July 23, 2020

Allison Vordenbaumen Benz, RPh, MS
Executive Director and Secretary
Texas State Board of Pharmacy
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Dear Ms. Benz,

On behalf of our members operating community pharmacies in Texas, NACDS greatly appreciates the opportunity to continue working with the Board to advance pharmacy practice for the ultimate benefit and improved safety and health of Texans. Given important Board discussions related to pharmacy technician role expansion last year, NACDS thanks the Board for their continued engagement and consideration of our perspective on these critical issues.

The unfolding COVID-19 pandemic continues to challenge healthcare systems and providers across Texas and the country more broadly. With more than 9,500 new COVID-19 cases reported in Texas on July 23rd, it is imperative that systems and providers, including pharmacies, continue have the ability to leverage all pharmacy staff to meet public health demands and provide the best possible care for the public during this unprecedented time and beyond. Pharmacies must be empowered to provide critical COVID-19 care along with traditional care to the communities they serve, especially as pharmacies gear up to begin providing influenza vaccines in only a few short weeks, and make preparations to provide COVID-19 vaccines once available.

NACDS represents traditional drug stores, supermarkets and mass merchants with pharmacies. In Texas, NACDS member companies operate more than 3,000 locations that employ about 300,00 people. Our members operate 40,000 pharmacies in total and include regional chains with as few as four stores as well as national companies. Across the nation, chain pharmacies employ more than 3 million individuals, including 157,000 pharmacists. They fill over 3 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative patient-care services that improve patient health and healthcare affordability. NACDS members also include more than 900 supplier partners and over 70 international members representing 21 countries. Please visit nacds.org.

Expanding the ability for pharmacies to leverage the unique skills of all pharmacy staff, including pharmacy technicians, is critical given the present circumstances, but would allow for more optimized patient care delivery every day even beyond the pandemic. NACDS urges the Board to better support pharmacists to meet the clinical needs of patients by allowing pharmacy technicians to perform all technical functions not requiring clinical or professional judgement, including product verification and vaccine administration. Decades of research and pilot programs have demonstrated the safety of pharmacy technicians performing such duties.

A. Leveraging All Pharmacy Team Members to Improve Care and Meet Increasing Demands

In the context of an aging population with increased chronic disease prevalence and medication use, and a looming physician shortage, community pharmacists are well-positioned and trained to deliver a wide range of relevant care services to help fill gaps, improve care coordination, and complement the care delivered by others across the continuum. However, the extent to which a pharmacist can engage in direct patient care activities and meet dynamic needs, depends heavily upon whether non-judgmental tasks can be delegated from a pharmacist to pharmacy technicians. Innovative workflow models and the smarter use of pharmacy technicians to perform a comprehensive assortment of administrative, nondiscretionary tasks are integral to better supporting pharmacists to maximizing their ability and refocusing their time as they aim to best meet the needs of patients (e.g. delivery of patient care services, use of clinical judgement, etc.). For Texas pharmacies to best balance and meet the dynamic needs of patients in today's evolving healthcare environment, community pharmacists must be able to better deploy, maximize, and leverage their most valuable resource – the team behind the counter – inclusive of pharmacists and pharmacy technicians.

Based on data from a high-risk Medicaid population, patients visit pharmacies ten (10) times more frequently than they see other healthcare providers, meaning pharmacists are ideally positioned to fill gaps in patient care and support the healthcare team. Given their accessibility and expertise, pharmacists are often cited as a seriously underutilized asset to improve health and care experiences for patients and reduce healthcare costs. Healthcare researchers, thought leaders and policymakers more and more are advocating for pharmacist-provided clinical patient care as one strategy to advance the "Triple Aim."[1] However, if community pharmacists cannot delegate non-discretionary tasks to pharmacy technicians, opportunities to evolve clinical community pharmacy practice as part of the value transformation of healthcare may remain largely out of grasp. This is not only disadvantageous for the viability and advancement of the pharmacy profession; it is harmful for patient health and the efficiency of our healthcare system based a myriad of evidence. By shifting the roles of pharmacy technicians to better support pharmacists, we can move the dial toward solving this problem.

