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

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

MEDICATION ERROR REDUCTION AND WORKFORCE CHAIR REPORT
September 14, 2022

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

I. Call to Order and Establishment of Quorum

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

*(Note: the committee may not discuss or take action on any matter raised during the public comment section that is not included on this agenda, except to decide to place the matter on the agenda of a future meeting. Government Code Sections 11125 and 11125.7(a).)

III. Discussion, Consideration and Approval of Draft Minutes from the June 22, 2022, Medication Error Reduction and Workforce Committee

Attachment 1 includes a copy of the draft minutes.

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

Relevant Law
California Code of Regulations Section 1711, establishes 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.

For Committee Consideration and Discussion

As part of the Committee's evaluation of medication errors and workforce issues, it is appropriate to consider the Board's current QA program requirements to determine if changes to regulation are necessary to advance error prevention. Provided below are some questions that may assist members in the discussion.

1. Should the date the error occurred be required?
2. Should the staff involved in the error be documented?
3. Should the type of error be required? (e.g., wrong patient, wrong directions, relevant drug information, etc.)
4. Should the volume of workload completed on the date the error occurred be required?
5. Are there standardized items that should be captured, e.g., prescription volume (new and refill), immunizations provided, MTM, etc.?
6. Should the number of staff and classifications on the date of the error be required?
7. Should requirements be updated to require documentation of the actions taken (as well as recommended changes) and the date those actions occurred?

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.
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.)
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?

ISMP provides on its website a root cause analysis template that may highlight some additional elements to incorporate into the Board's current QA regulation.

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

Background

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

This issue of medication errors is not new. A study published in 2003, National Observation Study of Prescription Dispensing Accuracy, concluded that dispensing errors are a problem on a national level with a rate of about 4 errors per day in a pharmacy filling 250 prescriptions daily.

Additionally, between February 1, 2007, to July 31, 2012, medication errors reported to the New Hampshire Board of Pharmacy were reviewed. Results of this study were provided in Evaluation of Medication Errors in Community Pharmacy Settings, published in the Journal of Pharmacy Technology in 2016. Results included:

- 40 percent of errors involved dispensing of incorrect medication
- 31 percent involved incorrect doses
- 12 percent involved incorrect directions
- 78 percent involved new prescriptions
- 51 percent occurred during the pharmacist final check

- 26 percent occurred during the data entry phase of the initial processing
- 68 percent of the errors occurred when only 1 pharmacist was on duty

Conclusions noted that a contributing factor for errors included high prescription volumes and lack of adequate pharmacist coverage. Limitations on the results of the study included that reporting of errors is not mandatory as well as bias related to the duration of time between when the error occurred and the QRER form was completed.

The practice of pharmacy has changed since these publications; however, published information (referencing 2018 data) suggests that about 1.5 percent of all prescriptions in the community setting have a dispensing error. The Board's survey results appear to demonstrate that a correlation between workload and medication errors continues. According to information published by the Kaiser Family Foundation, 333,906,521 retail prescription drugs were filled at pharmacies in California in 2019, which would total over five million dispensing errors in California that year.

For Committee Discussion and Consideration

During the meeting members will have the opportunity to discuss medication error reporting. Items for policy consideration include the following:

1. Should the Board establish a requirement to report medication errors?
2. If yes, what would be the appropriate entity to receive such reports?
3. If yes, should the requirement be limited in duration for purposes of conducting a study similar to the approach taken in New Hampshire?
4. Should the Board establish a standardized medication error reporting form?

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

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

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

Pending legislation in New York would prohibit publicly traded pharmacies with twenty or more stores from establishing or enforcing quotas for duties performed by pharmacist and pharmacy technicians.

Below are more detailed examples from some state provisions.

Illinois

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

1. Failing to provide a work environment for all pharmacy personnel that protects the health, safety, and welfare of a patient which includes, but is not limited to, failing to:
    a. Employ sufficient personnel to prevent fatigue, distraction, or other conditions that interfere with a pharmacist's ability to practice with competency and safety or creates and environment that jeopardizes patient care.
    b. Provide appropriate opportunities for uninterrupted rest periods and meal breaks.
    c. Provide adequate time for a pharmacist to complete professional duties and responsibilities, to complete professional duties and responsibilities including, but not limited to:
        i. Drug utilization review
        ii. Immunization
        iii. Counseling
        iv. Verification of the accuracy of a prescription
        v. All other duties and responsibilities of a pharmacist as specified.
2. Introducing or enforcing external factors, such as productivity or production quotas or other programs against pharmacists, student pharmacists or pharmacy technicians, to the extent that they interfere with the ability of those individuals to provide appropriate professional services to the public.

Oklahoma

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

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

    The forms are not sent to the Board.
3. A pharmacist shall complete the staffing report form when:
    a. A pharmacist is concerned about staff due to specified criteria including inadequate number of support person or excessive workload.
4. If the pharmacy manager feels that the situation warrants earlier Board review, the pharmacy manager shall inform the Board.
5. Each pharmacy shall review staffing reports and address any issues listed as well as document any corrective action taken or justification for inaction to assure continual self-improvement.
6. Each pharmacy shall retain completed staffing reports until reviewed and released by the Board. Such reports requiring further review may be held by the Board and may become part of an investigation file.
7. A registrant, including a pharmacy, a pharmacy manager, or a pharmacist, shall not be subject to discipline by the employing pharmacy for completing a staffing report in could faith.

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

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

As reported in several news outlets, Oklahoma fined CVS Health $125,000 after receiving multiple complaints about errors and inadequate staffing and errors made in filling prescriptions.

Vermont

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

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

Virginia

Virginia Law provides that, except in an emergency, a permit holder shall not require a pharmacist to work longer than 12 continuous hours in any workday and shall allow at least six hours of off-time between consecutive shifts. A pharmacist working longer than six continuous hours shall be allowed to take a 30-minute break. Based on an investigation in Virginia, a single CVS store resulted in a $427,000 fine for the chain and one unannounced inspection within the next 12 months. According to the an article, CVS "respectfully disagrees" with the board's order, and is "considering our options" for potential next steps.

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

For Committee Consideration and Discussion
During the meeting members will have the opportunity to discuss some of these provisions and determine if any of the approaches offered may be appropriate to consider in California.

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

In 2012, ISMP included an article, Just Culture and Its Critical Link to Patient Safety. As part of the article, ISMP noted that "Just Culture" is more than a trendy metaphor for what was previously called a "non-punitive or "blame-free" culture. "It is a robust set of values, beliefs and actions that provide solid guidance on how an organization can best manage safety."

As part of this article, ISMP discussed components associated with values, justice and safety, and reduction of at-risk behaviors.

Organizational Values include:
1. What are the organization's primary and secondary values?
2. Do managers' behaviors demonstrate that safety is a primary (high) value?
3. Is safety a value or a priority?

Justice and Safety
1. How does the organization respond to human error, at-risk behavior, and reckless behavior?
2. Are individual accountabilities documented in job descriptions, performance evaluations, and/or policies, and communicated to staff?
3. Does the potential or actual severity of an outcome play a role in how staff are treated when evaluating risks and errors?

Management of At-Risk Behaviors
1. Is the culture tolerate of at-risk behaviors?
2. Does the organization tend to punish safe behavior and/or reward at-risk behavior?
3. Is there visible evidence of coaching around at-risk behaviors?

ISMP followed with a second article, focusing on components associated with the establishment of an effective safety information system and learning environment.

Safety Information System and Learning

1. Is there an effective patient safety information system that collects and analyses information about hazards, at-risk behaviors, close calls, and errors both within the organization and externally?
2. Are staff committed to safety and willing to report hazards, risks, close calls, and errors, thus arming the organization with an accessible body of safety information?
3. Does the patient safety information system provide staff with knowledge of the current risks, errors, and prevention strategies necessary to improve safety?
4. Does the organization seek long-term system remedies to safety problems?
5. Does the organization possess the willingness and competency to dray responsible conclusions from the organization's safety information system so they can make substantial changes when necessary?

For Committee Consideration and Discussion

During the meeting Chairperson Thibeau will discuss her experience with Just Culture. In addition, members will have the opportunity to discuss and determine if a just culture approach is currently used in community pharmacy as a means to reduce medication errors.

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

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

The Board recently included information on the Index in its newsletter. Staff was recently advised of a significant increase in the number of California licensees using the Index. The most recent report indicates a slight increase in the distress percent for California respondents.

Attachment 2 includes a copy of the most recent state report. The August 2022 Pharmacy Workplace and Well-being Report is also available.

