

7543 group topic	
Group	Topic
1	Mandatory new prescriptions pick-up inside pharmacy facility (home delivery excluded)
2	make it possible for prescriptions written by out-of-state PA’s and ARNP’s to be filled when within scope of practice
3	Schedule II prescription and prescriber identification and tracking → <b>universal personal health information system in WA???</b>
4	Notation of purpose on prescriptions
5	Waste management of unused and expired medications in community pharmacy [changed 071012]
6	Statewide drug-monitoring program
7	Establish enforcement criteria for illegible prescriptions
8	Clarify personal health information confidentiality requirements for HIPAA and WA state laws [modified 071012]
9	Define 60-day supply for medical marijuana
10	Improve emergency buprenorphine access through collaborative practice agreements
11	Notation of purpose on prescriptions through enforcement of "legitimate medical purpose" requirements in RCW 69.41.040
12	Expiration date on C-II; federal petition

Josh’s Comments

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1	<p>-Not clear on how the selected alternative is the most “patient-centric” because it will require patients to be counseled more often, which many patients will not like (want quick &amp; easy service). It seems that the patient-centric nature of this approach hinges on you presenting evidence that implementation will increase patient safety (decreased medication errors, etc.). If this is not established, you are adding more “burden” to patients with uncertain benefit.</p> <p>-If your policy is implemented, approximately how many medication errors do you expect to avoid in the first year? What about the 5<sup>th</sup> year. Stakeholders will likely request this type of information when considering your proposed change.</p> <p>-It seems like this alternative might be more pharmacist-centric based on the statement, “this alternative provides a means for pharmacists to shift his/her paradigm from pill counting to providing patient-centered care”.</p>
2	<p>-Good approach to thinking about sustainability in your “justification” section.</p> <p>-Good focus on providing benefit without creating additional system complexity. This is a good point to focus on when selling to stakeholders.</p> <p>-How do you think other states will feel about your chosen alternative?</p>
3	<p>-Not clear on the scope of your selected alternative. Are we talking about a fully-functional statewide electronic medical record (EMR)? That is, will the</p>

	EMR include all patient encounter info past & present, pharmacy info, imaging info, CPOE, billing info, etc.? Or, is this system just pharmacy information? Regardless, the fixed costs will be high for a statewide project, so it might be more cost-effective to go for full functionality.
4	-Good justification in your alternatives section -From a point-of-service perspective, how will implementing your alternative materially impact “medication therapy management”, “ability to counsel patients”, “ability to detect medication errors”, etc. I don’t doubt the potential to change all of these things, but I’m curious to hear your vision of how the policy will change the experience of patients, pharmacists, prescribers, etc. Once you enumerate these points, do they justify the time/resource investment necessary to establish your chosen alternative?
5	-Good choice of a logistically feasible alternative. Its going to be difficult to get patients to dispose of their unused prescriptions, but this is a step in the right direction. -Will you do anything to ensure that patients know about the disposal system (e.g. will pharmacists be required by law to notify patients)?
6	-It seems like you will encounter substantial opposition from alcohol & tobacco industry (who bring powerful lobbies...) -The question will likely be asked why should alcohol/tobacco users pay for a prescription drug monitor program. What is the connection between the two? -I think WA already has very high alcohol and tobacco taxes, so will the public tolerate further increases, particularly for seemingly unrelated purposes?
7	-Good explanation of alternatives. I agree that your selected alternative is a step in the right direction, and enforcement is relatively difficult.
8	-Good explanation of your selected alternative. -Would it be possible to align with pharmacies to create a short (2-4/hour) in-person training program? You might consider initially getting large pharmacies to commit to this (Bartells, Rite Aid, etc.), give them some sort of participation token to display (sticker, certificate, etc.), see if market forces lead smaller providers to enroll in the program too (i.e. consumers start asking why do you, or don’t you, have that sticker...).
9	-Good focus on an evidence-based approach. This will strengthen your position when you appeal to stakeholders in opposition of your policy.
10	-If “doing nothing” is the best alternative, are there any minor changes you could make within the current framework? Perhaps there is some subtle policy nuance that could be improved?
11	-How do you know this alternative will decrease medication errors and increase patient safety? Approximately how many medication errors will be avoided in the first year of implementing your notation of purpose policy? What about after 5 years? -Why can insurance not require the notation of purpose? Can’t they essentially force patients to allow the notation by refusing to pay/reimburse otherwise? Will you pass a law to address this? (though this seems like a policy project of its own...)

