California State Board of Pharmacy
1625 N. Market Blvd, Suite N219, Sacramento, CA 95834
Phone (916) 574-7900
Fax (916) 574-8618

STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
ARNOLD SCHWARZENEGGER, GOVERNOR

NOTICE OF MEETING and AGENDA
Communication and Public Education Committee

Contact Person: Virginia Herold
(916) 574-7911

Time: 9:30 a.m. – 12 noon
Date: September 22, 2006
Place: Department of Consumer Affairs
El Dorado Conference Room (Second Floor)
1625 N. Market Boulevard
Sacramento, CA 95834

This committee meeting is open to the public and will be held in a barrier-free facility in accordance with the Americans with Disabilities Act. Any person with a disability who requires a disability-related modification or accommodation in order to participate in the public meeting may make a request for such modification or accommodation by contacting Candy Place at (916) 574-7912, at least five working days before the meeting.

Opportunities are provided for public comment on each agenda item. Board members who are not on the committee may also attend and comment.

Note: Pharmacists and pharmacy technicians who attend the full committee meeting can be awarded two hours of CE, in accordance with the board's CE policy. A maximum of four CE hours can be earned each year by attending the meetings of two different board committees.

Call to Order 9:30 a.m.

1. Consumer Fact Sheet Series with UCSF's Center for Consumer Self Care
2. Update on the Activities of the California Health Communication Partnerships
3. Update Report of *The Script*
4. Recent Study of Patient Medical Literacy
5. Development of New Consumer Brochures
6. Development for a New Notice to Consumers as Proposed by AB 2583 (Nation)
7. Miscellaneous Consumer Issues/Articles in the Media
8. Evaluation of the Board's Consumer Materials
9. Update on the Board's Public Outreach Activities

Adjournment 12 noon

Meeting materials will be on the board's Web site by September 11, 2006

State of California | Department of Consumer Affairs

Memorandum

To: Communication and Public Education Committee **Date: September 9, 2006**

From: Board of Pharmacy – Virginia Herold

Subject: Development of Fact Sheet Series for Consumers

Two and one half years ago, the board approved a proposal by the committee to integrate pharmacy students into public outreach activities. The project involves UCSF students developing one-page fact sheets on diverse health care topics for public education.

The UCSF's Center for Consumer Self Care works directly with the students to develop the fact sheets, which are then reviewed by faculty members and then by the board.

The board distributes these fact sheets at community health fairs and has them available online. The fact sheet format is intended to be attractive whether printed or photocopied.

So far, nine fact sheets have been developed. These fact sheets are currently being translated by the board into Spanish, Vietnamese and Chinese.

Bill Soller, PhD, of the UCSF Center for Consumer Self Care is overseeing this project. At the last committee meeting, Dr. Soller provided a list of six fact sheets that are under development by the students (in this tab section).

At this meeting, Dr. Soller will provide an update of the status of the new fact sheets and the project itself.

Possible Topics for Consumer Fact Sheets
UCSF Center for Consumer Self Care
6/28/2006

Tips for Parents
- read the label
- teaspoons and tablespoons
- more is not better
- ask your pharmacist

Aspirin for Heart Attack and Stroke
- aspirin is not for everyone
- risks associated with aspirin
- what to think about before starting daily aspirin

Counterfeit Medicines
- dangers of using counterfeit medicines
- what to look for
- ask your pharmacist

Consumer Drug information on the Internet
- how to judge reliable information
- sites to trust
- where to look
- ask your pharmacist

Allergies to Medicines
- what to look for
- what to do
- before purchase, read the label – inactive ingredient section
- consumer reports to FDA (MedWatch)
- ask your pharmacist

Immunizations
- immunization schedules
- what schools require
- awareness alert that some pharmacies provide immunization services
- ask your pharmacist

Memorandum

To: **Communication and Public Education Committee** **Date: September 9, 2006**

From: **Board of Pharmacy – Virginia Herold**

Subject: **California Health Communication Partnership Meeting Update**

The board is a founding member of California Health Communication Partnership. This group is spearheaded by the UCSF's Center for Consumer Self Care to improve the health of Californians by developing and promoting consumer health education programs and activities developed by the members in an integrated fashion.

The function of the group is to develop and/or disseminate integrated public information campaigns on priority health topics identified by the partnership members. Other active members of the group are the Medical Board of California, the Food and Drug Administration, CPhA and California Retailers Association. For example, pharmacists, nurses, physicians will receive information from their respective regulatory boards or associations that will mesh with concurrent public outreach efforts.

There have been three major campaigns since the formation of the group two years ago.

Currently underway is the second year of the cancer screening campaign, which aims at educating the public about the need for and importance of breast cancer or prostrate cancer screening. It is titled: "It's Your Life, Do it Today." Outside funding from a private foundation has enabled the use of a vendor that specializes in distributing prewritten consumer columns for small and typically weekly newspapers. There are also public service announcements intended for airing on radio. This greatly expands the exposure and reach of the campaign.

Last year's cancer screening campaign was highly successful in terms of print media publication, due principally through the use of this vendor.

Since Dr. Soller will attend this committee meeting, he will be able to update the committee on the current status of this program. The partnership Intends future development of outreach efforts for Generic Medicine and Diabetes and Aspirin.

At the last Communication and Public Education Committee Meeting, the committee discussed the importance of public education campaigns about pharmacist-to-patient consultation since many consumers are not aware of this requirement and the importance of seeking and following a pharmacist's knowledge of drug therapy and how this can benefit their health. The committee also suggested that some form of outreach to educate other health care providers about a pharmacist's requirement to consult would benefit both providers and patients.

