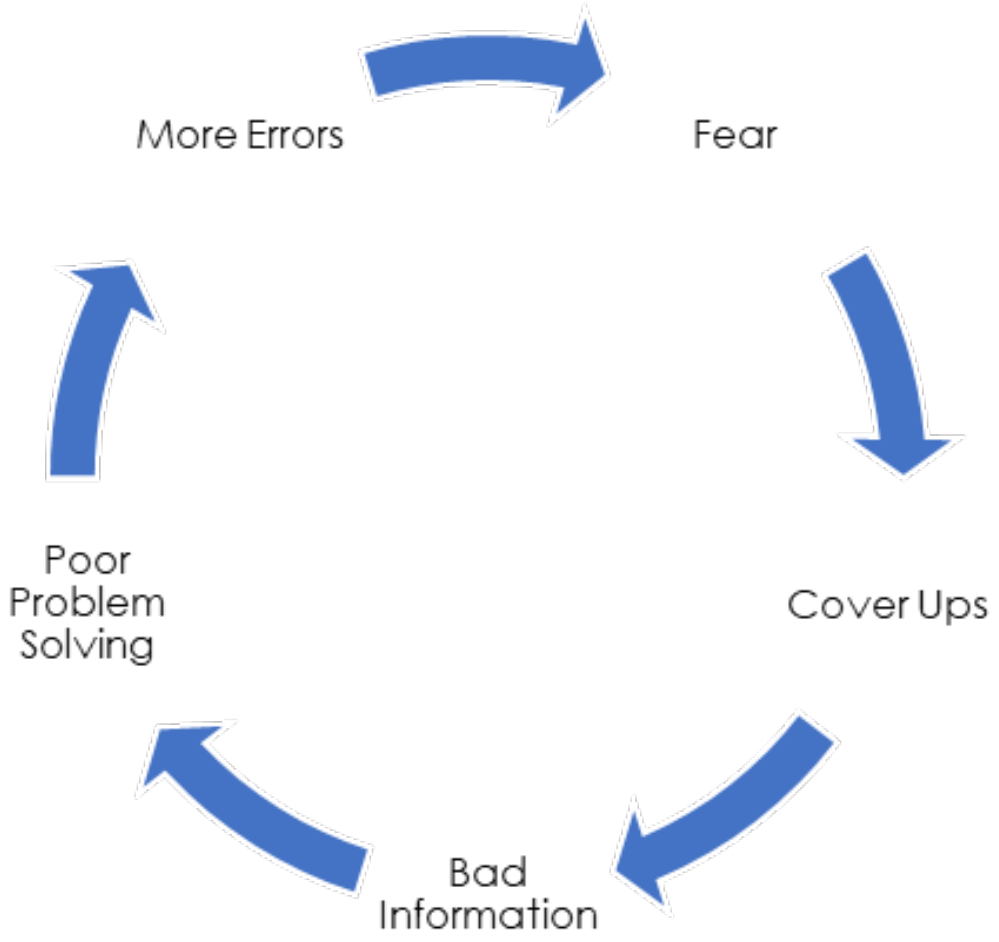
Why is this important?

- How we think about and respond to errors (both active and latent failures) reflects our healthcare culture
  - Effect on pharmacy staff?
    - Unfair to workforce
    - Underreporting
    - Not learning or improving
    - Can’t fix what you don’t know

What Does a Punitive Culture Look Like?

- Degree of discipline and strength of action are determined by severity of outcome
- Procedural violations are unacceptable
- Telling staff to “be more careful”
- Focus on re-education of individuals



