California State Board of Pharmacy
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Business, Consumer Services and Housing Agency
Department of Consumer Affairs
Gavin Newsom, Governor

STANDARD OF CARE COMMITTEE
MEETING MINUTES

DATE: November 16, 2022

LOCATION: Note: Pursuant to the provisions of Government Code section 11153, neither a public location nor teleconference locations are provided. Public participation also provided via WebEx

COMMITTEE MEMBERS PRESENT: Seung Oh, Licensee Member, Chair
Maria Serpa, Licensee Member, Vice Chair
Renee Barker, Licensee Member
Indira Cameron-Banks, Public Member
Jessi Crowley, Licensee Member

COMMITTEE MEMBERS NOT PRESENT: Nicole Thibeau, Licensee Member

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

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

Chairperson Oh called the meeting to order at 2:00 p.m. Chairperson Oh reminded everyone present that the Board is a consumer protection agency charged with administering and enforcing Pharmacy Law. Dr. Oh advised where protection of the public was inconsistent with other interests sought to be promoted, the protection of the public shall be paramount. The meeting moderator provided instructions on how to participate during the meeting, including the process to provide public comment.

Chairperson Oh took roll call. Members present included: Maria Serpa, Licensee Member; Renee Barker, Licensee Member; Indira Cameron-Banks, Public Member; Jessi Crowley, Licensee Member; and Seung Oh, Licensee Member. A quorum was established.

Due to technical difficulties, the Committee took a break from 2:05 p.m. – 2:13

p.m. Chairperson Oh took roll call. Members present included: Maria Serpa, Licensee Member; Renee Barker, Licensee Member; Indira Cameron-Banks, Public Member; Jessi Crowley, Licensee Member; and Seung Oh, Licensee Member. A quorum was established.

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

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

A pharmacist commented that going to the standard of care enforcement model may include items such as naloxone administration. The pharmacist provided an example of how a pharmacist should react in the event of an emergency when naloxone was needed.

Members were provided an opportunity to add items to a future agenda.

Member Crowley commented in support of adding the naloxone item to a future agenda item. Chairperson Oh agreed it could be impacted by standard of care enforcement model and should be discussed.

III. Continuation of Discussion and Consideration of Policy Questions Related to Standard of Care Enforcement Model in the Practice of Pharmacy

Chairperson Oh reminded attendees of the language provided in Business and Professions Code (BPC) Section 4301.3: On or before July 1, 2023, the Board shall convene a workgroup of interested stakeholders to discuss whether moving to a standard of care enforcement model would be feasible and appropriate for the regulation of pharmacy and make recommendations to the Legislature about the outcome of these discussions through a report submitted pursuant to Section 9795 of the Government Code. Chairperson Oh reminded attendees the Board already uses a hybrid standard of care enforcement model.

Dr. Oh provided a summary of the Committee's discussions to date. Dr. Oh noted there appeared to be consensus that the Board's current enforcement model, which is a hybrid, was appropriate for facilities licensed by the Board. Dr. Oh added as part of the discussion, the Committee noted that unlike pharmacists, facilities do not have extensive education and experience, nor do they exercise professional judgement.

Chairperson Oh continued noting there appeared to also be consensus that the Board's current enforcement model was appropriate in the regulation of non-pharmacists licensed personnel such as pharmacy technicians, designated representatives and possibly interns. Dr. Oh added Members noted there may be an opportunity to expand the scope of practice for pharmacy technicians; however, pharmacy technicians operate under the direct supervision and control of a pharmacist. The Committee noted that technicians should not have discretion.

Chairperson Oh reminded participants the Committee transitioned its discussion to evaluation of the questions related to pharmacists and pharmacists-in-charge (PICs). Dr. Oh noted that the Board may need to draw a distinction between a pharmacist and a PIC, noting that a PIC is responsible for compliance with the law. Members also noted the different types of practice settings and functions that a pharmacist may perform and the need to perform clinical judgement. Dr. Oh added there appeared to be some consensus that there was an opportunity to use a more robust standard of care enforcement model for pharmacists. Public comment also appeared to agree there was an opportunity for more robust use of a standard of care enforcement model for pharmacists. One large challenge identified during the discussion was how a PIC can be autonomous and control the operations of a pharmacy when corporate practices exist that undermine PICs.

