Roth

Group	Comments
1	-#1, the phone conversation will add cost to the pharmacy (pharmacist time, cost of call, additional phone lines to do this, etc.). How many times must the pharmacist try to call before they can give up? Will patients like this policy? If patients do not like it, are you driving business out of community pharmacies and to mail-order operations? -#2, more viable option, still a potentially expensive approach. This alternative benefits from a more clear connection to quality improvement (N.B. check out the Institute of Medicine "To Err is Human" report for some good information and additional resources-click: http://www.iom.edu/Object.File/Master/4/117/ToErr-8pager.pdf) -#3, will add much burden/expense to pharmacies, likely to encounter much resistance. How would you address this? -Is there a way to inform patients about medications at the drive-thru? Think about IT solutions. -What about doing nothing? What are the implications of this approach?
2	-#1, how does current law "decrease efficiency"? Relative to implementing this system, doesn't the current law encourage greater efficiency because pharmacists don't have to invest the time/resources to research the scope of practice of various practioners? How would you address this concern? -#1 & #2, OK-but how will pharmacists actually verify each practioners scope of practice (i.e. electronic system, paper booklet, phone-in system, etc.)? -What are the implications of doing nothing? How many people are current having their prescriptions denied because they were written by out-of-state Pas or ARNPs?
3	-This is a very important initiative, but it will likely require hundreds of millions of dollars in investment (e.g. I know Swedish just spent in the ballpark of $20 million to implement a system-wide electronic medical record). Who will pay for this? Who will coordinate/manage the implementation process? Will the Feds chip in? -#2, There would be such high fixed costs associated with implementing a system with any degree of functionality that you might as well go for total functionality all at once. -Many WA providers (an especially those in Seattle) already have electronic medical records implemented. Generally speaking, these systems are not interoperable (i.e. they don't "talk" to eachother), and there are not incentives for providers to move in this direction. Would it make sense to explore a way to link up existing systems, rather than designing a new system from scratch?
4	-Alt #1, will this make economic sense for insurance companies (i.e. what is their "return on investment")? Who will pay for this?

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	-Are your "alternatives" intended to be mutually exclusive options, or are they complimentary policies? I'm not clear on this… -What about doing nothing? What are the implications of this approach?
5	-Alt #1, why are your incentives focused on pharmacies? There will be some degree of additional cost to them as a result of this policy, but it seems like it is the patients that you really need to convice. -None of the alternatives seem to address the fact that patients are not going to want to give up drugs after they pay a lot of money to get them. Why would John throw out his hydrocodone if he knows he can give/sell it to his friend or save it until he experiences pain in the future? Take a more patient-centric approach to this issue.
6	-Good ideas about funding alternatives. -Have you researched the approximate total dollar amount required to implement your policy? Will your funding sources completely cover this expensive given forecasted volume? -What about alternatives for the drug monitoring program itself? What if you choose to do nothing? What are the implications of each alternative?
7	-Good thorough job with the alternatives. -Which stakeholders will support each alternative? Which stakeholders will oppose each alterative? Does a "best" alternative emerge? -Check out the Institute of Medicine (IOM) "To Err is Human" report for good information and resources. Click here for summary: http://www.iom.edu/Object.File/Master/4/117/ToErr-8pager.pdf
8	-While clarification of current privacy laws would likely be well received by stakeholders, any attempt to change privacy law (i.e. make it more rigorous) would be likely to encounter some degree of industry opposition (think hospitals, pharmacy chains, insurance companies, small clinics, etc.). I primarily say this because a major regulatory change would lead to major provider expense as they try to become compliant…How would you address these types of concerns?
9	-Good ideas. -I think the stakeholders approach will be critical to the ultimate success of this effort. You should strategically evaluate your approach(es) to maximize support from key groups while simultaneously minimizing the degree of opposition from others. Forcefield analysis could serve you well in this respect.
10	-Alt #1, how will the DEA feel about this change? How will you address them? -Alt. #3, Could this ultimately increase abuse of these drugs as you broaden the spectrum of practioners that can prescribe? Who will oppose this? What will MDs and DOs think? -Alt #4, good point.
11	-How will notation of purpose "decrease cost", especially in regard

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	to the fact that it will take investment to build the infrastructure to facilitate this policy. This could be a critical point to stakeholders, so how do you respond to this concern? -Alt #1, it seems that unless you pass a law compelling insurance companies to act as you say in this alternative, they will utilize the notation of purpose to deny payments. Insurance also has a strong lobby. How would you approach implementing a policy that runs counter to a powerful stakeholder group like this? -Alt #2, don't understand the malpractice compensation component…How will the public feel about this approach? -Are there advantages to patients/prescribers/pharmacists/etc. as a result of an unenforceable "legitimate medical purpose" policy? What are the repercussions of eliminating this type of ambiguity (i.e. what is the "ripple effect")?
12	-#4, is this intended to be an expansion of pharmacist scope of authority? Would current prescribers see this as an infringement on their professional autonomy? How would you address this concern? -Are there any other viable alternatives that do not primarily focus on an expiration date?

Hazlet

Group	**Comment**
1	Alternatives 1 & 2 – good. Alternative 3 is so improbable that it should be changed to something else. You indicate that you proposed to amend section 3 of WAC 246-869-220. Recall that this is NOT a guideline, as indicated. Do you mean that you are developing a guideline to explain this section?
2	In alternative 3, how will you know if a prescriber is practicing within his/her scope of practice?
3	In #1, you mention HIPAA infringements and identity theft. How? In #2, you propose a "lock and key" scheme. You may want to evaluate how successful these are – how frequently passwords have to be changed because they are forgotten, etc. In #3, have you considered the opportunities with evaluating usage patterns for non CS drugs, i.e., Soma, "Trail Mix", etc.?
4	
5	
6	Need to justify your mill tax rate; shouldn't both prescribers and dispensers be taxed?
7	Note that fine revenues are generally placed in the state's general fund. Who picked $200? Need to be able to justify it.
8	Do suggest taking on a HIPAA revision. Note preemption issues and likely constitutional challenges.
9	Who are "valid" stakeholders. Need to include an extensive (possibly annotated) bibliography.

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10	OK, but how do the proposed alternatives fix your problem – emergency access when the doc is out of town?
11	In Alt 2, do you have a legal basis for your alternative?
12	Note that you can only petition the DEA to change CFRs, not USC – need to go to the federal legislature for that. Note, be sure that you include suitable exceptions for chronic diseases.