Also discussed at the last meeting was that written information provided to patients with their prescription medication is only read by 44 percent of patients surveyed.

These issues may also be topics for the future.

State of California | Department of Consumer Affairs

Memorandum

To: Communication and Public Education Committee

Date: September 8, 2006

From: Virginia Herold

Subject: Update on *The Script*

The August issue of *The Script,* became the September issue and is being printed and mailed to California pharmacies as I prepare this memorandum. Board Analyst Victor Perez, instead of the graphics unit of the State Printing Plant, graphically designed this issue.

The Pharmacy Foundation of California will again mail this newsletter shortly to all California licensed pharmacists.

The next issue of the newsletter is being developed for publication for January 2007. It will focus on new legislation and regulations.

State of California | Department of Consumer Affairs

Memorandum

To: **Communication and Public Education Committee** **Date: September 9, 2006**

From: **Board of Pharmacy – Virginia Herold**

Subject: **Public Health Literacy**

A recent report by the National Center for Education Statistics found that most people had only intermediate health literacy. This means that "a majority of U.S. adults will have some difficulty using health-oriented materials with accuracy and consistency." The study, based on data from the 2003 National Assessment of Adult Literacy, involved 19,000 individuals. The data indicate that that fewer than one in six persons is proficient in health literacy.

Low health literacy results in patients not understanding medical instructions and terms, and leads to higher costs and poor health outcomes.

Generally:

- Whites and Asian adults had higher health literacy rates than blacks, Hispanics and American Indians.
- Hispanic adults had the lowest health literacy rates.
- Adults older than 65 had lower health literacy rates than younger age groups
- Women had slighter higher health literacy than men.

These statistics again underlie the importance of patient education – by pharmacists and other health care providers as well as by this board. The data also emphasize the need to provide appropriate tools for patients to educate themselves.

A copy of a press release and the executive summary (which is essentially survey statistics) are provided in this tab section for your reference.

The full report, which is over 60 pages, can be viewed at:
http://nces.ed.gov/pubsearch/pubsinfo.asp?pubid=rev

SFGate.com Return to regular view

Print This Article

Study: Medical Instructions Stump Many

- By KEVIN FREKING, Associated Press Writer
Wednesday, September 6, 2006

(09-06) 17:48 PDT WASHINGTON (AP) --

Most adults can determine at what age their children should get vaccinated or discern from a label when to take medicines, but they still need help understanding many basic health instructions.

A new report by the National Center for Education Statistics found that most adults have an intermediate health literacy. However, intermediate is far from good, because so many health instructions are written in a way that's foreign to how people talk and think, said Dr. Rima Rudd of the Harvard School of Public Health.

"Intermediate skills means that a majority of U.S. adults will have some difficulty using health-related materials with accuracy and consistency," Rudd said.

The series of tests had a total of 500 points for a perfect score. Women averaged 248 points. Men averaged 242 points. The study showed that fewer than one in six people are proficient when it comes to health literacy.

Many health directions are written at a level that's above the average consumer, Rudd said. A simple example, she said, would be a can of baked beans at the supermarket. A consumer may want to know the salt content before buying, but the word salt isn't on the label.

"Of course, they wrote 'sodium,' but that's a technical term, that's a chemistry term," Rudd said. "You don't sit at the family table and say, `Pass the sodium please.'"

The government attempts to measure comprehension of basic medical instructions because low health literacy can lead to higher costs and poor health outcomes. If officials can make it easier for patients to understand how to maintain their health, patients may get more frequent screenings or checkups, and perhaps they won't have to resort to emergency rooms to get care.

The data analyzed comes from the 2003 National Assessment of Adult Literacy, and it allows researchers to examine the relationship between demographic characteristics and literacy. Besides comparing gender, officials also reviewed the race, age and educational levels of the 19,000 people who took the test.

The analysis showed adults older than 65 had lower health literacy rates than younger age groups.

Also, whites and Asian adults had higher health literacy rates than blacks, Hispanics and American Indians. Hispanic adults had lower average health literacy than adults in any other

racial group.

The study's message is that health literacy skills are not what they should be. The message for insurers, drug manufacturers and doctors is that they must improve their communication skills if they want to help consumers understand information, Rudd said.

"They're writing things at a level in the health field that is very difficult for the general public to work with," Rudd said.

On the Net:

Report on Health Literacy:

nces.ed.gov/pubsearch/pubsinfo.asp?pubid2006483

URL: http://sfgate.com/cgi-bin/article.cgi?file=/n/a/2006/09/06/national/w111429D50.DTL

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Health Literacy

Highlights of Findings

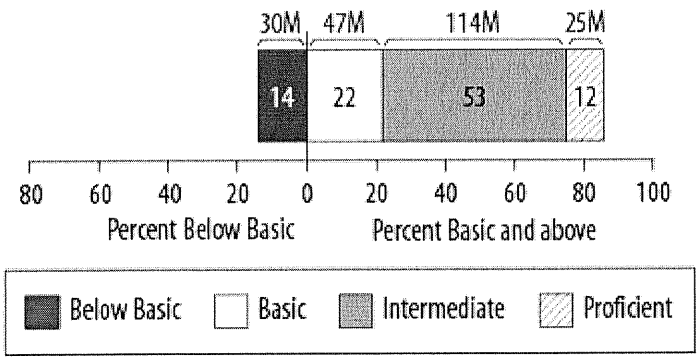
Following are highlights from The Health Literacy of America's Adults:

- Overall
- Gender & Health Literacy
- Age & Health Literacy
- Educational Attainment & Health Literacy
- Health Literacy & Health Insurance Coverage

Overall

Total Population: Number & Percentage of Adults in Each Health Literacy Level: 2003

- A majority of adults had *Intermediate* heath literacy.
- Over 75 million adults combined had *Basic* and *Below Basic* health literacy.



