MEETING MINUTES

Oregon Board of Pharmacy
2016 Strategic Planning Meeting
November 8-9, 2017

Oregon Garden Resort
895 West Main St.
Silverton, OR

The mission of the Oregon State Board of Pharmacy is to promote, preserve and protect the public health, safety and welfare by ensuring high standards in the practice of pharmacy and by regulating the quality, manufacture, sale and distribution of drugs.

Wednesday, November 8, 2017 @ 9:00 AM – 4:30 PM - Orchid Ballroom
Thursday, November 9, 2017 @ 8:30 AM – 4:00 PM - Orchid Ballroom

WEDNESDAY, NOVEMBER 8, 2017

9:03 AM OPEN SESSION, Penny Reher, Presiding

Roll Call
Penny Reher, President                      Rachael DeBarmore, Vice President
Roberto Linares                           Kate James
Shannon Larson                            Cyndi Vipperman
Dianne Armstrong                         Second Public Member - vacant

Excused Absence: Christine Chute

The following staff members will be present for all or part of this session:
Marc Watt, Executive Director              Brianne Efremoff, Compliance Director
Karen MacLean, Administrative Director    Chrisy Hennigan, Licensing Supervisor
Fiona Karbowicz, Pharmacist Consultant    Tim Frost, Board Fellow

Tom Cowan, Sr. AAG Board Counsel

MOTION
Motion to approve the agenda was made and unanimously carried (Motion by James, second by Armstrong).

Board President, Penny Reher, introduced facilitator, Donna Silverberg, and turned the meeting over to her for introductions. Donna welcomed board members, staff and members of the public to the Oregon Board of Pharmacy's 2017 Strategic Planning Meeting. Students in the audience were invited to introduce themselves, and discussion protocols were presented to the room.
Following board member and staff introductions, Donna noted that strategic planning is the prerogative for the board, and that the public was invited to watch, listen and learn, not to engage. She also emphasized that this retreat would be different than issue specific meetings in the past, and that the group would focus on looking ahead at the bigger picture to brainstorm 5 to 10-year plans. Donna asked that board and staff think about what the group can do as a team to find ways to connect with each other and dream for the future. Some questions to consider included: (1) What does the board collectively want to work towards? (2) How can the board and staff achieve these high-level plans within the scope of OBOP’s mission?

Donna provided some background to general strategic planning approaches. She concluded that the Board would be best served by using the “Balanced Scorecard” (see Appendix A) approach and explained that the pillars of the house represent the strategic themes the board thinks OBOP should focus on for the next 5-10 years. Each pillar, or strategic theme, will lead to a strategic result.

Donna then asked the board to consider: what pillars of excellence or stability are needed to support OBOP’s desired strategic results and mission? The pillars should clarify strong and stable strategic themes that the board believes the organization needs to focus on for the next 5 to 10 years, within the context of OBOP’s mission:

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The board discussed 5 to 10-year visions and how they would like to strategically plan annually. Executive Director Marc Watt added suggested the Board look toward painting a vivid high-level picture and staff can make a step-by-step process for how to the board where it wants to go to achieve its visions.

**Current Trends that Impact and Influence OBOP’s Work**

Donna reminded the group that OBOP is a regulatory board, which has unique oversight and relationships with its communities. Before defining the pillars of OBOP, she asked the group to work in small groups to brainstorm local, state, and national level trends that board members are seeing. She noted that the ‘5 to 10-year ideas’ that were listed on the agenda have a good variety of levels to talk about. The board and staff divided into two groups to identify these trends, discussing influences, impacts, and pressure points that most affect the board, with the goal of determining the next direction for OBOP. (see Appendix B)

Some of these included:

- Technology intersection with many rules/pace, Pharmacy technician roles - minimum qualifications/training/ education/certification and Pharmacist expanded scope of practice, financial constraints leading to downward pressures on pharmacy and continued industry disruption related to the delivery of pharmacy.

Some comments and reflections from this small group brainstorming included:

- We have a broad spectrum authority as a board to make change.
- It’s a little bit discouraging, because it all comes down to money.
• When talking about the issue of money, we can trace a lot of the pressures back to where the money comes from. Many of these topics have been discussed in pharmacy for years, and it would be beneficial to look back and acknowledge that we’ve been struggling with some of these issues for a long time.
• It’s interesting to see how interwoven a lot of topics tend to be, there is a lot of blending that’s happening which makes it more complex
• Many of the trends dovetail into one another.
• There are many similarities between the two groups’ lists.
• Are we driving our own priorities or are they being given to us by the requests we receive for waivers etc.?