Compelling scientific research continually supports the value of community pharmacists to improve healthcare outcomes and reduce preventable downstream costs by providing clinical care such as preventive interventions, chronic disease management, and medication optimization. Pharmacists also provide tremendous value across the healthcare continuum, including as an accessible clinical healthcare provider and a dispenser of medications and related information such as adherence strategies, proper use, contraindications, interactions, side effects, storage, disposal and more. Therefore, as the healthcare landscape continues to evolve, increasing expectations of the whole continuum, the pharmacy team must be leveraged and maximized to their highest ability in order to optimally provide care to patients. <u>NACDS encourages the Board to allow pharmacists to better delegate their workload and use their time by engaging pharmacy technicians to take on any administrative and non-discretionary tasks, thereby optimizing the value and role of pharmacy care to serve patients and improve health. Similarly, the Board should</u>

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[1] The Institute for Healthcare Improvement (IHI) defines the Triple Aim as a framework to describe an approach to optimizing health system performance, with the belief that new designs must be developed to simultaneously pursue three dimensions: improving patient experience (quality and satisfaction), improving the health of populations, and reducing the per capita cost of healthcare.
http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx#targetText=The%20IHI%20Triple%20Aim%20is,to%20optimizing%20health%20system%20performance.&targetText=Improving%20the%20patient%20experience%20of,capita%20cost%20of%20health%20care

remove the unnecessary pharmacist to technician ratio that restricts appropriate use of all members of the pharmacy staff team to best serve patients.

B. Expand Permissible Duties for Pharmacy Technicians in Texas to Better Serve Patients

As mentioned, community pharmacists are increasingly called upon to apply their advanced-level clinical training and medication expertise to improve health outcomes and add value across the care continuum. As such, there is a corresponding need to delegate administrative, nondiscretionary tasks to pharmacy technicians so that pharmacists can focus on providing more care to the communities they serve. Specifically, NACDS encourages the Board to permit pharmacists to delegate any administrative, non-discretionary, non-judgmental task, as has been done in Idaho, where pharmacists may delegate any act consistent with a technician's training, aligned with accepted standards of care, and unless expressly prohibited.[2] Such authority empowers pharmacists to determine what administrative, nonjudgmental tasks are appropriate for delegation, while considering pharmacy-specific workflow needs. Specifically, pharmacy technicians should be authorized to perform final product verification, immunization administration, and others.

Transfers & Verbal Orders. Based on research published in 2017, at least 17 states allow pharmacy technicians to accept verbal prescriptions called in by a prescriber or prescriber's agent or transfer a prescription order from one pharmacy to another.[3] The authors of this research concluded that these tasks can be performed safely and accurately by appropriately trained technicians, and the track record of success with these tasks spans four decades.[3] The authors also noted that the delegation of verbal orders and prescription transfers removes undue strain on pharmacists and frees up pharmacist time for clinical care.[3] Further, it has been suggested that when information on a prescription is incomplete, a pharmacy technician can contact the prescriber and appropriately obtain the needed information. Currently, at least six states permit this activity for certified technicians.[4] Based on a recent survey of nearly 650 pharmacy technicians across the country, over 56% are already regularly involved in clarifying prescriptions, and over 75% are "very willing" to perform this activity. Additionally, 50% are "very willing" to accept and transcribe a verbal prescription and to transfer prescriptions.[5]

Immunization Administration. Additionally, research supports pharmacy technicians to successfully perform the technical task of administering immunizations. Upon pharmacist review of vaccine appropriateness and patient counseling, authorization of pharmacy technicians to administer vaccines results in more time for pharmacists to focus on tasks requiring clinical judgement, which is no different than support staff administering vaccines in physician offices. States such as Idaho, Utah, and Rhode Island have incorporated the ability for technicians to perform this technical task.[6] In a recent pilot, pharmacy technicians delivered over 950 immunizations between December 2016 and May 2017 without adverse effects.[7] Given the technical nature of vaccine administration, pharmacy technicians should be authorized to administer all types of immunizations. Further, the training program