12	<p>-How will a 90-day expiration date reduce medication errors? Approximately how many “errors” will potentially be avoided per year as a result of your policy being implemented?</p> <p>-Is drug abuse considered “medication error”? (i.e. patient fills prescription for recreational purposes when they no longer need it).</p> <p>-How will you address the potential opposition of prescribers? You may want to focus on data, i.e. dollars that will be saved, abuse avoided, ER visits avoided for overdose, etc.</p>
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Tom’s Comments: Note – the point of this exercise is to connect evaluation criteria with other info you’ve gathered to pick the “best” alternatives.

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1	<p>Note: I was at the Sand Point Clinic Pharmacy last week getting my flu shot and discussed their drive-up pharmacy with Gina ... suggest you visit with her.</p> <p>I’m working from a remote computer and can’t find your alternatives so ...</p>
2	<p>Not sure about admin operability for #1 – won’t there be DEA issues?</p> <p>For #3, who will maintain the database? Effectively, this requires someone to scan all 50 states &amp; whatnot continuously to reflect whatever changes have occurred. Maybe this is something that a national organization could take on.</p>
3	<p>Topic change? Chart went bonkers ...</p> <p>Interesting, out-of-the-box ideas. Note that the costs associated with “integrating” local systems to a common data set are enormous, many think prohibitive. Logging onto a common data set is much simpler. While your Alt B is probably the best long term goal, Ms. Clinton stumbled and fell some years back attempting to implement what you are, in part, suggesting.</p>
4	<p>Be sure that you have your facts in line. Have you contacted a malpractice carrier? If so, be sure to include an appropriate citation. Do you have valid estimates of the costs associated with doing nothing?</p> <p>Are the alternatives mutually exclusive? Couldn’t you do #4 along with other alternatives?</p>
5	<p>Such cynicism re #2! If legislation is involved, all the wrangling would be sorted out by the legislature; further, under compelling circumstances, the legislature could preempt local municipalities, making them behave.</p> <p>Why is Alt #3 only a “+” for technical feasibility? Seems pretty simple to me.</p>
6	<p>Some caution is necessary in linking a public “good” such as your program to funding from “sin” taxes? What happens if everyone stops smoking and/or drinking. This may be the best choice for political reasons, but the pointy-headed academics generally object to this approach.</p> <p>While I’m sympathetic to DSHS’ objection to a mill tax – they are always worried about having to pay more – they, too, need to balance benefits with risks. I’d think that they would appreciate access to the sort of information that would be available to them through your program. Ditto, licensing fees.</p>

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7	OK. Be sure to adequately cite your information sources.
8	Be sure that you have valid information to support your analyses. If you’ve contacted knowledgeable folks about HIPAA, for instance, be sure to provide adequate citations.
9	OK
10	What became of the collaborative agreement alternative? Has your project morphed? Too bad, as I thought that you had some pretty compelling ideas!
11	Which WAC? Recall that the BOP doesn’t have regulatory authority for prescribers. So, are you really contemplating an all-prescribers RCW to compel notation of purpose. I’m confused by “insurance cannot require”.
12	Your written conclusions don’t match the chart – should it be a 3D chart showing consequences for DEA regulatory change in 21CFR1300 vs. BOP and WAC 246-887. Seems to me that the DEA petition would be the most “interesting”.