Current Organizational Capacity
Donna reviewed the trends identified, and asked the board to continue thinking about the 5 to 10-year strategic-theme pillars, as well as previous 5 to 10-year vision ideas. Keeping in mind OBOP’s organizational capacity load, what can staff undertake on top of current load?

Executive Director Marc Watt provided an update on OBOP’s organizational capacity. He stressed that staff are just about at capacity to do their work. He outlined some of the challenges staff is working with, including upgrading in-house software and support within the state’s slow-moving system, MLO project, drug take-back, HB 2397 Pharmacy Formulary Advisory Committee implementation and rule concepts in the pipeline.

The good news is that OBOP is fully staffed, with inspectors working at 100%. The efficiency is there, but Marc emphasized that staff is at maximum load. Other staff stated that they want to do it right. They are seeking operational excellence. Still, the consequences and complexity of how everything intersects is what keeps them up at night.

The board thanked staff for their continued hard work and efforts. They also noted the significance of doing this long-term planning, and the importance of looking into the future and having something to work towards to get priorities aligned.

Strategic Themes: Pillars to Pursue in the Next Five Years
Donna summarized that OBOP has engaged leadership and a solid foundation, and despite being fully-staffed, capacity is maxed out. She posed the question: When considering the mission and issues that the board has already, what are three or four areas on which you want to focus your attention, energy and staff to get you where you want to be in five years?

To answer this question, the group decided it would be helpful first to articulate and agree on their stakeholder list. Stakeholders were defined as “anyone affected by the decisions the board makes”:

Review of OBOP’s Stakeholders
• Public (#1 Priority)
• Patient
• Healthcare Providers
• Payers (?)
• Industry
• Other State Agencies
• Federal
• Accrediting Bodies
• Educators
• Associations – NABP, OSPA, OSHP etc.
Everyone agreed that the key stakeholder is the public. The number one job is protecting the public.

Once the board clarified its stakeholders, board members wrote the strategic theme they each thought the Board should focus on to represent their pillars of excellence for the next five years. Once these ideas were posted, common themes emerged: technology, human capital (workplace conditions, rules that assist with and support structure etc.), safety, patient care, standards of pharmacy (scope of practice and its changes, licensing) and organizational (board related). The board then assessed the themes for commonalities and, over lunch, considered how they wanted to name the pillars.

The group agreed that the following should be the three pillars for OBOP’s 2018—2022 work:

**Three Pillars**
1. Safe Drug Accessibility and Distribution
2. Entrustable Professional Activities (EPAs)
3. Define Standards of Practice
Testing the Identified Pillars
Questions to consider for each of the pillars:

- Is there organizational capacity and staff to work on these pillars?
- Are there internal processes to support these?
- Have we considered all stakeholders?

The board felt confident that they currently are and can continue to support the three pillars. Staff is already working on these issues; internal processes can support them, and all stakeholders can be related to one or more of them.

As a test case, the board engaged in a brainstorming session about the passage of 2017 HB 2397, the Formulary bill, which establishes a committee to determine what drugs can be prescribed by pharmacists and what protocols can be followed.

Marc asked the board to talk about what the impacts from the prescribing bill might look like in 5 to 10 years within the retail and health system realms. He asked for the board’s thoughts about what it should be, so he can take the vision to the committee when they meet next year.

Some of the comments associated with 2017 HB 2397 are listed under the possible pillar categories below:

1. **Safe Drug Accessibility and Distribution**
   - Access to information/Medical Records
     - Medical records are important because missing anything is critical.
     - Would be ideal to see retail pharmacists have access to medical records and healthcare information. The model for this already exists in closed health-care systems.
     - In retail, it’s going to be harder.
     - In hospitals, there are lab tests the pharmacists can link back to, so patients can get access to care faster.
   - Create that 3rd class of drugs for pharmacists to prescribe.
   - Consider continuation of refill medications.
   - Some concepts may require an established protocol for a pharmacist to follow.
   - Need a relationship between physician and pharmacist
   - Detailed recordkeeping

2. **Entrustable Professional Activities (EPAs)**
   - Appointments for complicated medication therapies may be utilized.
   - Traditional retail pharmacy workflows may need to be altered to accommodate these new services.
   - Establish systems which allow patients to be treated quickly and carefully.
   - The “dream” would be that pharmacists could rely on a universal electronic medical record, this way pharmacists could check it for every evaluation.
3. Define Standards of Practice
   • We would want the committee and pharmacists to consider what the increased liability for pharmacists will be going forward.
   • Whenever the dispenser and prescriber are the same entity, there is danger for conflict of interest. That conflict of interest is worrisome, and activities will need to be described clearly, so the public can trust this new system.
   • Pharmacists will also need to create new records that back up their decisions.