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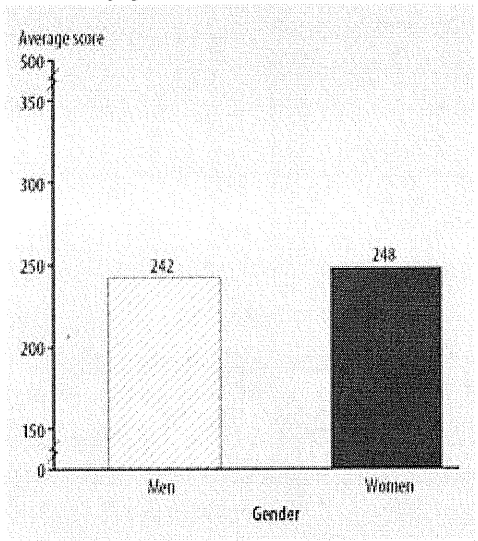
Gender & Health Literacy

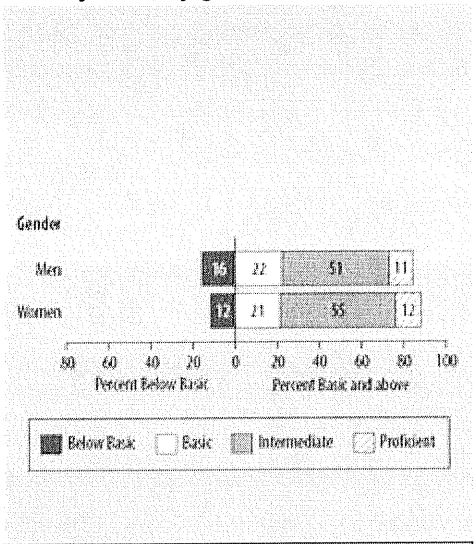
The average health literacy score for women was 6 points higher than the average health literacy score for men. A higher percentage of men (by a margin of 4 percentage points) than women had *Below Basic* health literacy.

Average health literacy scores of adults, by gender: 2003



NOTE: Adults are defined as people 16 years of age and older living in households or prisons. Adults who could not be interviewed because of language spoken or cognitive or mental disabilities (3 percent in 2003) are excluded from this figure.
SOURCE: U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, 2003 National Assessment of Adult Literacy.

Percentage of adults in each health literacy level, by gender: 2003



NOTE: Detail may not sum to totals because of rounding. Adults are defined as people 16 years of age and older living in households or prisons. Adults who could not be interviewed because of language spoken or cognitive or mental disabilities (3 percent in 2003) are excluded from this figure.
SOURCE: U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, 2003 National Assessment of Adult Literacy.

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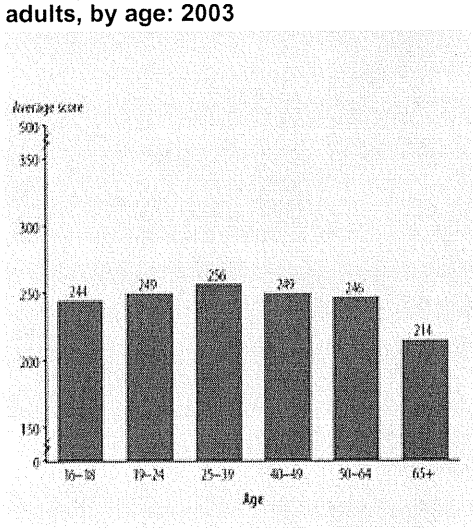
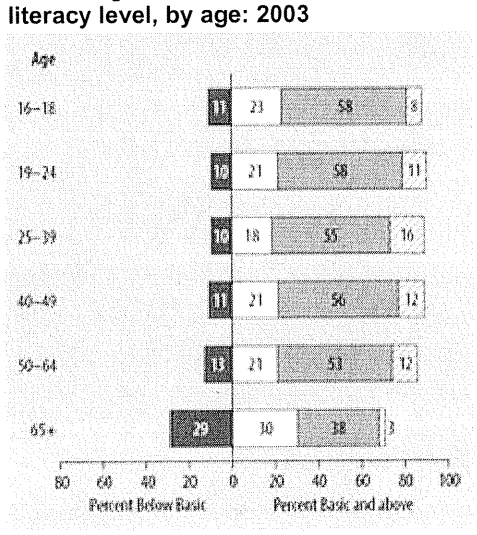
Age and Health Literacy

Adults in the oldest age group—age 65 and older—had lower average health literacy scores than adults in the younger age groups.

Average health literacy scores of adults, by age: 2003



Percentage of adults in each health literacy level, by age: 2003



NOTE: Adults are defined as people 16 years of age and older living in households or prisons. Adults who could not be interviewed because of language spoken or cognitive or mental disabilities (3 percent in 2003) are excluded from this figure.
SOURCE: U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, 2003 National Assessment of Adult Literacy.

NOTE: Detail may not sum to totals because of rounding.Adults are defined as people 16 years of age and older living in households or prisons. Adults who could not be interviewed because of language spoken or cognitive or mental disabilities (3 percent in 2003) are excluded from this figure.
SOURCE: U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, 2003 National Assessment of Adult Literacy.