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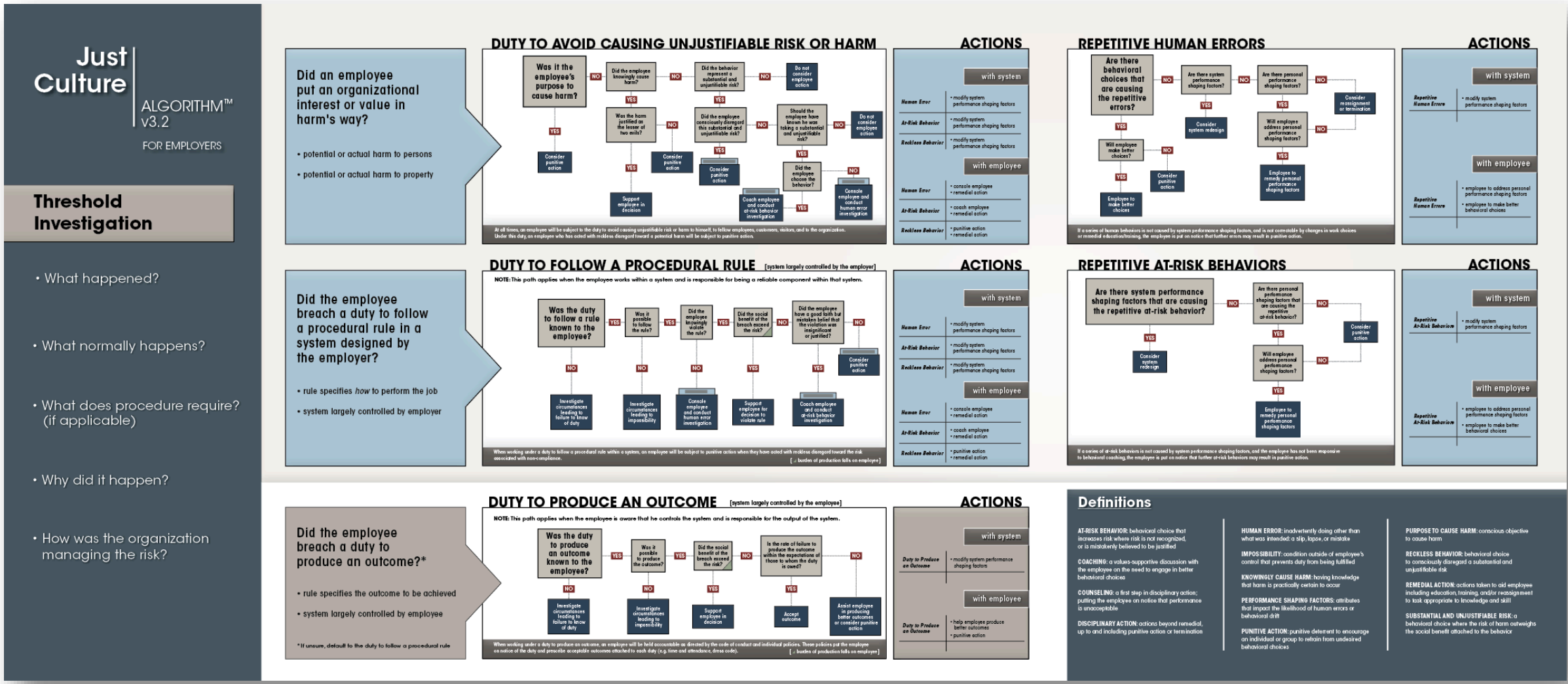
Just Culture Algorithm



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Questions?

Attachment 2

Proposal to Amend 16 CCR § 1711 as follows:

§ 1711. Quality Assurance Programs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attachment 3

APhA

WELL-BEING index

Well-being Index For Pharmacy Personnel

State Report For State Boards of Pharmacy

NABP District Eight States

OCTOBER 2022

pharmacist.com

For Every Pharmacist. For All of Pharmacy.