Implications outlined for retail and health system pharmacy practice:

RETAIL (considering future formulary)
   • Use established protocol (if no access to medical record)
   • Look at guidance to avoid problems
   • Established relationship & communication with doctor for more complex cases
   • “Pharmacist-Only” drugs
     o Spacers/Diabetic supplies
     o Strep tests & meds
   • Faster PDMP updates (Prescribed Drug Monitoring Program)
   • No controlled pain meds
     o Avoid “pharmacy shopping”
   • New set of liabilities need to be clear
   • Help with short-term refill

HEALTH-SYSTEM
   • Improved care via shared medical records & speed of prescribing
   • Potential for out-of-system record sharing?
   • Share access with retail
   • Shared medical records to support context for prescribing – “MyChart” travels to pharmacy
   • Definite post-diagnosis
   • Continuing therapy
   • Third class of drugs
   • Inter-company standard for records so all can understand
   • NO: Initiation of therapy that requires diagnosis

OBOP’s Relationship to & Picture of Technology in Pharmacy in 2027
   • How does the technology make it safer for the patient?
     GOAL: TO MAKE IT AS SAFE OR SAFER
   • Pharmacists removed from physical distribution of drugs
   • Barcode scanning to verify correct meds & protocol
   • Photos of mixing/preparation to double-check safety/errors
   • Human monitoring of new technology to assure safety (not just efficient)
     VIGILANCE!
   • Standards of practice evolve to meet/exceed degrees of technology
   • New technology is tested, evaluated, and has a track record.
   • Technology does not replace or erode role of pharmacist in patient safety/care (What are the non-negotiable aspects of practice?)

Some additional comments made during this discussion included:
   • Sometimes it’s good to be cautious. We need to make sure that the human element is kept in the process, not just blindly trusting the technology in the process. Because it’s being done more efficiently, the expectation is that people don’t have to
check things as closely – humans still must be vigilant in their responsibility to protecting the public.

- When talking about pillars, we have the ultimate goal of perfectly filled prescriptions.
  - Did the pharmacist correctly educate the patient on the drug? Our goal is that the patient has the correct understanding on how to use it. We need to think of this as a wider discussion, we cannot have one rule for each drug.
  - Fill the prescription right, educate the patient, using the standards of practice as baseline for evaluation.
- How do you know, if technology is so immature and there is no history of accuracy, what happens if harm comes to hundreds of people? The technology needs to be mature enough and have enough testing.
  - There may be times when Oregon wants to be first – but there needs to be adequate testing.
- Clearly defining critical elements of pharmacist practice will allow for appropriate delegation and automation of non-professional activities.

Donna then asked what the board wanted to do next with the strategic theme pillars, which lead to a discussion of non-negotiables for pharmacists. The following is an initial brainstormed list that the board created. One or two board members suggested items that might be considered as negotiable at a later date. These items are italicized, and the board will need revisit them in the future:

**Non-Negotiables**

- Patient Counseling
- DUR (Drug Utilization Review)
- Open pharmacy outlet- onsite security
- Clinical decisions
  - e.g. Counsel, assessment, & recommendations
- Ordering / Signing “CIIs”
- Therapy management
- Prescribing
- Immunization / administering drugs
- New prescriptions/transfers (only a pharmacist can take them)
- Review order verification
- Professional discussions with doctors and others
- Final verification of prescription/order
  - (Consider delegating ‘product verification’ task)
- No delegation of duties that are specific to the pharmacist scope of practice
- Supervision, direction & control of ancillary staff
  - (Consider allowing technicians to be unsupervised in certain, clearly defined circumstances)

**Discussion**

The board discussed the process of final product verification – which includes the components of matching a picture to a picture or a number to a number. One member suggested the potential for delegating the task of product verification. The board needs to define exactly what final verification is to determine whether that is something that could even be delegated away from pharmacists?
Board members spoke about the idea of having unsupervised technicians in certain circumstances. Some board members had positive thoughts, while others felt strongly against the idea, and had concerns about accountability, security, and oversight. Comments included:

- Consider when technicians could be unsupervised and under which certain circumstances.
  - Understand implications if allowing that there are conditions when a pharmacist may not need to be present at all times when ancillary staff is in the pharmacy.
  - We would have to raise the bar on accountability.
  - This would require a statutory change. The board would have to define the circumstances VERY well.

- Paying attention to context is critical. Under what circumstances would these scenarios work? How can we reframe the conversation?
  - It keeps going back to accountability. The pharmacist being asked to accept these new potential rules, puts his/her license at risk.