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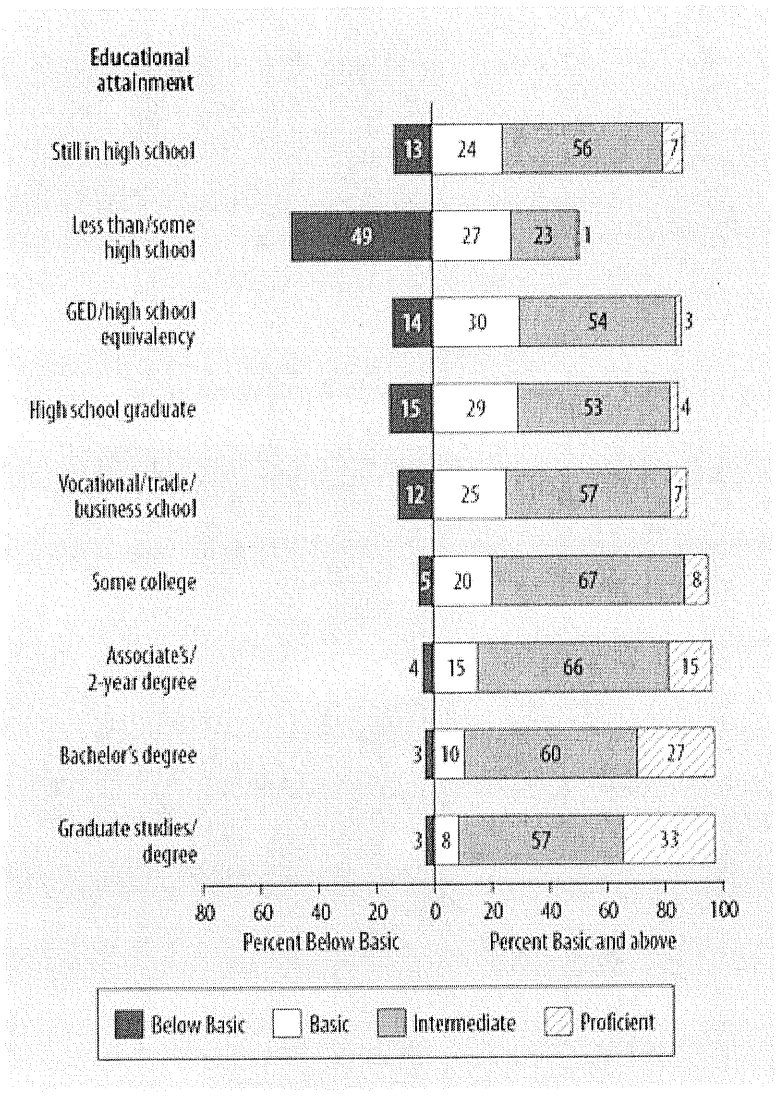
Educational Attainment & Health Literacy

A higher percentage of adults who had not attended or completed high school had *Below Basic* health literacy than adults with higher level of education.

Percentage of adults in each health literacy level, by highest educational attainment: 2003



NOTE: Detail may not sum to totals because of rounding.Adults are age and older living in households or prisons. Adults who could not language spoken or

cognitive or mental disabilities (3 percent in 2003)
SOURCE: U.S. Department of Education, Institute of Education Sciences, Education Statistics, 2003 National Assessment of Adult Literacy.

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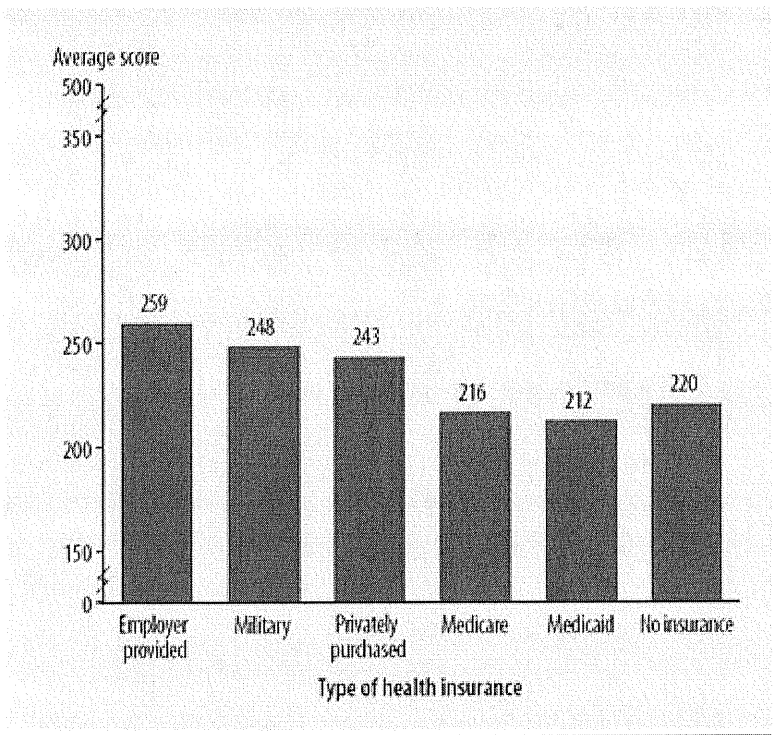
Health Literacy & Health Insurance Coverage

- Adults who received health insurance through an employer had the highest average health literacy.
- Adults who received Medicare or Medicaid and adults who had no health insurance had lower average health literacy than adults who were covered by other types of insurance.

Average health literacy scores of adults, by type of health insurance coverage: 2003



NOTE: Adults are defined as people 16 years of age and older living in households. Adults who could not be interviewed because of language spoken or cognitive or mental disabilities (3 percent in 2003) are excluded from this figure. Adults who reported they had more than one type of health insurance are included in each applicable category in this figure.
SOURCE: U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, 2003 National Assessment of Adult Literacy.