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[2] https://bop.idaho.gov/wp-content/uploads/sites/99/2019/07/2019_Law_Book.pdf
[3] https://www.sciencedirect.com/science/article/abs/pii/S1551741116305721?via%3Dihub
[4] Currently allowed in DE, IL, ID, IA, MI and SD.
[5] Doucette W, Schommer J. Pharmacy Technicians' Willingness to Perform Emerging Tasks in Community Practice. Pharmacy. 2018;6(4):113.
[6] https://www.pharmacytimes.com/publications/supplements/2019/March2019/an-update-on-technicians-as-immunizers
7 McKeirnan KC, Frazier KR, Nguyen M, MacLean LG. Training pharmacy technicians to administer immunizations. J Am Pharm Assoc (2003). 2018;58(2):174–178.e1. doi:10.1016/j.japh.2018.01.003

developed for pharmacy technicians in Idaho included both intramuscular and subcutaneous administration routes and techniques, equipping technicians to offer a wide range of vaccinations.[8] Limiting the types of vaccines pharmacy technicians can provide would limit benefits for patients and may have unintended consequences as our healthcare system advances and new vaccine products become available. For example, limitation on the types of vaccines that pharmacy technicians can administer would restrict pharmacy technicians' ability to directly assist during a public health outbreak of a novel disease or virus. Importantly, even when pharmacy technicians administer immunizations, pharmacists continue to maintain all aspects of clinical decision-making.

Product Verification. Product verification performed by pharmacy technicians has been well studied over decades and proven to not only maintain patient safety, but also to promote job satisfaction of the community pharmacy workforce, allowing pharmacists to perform more clinically meaningful activities while providing opportunities for pharmacy technicians to synergistically elevate their work. Also, product verification by technicians is permitted in at least 6 states based on permanent rule (Arizona, Idaho, Iowa, North Dakota, West Virginia, and Wisconsin). The NACDS Optimizing Care Program in Iowa, Wisconsin and Tennessee, has shown through evidence-based pilot studies that technicians can and do safely verify medication products filled by other technicians. Specifically, the Optimizing Care Program aims to evaluate a new pharmacy care model, which includes a pharmacy technician with training in product selection performing the final verification of medications, allowing pharmacists to redirect more of their time to providing clinical patient care. This new role empowers technicians and frees up more time for pharmacist-provided patient care activities. Some states have implemented the use of technology to further support technicians to perform additional dispensing functions including technician product verification (TPV).[9] Further, this new care delivery model does not remove the pharmacist from any clinical decision-making process, drug utilization review (DUR), counseling, or any other clinical component of the prescription dispensing process. Likewise, this model does not reduce pharmacists' time in the pharmacy, but redistributes their time from technical duties to more clinically meaningful tasks.

Further, these pilot studies have demonstrated that TPV, which has been done in hospital pharmacies for decades, can similarly be performed in community pharmacies safely. For example, results of the NACDS Optimizing Care Program are provided:

NACDS Optimizing Care Program Overview: Technician Product Verification (TPV)	
State & Pilot Background	Results
Iowa[10] 18-month pilot began in 2014 and included 7 community pharmacies	• There was no significant difference in overall errors, patient safety errors, or administrative errors. • Pharmacists' time in dispensing significantly decreased (67.3% vs. 49.06%, P = 0.005), and time in direct patient care (19.96% vs. 34.72%, P = 0.003), increased significantly. • Total services significantly increased (2.88 vs. 5.16, P = 0.044).