**MOTION**

Motion to adjourn at 4:30PM was made and unanimously carried (Motion by James, second by DeBarmore)
Reflecting on Desired State of the Profession
Donna provided the group with an agenda for the day and began by asking board members to envision their “overall desired state” for the field in 5 to 10 years. What should the field of pharmacy look like? (Facilitator’s note: board members shared their responses aloud at the session. See Appendix C “Desired State” for individual written responses)

There was a strong, shared board sentiment regarding the need to strengthen relationships between the pharmacy/pharmacist and their patients.
- Patients’ needs will be met when they can connect with pharmacy staff.
- In addition, in community pharmacy, documentation is critical because everyone in an office should be able to access every record and understand every interaction with each patient within that pharmacy.
  - This means the patient can seamlessly visit with any pharmacist in the office. This only works when there is diligent record keeping and documentation.
Further comments from board members included:
- Taking the time to develop relationships makes you a more valuable provider. Technician roles are valuable, too, as they do prep and time-consuming work assisting pharmacists. If I can recruit someone good to my team that brings their patients with them, that helps everyone.
- We document every interaction, by doing that and having a system, it doesn’t matter who picks up the phone, all previous interactions have been recorded, and we are able to follow up accurately based on that documentation. This level of care helps people decide that this is where they want to have prescriptions filled.

Desired Strategic Results from Strategic Theme Pillars
Donna asked the board to consider their desired strategic results based on the three pillars. She posed the question: How do you know you have met your goal for each pillar?

The group identified the following results for each strategic theme:
-> ACTION: Prior to the February board meeting, staff will research and present models of standards of practice from other fields/organizations.

The board and staff voiced concerns over the ideas they were discussing and the potential for them to get lost given the day-to-day demands of their work as a board. Donna suggested the board look 5-10 years out to determine a timeline that matches administrative and legislative deadline constraints with the desired results the board hopes to achieve.

Tom Cowan, Board Counsel, said he was sensitive to concerns about strategic planning results, and noted that it comes down to the board building consensus for developing specific concepts. He suggested that time be set aside on future board meeting agendas to continue with strategic planning work. This is why staff observes these conversations: to see where board consensus is building, in order to build a basis for their work, and to get

"Safe Drug Access & Distribution"
- Develop and maintain strong partnerships to ensure manufacturing practices that lead to strong, full pipeline of necessary medications (regulatory bodies).
- Clearly defined distribution pathways from manufacturing all the way to the patient.
- Ensure workplace conditions that allow for safe distribution of medications.
- Zero errors/Zero counterfeits.
- Feds and state work together.
- Technology is used to safely support patient access.

"Entrustable Professional Activities (what Rph’s do)"
- Each patient’s medication and health needs are being met.
- Pharmacy workflow facilitates meaningful patient interactions.
- Clinical recordkeeping is expanded and perfected.
- The public has a clear understanding of pharmacy services provided; they trust and want to use those services.
- Pharmacists & technicians are confident, prepared professionals through education and training.
- Pharmacists communicate to the patient in a way they can HEAR: Listen and verify their understanding of their medicine regimens.
- Licensees retain competence in the practice of pharmacy.
- Clearly defined Rph-only activities

"Define Standards of Practice (how Rph’s do their work)"
- Decreased to zero errors.
- Technology’s role has been defined.
- Facilitate the advancement of safe practice (by board & staff).
- Education and training produce competent, confident and trusted pharmacy professionals.
- Technology supports goals and roles of pharmacists and technicians.
- Allow for evolving roles (do not “define” everything).
- Clear definition of Board’s role in the “practice” of pharmacy (this may need to be re-defined).
concrete deliverables. He discussed the appropriate flow of communications between board members and staff.

The group agreed that future meeting agenda management was critical in order to keep strategic planning concepts within the proper overall agency priorities.

Other comments made during this discussion included:

- Use the agenda placeholder more effectively - Set aside 30 minutes at every meeting to look at strategic plan and figure out ‘next deliverables’, so staff knows exactly what they need to work on next.
- There needs to be clear direction on the board’s list of priorities for staff
- It is important to integrate the plan with other things we are working on or things will get lost. Especially with legislative work in front of us, priorities will change over time and we need to recognize and focus on the desired deliverable.
- Staff needs the board’s destination, a picture of where they want to be. With this, staff can figure out the process and how to get there.
- Kate James suggested creating a roadmap to put into the resources folder for people to review before meetings. This would establish clarity on the work needed to be done on rules and how that work relates to progress towards our bigger plan. It was noted that the resource folder was very helpful to all.
- It will be important to bring Christine up-to-date at the next board meeting.