Chairperson Oh recalled the Committee transitioned to a larger question regarding opportunities to expand the scope of practice for pharmacist and/or remove some of the prescriptive provisions that exist with some of the current authorized scope of practice. There was consensus that opportunities do exist and noted there were many opportunities for regulations to be less restrictive. Members also noted some challenges with such a transition including if pharmacists would be empowered to provide clinical services autonomously. Members indicated the need for some consistency and to ensure pharmacists are appropriately educated and trained to provide the services. Members also considered if current CE requirements related to specific authorities would still be necessary. Public comment appeared to be in support with some commenters noting the number of specialties available for pharmacist. Public comments indicated that a standard of care enforcement model enables pharmacist to exercise professional judgement. Members concluded also that changes to regulation should not be limited to specific practice settings.

Chairperson Oh provided the Committee appeared to reach consensus that a transition to standard of care could result in expanded access to care and improved patient outcomes. Members noted that some conditions may be necessary and cautioned that as the Board moves forward it was necessary to make sure that the unintended consequence did not result in a lowering of the standard of care. Public comment agreed with Members.

Chairperson Oh advised the Committee considered if minimum requirements on training or education were necessary or requirements to ensure baseline competencies were met. Members noted some challenges. Some members noted the need for some minimum training while other members cautioned about being too specific.

Policy Question #5b
Does the Committee believe that setting minimum requirements on training or education or requirements to ensure baseline competence across the state is preferable or to allow for deviations based on geography, size of practice or other variables?

Chairperson Oh believed the Committee could look to the advanced practice as a possible model noting the Committee learned from Dr. Chen that extensive training was required to perform these advanced duties. Dr. Oh didn't believe geographic differences would be appropriate or there could be differing levels of minimum care across the state of California. Dr. Oh stated the Committee needed to advance patient care while ensuring health care equity.

Members were provided the opportunity to comment.

Member Serpa believed there should be minimum standards for training and education and geography shouldn't impact minimum standards. Dr. Serpa was interested in other Members' comments about the size of practice.

Member Barker agreed minimum standards should be established to provide a standard of care practice. Candidates would also have to demonstrate and verify that minimum requirements have been met. Dr. Barker stated any lack of qualification based on geography, size of practice, etc. would not be in the interest of patient safety.

Member Cameron-Banks stated to ensure patient safety there must be a baseline minimum competence for the entire state and it shouldn't vary based on geographic location.

Member Crowley struggled to envision what the minimum training other than CPJE would look like. Dr. Crowley noted the Committee was discussing how this would look (e.g., exam, continuing education, etc.) adding what was decided shouldn't be different based on geography or size of practice. Dr. Crowley added the training may look different depending on what the practice is to determine the baseline competency which could result in multiple types of trainings.

Chairperson Oh summarized the Committee's agreement there must be some minimum requirement but the Committee was not sure what it looks like if standard of care model was used.

Members of the public were provided the opportunity

A pharmacist stated the minimum academic and licensing standards have already been set. The pharmacists are already considered health care professionals by BPC that states licensed pharmacists are health care providers in the state of California. The commenter added pharmacists are qualified to provide health care and what needs to be done is to create a regulatory environment that supports the pharmacists' ability to provide quality health care services. The commenter discouraged requiring different types of training noting doctors do not have different level of trainings but are required to adhere to the standard of care. The commentor noted only three states in the US prohibit a newly licensed pharmacist from participating in collaborative practice agreements and noted many associations support moving to standard of care model.

A pharmacist commented in support of not dividing by county but concerned there would be additional levels for standard of care that would bifurcate pharmacy as a profession. The pharmacist noted there is already a methodology for stating pharmacists are practice ready which should also speak to standard of care if the Board decides to move in that direction.