Well-being Index Resources Accessed

July 2019 to October 2022 and January 2022 to October 2022

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

Well-being Index for Pharmacy Personnel *Resources Accessed*

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

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

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

Well-being Index for Pharmacy Personnel

Resources Accessed – Percentage of All Views

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

The only difference in rank order

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

DISTRESS PERCENT CHANGES

National and District

October 2022 versus September 2022

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Changes in Distress Levels

As of October 2022

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

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

Changes in Distress Levels – District Eight

As of October 2022

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

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

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

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

WELL-BEING INDEX FOR PHARMACY PERSONNEL

STATE DISTRESS PERCENT*

OCTOBER 2022

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

SEPTEMBER 2022

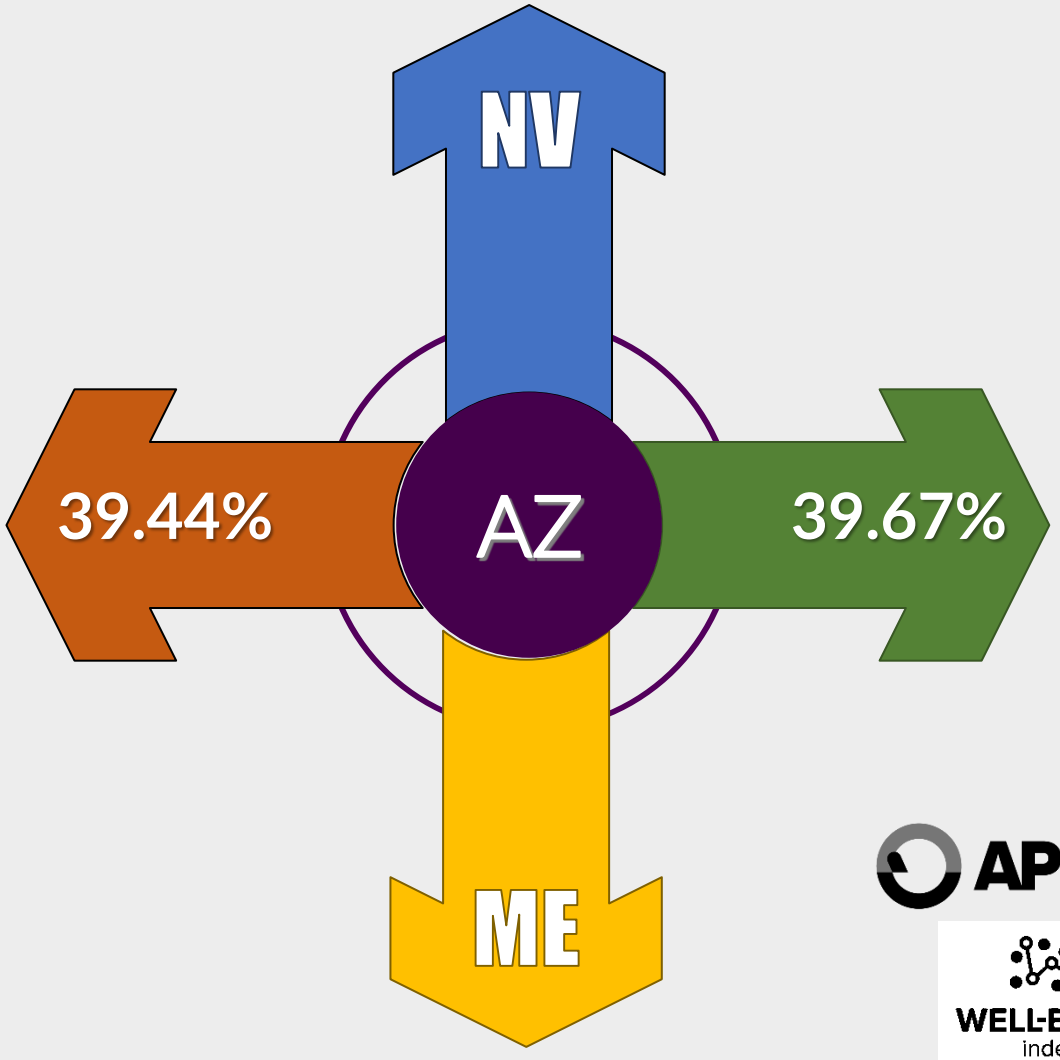
As of September 6, 2022, the Arizona distress percent was 39.44% (ranked 12/52) with 192 assessors.

STATE COMPARISON

As of October 6, 2022

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

Maine has the lowest 19.05% (n=26)