VII. Future Committee Meeting Dates

- November 16, 2022

VIII. Adjournment

Attachment 1

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

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

MEDICATION ERROR REDUCTION AND WORKFORCE COMMITTEE
Draft MEETING MINUTES

DATE: June 22, 2022

LOCATION: Department of Consumer Affairs
1625 N. Market Blvd. 1st Floor Hearing Room
Sacramento, CA 95834

Department of Rehabilitation
150 S. Los Robles Avenue, Suite # 300
3rd Floor, Conference Room #312
Pasadena, CA 91101

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

COMMITTEE MEMBERS NOT PRESENT: Jignesh Patel, Licensee Member

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

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

Chairperson Thibeau called the meeting to order at 1:04 p.m. Chairperson Thibeau reminded everyone present that the Board is a consumer protection agency charged with administering and enforcing Pharmacy Law.
The meeting moderator provided instructions on how to participate during the meeting, including the process to provide public comment.

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

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

Members of the public were provided the opportunity to provide comments for

items not on the agenda.

A pharmacist team lead from Pizza is not Working movement thanked Committee for having the meeting. The pharmacist provided examples of pharmacists being chastised for calling in sick or were told to wait for coverage in the pharmacy when going into labor or medical assistance was needed noting in most cases coverage never arrived. In one instance, a pharmacist waited over two hours before dying in the pharmacy. The commenter stated it is unacceptable and inhumane especially for a profession who cares for others. The pharmacist noted from survey results from APhA and Board of Pharmacy these are not outliers or isolated problems. The commenter noted it was a systematic corporate accountability problem. The pharmacist noted Virginia passed a bill (Number 54.1-3434) placing responsibility on the pharmacy permit holder rather than the pharmacist whose hands are tied; including a staffing reporting form; and including an antiretaliation clause. The pharmacist noted in California violations of SB 1442 are commonplace and have not yet seen enforcement or consequences. The pharmacist requested protecting pharmacy staff be priority number one as it is protecting the public. She requested protections for pharmacy staff from intimidation and retaliation be added to the next agenda and expedited as well as move up the next meeting to reflect the urgency of the crisis.

A pharmacist from the Pizza is not Working movement spoke in favor of moving the next meeting forward. The pharmacist noted the team put together a survey that ran for two weeks with two questions: 1.) Do you want to submit a complaint to your state Board of Pharmacy regarding workplace conditions? and 2.) Are you dissuaded from making such complaints due to fear of retaliation from your employer? Of the 1,081 survey responses received, 972 responses were related to a pharmacy license and 87 percent of the 972 responses stated yes to question 1. Of those who said yes to question 1, 89 percent also answered yes to question 2. Of the 1081 survey responses, 181 claimed to be located in California where 92 percent said yes to question 1. Of those who said yes to question 1, 91 percent said yes to question 2. The commentor noted the small sample size and stated the survey may be indicative of a larger population given the Board's workforce study results. The commentor requested whistleblower protection.

A chain retail pharmacist in California commented anonymously for fear of retaliation from the pharmacist's employer. The pharmacist commented seeing too many medication errors included patients receiving another patient's HIPPA

information; prescriptions being filled incorrectly; or patients receiving the wrong vaccine. The pharmacist noted the errors occur in understaffed stores and because staff is expected to do too many tasks at one time and working conditions at retail pharmacies have become commonplace and systematic where quantity over quality is the focus. The pharmacist noted SB 1442 and SB 362 are in place to improve working conditions but are only effective if corporations are held responsible for the safety of pharmacies and patients. Additionally, pharmacy staff need to report violations which isn't being done for fear of retaliation and don't feel the Board will or can do anything about the violations even if a report is made. The pharmacist stated improving working conditions in pharmacies should be a top priority for reducing medication errors and improving safety for patients and can be done by having a way for pharmacy staff to report violations of these laws and unsafe working conditions without fear of retaliation.

III. Approval of January 27, 2022, Committee Meeting Minutes

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

Motion: Approve the January 27, 2022, meeting minutes as presented in the meeting materials.

M/S: Oh/Crowley

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

Support: 4 Opposed: 0 Abstain: 0 Not Present: 1

Member	Vote
Crowley	Support
Koenig	Support
Oh	Support
Patel	Not Present
Thibeau	Support

IV. Presentation by National Association of Boards of Pharmacy on its Workforce Task Force Report and National Perspective of Workforce Related Issues including Discussion and Consideration

Chairperson Thibeau introduced Beverly Zwicker, CEO and Registrar, with the Novia Scotia College of Pharmacists (NSCP) presenting on the Nova Scotia Workplace Conditions Strategic Work.

Bill Cover, RPh, Associate Executive Director, National Association of Boards of Pharmacy (NABP), presenting on the NABP's Workforce Task Force Report and national perfective of workforce related issues. Mr. Cover reviewed the NABP mission, vision, and purpose.

Mr. Cover reviewed the NABP Taskforce on Workplace Safety and Well-Being's charge to examine the topics of pharmacy workplace safety and pharmacist well-being and their effects on patient safety; review existing guidelines and objective tools that address these issues and make recommendations regarding their use; and amend, if necessary, the Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy (Model Act) to reflect the work of the task force.

Mr. Cover shared the taskforce recommendations as: collaborate with relevant stakeholders including AHRQ, ISMP and others to develop standardized CQI program that boards of pharmacy can recommend to their licensees and include training on development and implementing the program and monitoring on an annual basis to ensure it is effectively being used; collaborate with AHRQ to provide a platform to obtain de-identified aggregation medication error data that can be shared with boards of pharmacy, pharmacies or pharmacy chains and other industry specialists; endorse the recommendation of the Task Force on Safety Sensitive Measures to Review Medication Errors to explore the development of medication safety training academy; measure to Review Medication Errors to explore the development of a medication safety training academy; measures to Review Medication Errors to explore the development of a medication safety training academy; endorse the APhA/NASPA Pharmacist's Fundamental Responsibilities and Rights while acknowledging that certain provisions pertaining specifically to business models may fall outside the boards of pharmacy's regulatory purview; collaborate with organizations such as impaired pharmacist programs and development of webinars for burnout, well-being and stress management as well as dissemination of information regarding the correlation between a poor well-being index and increased medication errors; and review the Model Act and if necessary consider adding/further amending the definitions pertaining to errors, adverse events, and missed errors to mirror those used by CMS, adding a provision for mandated breaks, and adding provision for anti-retaliatory (whistleblower) protections.

Mr. Cover continued with the NABP Incoming Presidential Initiative to include President Dillard's message; initiative with a comprehensive review of current pharmacy regulatory environment; consider pharmacy education and other external factors that impact patient safety; and focus on three key areas identified as 1.) Barriers in existing statutes or regulations that limited patient access to medication and care, 2.) Opportunities to increase patient safety by enabling

pharmacists to practice at the top of their education and training, 3.) Extrinsic factors that foster unsafe working environments when delivering patient care not already idenfieid by the Working Conditions Task Force.

Mr. Cover highlighted the Workforce's Member Board and stakeholder suggested approaches for consideration: promote creation of contingency plan for a pharmacy that is understaffed relative to patient demand to ensure safe staffing levels; encourage PIC/pharmacy manager to develop/implement a Board of Pharmacy staffing report form; develop regulations related to CQI programs, error reporting and just culture approach to quality events; allow for the aggregation of medication error data that can be shared with boards of pharmacy and industry; review daily workflow report to identify pharmacies in need of assistance and route additional staff to support those locations; and encourage managers to utilize alternative methods to monitor the individual pharmacists' work patters to prevent burnout.

Mr. Cover continued reviewing suggested approaches for consideration including analyze workplace/well-being status of pharmacy teams within states that have progressive/permissive pharmacist's authority or regulation; encourage management to spend time within pharmacy sites to observe what teams are facing and have open/safe space to discuss with team members; provide appropriate opportunities for uninterrupted rest periods/meal breaks; delegate non-discretionary tasks to properly trained pharmacy technicians and interns; report violations and/or unsafe conditions to boards; provide an option for patients to have prescriptions shipped/delivered to homes for convenience; information patients if the pharmacy is experiencing delays and can't dispense in a timely manner; and adding outside staff to clean the pharmacy/clinical areas to prevent insanitary conditions.