Policy Question #6
Does the Committee believe under current working conditions, a transition to a less prescriptive scope of practice is possible and appropriate and if so under what conditions?

Chairperson Oh advised working conditions are a large problem that cannot be ignored and noted in the survey responses that challenges appear to exist in the hospital environment as well. Dr. Oh inquired if pharmacists would be set up to fail if the Board removed some of the specified requirements related to performing some functions without putting in sufficient safeguards to ensure appropriate staffing and resources were available. At this time, Dr. Oh was not sure removing some of prescriptive requirements included in the scope of practice could be done in a safe manner in some environments, particularly the chain setting. Dr. Oh posed who would develop policies for providing clinical services? Dr. Oh also posed who would be responsible for ensuring a pharmacy was adequately staffed for a pharmacist to perform such services without sacrificing the quality of a pharmacist dispensing of medications while continuing to provide consultation which was vital to preventing medication errors? Dr. Oh added expanding access was necessary, but only if it can be done in a safe and appropriate manner.

Members were provided the opportunity to comment.

Member Barker agreed with Dr. Oh's points that a transition to a more expanded scope of practice was a possibility but agreed consideration of the current retail conditions would be significant hurdles to overcome. Dr. Barker noted adding additional services would require pharmacists to be able to have additional support for increased patient care.

Member Cameron-Banks stated the current working conditions would not allow for an expanded scope of practice.

Member Crowley agreed it was not appropriate given the current working conditions before transitions were to occur. Dr. Crowley indicated concerns included minimum staffing level and noted lower volume pharmacies are understaffed. Dr. Crowley noted some of the pharmacies are required to take appointments for additional patient care services without the ability to change the appointments. Dr. Crowley added expanded services shouldn't be done until working conditions are addressed. Dr. Crowley added working pharmacists need to be developing the standards used by pharmacists.

Member Serpa stated this had been indirectly delt with for years through ratios and not allowing quotas but it comes down to developing a metric or measure to ensure a safe environment to provide the care that was needed. Dr. Serpa indicated the regulator shouldn't set it. Dr. Serpa stated it was attempted to be developed in the acute care setting but it wasn't completed and warned of unintended consequences.

Chairperson Oh summarized the Committee's agreement that there must be some minimum requirements but the Committee was not sure what it would look like if standard of care model is used.

Members of the public were provided the opportunity to comment.

A retail pharmacist commented this was a standard of care enforcement model question and not expanded scope of practice. The pharmacist believed it would be possible to do but was not in the best interest of patients and pharmacists as it would be unclear who would be developing the standards. The pharmacist noted the decision-making power is often not the pharmacist in the pharmacy. The commenter added each pharmacist should be able to decide for themselves and decisions shouldn't be made by the district manager.

A medication safety officer in the hospital setting commented in support of transitioning to a standard of care enforcement model noting it would apply in

areas not addressed in the law and didn't see it as an expansion of scope. The commenter thought it was common practice in the hospital setting.

A pharmacist agreed with the previous comments and agreed that the standard of care enforcement model wouldn't cause an expansion of scope. The commenter noted the evaluation of conduct would be based on standards of other practitioners in the field.

A pharmacist noted the conversation had changed to "Would the current working condition allow for standard of care enforcement model?" and was concerned of the delay in access to care. The pharmacist felt it could be achieved by empowering the pharmacist and giving the pharmacist the ability to be able to refuse to offer services and determine if they are able to provide the level of care needed by the patient.

Policy Question #7
If the Committee believes that expanding some pharmacist clinical duties by using a standard of care model is appropriate, does the Committee believe it is appropriate to allow a business to develop policies and procedures for a pharmacist to follow, or could such a practice impede a pharmacist's ability to exercise professional judgement?

Chairperson Oh noted the Board was asking if there were too many policies and procedures as pharmacy law requires numerous policies and procedures. Dr. Oh reminded the Committee was discussing policies and procedures related to pharmacist clinical or professional judgement and not policies and procedures related to business functions (e.g., inventory reconciliation).

