7543 Homework 3 Tom's Comments – sorry for the delay – See comment for Group 4

Group	Comment
1	Note that 220 was a compromise; please keep after me to get the DOH guideline on doing guidelines
2	Measuring complaints is reasonable on its face, but there are few of any kind. Have you thought of any down-side to your plan? RE C-II, save this as an alternative. Something you want to think about is some sort of standardized reporting system.
3	"enumerate the number of fraudulent prescriptions"; sounds good, but technically difficult and very expensive.
4	See the Public Disclosure Commission web site and hunt for appropriate lobbyists: http://www.pdc.wa.gov/Public/Lobbyist/Default.aspx For example, look in the registry of employers of lobbyists, check out WA ST Medical ASSN.
5	… the file seems to have all three assignments concatenated … please do one week at a time
6	Be sure to emphasize public health issues. How will you pay for your intervention?
7	The technical name for the medical board in WA in Board of Medical Quality Assurance; you will want to provide evidence of the support you describe; note that the inspectors for BMQA and BOP are different – and there are associated issues.
8	… alternate format for report – let's discuss
9	… alternate format for report; importance of comprehensive (annotated?) bibliography
10	Be sure to contact Tim Fuller about collaborative practice agreements – he's the expert. Tim.Fuller@doh.wa.gov. Note in Administrative operability – isn't what you are proposing beyond the scope of the BOP. Maybe you also need to do a deal with SAMSA. Will you be petitioning DEA?
11	Keep track of federal vs. state agencies. Why would CMS have any say about something that is regulated by the states?
12	Isn't the real focus of your project to correct an inconsistency in the law, as other states have. Do you have evidence that there is a bunch of misbehavior related to the inconsistency? On the other hand, what would between-states uniformity be worth to organizations operating in multiple states?

Group #	Comments
1	-You say you will measure effect by examining "if patients are more educated and better equipped…", what will these measures look like (i.e. how will you operationalize these variables?) Will you conduct some sort of controlled trial?

	-If the impact of the policy change is long-term, how will you convince stakeholders to do this today? -How strict will consultation monitoring/sanctioning be? Doesn't individual pharmacist practice/preference account for much of the variation in consultation style? Will more lax pharmacists change their practices if there isn't a very strong (and thus expensive) enforcement mechanism? -Why will stakeholders want to invest in this change?
2	-You say you intend to measure the impact of the policy change by change in # of complaints to WA BOP. Are there a large # of complaints to the board currently? Are there any estimates regarding the % of actual incidents that are captured in complaints? -Good point about the support from towns/cities boardering other states, need to find a way to maximize the impact of this support, assuming that it exists -Is there any chance that this policy change could create even more confusion for pharmacies (e.g. as a result of varying state laws)? If so, how would you address these concerns?
3	-How will you ensure that pharmacists report fraudulent prescriptions? Will there be incentives that make reporting worth their time (both financially and professionally)? -If compliance is made "optional", will anyone comply? If there is minimal compliance with an optional policy, will consumers/abusers figure this out and increasingly go to non-compliant pharmacies? If this happens, the policy would serve give financial incentive to not adopt electronic systems. -Who will pay for implementing the infrastructure to run this system? Why will they want to pay for it?
4	-There is an increasing trend for hospitals and clinics to implement computerized physician order entry (CPOE) to deal with many of the same issues you address with your policy. Is there any way to align with this movement? Is there a threat that this movement will make your policy a moot point? -You talk about examining the impact of the policy by measuring pre & post-implementation medication errors. How do you define a medication error? Is it still a medication error if an inappropriate drug/dose is given, but there is no adverse event that results? How do you capture these sorts of events? -Good point that physicians will need to feel like the policy change will not require them to invest additional time & effort. How will you accomplish this, or create this perception?
5	-Why will consumers want to use this program? How will you create a sense of importance/urgency to get people to "buy into" this initiative? -Tough to convince someone that they should pay you to dispose of the medication that they already purchased themselves (and sometimes at great cost). Why would someone do this with their pain meds if they know they will experience pain again in the future? -Who will pay for this system? Why will that given stakeholder choose to invest in this initiative? (or how do you create this desire?) -Though this policy has good intentions, it seems like it would take a major marketing campaign to "sell