Chairperson Thibeau thanked Mr. Cover for his presentation. Dr. Thibeau noted many of the recommendations are outcome focused and reflecting on some of the information received during the last meeting from ISMP representatives. Dr. Thibeau agreed that training on continuous quality improvement is important. Dr. Thibeau noted at the last meeting, she was surprised to learn that pharmacy education may not address learning continuous improvement process which may result in some new practitioners not having training on how to implement such a process.

Members were provided the opportunity to provide comment.

Member Koenig inquired if the number of people in the workforce was an issue and if so, how would a pharmacy have uninterrupted breaks without coverage. Mr. Cover advised the APhA Workplace Summit agreed there is a workforce issue. He noted pharmacists are the most accessible health care professionals in

communities and when hours are being reduced that intensifies accessibility. He noted trends of pharmacies closing during certain times of the day.

Member Crowley stated she wasn't aware of any retail pharmacist that takes rest breaks because they don't want to fall behind. Dr. Crowley asked Mr. Cover to explain just culture. Mr. Cover noted just culture related to medication error is a holistic way to identify what happened to cause the error and identify if the environment is safe. He noted ISMP has a proactive tool to assess a worksite to prevent errors.

Member Crowley requested clarification of the definition of errors and near misses used by Centers for Medicate and Medicare services versus the definition used by pharmacy practice today as well as the data on medication errors at the national level that might identify patterns of errors related to demographics of the location of the error (e.g., hospital/community setting, high/low volume setting, lower/higher income areas, trend on demographics, etc.). Mr. Cover stated he would need to pull the data and work with other organizations and could report back.

Member Oh commented favorably in seeing the workforce suggestions and inquired if NABP is able to do research on staffing challenges such as work with an industrial engineer to understand why there are such staffing challenges and underlying reasons for the issue. Dr. Oh stated anecdotally in his experience there is not a shortage of pharmacists while there may be a shortage of pharmacy technicians. Mr. Cover advised NABP works with ACPE to monitor the ebbs and flows of staffing over time. Dr. Oh inquired if NABP could do studies to determine staffing levels needed for patient safety. Mr. Cover indicated drawing a specific level would be difficult due to so many variables. Dr. Oh inquired if other states use staffing forms or require medication error reporting to state boards. Mr. Cover indicated he could the information to the Board.

Ms. Sodergren inquired if any of the medication error reporting include staffing and if during the CQI processes where staffing was identified as the root cause and any changes were made as a result. Mr. Cover reported he could get that information as well.

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

The Committee heard comment from a pharmacist inquiring if results have been stratified by chain pharmacy versus independent pharmacy as results from independent pharmacy seem to be better and can look to them as examples of what works better. The pharmacist inquired if the NABP recommendations were prioritized as she believed pharmacist well-being is of the utmost importance and has the potential to have the biggest impact. She cited an APhA pharmacist

workplace and well-being report that mentioned there is a two time increase of medication error for pharmacists that are identified as a risk of high distress.

A pharmacist spoke in favor of the presentation and noted when he worked in retail/chain his error rates were due to reasons explained today.

A pharmacist commented corporations don't allow staffing to be listed on a corporate prescription error report and statistics from these reports would be misleading as staffing is not included as a factor.

A pharmacist commented the wage and hour report in California requires pharmacists to be paid on an hourly basis and to receive rest/meal breaks. The pharmacist noted Business and Professions Code (BPC) section 800 requires all judgements and settlements for errors, negligence, omissions, etc. to be reported to the Board if over $3,000. He noted it should be shared with the pharmacists.

The Committee took a break from 2:07 p.m. – 2:17 p.m. Roll call was taken and members present included Seung Oh, Jessica Crowley, Kula Koenig, and Nicole Thibeau. A quorum was established.

Note: Items were taken out of order during the meeting and the minutes reflect the order agenda items were taken.

VI. Presentation by the Nova Scotia College of Pharmacists on the Nova Scotia Workplace Conditions Strategic Work

Chairperson Thibeau introduced Beverly Zwicker, CEO and Registrar, with the Novia Scotia College of Pharmacists (NSCP) presenting on the Nova Scotia Workplace Conditions Strategic Work.

Ms. Zwicker advised NSCP's mandate is to govern the practice of pharmacy leading to optimal patient care which is higher than ensuring pharmacies do not cause harm or patients aren't being harmed by medication errors. She noted when there is a rise of medication errors that is evidence that there is failure in the mandate of ensuring pharmacies are providing optimal care. She added it is out of an abundance of concern that workplace conditions are creating substantial risk to the NSCP's mandate and has now become NSCP's priority focus.

Ms. Zwicker noted the concerns are supported by NABP and APhA. She cited a 3rd party organization of the workforce nationally that said 90 percent of Canadian pharmacists are at risk of burnout; 60 percent say when they are at work they are not thinking about what they do as it is very automated; 70 percent anticipating changing employers; and 40 percent considering leaving the profession.

Ms. Zwicker reported starting working with an engineering firm to reviewing literature; interview pharmacy practitioners; validate survey of pharmacy practitioners; interview with sector stakeholders; and survey pharmacy managers. She noted the literature was very clear in that there was a link between the state of the pharmacy workforce and the quality of practice that they provide and risk of errors.

Ms. Zwicker provided an overview of the NSCP work to address pharmacy practice environment challenges: 2019-22 – conduct background research; Feb. 2022 – develop visual summary; Mar. 2022 – undertake factor prioritization; Apr. 2022 – establish new strategic objectives; and Jun. 2022-23 – design and implement interventions.

Ms. Zwicker reported staffing levels created by business models is the primary factor that should be the focus to make a meaningful impact on current practice conditions. She noted there are many factors to consider but this was the number one focus.

Ms. Zwicker advised the research established the linkage between professional burnout/job dissatisfaction and how it can compound into negative system outcomes such as increased risk to patient safety. The themes found in the pharmacy practitioner interviews included: pharmacy practitioner workloads/demand for pharmacy services; accessibility of pharmacy professionals (i.e., on-demand services); scope of practice; labor models; and staffing levels.

Ms. Zwicker reported the validation survey results: 85 percent – workload levels are unsustainable; 71 percent – staffing levels are inadequate; 81 percent – experience burnout; 76 percent – current pharmacy practice challenges result in reduced standard of care; and 75 percent – current pharmacy practice challenges result in a risk to patient safety. She noted this is compelling evidence to the regulator and no further evidence was required to say action was needed.

Ms. Zwicker advised a visual was created to demonstrate the factors are categorized into practice site conditions including factors speaking to the volume of working such as quality of work, service culture, physical space; and HR capacity such as the HR plan/budget, availability, skill, and utilization. There is more work to do than there is HR capacity to do the work. The resulting harms include risk to patient safety, burnout/job dissatisfaction, unmet patient expectations, unmet patient health needs, reduced service quality/standard of care, and reduced service offering. She noted external factors outside of the control of the regulator but is important to be mindful. External contributors for practice site conditions include ownership strategy, space constraints, professional scope, pharmacy culture, customer service expectations, targets/quotas, pharmacy growth, culture of accessibility to patients, and third-party insurance requirements. External

contributors for HR capacity include ownership business strategy, recruitment challenges, labor models, retention challenges, pharmacy regulations, access to training/education, pharmacy professional wages and pharmacy culture. System context include healthcare funding/prioritization, healthcare change/integration, healthcare communication, government/political priorities, regulatory reform, pharmacy business sector disruption, technology, increase in complex comorbidities, aging population, population growth, labor/physician shortages, and pandemic.

Ms. Zwicker identified the framework considering impact and feasibility varying from how to high considering input from outside the industry. The results included two recommended factors for strategic focus: staffing levels and mix including factors such as lack of overlap and handover time, as well as pharmacists working alone; and business model misalignment includes factors such as workload centered on volume vs. quality and lack of professional autonomy. It was recommended and agreed upon the Council focus its work on the intersection of the two factors as staffing levels established by business staffing models.

Ms. Zwicker reported the current objective is the pharmacy practice environment optimizes the quality of healthcare provided by pharmacy practitioners. The recommended objective is staffing levels are not a detriment to the public receiving quality pharmacy care.

Ms. Zwicker explained the next steps include a short list of potential interventions developed based on identified barriers and multisector research including a staffing formula; NSCP will engage in multistakeholder steering group to recommend interventions; and NSCP Council and staff will work to refine recommended intervention(s) and begin to design intervention components. Factors to be considered include interruptions, downtime needed, reviewing other industries, decisions made not align with needs of pharmacist, etc. when developing the staffing formula that is needed.