Chairperson Oh noted this was one of the biggest challenges. Dr. Oh added the Committee learned from Ms. Webb, counsel for the Medical Board, within the medical profession there was a bar on the corporate practice of medicine; however, there was not a similar bar in pharmacy. Dr. Oh inquired if the Committee believed pharmacists need to be positioned to work and practice under a standard of care model. Dr. Oh did not believe in general a business should be allowed to develop policies and procedures dictating their practices or professional judgements unless the pharmacists maintain sufficient autonomy and can override the policy when deemed appropriate. Dr. Oh added that businesses develop multiple policies and procedures required by pharmacy law but those are policies and procedures that involve the pharmacy license and functions. Dr. Oh believed when a pharmacist was working under a pure standard of care model, absolute autonomy was necessary.

Members were provided the opportunity to comment.

Member Cameron-Banks commented there was tension between pharmacists exercising autonomy and exercising professional judgement versus being forced to follow policies and procedures required by a corporation. Ms. Cameron-Banks commented it seemed it would not be appropriate based on the information presented.

Member Crowley inquired if there was an example when a policy and procedure may conflict with the standard of care enforcement model. Ms. Sodergren provided an example where a computer system may prevent a pharmacist from providing medication even if clinically appropriate because of the hard stop in the computer system. Dr. Crowley stated businesses should be able to create policies and procedures.

Member Serpa commented there shouldn't be policy and procedure in patient care but it did make sense for continuity of care, access to care, and start/end care. Dr. Serpa added what may seem like a computer system issue could be an insurance or separate issue. Dr. Serpa stated policies and procedures were needed for processes but not for clinical decisions.

Chairperson Oh posed the question if protocols were removed with the change to standard of care enforcement model, would policies and procedures stop or hindered patient care? Dr. Serpa noted in acute care 50 pharmacists work with a protocol each pharmacist may have unique approaches but protocol allows for the standard of care to be formalized.

Member Barker agreed a business will need to have policies and procedures that include the pharmacists to guide the business. Dr. Barker noted as far as providing clinical services the policies and procedures should not hinder pharmacists' professional judgment or clinical practices.

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

A pharmacist agreed with Dr. Serpa and Dr. Barker where clinical decisions need to be made by the pharmacist noting if the business can dictate how the pharmacist must act, the pharmacist's clinical judgment can be hindered. The pharmacist added if the Board decides to switch to the standard of care enforcement model, the standard of care will be developed. The pharmacist noted policies and procedures have their place but where they inhibit the clinical judgment, it is a problem.

A health-system pharmacist commented the standard of care enforcement model was not intended to govern clinical practice or inhibit the businesses' ability to create policies and procedures. The pharmacist cited the definition of how a

prudence pharmacist would provide the degree of care one will exercise under similar circumstances.

A pharmacist commented in agreement with the direction the Board noting support of protocols that focus on processes rather than clinical decisions. The pharmacist spoke in support of empowering the pharmacists to provide the legal authority needed so the pharmacist can do what is clinically required for the patient.

A representative from CPhA agreed with the comments that it would be a mistake to not allow policies and processes. The representative agreed the policies and procedures are for the processes but not clinical decisions.

A pharmacist recommended using evidence-based guidelines consistent with current compendia to enable organizations to utilize the knowledge for the consistency for providing patient care that is not delayed. The pharmacist noted this would ensure how the pharmacists operate is consistent with what is needed for the patients.

Policy Question #7a
For instance, should patient care policies be required to be developed by the PIC or merely approved by the PIC?

Chairperson Oh stated the PICs should be involved in some part of policy development.

Members were provided the opportunity to comment.

Member Crowley agreed in some capacity the PIC should sign off on what patient care policies were used in the store but was not sure where in the process the PIC should be involved in the development or approval process and was interested in hearing others' comments.

Member Serpa stated care areas were so complex that PICs can't be experts in every area but needed to be the responsible party. The PIC should hire or have experts available to help create those policies. Dr. Serpa felt PICs should approve the policies.

