TELEPHARMACY TASK FORCE

Meeting 4 Summary — For Members Who Could Not Attend

July 17, 2026 • Virtual (Teams) • ~1h 29m • Facilitator: Aaron Patterson (HLB)

Note: This committee operates by consensus rather than formal voting. "Consensus" below means no member present objected once the point was discussed; where the group did not fully agree, that is noted explicitly.

Attendance & Housekeeping

- Present: Aaron Patterson & Katrina Howard (HLB, facilitators), Ryan Hannan, Ann Harty, Katherine Zakrajsek, Samantha Ketterling, Amanda Schmitz, and Max Stork.
- Not present: Jim Novak (submitted homework in advance).
- Membership update: Savannah Middlestead has resigned from the committee due to a change in role; the committee now has approximately 11 members.
- Four homework responses were received ahead of the meeting (Annie Danielson, Jim Novak, Max Stork, Samantha Ketterling) and remain available in the shared Google Drive.
- The group confirmed there is more alignment than conflict overall, with two areas flagged in advance as needing real discussion: remote dispensing scope, and interstate licensure for cognitive/clinical services.

1. Definition of "Dispense"

Discussed — refined, not finalized

Aaron presented the current Minnesota statutory definition alongside a synthesized draft that added coverage for delivery to a patient's agent, to authorized healthcare personnel, and through automated distribution systems. Initial reaction favored the broader, synthesized version as more future-proof.

Ryan Hannan raised a substantive concern: an all-encompassing definition could blur the line between "preparation" and "dispensing" for automated dispensing systems (ADS) — e.g., is loading an ADS cabinet dispensing or just a preparation step? He also noted patient-specific labeling doesn't occur with ADS, and that a "valid prescription drug order" standard could create problems in independent-prescriber or procedural settings where a prescriber dispenses without a pharmacist.

Katherine Zakrajsek and Samantha Ketterling both cautioned against listing specific pharmacy types or venues in the definition, since statutory language is slow to update and overly specific language could unintentionally exclude legitimate or future practice models. Samantha also suggested the current "preparation" discussion may belong under the group's separate "administrative functions" concept rather than inside the dispensing definition itself.

Where the group landed:

Keep the core structure of the existing MN dispensing definition largely intact, but broaden it to explicitly cover delivery to a patient's agent and to "authorized healthcare personnel" (kept intentionally broad rather than narrowed to "licensed" personnel), and resolve whether ADS activity counts as dispensing. This item needs further legal/drafting refinement and was not treated as finalized.

2. Two-Category Framework (Remote Pharmacist Services vs. Remote Pharmacy Services)

Consensus on the structure — several open questions flagged

The group reaffirmed support for keeping two distinct categories rather than one blended list of remote activities.

- Ryan flagged that medication reconciliation being listed as pharmacist-only under this framework overlaps with the medication-history debate in Item 4 (see below) — noted but not re-litigated here.

- Katrina asked whether "licensed" pharmacy technicians was intentional language; Aaron confirmed this was not a deliberate choice — the prior task force agreed not to introduce a new licensure tier, so "registered" technician remains the operative term.
- Ryan raised whether remote pharmacist services should be restricted to occurring only within Minnesota, while remote pharmacy (technician-level) services might be more flexible — an open question for future refinement.
- Amanda and Ryan discussed whether technicians performing remote pharmacy services should be required to hold certification (e.g., CPhT) rather than just board registration; there was general support for encouraging/requiring certification, though Samantha cautioned against naming a specific certifying body given the evolving technician-credentialing landscape (suggesting broader language such as an NABP-approved certification or equivalent).
- Ann Harty raised a policy concern: if the rule allows fully remote staffing, could pharmacies relocate remote-service jobs to lower-cost, out-of-state locations in ways that reduce local access or worsen "pharmacy deserts"? No solution was proposed; it was acknowledged as a real risk without an easy legislative fix.

Where the group landed:

Two-category structure (Remote Pharmacist Services / Remote Pharmacy Services) is confirmed as the working framework. Technician title/certification language, in-state vs. out-of-state limits, and the business-model/access concern remain open items for future refinement.

3. Technician Role in Services

Unanimous items confirmed — extended discussion on medication history

The group confirmed, without objection, the following activity classifications carried forward from homework:

- Without pharmacist supervision: data entry, insurance/billing, scheduling, administrative calls, inventory, and consent/demographics collection.
- With pharmacist oversight: immunization administration and point-of-care testing collection.
- Pharmacist only: DUR/clinical order review, final verification, patient counseling, medication reconciliation, MTM clinical review, test result interpretation, and immunization eligibility determination.

Ryan raised that "oversight" needs more precision — it could mean a pharmacist physically present on-site (e.g., in a nearby counseling room) or simply available and signing off remotely, without being physically present. This distinction was noted as needing definition but not resolved.

The bulk of discussion focused on the contested item: medication history collection. Ryan proposed a working distinction, drawing on his homework submission and supporting literature: medication history is objective fact-finding and documentation (a patient interview plus review of what they're taking), while medication reconciliation is the clinical-judgment step that occurs at a transition of care, comparing two sets of records to decide what to continue, adjust, or discontinue. The group generally agreed this distinction was useful and workable.

Discussion also touched on real-world risk: Ryan noted that because technicians currently cannot formally take medication histories in some settings, that task sometimes falls to staff with no pharmacy affiliation at all, occasionally with poor results — suggesting that allowing trained/certified technicians to do this work, under pharmacist verification, could be a net safety improvement rather than a risk. Amanda proposed that the patient interview itself be reserved for pharmacists while fact/data collection is delegated to technicians; Ryan pushed back, noting the interview is central to a good history and that limiting technicians to data pulled from fill history alone would lose valuable information available from clinical notes, PDMP, and other sources (assuming no pharmacist would fill that role?).