Ms. Zwicker noted in Nova Scotia there is a requirement that pharmacy managers ensure the staffing plan is commensurate with the needs of the patient in the pharmacy. When staffing issues are related to errors, they are able to require the pharmacy owners and managers to show proof of how they insured the regulatory requirement has been met. She noted this is a different approach providing that they haven't put the responsibility on the regulator. Ms. Zwicker provided an example where the pharmacy manager may have to demonstrate feedback from the pharmacy staff that staffing is commensurate with the needs of the patient in the pharmacy. It is a new short-term strategy to help create a heightened awareness.

Ms. Zwicker advised there will be a presentation to the college inviting health economists, legal, and strategists to hear presentations with the objective of flagging items that are nonstarters. They will next work on a short list of interventions and narrow down to two interventions to propose how to do it. The goal is to select at least one intervention by August/September 2022.

Ms. Zwicker provided Nova Scotia was the first province in Canada to establish a CQI requirement for pharmacies to engage in. She noted CQI requires minimum workplace conditions that do not exist. Without the required staff, you are not able to execute action plans to improve identified areas. Ms. Zwicker provided CQI has been in place since 2011 with inspections to make sure they are engaged, reporting errors are being learned from and doing quarterly meetings. She added none of that has mitigated the fact that there are still pharmacies with inadequate staffing that are overwhelmed and burned out.

Ms. Zwicker noted if the 40 percent decide to leave the profession, there could be a real pharmacy shortage. She added compromised patient safety outcome is not acceptable. She indicated if a model is pursued, it may be more of a floor requirement than a ceiling. Ms. Zwicker stated a lot of the concerning workplaces are owned by corporations and independent pharmacies are less of a concern.

Members were provided an opportunity to comment on the presentation. Dr. Oh inquired if it would be possible to initiate similar research. Ms. Smiley indicated a motion was not required as it could be direction to staff. Ms. Sodergren mentioned the impact of such a study to the budget would have to be evaluated or if a school of pharmacy might be interested in assisting with the research.

Member Crowley commented staffing levels and mix as the experience of the staff does impact the supportive staff need to provide quality care. She added the staffing model is interesting as corporate staffing models are solely dependent on the number of prescriptions sold not accounting for prescriptions processed not picked up or patient care services and labor involved for vaccines, birth control, naloxone, etc. Dr. Crowley inquired if the research found a correlation between the expansion of technician roles and impact on pharmacist burnout.

Ms. Zwicker didn't recall a finding that came out of review. Ms. Zwicker clarified the staffing models is one of the options but has not been finalized as an option. She also advised another possible intervention being considered is to allow the public to better assess the quality of care and have public accountability through public rating systems (e.g., on the quality of counseling received, amount of time the pharmacist spent with them gathering information and understanding, etc.). She clarified staffing models isn't the only intervention being considered and agreed other factors need to be considered.

Member Crowley inquired if service culture can be addressed. Ms. Zwicker added pharmacy owners are redesigning the pharmacy to allow for pharmacists to not be interrupted. Member Koenig inquired about the possibility of reservations or appointment to assist with staffing and quality control.

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

A pharmacist commented on the strategy to put the onus on the corporation to provide documentation that current staffing is adequate versus the opposite. It is important to protect pharmacy staff from intimidation and retaliation for this to work. Pharmacists don't feel safe to freely express concerns. She suggested the Board enforce existing laws more visibly or assertively such as SB 362 and SB 1442. Pharmacists do not report for fear of retaliation.

A pharmacist emphasized the importance of staffing. Unfortunately, employers can't provide minimum staffing or abide by the current regulation. Companies need to be fined or penalized that ignore and violate current laws.

A pharmacist commented in pharmacy the economic equation is fixed as pricing and insurance are not negotiable. The only controllable factors are to increase volume or decrease labor costs. Corporations are looking to increase profits. She noted pharmacy is a profession where knowledge is given away for free.

V. Presentation by the American Pharmacists Association on the Well-Being Index, Pharmacist's Fundamental Responsibilities and Rights and Survey Results including Discussion and Consideration

Chairperson Thibeau advised at the last meeting, the Committee received a brief overview of the Well-Being Index and noted that among issues raised as indicators that pharmacists identified as being at a risk of high distress are, among other things, at a 2-fold higher risk of medication errors. Dr. Thibeau noted members requested a presentation from the American Pharmacists Association on the well-being index as well as other efforts underway by the association. Dr. Thibeau introduced April Shaughnessy, APhA Well-being Initiative Project Manager.

Ms. Shaughnessy provided a brief history of the concept of pharmacist well-being first being mentioned in 2018 when APhA's Board issued a statement with its renewed commitment to pharmacists' well-being and noted the pandemic magnified well-being and workplace concerns in 2020-21.

Ms. Shaughnessy advised APhA partnered with Mayo Clinic in 2019 to use the well-being index used for nurses and physicians to be used by pharmacy personnel. It is a research-validated online tool invented by the Mayo Clinic that is 100 percent

anonymous and participants do not have to be an APhA member to use the tool. The tool measures dimensions of distress and well-being the person taking the assessment. The assessment consists of 9 questions that takes five minutes and APhA added three questions on: engagement with profession; workplace support of patient care services; and what APhA could do to help.

Ms. Shaughnessy provided a sample assessment dashboard showing scores on all 9 questions and score relative to other US pharmacists. Reminders can be sent to participants. Participants are matched with well-being index (WBI) assessor resources based on their assessment developed by Mayo Clinic, APhA, and other well-being resources.

Ms. Shaughnessy provided based on the tool, an aggregate distress percent can be found defined as the percentage of individuals with a WBI score greater than or equal to 5, the validated score that indicates risk of high distress. This is important because when someone is at risk of high distress they are also at risk of negative consequences including: 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; and 2-fold higher risk of medication error.

Ms. Shaughnessy reported as of May 30, 2022, all national assessors distress percent as 32.01 percent with a sample size of 8,457 where all California assessors was 29.16 percent with a sample size of 601. Ms. Shaughnessy provided student pharmacists nationally were 26.28 percent with a sample size of 1,596 and California assessors were 30.48 percent with a sample size of 164; for pharmacists nationally were 33.38 percent with a sample size of 6,240 and California assessors were 28.40 percent with a sample size of 402; and pharmacy technicians nationally were 45.39 percent with a sample size of 404 and California assessors was 52.00 percent with a sample size of 19.

Ms. Shaughnessy reviewed the WBI distress percent by practice settings for pharmacists. She reviewed a sample month report of the pharmacist well-being index state distress percent. California receives each month for the NABP District VIII.

Ms. Shaughnessy reviewed the Pharmacist's Fundamental Responsibilities and Rights (PFRR) developed by APhA and NASPA. PFRR outlines fundamental responsibilities that are required for each pharmacist; builds on principles of Oath of a Pharmacist and Pharmacist Code of Ethics; and to fulfill these responsibilities, certain workplace expectations that are needed. PFRR can be used as a platform to start meaningful discussions with leadership; a tool to initiate a discussion of issues and solutions; used in discussions with state board of pharmacy about workplace conditions; and used in meetings state legislators to address laws and regulations

affecting practice. Ms. Shaughnessy reported in January 2022 NABP issued a resolution in support the PFRR.

Ms. Shaughnessy reviewed APhA Workplace Reports and Data. She reviewed the Final Report Highlight of the 2021 APhA/NASPA National Pharmacy Workplace Survey based on 7,000 respondents from 17 different practice settings received noting pharmacy personnel reported harassment and bullying from patients without support of their employers. It is a real concern for pharmacists and likely cause for medication errors. Additionally, pharmacists do not feel valued by their employers.

Ms. Shaughnessy reported APhA and NASPA developed the Pharmacy Workplace and Well-being Reporting (PWWR) tool to address pharmacists desire to have a safe space to tell their practice experience stories; report both positive and negative workplace experiences to a secure, confidential online portal; reports are collected and analyze by a Patient Safety Organization (PSO) affording the reports all the legal confidentiality protections provided by national PSO laws and regulations; and aggregated data reports and findings are generated approximately each quarter and can be found at www.pharmacist.com/pwwr.

Ms. Shaughnessy reviewed key takeaways from the PWWR Report I and II include: harassment of pharmacy personnel by patients and consumers is real; two-way lines of communications are not perceived to be open; and positive experiences have a long-term positive effect on well-being.

Ms. Shaughnessy reported pharmacists are ready, willing, and able but stressed and stretched. APhA convened a stakeholder summit starting with a focus on community pharmacy. Ms. Shaughnessy reviewed the Summit Bright Ideas and Next Steps of the Community Pharmacy Workplace Summit.