Member Barker agreed with Dr. Serpa noting the PIC needs to have the awareness and know the appropriateness of the policies but the PIC may or may not be the ones developing the policies.

Member Cameron-Banks agreed the PIC should be involved in the process and approval seemed appropriate.

Members of the public were provided an opportunity to comment.

A representative from CPhA commented the PIC should have the final say and be involved in the approval of the policies and procedures. The representative noted in hospital and ambulatory care settings there were committees consisting of experts who can have a say in how the policies and procedures are developed. For smaller pharmacies, consultants and experts can be hired. For chain store pharmacies, committees can be conducted by regions.

Policy Question #7b
Could practice setting impacts the power that the pharmacist has in setting appropriate care responses if scope of practice is expanded by standard of care model?

Chairperson Oh was not in favor of delineating provisions by practice setting.

Members were provided the opportunity to comment.

Member Serpa was not in favor of different rules based on practice settings.

Member Cameron-Banks commented it seemed the power could be impacted and could negatively impact patient safety.

Member Crowley agreed while in a perfect world the standard of care should be the same across all settings but could differ if the scope of practice was expanded by converting into a standard of care model. Dr. Crowley provided as an example, differences in policies and procedures may lead to different care across different settings.

Member Barker expressed a concern that it could negatively affect a pharmacist's patient care response.

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

Policy Question #8
In light of the survey responses provided, does the Committee believe steps need to be taken to ensure pharmacists are empowered to provide appropriate patient care versus policies and procedures developed by corporations or business entities that would dictate patient care?

Chairperson Oh believed steps must be taken to ensure autonomy for pharmacists.

Members were provided the opportunity to comment.

Member Barker commented the pharmacist should be protected and ultimately the patient should be protected from corporate focused policies and procedures that don't originate or include input from the pharmacist or prevent pharmacists from using clinical judgement for a patient.

Member Cameron-Banks commented yes as the motivation of companies behind policies and procedures is different than the motivation of pharmacists to provide patient care.

Member Crowley noted the barrier for pharmacist was the working conditions and burnout rather than the barriers of policies and procedures.

Member Serpa added pharmacists need to be involved but not sure the Board needs to be involved with human resources issues or decisions.

Members of the public were provided the opportunity to comment.

A pharmacist commented the pharmacist needs more support to advocate for their patients but not necessarily something that needs to be legislated.

A pharmacist commented this policy question doesn't belong in the discussion and anything that disrupts patient care must be handled at the employer level. Every pharmacist has the responsibility to escalate when they feel a policy interferes with their ability to do the right thing for the patient.

Policy Question #8a
How does the Board ensure that patient care policies are being developed by licensed pharmacists?

Chairperson Oh did not have an answer.

Members were provided the opportunity to comment.

Member Cameron-Banks was not sure how this could be done other than through legislation.

Member Crowley commented it should be done by licensed pharmacists in California who are actively practicing and working in the practice setting but was unclear how that could be done.

Member Serpa commented it needs to be approved by the PIC but not necessarily developed by pharmacists. Dr. Serpa stated it didn't need to be developed by a

California licensed pharmacist as it could be developed by a pharmacist outside of California or by a physician.

Member Barker commented there would need to be best practice guidelines followed and not necessarily state specific.

Members of the public were provided the opportunity to comment.

A representative of CPhA was confused by the question and inquired if the question was asking about patient care policy specific to the institution or referring to the patient care policies that would create the standard of care that the Board would enforce. If the former, the commenter agreed with Dr. Serpa's comments.

A pharmacist didn't think the Board should be involved unless there was a complaint.

A pharmacist agreed the Board shouldn't be concerned with how the policies are developed until a complaint arises.

Policy Question #8b
If the Committee believes that moving scope of practice to a standard of care model is appropriate for all settings, does it believe, similar to the Medical Practice Act, that there should be a bar on the corporate practice of pharmacy?

Chairperson Oh thought a bar to the corporate practices of pharmacy removes the competing profit interest that exist in some settings but wasn't sure how this could be achieved or even possible in current arrangements.