Where the group landed:

Medication history may be collected by a technician (an emerging area of increasing comfort), but a pharmacist must review and validate that history before it is used clinically, drawing on the best available records. Medication reconciliation remains a pharmacist-only, transition-of-care function. Whether the patient interview portion of history-taking can itself be delegated was discussed but not resolved.

4. Remote Dispensing Scope

Genuine complexity — reframed rather than resolved

The group worked through the difference between centralized fill (physical, patient-specific medication preparation at a hub site, then delivered elsewhere for pickup — generally not considered "remote" in the pharmacist-absence sense, since the pharmacist is present at the fill site) and centralized/decentralized order entry or verification (a pharmacist reviewing or verifying orders from a different location than where the medication is physically prepared).

Samantha and Max described additional real-world models the current guidance doesn't address well — e.g., a pharmacist covering two sites from one central location, several remote pharmacists supporting a site with no on-site pharmacist, or a "pod" of pharmacies supporting each other during workflow backlogs or short-staffing. Several members (Ryan, Samantha, Max, Ann, Katherine) agreed that "central" vs. "decentral" terminology breaks down because it depends entirely on which location you're viewing it from.

Samantha proposed decoupling the task or function (what work is being performed — e.g., order verification) from the personnel and location question (who is doing it, and from where). Under that approach, each discrete task would have its own location/practice rules, and pharmacies or health systems could combine those building blocks into whatever workflow model fits their operation, rather than the rule trying to name and define specific business models.

Where the group landed:

General agreement to move away from rigid "model" definitions (central fill, central order entry, etc.) toward defining tasks and their location rules separately, then letting practices combine them. Aaron will turn this into a homework item to develop the concept further before the next meeting.

5. Supervising Pharmacist Location

Consensus confirmed

The committee confirmed its earlier direction: a supervising pharmacist is not required to be physically located at a licensed pharmacy hub site. Any secure, HIPAA-compliant location — home or otherwise — is acceptable provided all other licensure, communication, and system-access requirements are met.

- Ryan noted that, in his experience, an imperfect home setting isn't necessarily riskier than a busy hospital or retail floor full of interruptions and alarms.
- Katherine raised an open question worth flagging for the Board: if home offices are permitted, does that open pharmacists up to site surveys/inspections of their home workspace, given HIPAA and other requirements?

Where the group landed:

Confirmed — location isn't the determining factor; a defined minimum standard for what makes a home workspace "HIPAA-compliant" and appropriately uninterrupted still needs to be developed.

6. Interstate Licensure for Cognitive/Clinical Services

The sharpest conflict — a working direction emerged

Current Board policy requires a Minnesota pharmacist license for clinical services provided to Minnesota patients, regardless of whether dispensing is involved. The counter-argument is that this may restrict patient access, particularly for clinic-embedded pharmacists serving Minnesota patients from across state lines, and that other healthcare disciplines aren't held to the same standard.

Ann Harty raised a related complication: collaborative practice agreements (CPAs) vary by state, and if a pharmacist is leveraging an out-of-state CPA for a Minnesota patient, it's unclear how adequate oversight and prescribing authority (e.g., for medications not universally available by CPA across states) would be ensured.

Samantha Ketterling offered a distinction that gained traction: dispensing is governed by state-specific rules (e.g., days'-supply limits differ by state), while cognitive/clinical services like MTM are typically delivered under more uniform national standards — she noted CMS does not require a state-specific license for MTM services under

Medicare Part D, only that the pharmacist hold a pharmacist license somewhere. Ryan noted he personally favors requiring MN licensure but acknowledged the inconsistency with how other professions are regulated. Katherine raised border-community safety and liability concerns (citing sensitive dispensing situations near state lines) as a reason to maintain a higher Minnesota standard regardless.

The group also discussed whether patient counseling should be treated differently from MTM/cognitive services generally. Ann argued counseling isn't tied to licensure at all in practice (any pharmacist can informally counsel any patient who asks). Samantha suggested counseling tied to a dispensing event is state-specific and should require MN licensure, while counseling or education not tied to dispensing could be treated as a separate, non-licensure-triggering category — informally suggested as something like "pharmacist education" rather than a clinical/cognitive service.

Where the group landed:

General direction (not unanimous or finalized): cognitive/clinical services and counseling tied to a Minnesota dispensing event would require MN licensure; standalone cognitive services or education not tied to dispensing would not. The facilitator noted discomfort with creating two different standards but the group did not raise objections to this framing in the time available.

Items Not Reached — Carried to Next Meeting

Time ran out before the group could get to the remaining agenda items. These will be picked up next meeting:

- Consultation standards — timing requirements by scenario, minimum communication modality, and Annie Danielson's proposed kiosk consultation (phone-and-unlock) workflow.
- Technical standards — proposed additions to the Track 2 minimum standards (image documentation, individual audit trail, provider escalation pathway) and the technology downtime/contingency plan, which Ryan flagged in his homework as a current gap in the guidance.
- Smart lockers, kiosks & off-site pickup — introduction of physical-distribution hybrid models, to be a major focus of the next homework and meeting cycle.

Homework & Next Steps

- Aaron will send a scheduling poll for the next meeting; the group leaned toward the week of July 29–31, likely at the same early-afternoon time slot that worked for most schedules today.
- Next homework: review the Board's current guidance and policy statements, and note for each one whether the committee agrees, disagrees, or would propose a change — and flag any topics the group has discussed that aren't currently addressed anywhere in the existing guidance.

Prepared as a summary for members unable to attend Meeting 4, based on the meeting transcript and the Meeting 4 Facilitator's Guide. Not an official record of votes — this committee proceeds by consensus.