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State of California | Department of Consumer Affairs

Memorandum

To: **Communication and Public Education Committee**

Date: September 9, 2006

From: **Board of Pharmacy – Virginia Herold**

Subject: **Development of New Consumer Brochures and Materials**

The board received one half-time position for public and licensee education with the new fiscal year that started July 1. This restores part of the two similar positions that were lost due to hiring freezes in 2001.

The board will fill this analyst position as a full-time position. We intend to invigorate our public information and outreach with this position, and have received applications following recruitment. Interviews are scheduled for the week before our committee meeting.

1. Consumer Materials

There has been no work on the following projects since the last board meeting. Here is the status of work underway.

Prescription Drug Discount Program for Medicare Recipients

The board has started revision of the "Prescription Drug Discount Program for Medicare Recipients" brochure that was developed in response to SB 393 (Speier, Chapter 946, Statutes of 1999). This state program allows Medicare recipients to obtain medications at the MediCal price if the patients pay out of pocket for the medication. The brochure needs to be meshed with the Medicare Part D Plan benefits that became available to beneficiaries in 2006.

Earlier this year the board developed a short fact sheet on selecting a Medicare Part D plan that we have been distributing this year.

Under development are:

- The Beers list of medications that should not be provided to elderly patients
- Update of Facts About Older Adults and Medicines (revision)

2. Web Site Modification

The board has finalized its design for its new Web page. The site will be activated shortly, in all likelihood before our committee meeting.

3. Information on Preventing Prescription Errors

One of the hottest topics in the popular media recently has been medical errors, including medication errors.

The board has been actively involved in a number of activities aimed at reducing errors, including our quality assurance program requirements that mandate that pharmacies evaluate every prescription error.

Staff is beginning to build the components for a segment of the board's Web site to address medication errors. It will include data such as that presented at the July 2006 Board Meeting on prescription error data identified by the board through investigations of consumer complaints. It will also include information from other sources – ways to prevent errors, frequently confused drug names, etc. It will have links to other Web sites as well.

In this tab section are some materials discussing medication errors.

Public Ed.

Drug Name

Confusion:

Preventing Medication Errors

Avoid problems with look alike and sound alike drug names

By Carol Rados

An 8-year-old died, it was suspected, after receiving methadone instead of methylphenidate, used to treat attention deficit disorders. A 19-year-old man showed signs of potentially fatal complications after he was given clozapine instead of olanzapine, two drugs used to treat schizophrenia. And a 50-year-old woman was hospitalized after taking Flomax, used to treat the symptoms of an enlarged prostate, instead of Volmax, used to relieve bronchospasm.

In each of these cases reported to the Food and Drug Administration (FDA), the names of the dispensed drugs looked or sounded like those that were prescribed. There have been others: Serzone, an antidepressant, for Seroquel, used for schizophrenia, and iodine for Lodine, a non-steroidal anti-inflammatory drug.

Adverse events that can occur when drugs are dispensed as the wrong medications underscore the need for clear interpretation and better communication between the doctors who write prescriptions and the pharmacists who fill them. The FDA says that about 10 percent of all medication errors reported result from drug name confusion.

"These errors are not usually due to incompetence," says Carol A. Holquist, RPh, director of the Division of Medication Errors and Technical Support in the FDA's Office of Drug Safety. "But they are so underreported because people are afraid of the blame." Errors occur at all levels of the medication-use system, from prescribing to dispensing, Holquist says, which is why those people who receive the prescriptions must take action, too. "Everybody has a role in minimizing medication errors," she says.

PHOTOGRAPHY: CORBIS

The Problems

Medication errors can occur between brand names, generic names, and brand-to-generic such as Toradol and tramadol. But sometimes, medication errors involve more than just name similarities. Abbreviations, acronyms, dose designations, and other symbols used in medication prescribing also have the potential for causing problems.

For example, the abbreviation "D/C" means both "discharge" and "discontinue." The National Coordinating Council for Medication Error Reporting and Prevention (NCCMERP) notes that patients' medications have been stopped prematurely when D/C—intended to mean discharge—was misinterpreted as discontinue because it was followed by a list of drugs.

Illegible handwriting, unfamiliarity with drug names, newly available products, similar packaging or labeling, and incorrect selection of a similar name from a computerized product list all compound the problem. And, although some drug names and symbols may not necessarily sound alike or look alike, they could cause confusion in prescribing errors when handwritten or communicated verbally, according to the United States Pharmacopeia (USP).

For example, Holquist says that several errors have occurred involving mix-ups with the oral diabetes drug Avandia and the anticoagulant Coumadin. Although they don't look similar when typed or printed, the names have been confused with each other when poorly written in cursive. The first "A" in Avandia, if not fully formed, can look like a "C," and the final "a" has appeared to be an "n."

The XYZs of Naming Drugs

Names are part of developing a new drug. And coming up with a catchy, snappy moniker that distinguishes one drug from another isn't easy. For the most part, drug companies want a name that will boost sales, while consumers long for some indication

from the name of what the drug does. The FDA, however, won't allow names that imply medical claims, suggest a use for which a drug isn't approved, or promise more than they can deliver.

Naming a drug can be as complicated as creating a rhythmic cacophony of unpronounceable syllables and emphatic-sounding letters, such as C and P. Other naming strategies include letters that when strung together sound like something high-tech—think Zyprexa, Lexapro, and Xanax.

But whether it's the sound of certain letters that manufacturers like, or the vision that a name conjures up, the FDA says that selection must take into account concerns for reducing errors and for avoiding trademark infringement.

Because of today's tough trademark requirements, many drug companies are turning to a growing industry of "naming consultants" for the task. These consultants are charged with creating a unique name that will appeal to both health care providers and patients, particularly given the recent surge in direct-to-consumer advertising.