Members were provided the opportunity to provide comments.

Member Koenig commented that it is a business model problem and would like to explore with the Committee. She noted there are things that can be done now like a public relations campaign regarding a pharmacist who is dispensing medication. She inquired why Wyoming was so low but Ms. Shaughnessy didn't know why.

Member Crowley acknowledged pharmacists are harassed and bullied connected to a refusal to refill controlled substances where it is considered a customer complaint rather than a professional discretion.

Member Oh inquired what APhA's next step are to assist the Board so that changes can be made. Ms. Shaughnessy mentioned there have been talks with corporate staff on training to help a pharmacists/PIC deescalate a patient. They didn't at the

time but acknowledged they could do that. Ms. Shaughnessy noted small actions can be taken by employers.

Chairperson Thibeau noted as an industry pharmacy does not do a great job in looking at diversity and how the negative outcome impact different marginalized groups and wondered if the results get worse. Dr. Thibeau stated it would be helpful to have this factored in. Ms. Shaughnessy advised APhA has a DEI taskforce to report on issues. She also noted it came up in both PWWR reports that harassment and bullying is higher for females and persons of color. She noted it is not necessarily a trend but something to watch. Dr. Thibeau recommended adding sexual orientation and gender identity as part of demographics. Ms. Shaughnessy noted it could not be added now but could be considered in the future.

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

A pharmacist inquired if the PWWR data could be stratified by chain vs. independent pharmacy. The pharmacists inquired what percentage of responses per state vs. population. Ms. Shaughnessy clarified you can't extrapolate the WBI to the full population.

Chairperson Thibeau inquired if information on the WBI could be promoted as a way to promote for use in California. Ms. Sodergren noted the link could be added in the Board's newsletter. Dr. Oh added including it on the Board's website.

VII. Future Committee Meeting Dates

Chairperson Thibeau advised the next Committee Meeting was scheduled for September 14, 2022, and November 16, 2022.

The meeting adjourned at 4:09 p.m.

Attachment 2

APhA

WELL-BEING index

Well-being Index For Pharmacy Personnel

State Report For State Boards of Pharmacy

NABP District Eight States

SEPTEMBER 2022

pharmacist.com

For Every Pharmacist. For All of Pharmacy.

DISTRESS PERCENT BY PRACTICE ROLE

All Assessments versus First Time Assessments

January 2020/September 2020/September 2021/September 2022

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

Distress Percent – Overall and By Role

Since inception (July 2019) through month listed

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

	As of January 2020	As of September 2020	As of September 2021	As of September 2022
All Assessors *All Assessments**	35.25% n=5363	33.41% n=6775	32.12% n=7604	32.04% n=9010
All Assessors *1st Time Assessments Only*	37.31%	36.75%	36.09%	36.51%
Pharmacists Only *All Assessments**	36.74% n=4141	34.54% n=5007	33.46% n=5512	33.19% n=6674
Pharmacists Only *1st Time Assessments Only*	38.32%	37.81%	37.41%	37.65%
Student Pharmacists Only *All Assessments**	31.39% n=923	28.48% n=1194	26.35% n=1425	26.36% n=1646
Student Pharmacists Only *1st Time Assessments Only*	35.32%	32.19%	30.67%	30.78%
Pharmacy Technicians Only *All Assessments**	45.59% n=114	46.08% n=366	45.32% n=384	48.12% n=462
Pharmacy Technicians Only *1st Time Assessments Only*	49.12%	48.36%	48.18%	51.95%

** Combination of first-time assessments and reassessments*

DISTRESS PERCENT CHANGES

National and District

August 2022 versus September 2022

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

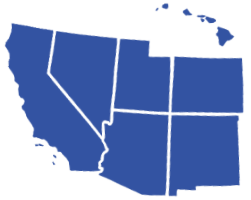
Changes in Distress Levels

As of September 2022

State	Change in Distress % August 2022 vs September 2022	Distress % September2022	State Rank for Distress Percent September2022
Largest Increase in Distress Percent			
North Dakota	+2.96%	34.78%	19
Utah	+0.53%	30.53%	39
Texas	+0.44%	34.38%	22
North Carolina	+0.43%	38.26%	15
California	+0.38%	29.37%	44
Largest Decrease in Distress Percent			
Wyoming	-0.72%	16.67%	52
New Hampshire	-0.66%	47.95%	2
South Dakota	-0.51%	25.00%	48
Virginia	-0.47%	44.72%	6
Pennsylvania	-0.45%	34.12%	23

Changes in Distress Levels – District Eight

As of September 2022



	Change in Distress % Aug2022 vs Sep 2022	Distress % Sep 2022	Distress % State Rank Sep 2022	Change in Distress % Jul 2022 vs Aug 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 Feb 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	**0.05%**	**39.44%**	**12**	-0.05%	12	12	13	13	13	13	13	14	13	16	17
California	**0.38%**	**29.37%**	**44**	-0.04%	45	45	45	44	44	43	41	40	38	35	35
Colorado	**-0.22%**	**31.41%**	**34**	0.03%	34	34	35	30	28	27	27(T)	25	23	14	19
Hawaii	**-0.43%**	**38.46%**	**14**	-0.44%	13	13	12	12	10	8	8	7	6	2	2
Nevada	**-0.26%**	**59.74%**	**1**	0.54%	1	1	1	1	1	1	1	1	1	18	11
New Mexico	**No Change**	**29.58%**	**43**	No Change	43	43	43	42	3	33	36	42	44	39	39
Utah	**0.53%**	**30.53%**	**39**	0.31%	40 (T)	42	42	41	39	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 August 2022

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

WELL-BEING INDEX FOR PHARMACY PERSONNEL

STATE DISTRESS PERCENT*

SEPTEMBER 2022

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

AUGUST 2022

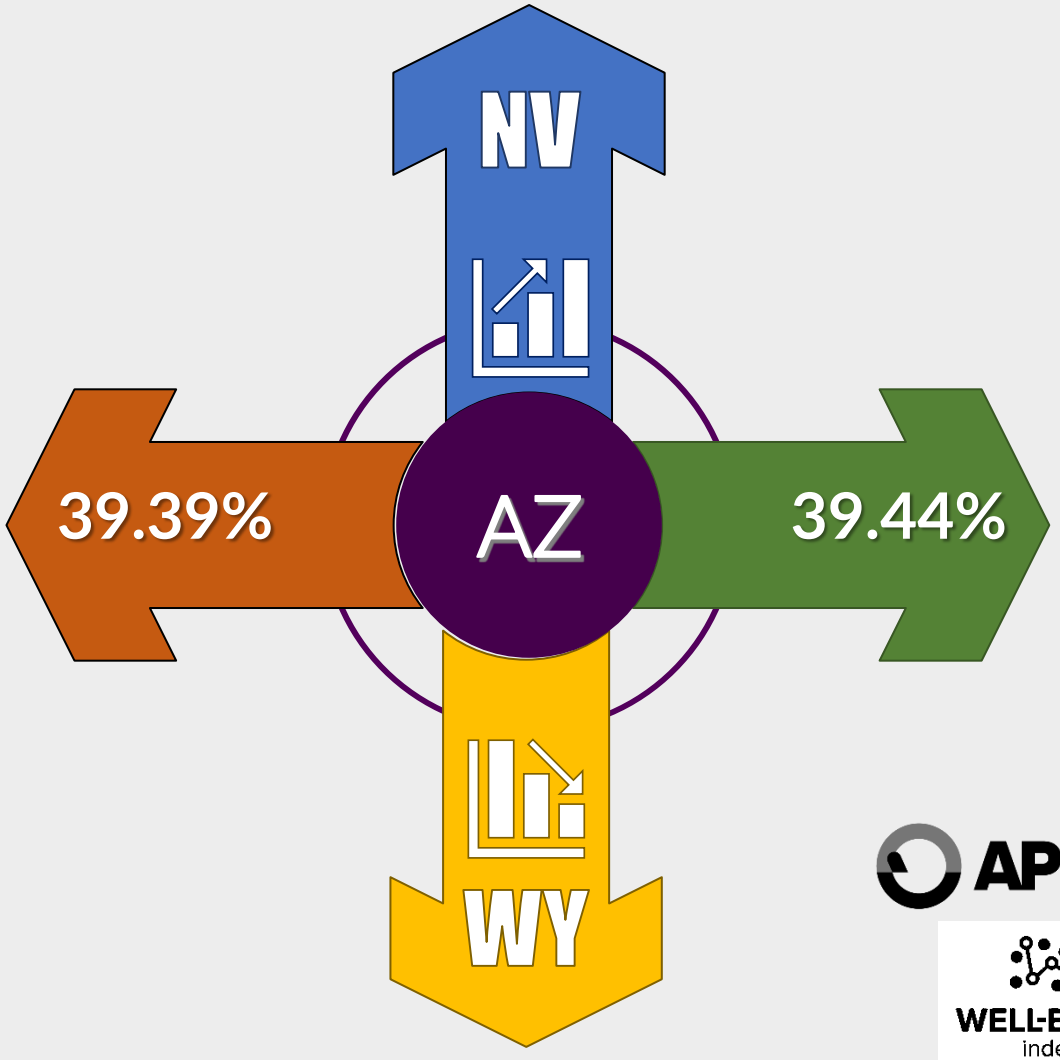
As of August 6, 2022, the Arizona distress percent was 39.39% (ranked 12/52) with 192 assessors.