**AGREEMENT**: The board agreed that every meeting should have at least some link back to these strategic planning discussions, to keep momentum going, and to review what the group is working on in relation to and as a result/outcome of the pillars. The group will watch to be sure discussions do not become redundant.

Marc stressed that the key to success will be prioritization, while always keeping in mind patient safety. The board needs to be clear on what exactly they want, so staff can prioritize to meet board goals. Staff needs to know if the board wants something in the pipeline. The board wondered if the current priority list needed to be revisited to determine how it fit with the current vision. They also noted that some new board members might not understand the realities of rules and rule-making.

**Revisiting Goals of Strategic Theme Pillars**

1. Safe Drug Access & Distribution
The board quickly reached consensus on this pillar and offered the following comments/desired results:

- Strong area that the board is committed to as an ongoing core value.
- Develop and maintain strong partnerships to ensure this.
- This is the black and white area, so it is logical for us to clearly define the boundaries. We are responsible for right drug distribution.
• Included zero counterfeits to ensure the grey and black market is addressed - that the board cannot do on its own.

• How do we find with whom we need to work while managing all of these pieces? 
  ->ACTION: Regularly review whether we are following these concepts.

2. Entrustable Professional Activities (EPAs) (the what, scope of what you do)
The board reached consensus on this pillar, and offered the following comments/desired results:
  • Each patient’s medical and health needs are being met.
  • Clinical record keeping is expanded and perfected.
  • Public has a clear understanding of pharmacy services provided.
  • Pharmacists and techs are confident, prepared professionals.
  • Communicate to patient in a way they can hear.
  • Licensee remains competent.
  • Clearly defined EPAs.
  • Counseling will be different as technology evolves. Must clearly communicate with patients, because hearing the information does not mean “digesting the information and understanding.” Maybe it involves face-timing, skyping etc.

3. Standards of Practice (guidance on how; standards for doing the job)
The board almost reached consensus, but hopeful about the concepts. Follow-up clarification will be needed on this pillar.
  • Clearly defined elements of the practice of pharmacy.
  • Decreased to zero errors.
  • Technology rules have been defined.
  • Allow for some rules/practices to evolve; do not define everything.

Donna asked if more clarification and discussions were needed. The intent of the final bullet was to support evolution of practice - without micromanaging, yet while also maintaining high degree of patient safety components. This will require evaluating practice regularly, with a constant focus on safety. A thought was the first step is to agree on pharmacist-only activities, then the other pieces will fill in. Are there simple rule changes or do they need statutory changes? There was then a concern about grey areas, fear of change, and needing things black-and-white for pharmacy to be safe and liabilities minimized.

Marc noted that many rules in place are prescriptive because another board thought they were important and needed to be clearer. He said, if the board wants changes, it will need to be done well, so that everything needing to be addressed doesn’t have to be rewritten. There are times that regulations need to be descriptive and other times they should be broad.
Donna asked what would be necessary for the board to reach consensus on the Standards of Practice issues. Could anything be added or clarified? This prompted a few board members to voice their concern because there were still so many things needing to be defined. There currently is no set standard of practice in the field so this area will take time. Further comments regarding standards of practice included:

- The more work done on pillar 3, the more pillar 2 will become clearer.
- It goes with HB 2397
- The board should utilize their Fellow for research in this area.
- There remains a need to discuss what pharmacists can and cannot do, because accountability falls into all three pillars.
- Do not expect all lists to be finished by December: expectations must be set, understood, and managed together.
- As the formulary committee develops, integrate some of their questions into the conversation: what does that mean for prescribing and pharmacy practice?

**->ACTION:** Staff should bring models from other healthcare professions for the board to look and consider by the February meeting.

Donna summarized the Define Standards of Practice pillar discussion: Over the next five years, the board will work to describe guidance for pharmacists about Standards of Practice. This information will be based on models from other healthcare settings, which staff will present to the board.