"Global companies want a name to be a worldwide mark," says Doug Kapp, vice president of brand strategy at RTi-DFD, a market research company in Stamford, Connecticut. In helping pharmaceutical companies set their products apart from others, Kapp says his company recognizes that the name must resonate with the market target and also must pass worldwide trademark requirements.

That recognition, he says, drove his company to develop "relational asemantics," a name-generation process that assists physicians in identifying the nature of a drug. Just as the erectile dysfunction drug Viagra might suggest vitality and vigor, two of RTi-DFD's successes include Advair, linked to "advantage air for asthma," and Amerge, named for "emerging from the pain of a migraine." Kapp says that regardless of how good a name seems, it must be reviewed for potential confusion with other drugs so that "any other associations would not harm the patient in the event of an error."

Satisfying the FDA

Each of the three types of drug names (chemical, generic, and brand), are subject to different rules and regulations.

The FDA requires that either the established, or official, name or in the absence of an official name, the common or usual name, appears on labels and labeling of a drug product. The common (generic) name must accompany the brand name, if there is one. The established name for a drug substance is usually found in the originating country's pharmacopeia, an official book or list of drugs and medicines and the standards established for their production, dispensation, and use.

The generic name is usually created for drug substances when a new drug is ready for marketing. It is selected by the United States Adopted Names (USAN) Council, whose expertise is recognized by the FDA, according to principles developed to ensure safety, consistency, and logic. These names are typically used by health care professionals.

Examples of Error-Prone Drug Information

Abbreviations	Intended Meaning	Misinterpretation	Correction
AD, AS, AU	Right ear, left ear, each ear	OD, OS, OU (right eye, left eye, each eye)	Spell out "right ear," "left ear," "each ear"
IJ	Injection	"IV" or "intrajugular"	Spell out "injection"
TIW or tiw	3 times a week	"3 times a day" or "twice in a week"	Use "3 times weekly"
Dose Designations			
Trailing zero after decimal point (1.0 mg)	1 mg	10 mg if the decimal point is not seen	Do not use trailing zeros for doses expressed in whole numbers
Abbreviations with a period following (mg. or mL.)	mg, mL	The period is unnecessary and could be mistaken as the number 1 if poorly written	Omit period and use mg, mL
Drug name and dose run together (especially problematic for drug names ending in "L" such as Tegretol300 mg)	Tegretol 300 mg	Tegretol 1300 mg	Place adequate space between the drug name, dose, and unit of measure
Symbols			
x3d	For three days	"3 doses"	Use "for three days"
/ (slash mark)	Separates two doses or indicates "per"	Number 1 (e.g., "25 units/10 units" misread as "25 units and 110" units)	Use "per" rather than a slash mark to separate doses
&	And	"2"	Use "and"

Source: Institute for Safe Medication Practices

Generic names are coined using an established stem, or group of letters, that represents a specific drug class. For example, the USAN stems include suffixes like -mab for monoclonal antibodies, such as infliximab, or prefixes like dopa- for dopamine receptor agonists. The arthritis medications celecoxib, valdecoxib, and rofecoxib are generic names containing the -coxib stem. Each belongs to a class of drugs known as the COX-2 inhibitors.

Names that include such stems, chemistry roots, or any other coded information are easier to remember, and give clues about what a drug is used for. These names, however, typically sound or look so much alike that they contribute to medication errors, especially if the products share common dosage forms and other similarities.

The brand name (also called trademark), can be created as soon as a generic name has been established. Only brand names of products subject to a new drug application or an abbreviated new drug application must be approved by the FDA first. This requirement distinguishes them from generic names. There are more than 9,000 generic drug names and 33,000 trademarked brand names in use in the United States.

Fixing the Problems

To minimize confusion between drug names that look or sound alike, the FDA reviews about 400 brand names a year before they are marketed. About one-third are rejected. An example of the FDA changing a drug name after it was approved was in 2005, when the diabetes drug Amaryl was being confused with the Alzheimer's medication Reminyl, and one person died. Now the Alzheimer's medicine is called Razadyne.

Generic name confusion also has led to regulatory action, as well as to pharmacy practice recommendations. For example, the USP and the USAN changed the drug name "amrinone" to "inamrinone" after receiving reports of serious outcomes from medication errors involving the similar name pair "amrinone/amiodarone." The generic drug industry also has responded to requests from the FDA to use a mixture of uppercase and lowercase letters to highlight differences in similar generic names, such as vinBLAStine and vinCRIStine. This step also encouraged manufacturers to supplement their new drug applications with revised labels and labeling that visually differentiated their generic names with the so-called "tall man" letters. And the NCCMERP recommendations encourage physicians to write both brand and generic names on prescriptions.

A number of other efforts are under way to reduce the incidence of medical errors stemming from similar-looking or similar-sounding names. The FDA, for example, is encouraging people to talk with their physicians to ensure that they have a complete understanding about their prescription before leaving the physician's office, and to verify the information with the pharmacist before the medication is dispensed.

FDA health professionals also are requested to interpret both written prescriptions and verbal orders through weekly in-house studies, in an attempt to simulate the prescription-ordering process. Holquist says that these studies are a valuable tool used in every review of proposed brand names. It is important, she adds, to be able to detect any potential sound-alike, look-alike confusion with proprietary names before a new drug application is approved.

Other efforts strongly encouraged for physicians include writing prescriptions more clearly, printing in block letters rather than writing in cursive, avoiding the use of abbreviations, and indicating the reason for the drug.