STATE COMPARISON

As of September 6, 2022

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

Wyoming has the lowest 16.67% (n=17)



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*

SEPTEMBER 2022

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

AUGUST 2022

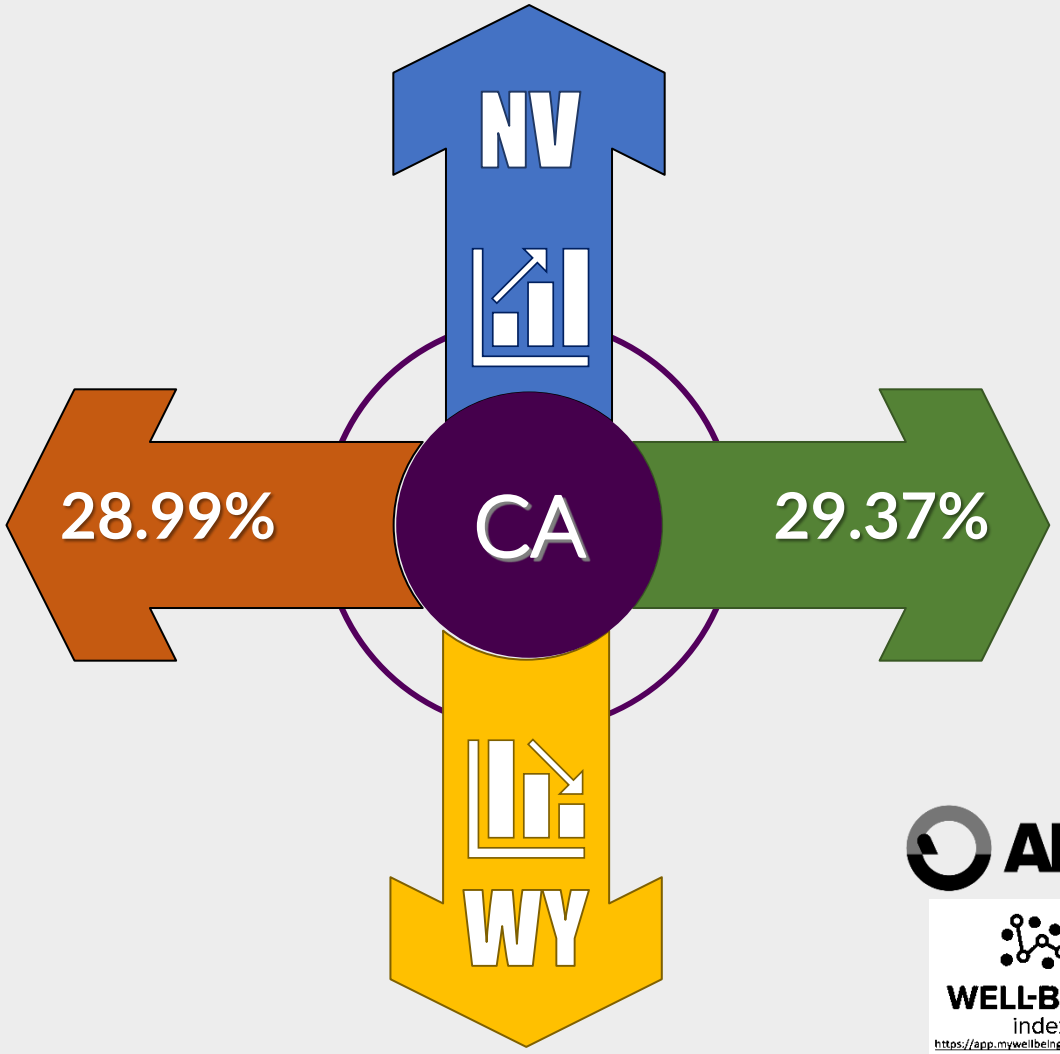
As of August 6, 2022, the California distress percent was 28.99% (ranked 45/52) with 611 assessors.

STATE COMPARISON

As of September 6, 2022

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

Wyoming has the lowest 16.67% (n=17)



APhA

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

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

WELL-BEING INDEX FOR PHARMACY PERSONNEL

STATE DISTRESS PERCENT*

SEPTEMBER 2022

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

AUGUST 2022

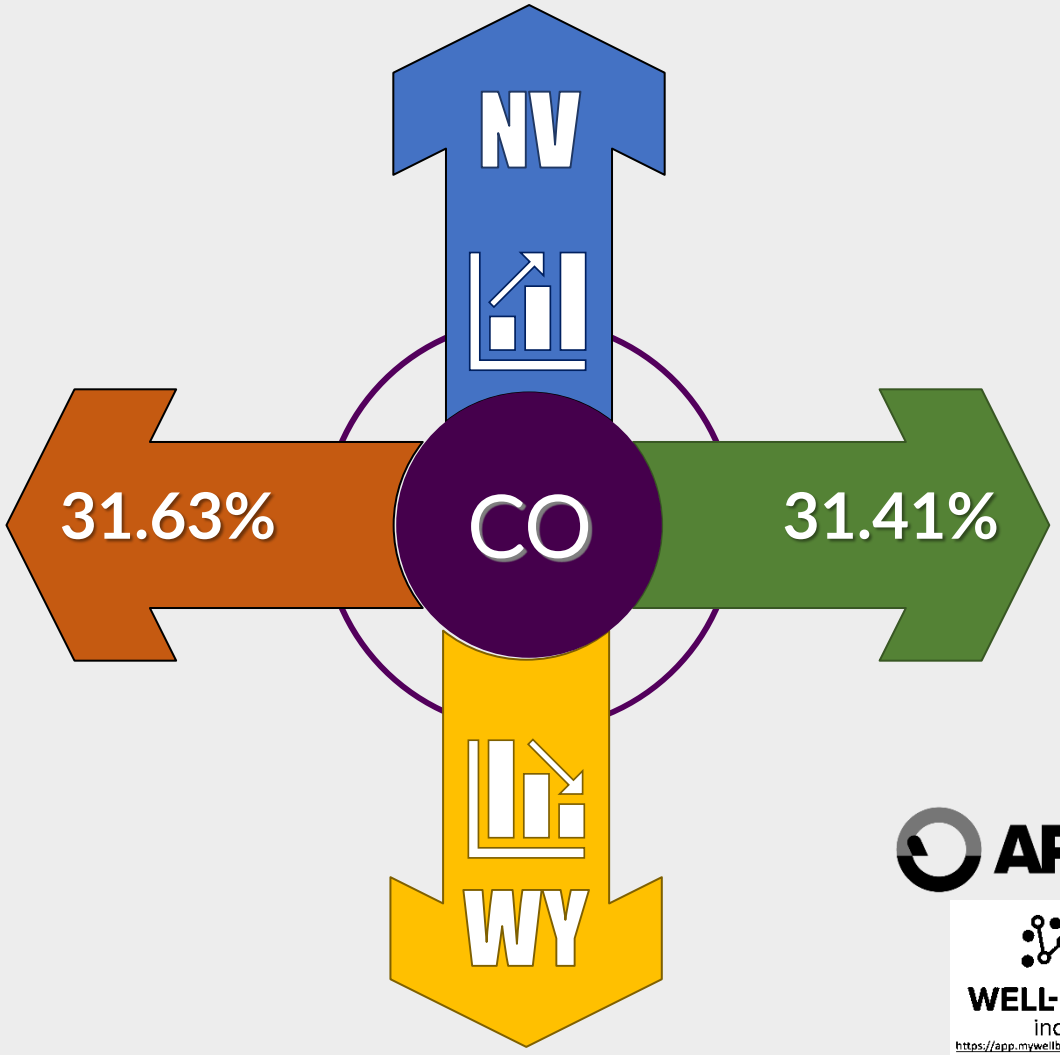
As of August 6, 2022, the Colorado distress percent was 31.63% (ranked 34/52) with 203 assessors.