[8] https://pharmacy.wsu.edu/pharmacy-technician-immunization-training/

[9] Arizona – Notice of Final Rule Making. Published by the Arizona Secretary of State. November 24, 2017. Vol. 23, Issue 47. https://apps.azsos.gov/public_services/register/2017/47/06_final.pdf
Iowa – Chapter 40. Technology-assisted Technician Product Verification Programs. May 2019. https://www.legis.iowa.gov/docs/iac/chapter/657.40.pdf

[10] Andreski M, Myers M, Gainer K, Pudlo A. The Iowa new practice model: Advancing technician roles to increase pharmacists' time to provide patient care services. J Am Pharm Assoc. 2018;58,268 -274. Accessed at: https://doi.org/10.1016/j.japh.2018.02.005. Further TPV research has been conducted in Iowa on new prescriptions with similar findings. Results not yet published.

Wisconsin[11] 3-year pilot began in 2016 and included 13 community pharmacies	• 12,891 pharmacist-verified prescriptions (baseline) and 27,447 Validated Pharmacy Technician-verified prescriptions were audited for accuracy. • The aggregate verification error rate for pharmacist-verified prescriptions was 0.16% and 0.01% for Validated Pharmacy Technician-verified prescriptions. • The mean error rate was significantly less for Validated Pharmacy Technician-verified prescriptions than for pharmacist-verified prescriptions. • The ability to delegate the final product verification task may free up pharmacist time for increased direct patient care, such as medication management and immunizations.
Tennessee[12] 2-year pilot began in 2017 and includes 14 community pharmacies	• Total undetected error rates were significantly less in the Optimizing Care Model phase compared to the traditional model (0.063%; vs. 0.085%; p<0.001). • Overall, pharmacist time spent delivering patient care services increased significantly upon implementation of the Optimizing Care Model (25% vs. 43%; p<0.001), while time spent performing dispensing-related activities decreased significantly (63% vs. 37%; p=0.02).

Qualitative findings[13]
 	
14 semi-structured interviews of pharmacy techs, managers, and pharmacists directly involved with implementation of TPV in any one of the three states – Iowa, Wisconsin, or Tennessee.
	• Key themes identified include:
	  ○ Optimizing Care Model catalyzes patient care service delivery expansion in the community pharmacy setting
	  ○ Effectiveness is driven by “freed-up” pharmacist time compared with the traditional model
	  ○ The model positively affects roles and job satisfaction of pharmacy personnel
	  ○ Technician engagement and ownership have a strong impact on the success and ramifications of the model

As described in the chart, recently conducted qualitative research on the expansion of pharmacy technician duties supports the tremendous potential not only to improve care for patients, but also to reduce undue burden on the community pharmacy workforce. For example, a survey of pharmacists, managers, and pharmacy technicians who implemented technician product verification across three states described highly positive outcomes of this model, including patient care delivery expansion, effectiveness based on “freed-up” pharmacist time, and positive impacts on roles and job satisfaction of personnel.[14]

Quotes from the research include:

“There’s definitely a lot more time to spend with the patient…I think it’s almost like the whole atmosphere of our job changes. … I just feel that the pharmacist is able to step back for a moment from the product and just be like, “Okay, so who can I help today?” (Pharmacist Manager)

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[11] https://pubs.lib.umn.edu/index.php/innovations/article/view/2340.

[12] Hohmeier KC, Garst A, Adkins L, Yu X, Desselle S, Cost M. The Optimizing Care Model: A Novel Community Pharmacy Approach to Enhance Patient Care Delivery by Leveraging the Technician Workforce through Technician Product Verification. Journal of the American Pharmacists Association. July 2019. https://www.japha.org/article/S1544-3191(19)30347-4/fulltext These preliminary results will be supplemented with a full analysis once the pilot concludes later this year.