**Vision Statement for Strategic Planning Session**

The board came up with the following statements:

- “We are the safety link between members of the healthcare team, patients, manufacturers & drugs”
- “Oregon’s pharmacists and pharmacy technicians focus on patient/public medication safety and needs while adapting to (and being **accountable** for) changes in technology, patient relationships & the healthcare system.”
- “Oregon pharmacists & technicians utilize changes in technology and advances in clinical information and practice to safely provide pharmaceutical services for patients in the healthcare system”

**Board Input:**

- Do we need to clarify “accountability”?
- Insert word “medication”
- Don’t like “focus” – rather have “the experts”
- Difference between pharmacists and technicians
- Not just about the medication, it’s about caring about patients’ general wellbeing
- Patient safety is about a lot of different things

After discussing issues and edits to the vision statement, the board agreed to proceed without a vision statement because it did not seem to add any clarity to their other work.
**Staff Capacity and Workload Issues to Consider**
The board thought they are still asking staff to prepare too many items for board meetings and discussions. Staff spends a lot of time preparing things for the board to discuss but, if the board were to delegate more to staff, then OBOP can utilize resources more efficiently.

Staff asked how they could be more efficient. Some board members expressed a hesitancy to delegate too many things to staff because not doing so is a more cautious approach.

- **ACTION:** Marc will look at ways to streamline the process for issues coming before the board.

**Succession Planning**
Marc reminded the group that, although it was subject to change, his plan was to retire after the 2019 legislative session. As such, the board needs to start thinking about the timeline and process for seeking his replacement. The board had previously said they might want internal candidates, which would require an internal hiring process. But, if the board wants to consider an external candidate, this may require a different hiring process. Marc noted that the board would need to: meet with the Executive Recruiter from DAS, create a recruitment plan, and remember that there are many points which must be discussed in open session. Marc noted that it would be good to start sooner than later, and address overlap.

The board requested that the schedule be developed from the back end. There should be two timelines: one for external candidates, one for internal. Clarification is needed about what the maximum allowed overlap is. Karen noted that a hiring plan should be established well in advance to allow for a smooth transition.

- **ACTION:** Karen will get preliminary hiring process information to the board at one of the next two board meetings.

**Opioid Crisis**

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<th>Have Done</th>
<th>Could Do</th>
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<tr>
<td>Made Naloxone available.</td>
<td>Encourage pain CE for pharmacists.</td>
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<td>Work with patients to shift off opioids to</td>
<td>Drug take-back (with grants/funds, if possible).</td>
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<td>other therapies.</td>
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<tr>
<td>Increased education for pharmacists about</td>
<td>Remember: There are patients who</td>
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<td>protocols for Naloxone.</td>
<td>legitimately need these pain medications &amp;</td>
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<td>Keep doing (and highlight) new requirements</td>
<td>help their access/lack of stigma.</td>
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<td>for dispensing.</td>
<td>Work with other healthcare boards to</td>
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<td></td>
<td>develop a hotline for when pharmacist sees</td>
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<td></td>
<td>over prescribing by...dentists, doctors etc.</td>
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<td>(add to PDMP training).</td>
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The group turned to discuss the Opioid Crisis and what, if anything, the Board could impact. A lot of multi-disciplinary work is being done on this topic throughout the state. PBMs (Pharmacy Benefit Manager) are trying to lobby for a seven-day supply of opioids given to patients. Some questions that arose included:

- Is the board doing everything we can?
- Is the board missing anything?
- Are we being helpful in this crisis and epidemic?
- Is anyone involved in his or her community?
- Is there anything that the board can be doing that it is not being done?

Important factors that were discussed included: pharmacy and ER hopping; good reviews for ER doctors; concept of two types of pain; slow updates on the PDMP allowing for multiple fills; discount cards; drug take-back; lack of training on Naloxone; requests for mandates; lack of funding; legitimate pain patients experiencing barriers; pharmacists’ difficulty reporting abuse; and lack of a communication channel.

Potential ways to combat the crisis included: an option for partial fills; licensees re-learning pain management; counseling patients regarding the pros and cons of multiple drugs at the same time; and including an article about abuse reporting process in OBOP’s newsletter. Penny asked Roberto to raise this issue and awareness at OSU. She sees an opportunity to educate both nursing and pharmacy students.

**Next Steps and Overview of 2016 Retreat Outcomes**

The group reviewed the 2016 strategic planning retreat outcomes, and revised the tasks: The “Division 45 Rewrite” might need to be revisited. Brianne and Fiona have been revising and working on new compounding rules, and looking at what is going on with the FDA. In response to drug shortages, Penny offered that Oregon might want to tap into the National Drug Stockpile for those experiencing shortages due to national disasters.