STATE COMPARISON

As of September 6, 2022

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

Wyoming has the lowest 16.67% (n=17)



APhA

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

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

WELL-BEING INDEX FOR PHARMACY PERSONNEL
STATE DISTRESS PERCENT*

SEPTEMBER 2022

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

AUGUST 2022

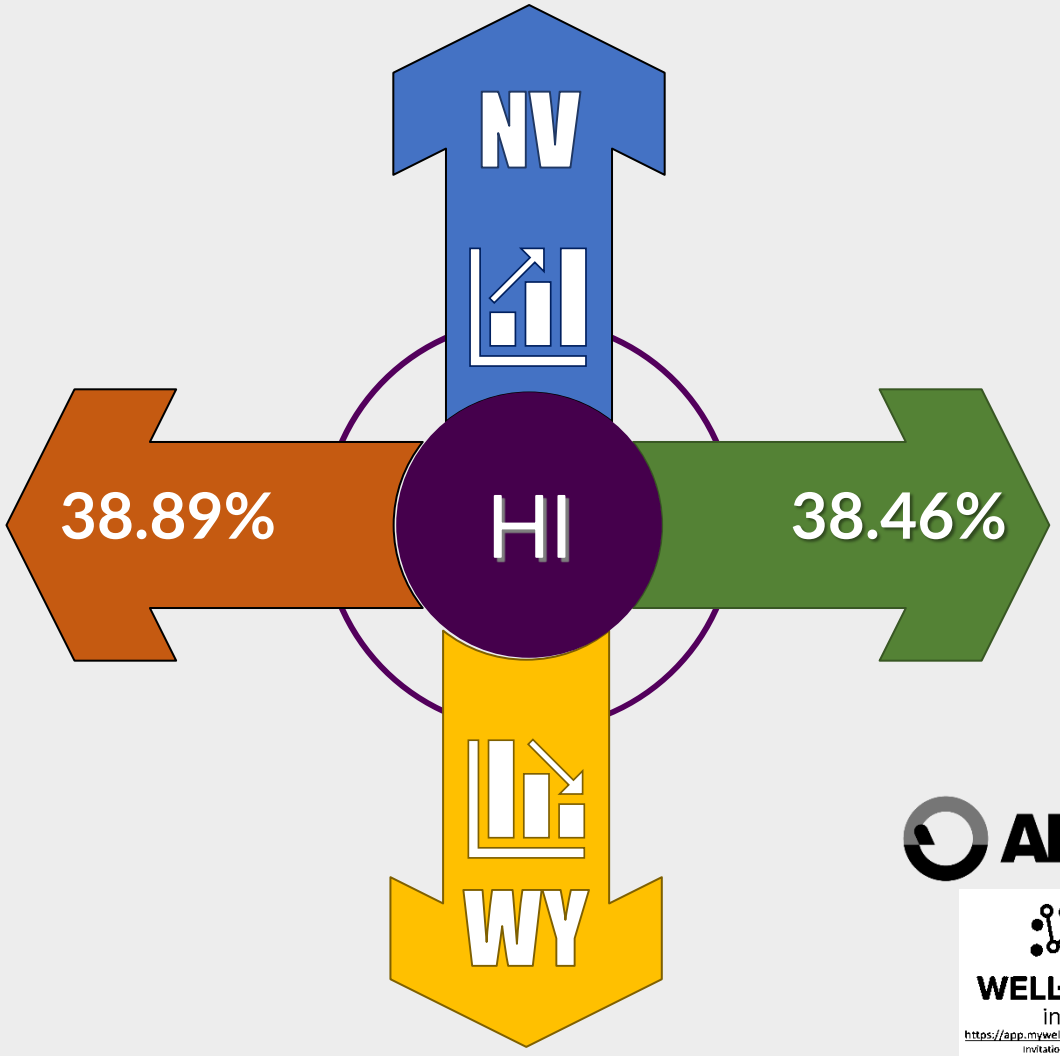
As of August 6, 2022, the Hawaii distress percent was 38.89% (ranked 13/52) with 29 assessors.

STATE COMPARISON

As of September 6, 2022

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

Wyoming has the lowest 16.67% (n=17)



APhA

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

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

WELL-BEING INDEX FOR PHARMACY PERSONNEL
STATE DISTRESS PERCENT*

SEPTEMBER 2022

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

AUGUST 2022

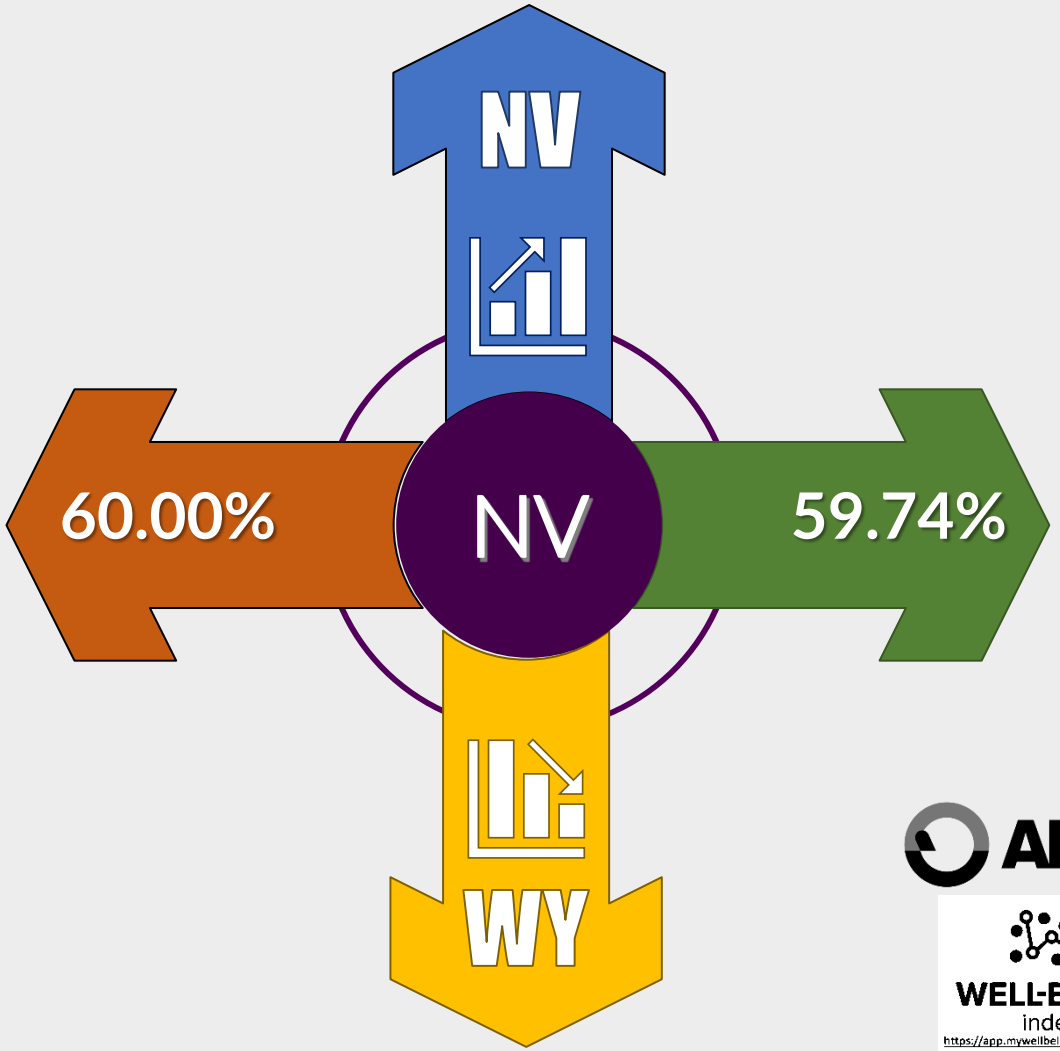
As of August 6, 2022, the Nevada distress percent was 60.00% (ranked the highest at 1/52) with 33 assessors.