	it" to the patient population.
6	-You say you will measure program effectiveness by change in law enforcement investigation time. Is this variable directly correlated with drug abuse? -Who will pay for the system? What short term objectives can you use to "sell" the program to stakeholders? -You say that the DOJ will potentially give grant money to fund the PDMP. What is the maximum amount of such a grant? Will this cover the full costs (approximation) of the measures you are proposing?
7	-There is an increasing trend for hospitals and clinics to implement computerized physician order entry (CPOE) to deal with many of the same issues you address with your policy. Is there any way to align with this movement? Is there a threat that this movement will make your policy a moot point? -Are there any reasons why the Board of Medicine would not support this policy change? How would you address their concerns?
8	-You propose measuring the effectiveness of the policy by looking at change in privacy complaints to the WA BOP. Do you have any sense of what % of current events lead to complaints to the BOP (i.e. can you extrapolate to determine the "real world" impact of the policy)? Are there confounding variables that could render this measure of effectiveness invalid? -What groups could potentially oppose this policy? How would you address their concerns? Think about a forcefield analysis (as discussed in class).
9	-Good job exploring the issues at hand. -Could benefit from more data sources, less speculation -What is the past experience (nationally, locally, etc.) in terms of passing medical marijuana policy? How can you preemptively address some of the issues that have been raised in the past?
10	-Tough to follow this outline…
11	-Good point that this policy could benefit interactions with insurance companies. Are there any ways that this policy could complicate interactions with insurance stakeholders? -Are there conditions that involve significant use of off-label prescriptions? Would this policy limit physician's ability to use off-label drugs in these situations because insurance won't pay, therefore patient can't afford the drug(s)? -Will # of medication errors and/or # of malpractice lawsuits give you direct evidence regarding the effect of this policy? Are there potential confounding variables in this line of logic?
12	-Good statement of the intent of the policy in 1st paragraph ("The purpose of implementing….no longer medically justifiable for them.") -What can drug abuse rates tell us about the impact of this policy? Is there a direct tie between the policy and drug abuse?

Group	Mindy's Homework 3 Comments
	-This policy may create incentive to fill prescriptions and then sell them in situations where the patient cannot afford the drugs within the 90 day limit (i.e. "use it or lose it" mentality). How would you address his concern?

1	Still concerned about the association between pharmacist consultation and patient compliance. I don't recall you referencing anything that firmly established: increased consultation time=>patient compliance=> decreased adverse events. Have these relationships been shown to be true?
2	Why could there not be a direct measure? If the policy was implemented, would it not be possible to sample some pharmacies and count the total number of out of state prescriptions written by ARNP or PAs and compare these numbers with historical values? Point being- it seems to me that there are ways of directly measuring results of your proposal.
3	Measuring ". . . how many fraudulent attempts were made"—Is this assuming that the fraudulent prescription was detected in the first place? How would you account for all those that go undetected? Be careful about your evaluation criteria—have all the associations you describe been established by data? (e.g. fraudulent prescriptions=> ER visits?)
4	Ok
5	One of your concerns is the cost of disposal (who will pay to dispose?). You state that the government would probably be the only payer—how do battery disposal or engine oil/household chemical disposal programs work? I take my batteries to Whole Foods and dump them into the plastic bin for free—who pays to get rid of those batteries? (Government? Non-profit groups?) Could a drug disposal program be modeled after disposal/recycling programs that already exist within communities for other toxic products (specifically the payer source)? What's wrong with having patients pay for some of the disposal costs?
6	Would not recommend measuring law enforcement time as a way to evaluate your policy. How does one control law enforcement actions? Perhaps each investigator will spend more time on each case rather than less time on more cases (resulting in the same amount of overall time). Point being- I don't think that law enforcement is reliable as an evaluation tool.
7	I forget- did you ever provide a definition/criteria of what is deemed "illegible?" (Is this or could this be a subjective term?) Could there be back-lash for "punishing" for something so subjective? Who will be the judge of legibility?
8	Ok
9	Ok
10	What specific tools would you use to measure your outcomes? (e.g. how does one measure "decreased rebound from missed doses?) What does "word of mouth" mean for direct impact? Why do you think pharmacies would be reluctant to change their business practices (even if it betters health outcomes?)? Is there a business impact that is implied, but has not been specifically described? Who's the "they" being referred to under Institutional Commitment?
11	"Off-label" use is the last resort for many patients. This patient population and their advocacy groups would most likely be against anything that would restrict or decrease off-label use. I don't understand what you

	mean by “power struggles with doctors.” The use of “medication errors” in context is a bit confusing- are you referring to dispensing errors by pharmacists?
12	Do not recommend using such “large” units of measurement to determine outcome (how would you ever prove that changes in incarceration numbers are specifically due to your proposal?) What about simply surveying pharmacies and measuring the quantity of Schedule IIs dispensed before and after policy implementation?