APhA

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

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

WELL-BEING INDEX FOR PHARMACY PERSONNEL

STATE DISTRESS PERCENT*

OCTOBER 2022

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

SEPTEMBER 2022

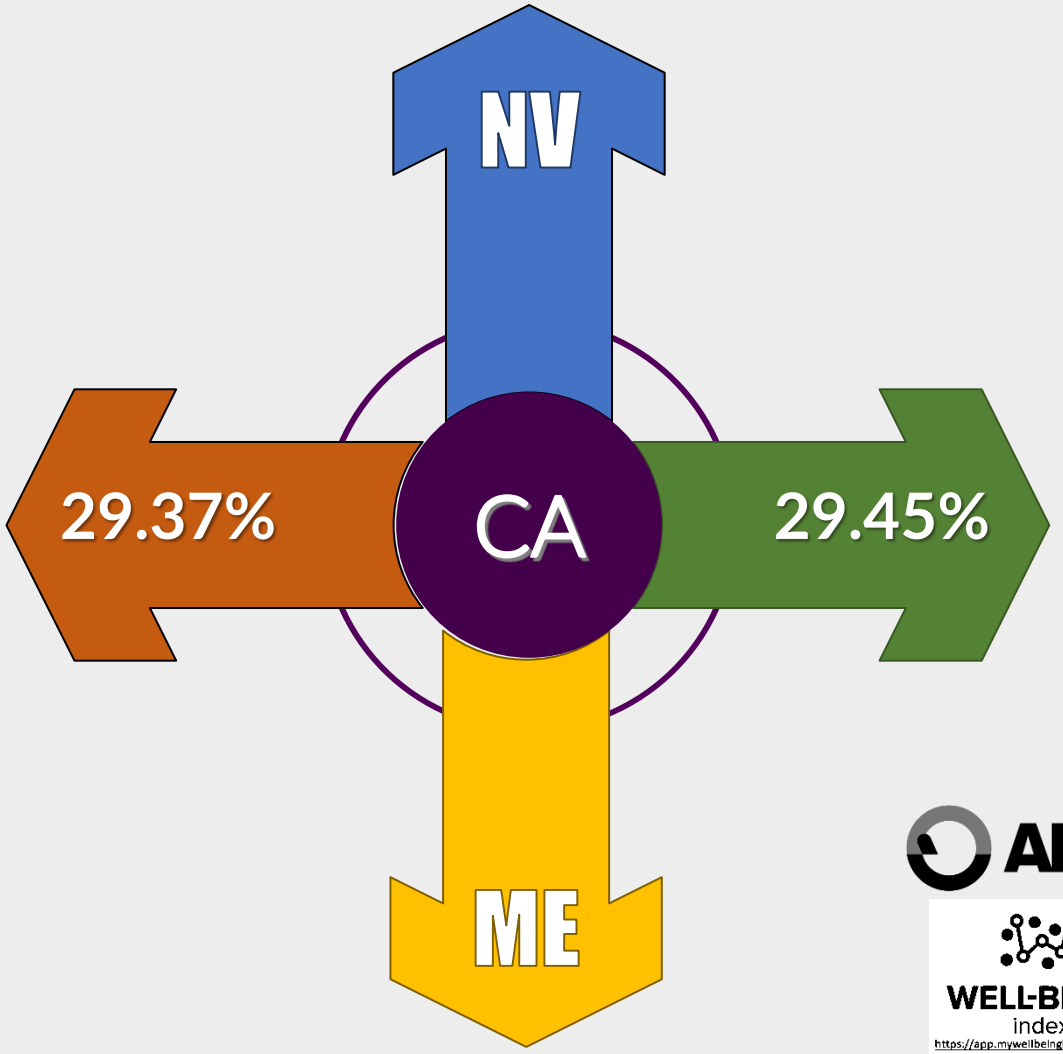
As of September 6, 2022, the California distress percent was 29.37% (ranked 44/52) with 756 assessors.

STATE COMPARISON

As of October 6, 2022

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

Maine has the lowest 19.05% (n=26)



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Invitation Code: APhA

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

WELL-BEING INDEX FOR PHARMACY PERSONNEL

STATE DISTRESS PERCENT*

OCTOBER 2022

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

SEPTEMBER 2022

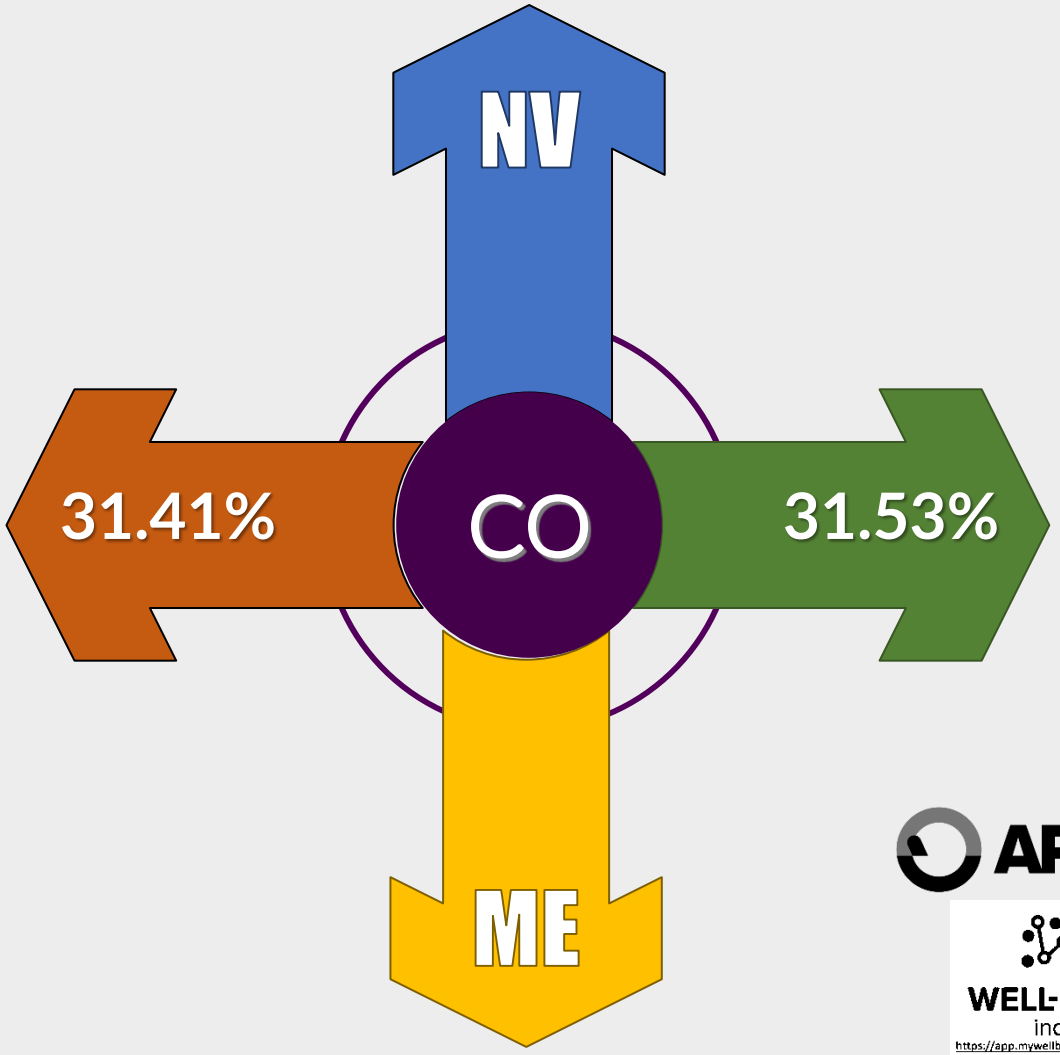
As of September 6, 2022, the Colorado distress percent was 31.41% (ranked 34/52) with 205 assessors.