Members were provided the opportunity to comment.

Member Crowley thought it should be possible in an ideal world but echoed Dr. Oh that it was not feasible or realistic. Dr. Crowley noted it would need to include pharmacy benefit management companies.

Member Serpa agreed it was impossible to do.

Member Barker commented it didn't seem possible.

Member Cameron-Banks commented the if the Committee believes there should be a standard of care model, the Committee should consider the possibility of impact on patient safety.

Members of the public were provided the opportunity to comment.

A pharmacist was confused by the question. Ms. Sodergren clarified the question was asking if there should be a prohibition of a corporation from driving clinical practice. The pharmacist commented if it was just barring pharmacies from being corporately owned, the pharmacist didn't think it should be done or interfere with the business of pharmacy.

A pharmacist commented decisions shouldn't be based on how the pharmacy is incorporated.

A representative of CPhA commented that the issue wasn't necessarily banning the corporate ownership of pharmacies but preventing or limiting the corporate authority to make decisions at a patient care level that the pharmacist or PIC should have the authority to do instead. The representative continued if someone was working in a corporate owned pharmacy, the decisions should not be dictated by the corporate owner but by the pharmacist/PIC.

Member Serpa commented corporations are involved in all levels of health care (including but not limited to retail, ambulatory, hospital, home infusions, compounding pharmacies, etc.) and recommended having additional attorneys for future discussions to ensure the legal definition of corporation was considered.

The Committee took a break from 4:03 p.m. to 4:11 p.m. Members present included: Maria Serpa, Licensee Member; Renee Barker, Licensee Member; Jessi Crowley, Licensee Member; and Seung Oh, Licensee Member. A quorum was established.

Member Cameron-Banks returned to the meeting at 4:15 p.m.

Question 9
What aspects of pharmacist's clinical practice, if any, does the Committee believe should not transition to an expanded standard of care enforcement model (e.g., compounding)?

Chairperson Oh believed if the Board transitioned to an expanded standard of care enforcement model, it would be imperative to convey to licensees a clear understanding that federal laws and relevant states laws are still applicable and would form the basis for license discipline or administrative action.

Members were provided the opportunity to comment.

Member Serpa commented in some areas such as compounding California has higher standards than other states and federal standards. While some may prefer the lower federal standard than the higher federal standard, in the interest of

patient safety Dr. Serpa added California does not want to go back to lower standards.

Member Barker noted the operational aspect of Pharmacy has so many specific requirements (e.g., drug storage, compounding, and drug management) that are best regulated with exact language to ensure high medication quality. Dr. Barker noted in compounding California has higher standards and it wouldn't be appropriate to go to lower standards.

Member Crowley agreed the standards of compounding in California that are higher than the federal standards should not be compromised. Dr. Crowley inquired if the Board was to transition to standard of care, was the expectation that the regulations would be consolidated or would regulations remain in place in addition to the federal and then standard of care enforcement model would be used for enforcement. Dr. Crowley recalled when Idaho transitioned, the regulations were consolidated. Chairperson Oh indicated it would have to be addressed at a future meeting and potentially as part of the report to the legislature.

Members of the public were provided the opportunity to comment.

A pharmacist expressed concern for tiers/levels of pharmacists.

Member Barker noted there are so many duties of a pharmacist and there wouldn't be a creation of two different classes but rather a requirement based on the functions required to be a pharmacist.

Policy Question #9a
For example, does the Committee believe that a potential expansion of scope of practice should be limited by setting or limited to clinical patient care (e.g., pharmacists providing direct patient care outside of their traditional dispensing role)?

Chairperson Oh did not believe so.

Member Barker didn't believe limiting it served the public.

Member Cameron-Banks didn't believe it should be limited.

Member Crowley didn't believe it should be limited but some factors should be kept in mind when considering changes (e.g., chain setting, independent, etc.) and it shouldn't be limited to one setting.

Member Serpa stated her answer was no.

Members of the public were provided the opportunity to comment.

A pharmacist stated it should not be limited with the exception of an advanced practice pharmacist.