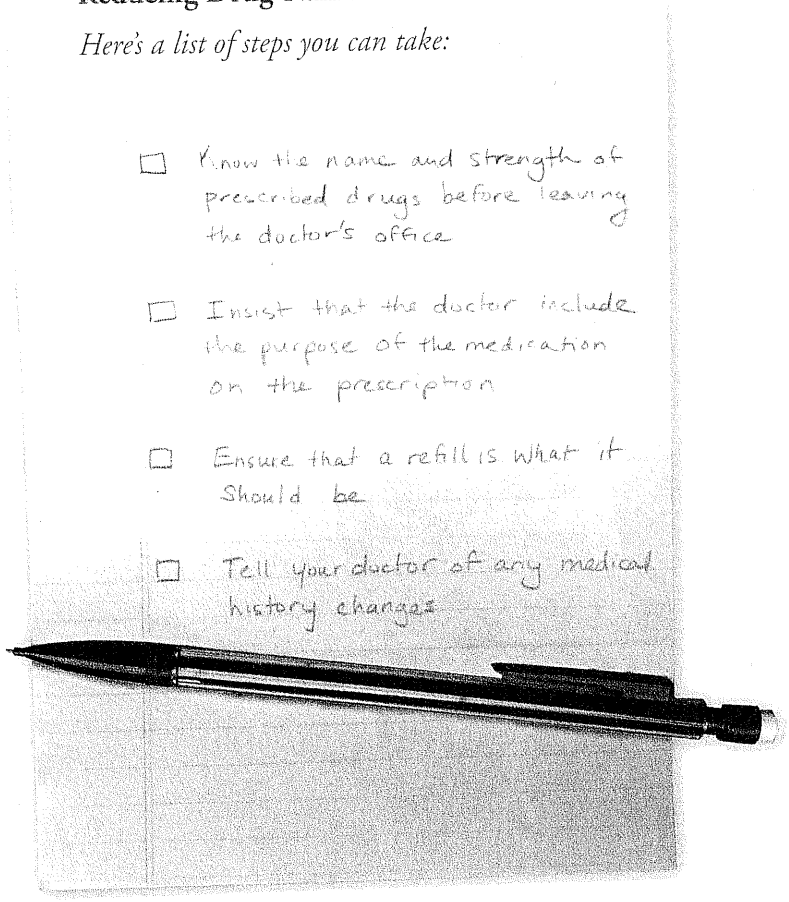
According to the FDA, pharmacists can help by keeping look-alike, sound-alike products separated from one another on pharmacy shelves, by avoiding stocking multiple product sizes together, and by verifying with the physicians information that is not clear before filling a prescription.

The FDA encourages pharmacists and other health professionals to report any actual or potential medication errors to the agency's MedWatch Adverse Event Reporting System online at www.fda.gov/medwatch/, by phone at 800-332-1088, or by fax at 800-332-0178. Caller identification is kept confidential and is protected from disclosure by the Freedom of Information Act. ■

Carol Rados is with the FDA Consumer Magazine, *published by the Food and Drug Administration. Reprinted with permission.*

Reducing Drug-Name Medication Errors

Here's a list of steps you can take:

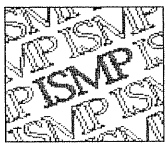


PHOTOGRAPHY: SARAH DAB

July 2006

National Pharmacy Compliance News

Preventing Errors Linked to Name Confusion



This column was prepared by the Institute for Safe Medication Practices (ISMP). ISMP is an independent nonprofit agency that works closely with United States Pharmacopeia (USP) and FDA in analyzing medication errors, near misses, and potentially hazardous conditions as reported by pharmacists and other practitioners. ISMP then makes appropriate contacts with companies and regulators, gathers expert opinion about prevention measures, then publishes its recommendations. If you would like to report a problem confidentially to these organizations, go to the ISMP Web site (www.ismp.org) for links with USP, ISMP, and FDA. Or call 1-800/23-ERROR to report directly to the USP-ISMP Medication Errors Reporting Program. ISMP address: 1800 Byberry Rd, Huntingdon Valley, PA 19006. Phone: 215/947-7797. E-mail: ismpinfo@ismp.org.

The Institute for Safe Medication Practices (ISMP) regularly hears about confusion between products with similar names. One such pair is OMACOR (omega-3-acid ethyl esters) and AMICAR (aminocaproic acid) an antifibrinolytic. Omacor is indicated as an adjunct to diet to reduce very high triglyceride levels (500 mg/dL or more) in adult patients. The drug is also being studied as adjuvant therapy for the prevention of further heart attacks in patients who have survived at least one. A pharmacist reported an error in which a telephone order for Omacor 1 gram BID was interpreted and dispensed as Amicar 1 gram BID. Counseling was not provided, but fortunately the patient read the drug information sheet for Amicar before taking any medication and called the pharmacy stating that he was expecting a medication to reduce his triglyceride levels.

While this case illustrates why manufacturers should review and test new trademarks for error potential before the product reaches the market, there are some things that practitioners can do to help prevent errors with products that have look-alike or sound-alike names.