[13] Hohmeier, Kenneth C. et al. Exploring the implementation of a novel optimizing care model in the community pharmacy setting. Journal of the American Pharmacists Association, Volume 59, Issue 3, 310 - 318

[14] Hohmeier, Kenneth C, et al. Exploring the implementation of a novel optimizing care model in the community pharmacy setting. Journal of the American Pharmacists Association, Volume 59, Issue 3, 310 - 318

"It's allowed every member of the pharmacy care team to practice at the top of their job description and enable pharmacists to really use that license." (Pharmacist Manager)

"It's really been helpful because it's been less stressful just being able to focus…" (Pharmacist Manager)

"The pharmacists feel that they are able to step back for a moment and not be in that kind of pressurized feeling all the time …" (Pharmacist Manager)

"I would hate to go back to the way that things were before… [The pharmacist] can go take their blood pressure or go over their meds with them …. [and] we have more time to call the doctor and ask about questions." (Pharmacy Technician)

Such evidence supports the ability of pharmacy technicians to take on additional, nondiscretionary duties, which expand pharmacists' capacity to provide patient care and focus on aspects of the dispensing process which require clinical decision making. Expanding technicians' ability to better support pharmacists does not remove pharmacists from any clinical aspect of pharmacy care, nor does it remove pharmacists from the dispensing process, diminish the importance of a pharmacist or the license they hold, nor does it replace pharmacists with technicians. Instead, the change in duties allows pharmacists to redirect their time toward activities requiring their clinical expertise and advanced-level training.

Especially given the rigorous training and certification requirements for pharmacy technicians already implemented in Texas, NACDS urges the Board to authorize technicians to better support pharmacists by providing a full range of administrative, nondiscretionary dispensing tasks. These tasks include – but are not limited to – immunization administration, final product verification, receiving and accepting oral prescriptions and reducing these orders to writing, either manually or electronically; transferring or receiving a transfer of original prescription information on behalf of a patient; and contacting a prescriber for clarification when information on a prescription is incomplete, unless the inquiry regarding missing information requires the professional judgment of a pharmacist. Because the literature strongly supports technicians safely performing such expanded duties without specific credentialing or extensive training, any additional requirements would be unnecessarily burdensome for pharmacies looking to improve the health of their patients. While NACDS strongly supports technicians being appropriately trained for assigned tasks, we believe that the employers are in the best position to decide what is necessary for their technician workforce in that pharmacy setting and provide that training.

In sum, to realize greater benefits for pharmacist-provided patient care and to reduce undue burden on pharmacy personnel, NACDS urges the Board to authorize pharmacy technicians to perform all technical, non-discretionary duties given maintained patient safety demonstrated in other states and underpinned by research.

C. Remove Antiquated, Unnecessary "Pharmacist to Technician Ratio" Which Hinders Care

Currently in Texas, pharmacies are subject to ratios ranging from 1:3 to 1:5, depending on precise circumstances, for instance: if a technician is a "trainee," if the number of drugs dispensed at that particular pharmacy exceeds 20, and based on the presence or absence of sterile compounding activity. However, no evidence exists to support any particular ratio for the circumstances listed, and NACDS is unaware of any reports or studies showing that ratios

improve patient safety. Arbitrary ratios undermine the ability of community pharmacists to best manage the needs and requirements of each individualized pharmacy to provide population-specific patient care. Such ratios especially prevent pharmacies from maximizing the use of pharmacy technicians to provide a broader set of patient care services to the public. Recognizing this to be true, many state boards of pharmacy have relaxed or totally removed pharmacist-technician ratios to allow for optimal use of pharmacy technicians. For example, the following 23 states, in addition to the District of Columbia, do not limit the number of technicians a pharmacist can oversee: Alaska, Arizona, Delaware, Hawaii, Idaho, Illinois, Iowa, Kentucky, Maine, Maryland, Michigan, Missouri, New Hampshire, New Mexico, Ohio, Oregon, Pennsylvania, Rhode Island, Utah, Vermont, Washington, Wisconsin, and Wyoming.[15] NACDS has not heard of any observed or reported excessive technician staffing or patient safety issues arising in those states in which ratios have been eliminated. Testimonials recently collected by NACDS add additional context and are provided below:

"I'm not aware of any information which suggests that patients in a state which has no ratio are any safer or worse off than patients in a state which has a ratio. There does not appear to be a public safety imperative for ratio requirements. *Since every practice site is different, it would appear prudent to task the pharmacist-in-charge of a pharmacy with the appropriate staffing mix commensurate with the nature and scope of the practice site." – Malcolm Broussard, RPh, Executive Director, Louisiana Board of Pharmacy*