Policy Question #10
Does the Committee believe, as part of its report to the Legislature, expansion of the scope of practice for pharmacists is appropriate? If so, how and in what areas?

Chairperson Oh believed it was appropriate to offer recommendations, especially given that a lot of the information received through this process focused on what some consider expanding scope of practice solely in the clinical setting. Dr. Oh added there were a few areas that may be appropriate (e.g., test and treat for things like ear infections and strep throat, prescribing for pink eye, etc.). Dr. Oh believed there should be authority similar to Idaho that allows for a pharmacist to autonomously adapt an existing prescription written by another prescriber if the action will optimize care and reduce burdens including completing missing information on a prescription as is allowed in Washington. Dr. Oh believed comments were received during Committee meetings about challenges experienced by pharmacists attempting to reach prescribers when a change is necessary, whether it is in a community pharmacy or a hospital. Dr. Oh stated when such challenges occur, patient care can be negatively impacted and thought providing treatments for disease conditions which can be confirmed via CLIA-waived testing was a home run and no brainer as was providing treatments for self-diagnosable conditions while self-diagnosable was debatable. Dr. Oh noted in chain community settings, being able to have a deep thorough conversation with a patient like at a doctor's office was not really a possibility at this point. Dr. Oh inquired how the Committee could ensure the Committee was moving in the right direction. Dr. Oh noted the Committee must be concerned about intentional and unintended consequences. Dr. Oh posed the following question: Does it need to be explicitly stated that these expanded functions are performed only if there must be another pharmacist available with added privacy?

Members were provided the opportunity to comment.

Member Serpa believed the Board has the opportunity to embrace a hybrid standard of care enforcement model to increase patient safety and patient access.

Member Barker believed it was appropriate to expand scope of practice and work at the top of their license to provide patient care services using the standard of

care enforcement model. Dr. Barker added access to health care would benefit greatly from the expanded role of pharmacists and more clinical services (e.g., management of chronic diseases, etc.).

Member Cameron-Banks believed there were examples where this could help patients and provide for greater equity of care. Ms. Cameron-Banks added what hasn't been discussed was worst case scenarios for patient safety and that should be discussed further.

Member Crowley noted there was an opportunity to increase accessibility for people (e.g., strep throat testing, UTI testing, possibly epinephrine prescribing or furnishing and expanding naloxone furnishing, etc.). Dr. Crowley stated there should be specific requirements for somethings (e.g., private room to discuss with patients, testing, etc.). Dr. Crowley stated there should be a second pharmacist outside of workflow in order to perform tasks. Dr. Crowley noted pharmacists are already burnt out which can increase medication errors and inquired how the Committee can ensure the scope of practice was being expanded without increasing the burden on the pharmacists. Dr. Crowley noted a baseline for what needs to be in place for these expanded roles was appropriate and the regulations were keeping up with changing guidelines. Dr. Crowley agreed with Dr. Serpa in a balance of a hybrid model.

Chairperson Oh wanted to look to the future to allow pharmacists to provide more clinical services. Dr. Oh noted pharmacists demonstrated during the pandemic they can do more than dispensing.

Members of the public were provided the opportunity to comment.

A pharmacist agreed with Dr. Oh and the future of pharmacy. The pharmacists warned about the legal expansion of practice and the standard of care takes away from the legal scope of practice.

A retail pharmacist agreed with the previous commenter noting not being able to practice at the top of the license could be holding back pharmacists. The commenter noted a concern with the working conditions.

A commentor agreed with the difference between scope of practice and standard of care and agreed that there was an application for a standard of care

model.

A representative of CPhA agreed with previous comments. Patient safety wasn't about what types of services were offered but that patient safety lies in the process of how the service is delivered. Limiting disease states would be contrary to the concept of standard of care and discouraged the Committee from limiting.

IV. Future Committee Meeting Dates

Chairperson Oh reported the future Committee dates as February 1, 2023, and May 10, 2023.

V. Adjournment

The meeting adjourned at approximately 4:48 p.m.