STATE COMPARISON

As of October 6, 2022

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

Maine has the lowest 19.05% (n=26)



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WELL-BEING INDEX FOR PHARMACY PERSONNEL
STATE DISTRESS PERCENT*

OCTOBER 2022

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

SEPTEMBER 2022

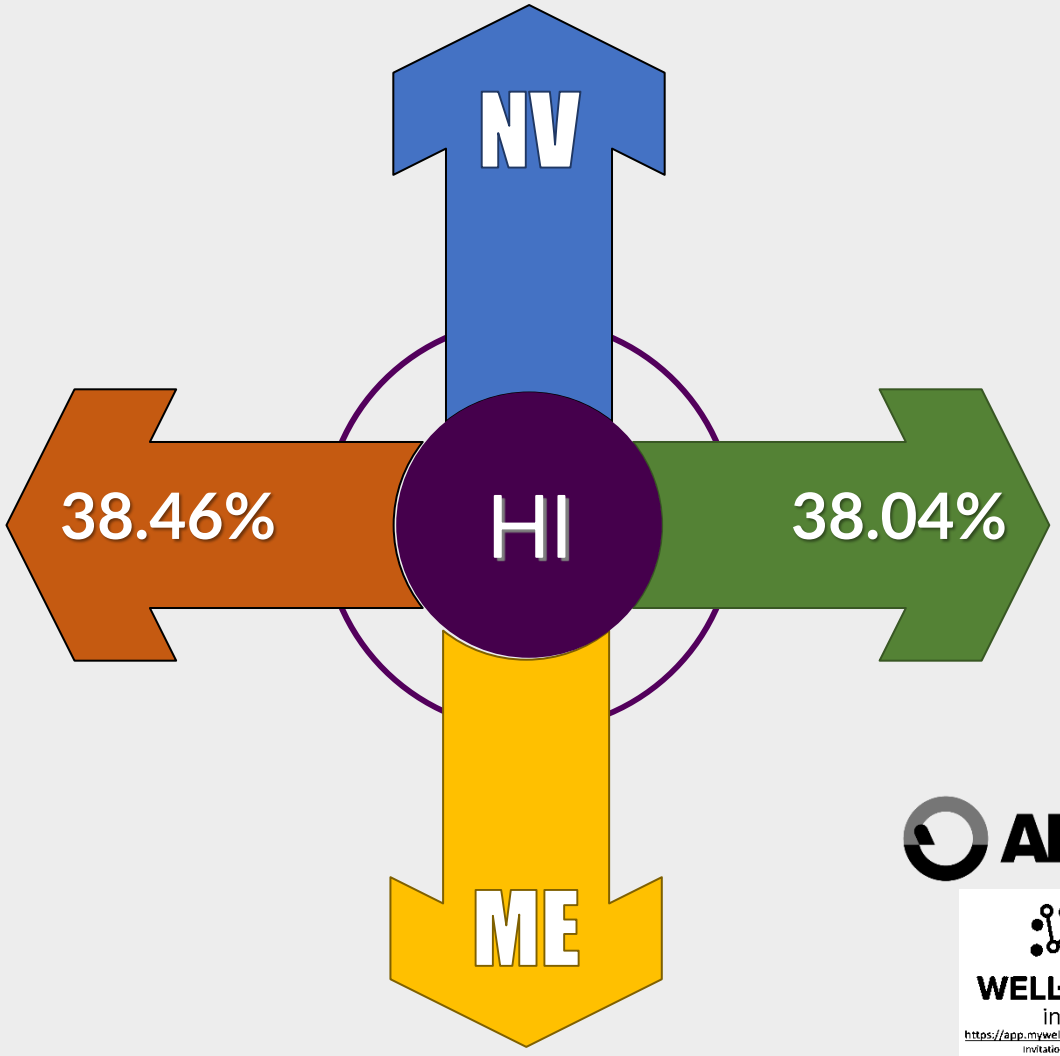
As of September 6, 2022, the Hawaii distress percent was 38.46% (ranked 14/52) with 29 assessors.