"The New Mexico Board of Pharmacy eliminated the tech ratio by rule change in June 2013. The Board reserved the right to impose a ratio on a licensee if it could be shown that a violation or complaint resulted from poor supervision due to the number of techs on duty. ***To date, the Board has not imposed a ratio on any licensee. I am not aware of any complaints or violations that have resulted from tech ratio issues****." – Rich Mazzoni, Past President of both the New Mexico Board of Pharmacy and the California Board of Pharmacy*

*"Arizona eliminated the ratio almost 15 years ago. …****In these 15 years, there has never been a case of an error related to an unsafe number of technicians in the pharmacy****." – Dennis McAllister, Arizona Board of Pharmacy*

"In the last several years, Maine migrated to a no ratio regulation and left the technician staffing up to the pharmacist licensed with their board. ***There have been no negative outcomes from this change. I believe the citizens are getting better and more timely service and taking a greater understanding of how to use their medications effectively home with them****." – Mark Polli, RPh, Maine Board of Pharmacy*

"I have spent 8 years on the Michigan Board of Pharmacy… Michigan is a state that has no pharmacist to technician ratio. In my 8 years on the board (2001-2009,) I did not review a case in either the full board or the DSC that involved an issue with a pharmacist that encountered a quality incident involving too many technicians to supervise. … ***The idea of restricting the amount of technicians a pharmacist can utilize in their practice setting, works to the detriment of the***

[15] NACDS internal research. 2020.

patient and inhibits the pharmacist to provide patient care at the top of their license since the technicians are there to assist the pharmacist and patient*, not make decisions regarding patient care or quality decisions." – Laura A. Shaw, Michigan Board of Pharmacy*

"I have been a Pennsylvania pharmacist for 27 years and served on the Pennsylvania Board of Pharmacy for 15 years, eight of those years as Chairman. ***During my tenure on the Board of Pharmacy, there was NEVER a disciplinary case, nor allegation that came before us, that alleged that an error or patient harm was caused by too many technicians on duty in the pharmacy****." – Mike Podgurski, RPh, Pennsylvania Board of Pharmacy*

Notably, the National Association of Boards of Pharmacy (NABP) has long supported the complete elimination of the pharmacist to technician ratio, and the cutting edge pharmacy care models implemented by the Department of Veterans Affairs (VA) health systems/military do not include the use of a pharmacist to technician ratio, which has not appeared to negatively impact patient safety in those programs.

Given the nonexistence of evidence supporting outdated, arbitrary ratios, and the imperative to reduce undue burden on pharmacy personnel, NACDS urges the Board to remove unwarranted ratio restrictions in the state of Texas. Such action would be an important step toward modernizing pharmacy practice in the state and aligning rules and regulations with the healthcare needs of today's patients. Removing ratio restrictions will empower pharmacists to best determine what staffing and optimal workflow models best meet their needs given the specific volume and patient care requirements of their pharmacy.

Conclusion

Amid the global pandemic and given escalating imperative to improve quality and transformation of healthcare delivery across the United States, community pharmacists are increasingly providing direct, clinical patient care in accessible neighborhood pharmacy locations across the country. By removing antiquated pharmacist to technician ratios, and expanding permissible duties for technicians, the Board will drive innovation and collaboration to maximize and empower pharmacies across the state to better care for their patients given evolving healthcare needs. NACDS encourages the Board to urgently act on these issues to advance pharmacy practice for the ultimate goal of improving healthcare in the state of Texas and buttressing the response to COVID-19 in communities across the state. We greatly appreciate the consideration of our recommendations and the opportunity to continue working with the Board on these critical issues. We greatly appreciate the consideration of our recommendations and welcome any further discussion on these issues. Please contact NACDS' Mary Staples at MStaples@NACDS.org or by phone at (817)-442-1155.

Sincerely,

Steven C. Anderson, FASAE, CAE, IOM
President and Chief Executive Officer