STATE COMPARISON

As of September 6, 2022

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

Wyoming has the lowest 16.67% (n=17)



APhA

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

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

WELL-BEING INDEX FOR PHARMACY PERSONNEL
STATE DISTRESS PERCENT*

SEPTEMBER 2022

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

AUGUST 2022

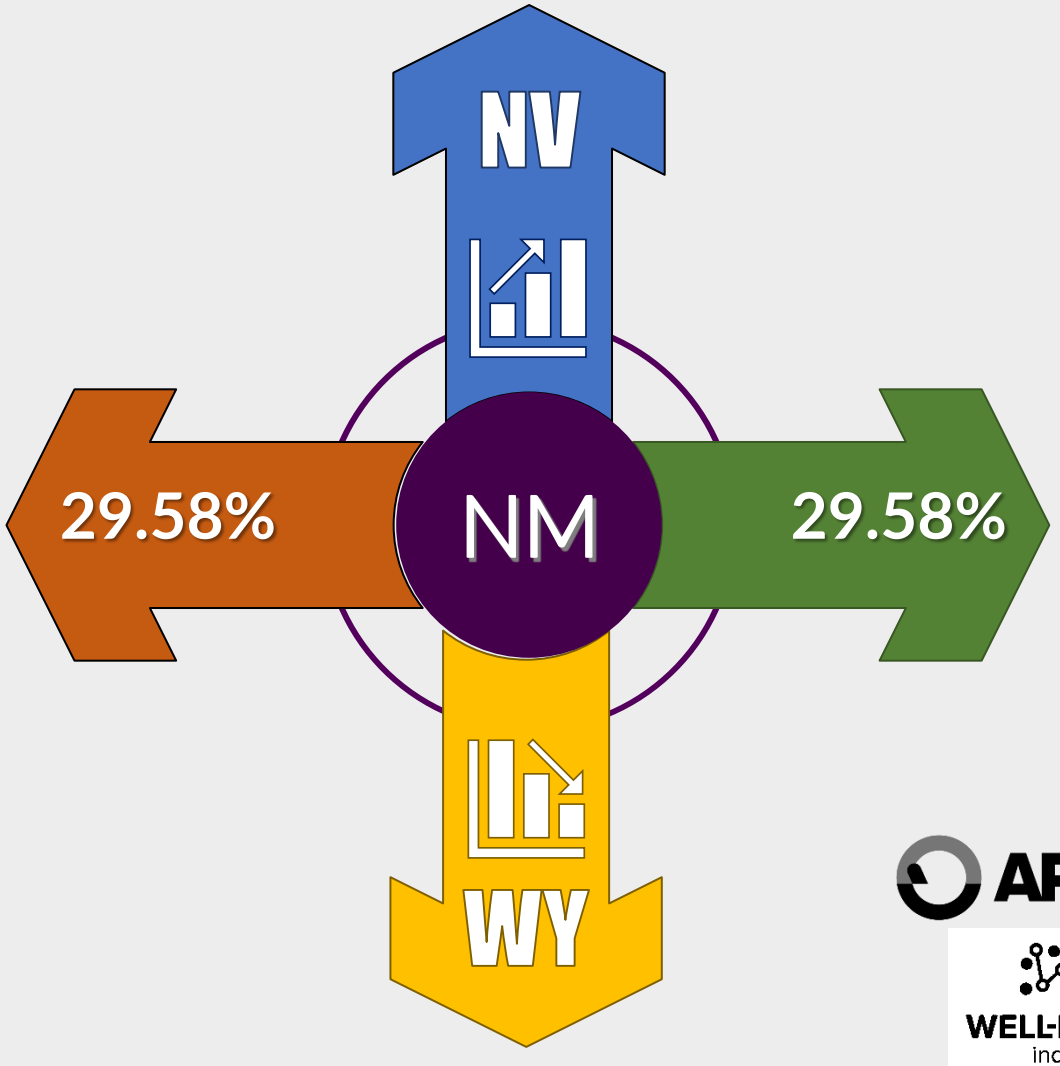
As of August 6. 2022, the New Mexico distress percent was 29.58% (ranked 43/52) with 50 assessors.

STATE COMPARISON

As of September 6, 2022

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

Wyoming has the lowest 16.67% (n=17)



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.

APhA

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

WELL-BEING INDEX FOR PHARMACY PERSONNEL

STATE DISTRESS PERCENT*

SEPTEMBER 2022

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

AUGUST 2022

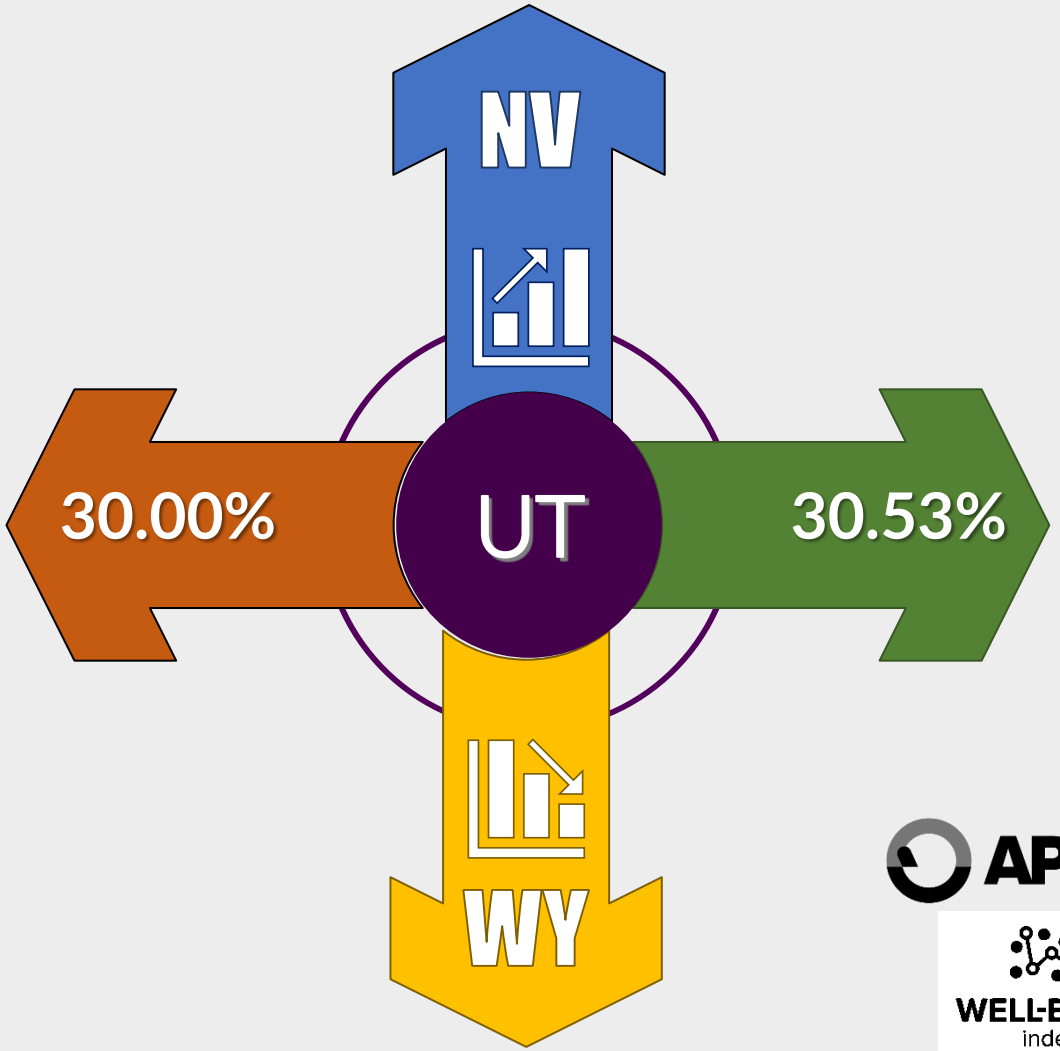
As of August 6, 2022, the Utah distress percent was 30.00% (ranked tied at 40/52) with 71 assessors.

STATE COMPARISON

As of September 6, 2022

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

Wyoming has the lowest 16.67% (n=17)



APhA

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

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

Well-being Resources Promo Slides*

For Your Use in State Social Media and Periodicals

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

WELL-BEING index

Burnout is real.

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

Well-being Index for Pharmacists, Student Pharmacists, & Pharmacy Technicians
https://app.mywellbeingindex.org/signup
Invitation Code: APhA

Or Scan

APhA

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

PWWR

PHARMACY WORKPLACE & WELL-BEING REPORTING

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

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

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

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

Share the PWWR link with your colleagues!