STATE COMPARISON

As of October 6, 2022

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

Maine has the lowest 19.05% (n=26)



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WELL-BEING INDEX FOR PHARMACY PERSONNEL
STATE DISTRESS PERCENT*

OCTOBER 2022

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

SEPTEMBER 2022

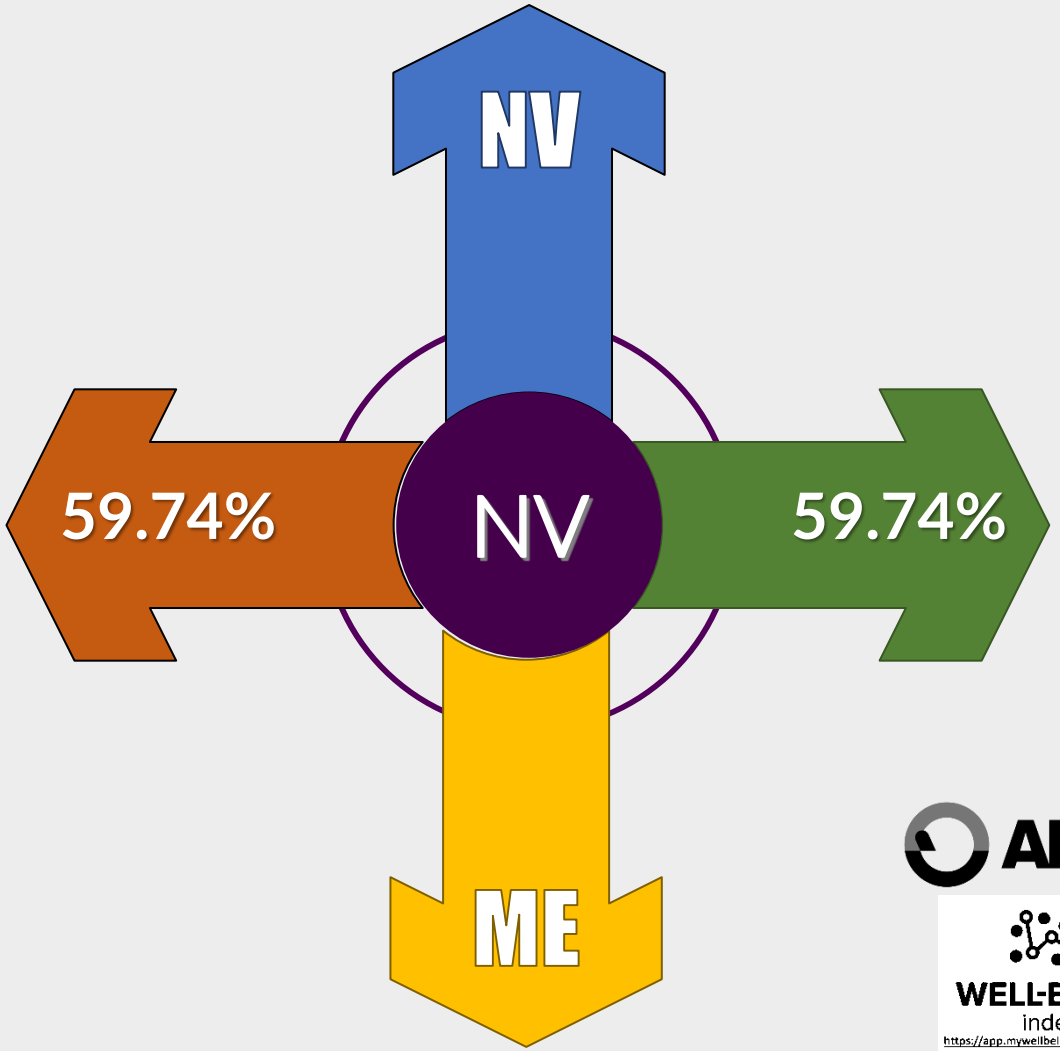
As of September 6, 2022, the Nevada distress percent was 59.74% (ranked the highest at 1/52) with 33 assessors.