- It was also noted that if the board wants to consider “Legislative Concepts” again, they must be submitted by April 13th, 2018. The board asked that staff discuss this and bring ideas back to the board.
- Concerning “Preventing Medication Errors,” the idea to work with the Oregon Patient Safety Commission never worked out due to staff changes at OPSC. Marc was encouraged to talk with other states about their approach, or through ISMP. The ability to confidentially report needs to be made much easier. One board member advocated working with OPSC if it became feasible. Marc noted it is difficult to draw any conclusions from the small amount of data that currently exists. The goal of this item was to get enough information reported to study the data.
- Staff is putting their compilation of meeting notes for “Medication Reconciliation History” into writing as an FAQ. They are seeing general consistency, and expect this will be coming out soon.
  - The board would like to see the FAQs before it is published, and staff would be happy to share it.
Tom noted that there was a lot of merit in keeping this topic in both pillar 2 and 3. Medication reconciliation could show why there is an important difference between pharmacists and ancillary technicians. Also, it is a national patient safety goal, licensees are held accountable, and OBOP needs to be on same page.

- ACTION - The board asked to have this added to a future agenda.

- ACTION - Karen will update the new ‘outcome plan’ with information from this strategic planning session.

To close the meeting, Donna asked the group to think about takeaways from the last two days. Board members agreed that these discussions were a long time coming, and, while difficult at times, they were pleased with the process and results. They were pleased to learn that others shared similar concerns and priorities. Many expressed excitement to see the issues and the field of pharmacy continue to evolve with positive energy and hope. There also was excitement expressed for furthering opportunities for technicians and pharmacists to ‘create a world where everyone in the field knows exactly how to get people the medications they need in a safe environment’. Penny was glad to see such positive energy, and said the group did a lot of great work. She wished everyone the best and noted that their work was a great endeavor.

Staff was realistic about their concerns on where to start to get these plans done, and they felt confident that the group was heading in a great direction. Donna closed by acknowledging that this kind of high-level thinking can be very challenging, and appreciated that the group enthusiastically worked through the process together.

**OPEN FORUM**

Only one member of the public wished to comment in the Open Forum.

- Chris Humberson, R.Ph. shared his thoughts on the opioid discussion: He had concerns about the pharmacist complaint process, and fears many have of retaliation for bringing up issues. He noted that pharmacists would benefit from reinforcement and support so they are not afraid to report. It is their duty to report.

Adjourn

**MOTION**

Motion to adjourn at 3:27PM was made and unanimously carried (Motion by James, second by Armstrong).

Attachments:

- Appendix A – Defining Strategic Planning
- Appendix B – Current Trends that Impact and Influence OBOP’s Work
- Appendix C – Board Members’ Overall “Desired State” in 5-10 Years
Defining Strategic Planning
Donna began by reminding the board that strategic planning is an important activity which allows the board, its staff and others to clarify the direction they are headed and be able to head there together. She presented the board members with two models to consider as they started their time thinking:

1): Strategic Planning 101 Model:
Most strategic planning processes have four distinct steps:

- **Analysis / Assessment** – this step allows an organization to consider current trends and realities: What is impacting the organization? What are the realities you see? Given these realities, what does this suggest for the future?
- **Strategy Formulation** is a step which is high level. It serves as the basis for the plan. It is the step through which the board clarifies what is important and what it seeks to do for the life of the plan. This is where we will spend our time during this meeting.
- **Strategy Execution** - Once the high-level view is clarified, then staff can put the ideas into operational action items. This step includes detailed actions and defines performance measurements.
- **Strategy Evaluation / Sustainment** is an active management phase, which includes: performance towards the goals, addressing organizational culture issues, communications with a variety of audiences, and on-going data reporting.

Donna presented two models for strategic planning.

1. **Strategic Planning 101 Model:**

[Diagram of Strategic Planning 101 Model]

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• **Analysis / Assessment** (what are the current trends and realities; what is impacting, what are the realities that we see?)
• **Strategy Formulation** (high-level / basic plan)
• **Strategy Execution** (operational / action items, details & measurements)
• **Strategy Evaluation / Sustainment** (management phase; includes performance, culture, communications, data reporting)

2). The Balanced Scorecard organization, a think tank for strategic planning in the public setting, suggests that a good strategic plan is like a house: the foundation is engaged leadership which describes and focuses on the pillars of excellence, which uphold the organization's overall mission. This house can and should be looked at from a variety of perspectives, starting from the bottom and working up:

- Organizational Capacity – given the human and fiscal resources, what can the organization do?
- Internal Processes – how do the organization’s processes allow us to affect the actions and changes we hope to achieve?
- Stakeholders – who are they? What impact does OBOP’s actions have on them and vice versa?
- Public Policy – how do all of the above affect what policies OBOP should create?
Appendix B

Current Trends that Impact and Influence OBOP’s Work

**Group 1 Trends:** (Dianne, Kate, Shannon, Bri and Tim)
- Technology intersection with many rules/pace
- Pharmacy technician roles
  - Minimum qualifications/training/education/certification
- Pharmacist expanded scope of practice
  - Prescribing
  - Training/education/qualification
- Business and Financial pressures
- Public patient safety
  - Awareness
  - Pressure
  - Accountability
- Patient cost/access to healthcare (ACA)
  - Political pressure
- Medication shortages
- Opioid epidemic
- Transitions of care
- Increased friction between expanded scope and the board role of protecting public
- Pharmacist as educator
  - Being impacted by "technology" replacing (self-driving?)