STATE COMPARISON

As of October 6, 2022

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

Maine has the lowest 19.05% (n=26)



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WELL-BEING INDEX FOR PHARMACY PERSONNEL
STATE DISTRESS PERCENT*

OCTOBER 2022

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

SEPTEMBER 2022

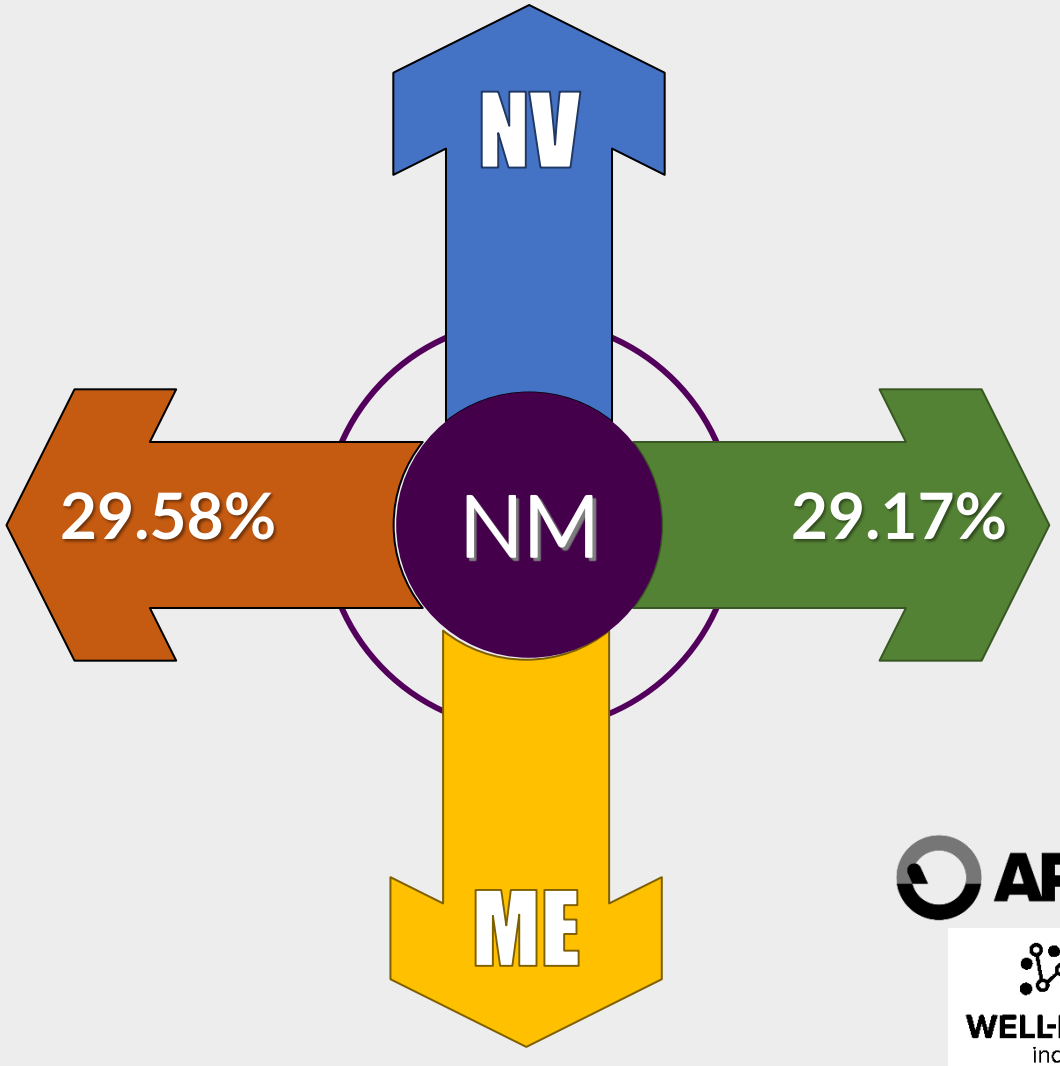
As of September 6. 2022, the New Mexico distress percent was 29.58% (ranked 43/52) with 50 assessors.