**Organizational issues/trends**
- Fewer "volunteers" willing to assist with organizational work
- Broader scope of input/wider set of stakeholders (e.g. technicians et al)
  - More voices to hear
  - Need for board to consider responses/reactions
  - Too nice?
- Board hearing/responding to more questions/request from stakeholders that push edges of rules
  - Require more reaction from Board & Staff
  - Pulling from higher-level view/work/priorities?
- Regulating increase in case complexity
- Continuing to write rules based on “one-offs” waivers
- Regulating based on the “exception”

**Group 2 Trends:** (Cyndi, Penny, Rachael, Roberto, Chrisy, Fiona, and Tom)
- Change in tech scope in other states
  - Big inconsistencies in other states
- Change in RPh scope
- Tele-pharmacy/Tele health
- Pharmacy as Partner in healthcare
  - More responsibility
  - More decision-making
  - Pharmacy metrics (health system grading)
- Money & downward pressure because of payers
- Drug Costs
- Continued industry disruption (Amazon, healthcare delivery methods)
- Technology
- Medical policy is being driven by “payers”
- Drug shortages – critical meds
  - Consolidation of manufacturers
  - Regulatory over-burden
  - Natural and/or man-made disasters
- Counterfeit drugs (ex: illicit Fentanyl)
- Opioid crisis
  - What is the board’s role?
  - What is RPh role? What is within our control?
- Accrediting bodies requiring compliance & standards (ex: Med rec)
- Regulatory bodies setting boundaries
- Patient-centric care
  - Organizational capacity trends
    - Legislative changes
    - Budget constraints

Appendix C
Board Members’ Overall “Desired State” in 5-10 Years (note card statements that were read during the meeting)

- Enhance opportunity for pharmacist / patient relationships
- Increased role for pharmacy in management of people’s medications by
  - Having pharmacist truly manage all of patients’ meds
- Pharmacist documenting patient interactions (including self-care), refills, new rules to truly create a pharmacy chart
- Pharmacist reimbursement for care

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- We will need to have adapted to market forces
  - No small challenges
  - NYT article that Rx largely hasn't changed
  - Bricks & mortar vs. regulatory constraints
- Techs advance to do much of mechanical functions of Rx along and technologies help
- Those technologies that have successfully kept patient safety advances at the forefront of their innovations will dominate

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- Patient centered care, individualized, not standardized
- RPh is the provider managing all patient medications. Necessary part of care team. A UNR between all providers ensuring good transitions of care. RPh has been removed from majority of dispensing model.
- Tech role is more professional / career oriented, technical training, more leadership opportunities
- Open access to medications & information
- Technology that allows the RPh to reach any patient

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- Evolution of accountability that coincides with evolution of RPh/tech roles & technology
- Maintaining the pharmacist as central to patient care & education
- Increased collaboration between RPh, MDs & providers
  - RPh prescribing divisive, trend toward collaboration on a universal scale (i.e. outside of health systems)
- Restructuring workload & or increasing support systems of staff – mental health, abuse/diversion & education, coping mechanisms, stress reductions, etc.
• Roles for RPh & Techs cohesive and able to handle increased/expanded areas of service (standards of practice)
• Technology rules addressed in such a way “must-haves” are clear, concise and allow for innovation (in distribution, EPA)
• Clearly communicated strategic plan and timeline is integrated with other priorities of the agency and tracked/discussed each meeting.

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• Pharmacists to be focused strictly on clinical functions & continuing patient care utilizing greatly expanded responsibilities of technicians to perform all operational duties.
• Also expect a much wider implementation of technology, for example unique barcodes via mobile devices used to dispense meds at an ATM like device.
• Expect pharmacy technicians to evolve into roles much as medical assistants today, performing various operational & managerial duties to free the pharmacists for prescribing consultations & clinical functions.

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• I see the pharmacy as a place where the technicians are used as a bigger role in getting info from patient before the RPh steps in. Example is making sure to have the records of anything they need, all the scripts done after the DUR, so that they can experience, research, and do clinical stuff.

Accepted by:

Marcus Watt, RPh
Executive Director