STATE COMPARISON

As of October 6, 2022

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

Maine has the lowest 19.05% (n=26)



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WELL-BEING INDEX FOR PHARMACY PERSONNEL
STATE DISTRESS PERCENT*

OCTOBER 2022

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

SEPTEMBER 2022

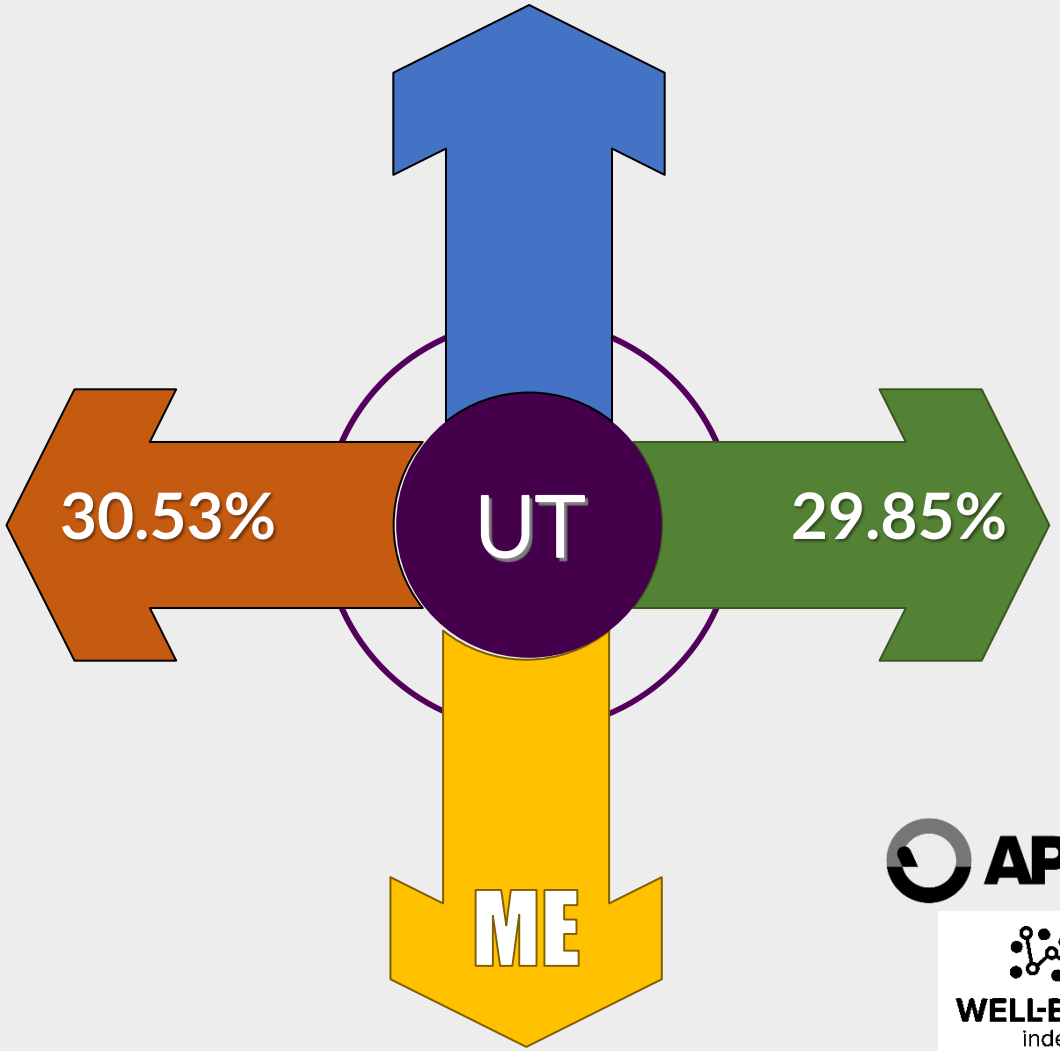
As of September 6, 2022, the Utah distress percent was 30.53% (ranked tied at 39/52) with 71 assessors.

STATE COMPARISON

As of October 6, 2022

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

Maine has the lowest 19.05% (n=26)



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

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

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www.pharmacist.com/wellbeing

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