- Look for the possibility of name confusion before a product is used. Use the concepts of failure mode and effects analysis (FMEA) to assess the potential for error with new medications that will be prescribed or added to your inventory. If the potential for confusion with other products is identified, take the steps listed below to help avoid errors.
- Prescriptions should clearly specify the drug name, dosage form, strength, complete directions, as well as its indication. Most products with look- or sound-alike names are used for different purposes. If the indication is not available, pharmacists and nurses should verify the purpose of the medication with the patient, caregiver, or physician before it is dispensed or administered.
- Reduce the potential for confusion with name pairs known to be problematic by including both the brand and generic name on prescriptions, computer order entry screens, prescription labels, and MARs.
- When accepting verbal or telephone orders, require staff to write down the order and then perform a read back (or even spell back) of the medication name, strength, dose, and frequency of administration for verification.
- Change the appearance of look-alike product names on computer screens, pharmacy product labels, and MARs by emphasizing, through bold face, color, and/or tall man letters, the parts of the names that are different (eg, hydrOXYzine, hydrALAzine).
- Pharmacists should work under good lighting and use magnifying lenses and copyholders (keep prescriptions at eye level during transcription) to improve the likelihood of proper interpretation of look-alike product names.
- Install computerized reminders for the most commonly confused name pairs at your site so that an alert is generated when entering prescriptions for either drug. If possible, make the reminder auditory as well as visual.
- Store commonly confused products in different locations. Avoid storing both products in a "fast-mover area." Use a shelf sticker to help find relocated products.
- Affix "name alert" stickers to areas where look- or sound-alike products are stored (available from pharmacy label manufacturers) or to the actual product containers.
- Employ at least two independent checks in the dispensing process (one person interprets and enters the prescription into the computer and another compares the printed label with the original prescription as well as the manufacturer's product).
- Open the prescription bottle or package in front of the patient to confirm the expected appearance of the medication and review the indication. Caution patients about error potential when taking a product that has a look- or sound-alike counterpart. Encourage patients to ask questions if the appearance of their medication changes. Take time to fully investigate any patient concerns.
- Encourage reporting of errors and potentially hazardous conditions with look- and sound-alike names to the ISMP-USP Medication Errors Reporting Program and use the information to establish priorities, as listed above, for error reduction. Maintain an awareness of problematic product names and error prevention recommendations provided by ISMP (www.ismp.org), FDA (www.fda.gov), and USP (www.usp.org).

If you are interested in learning what look-alike and sound-alike name pairs have been published in the ISMP Medication Safety Alert!®, a free list is available at www.ismp.org/Tools/confuseddrugnames.pdf.

Kaiser Daily Health Policy Report

Wednesday, September 06, 2006

Coverage & Access

Studies Indicate Long Hours Cause of Medical Errors Among Residents

More than 80% of first-year medical residents work more hours than allowed by national accreditation rules, according to two studies published on Wednesday in the *Journal of the American Medical Association*, the *Washington Post* reports (*Washington Post*, 9/6). Under rules established by the Accreditation Council for Graduate Medical Education, residents can work no more than 80 hours per week. In addition, residents must have at least 10 hours of rest between shifts and cannot work more than 24 hours at a time (*Kaiser Daily Health Policy Report*, 10/28/04). For one study, Christopher Landrigan of Brigham and Women's Hospital and colleagues surveyed 4,000 residents online from July 2003 through May 2004. According to the study, 84% of first-year residents violated the rules at some point. The study also finds that residents at nine in 10 hospitals violated the rules at some point (Kowalczyk, *Boston Globe*, 9/6). For a second study, Nijib Ayas of Harvard Medical School and colleagues surveyed 2,737 first-year residents online to determine the effects of a longer workday on their performance. Respondents who worked 20 consecutive hours had a 61% higher risk for self-injury through needle or scalpel sticks than those who worked 12 consecutive hours, the study finds. According to the study, 498 respondents reported self-injuries during a one-year period (Talan, Long Island *Newsday*, 9/6).

Medical Errors

In related news, a third study published in *JAMA* finds that internal medicine residents often commit medical errors that lead to depression, burnout and less empathy for patients, the *Washington Times* reports. For the study, Tait Shanafelt of the Mayo Clinic and colleagues analyzed data on 84% of eligible internal medicine residents at the hospital between 2003 and 2006. About 15% of participants reported that they had committed a medical error in the previous three months, and 34% reported that they had committed at least one major error over a one- to three-year period, the study finds. According to the study, participants who reported that they had committed medical errors were three times more likely to test positive for depression than those who had not committed errors. In addition, the study finds that participants with symptoms of depression and burnout were more likely to commit medical errors in the subsequent three months. The study recommends that residency programs attempt "to prevent, identify, and treat burnout and to promote empathy and well-being for the welfare of (both) residents and patients" (Howard Price, *Washington Times*, 9/6). Shanafelt said, "There may be problems with the system. Work-hour limitations are a step in the right direction. But there still may be more to do" (Ritter, *Chicago Sun Times*, 9/6).

An abstract of the Landrigan study is available online, and an abstract of the Shanafelt study also is available online. In addition, the Ayas study is available online. An extract of a related *JAMA* commentary published in is available online, and an extract of a related *JAMA* editorial also is available online.

Broadcast Coverage

NPR's "All Things Considered" on Tuesday reported on the studies. The segment includes comments from Charles Czeisler, a professor of sleep medicine in the Division of Medical Sciences at Harvard University; Landrigan; David Leach, executive director of ACGME; and Troy Madsen, an emergency department resident who had to transfer to different hospital after a violation of rules on work hours (Rovner, "All Things Considered," NPR, 9/5). The complete segment is available online in RealPlayer.

Report: Medication errors run rampant

LOS ANGELES TIMES

At least 1.5 million Americans are injured or killed every year by medication errors at a direct cost of billions of dollars, according to a report issued Thursday by the prestigious Institute of Medicine.

For hospitalized patients, the report said that on average one medication error per day is caused by confusion in drug names, wrong doses, failure to deliver drugs and a host of other problems.

"We were initially quite surprised by the number of mistakes, but the more we heard, the more convinced we were that these are actually serious underestimates," said panel member Dr. Kevin Johnson.

The study details a series of recommendations for new procedures and research to minimize the risk of medication errors, emphasizing computerization of prescribing and administering drugs and data acquisition.

Betsy Lehman, a health reporter for the Boston Globe, was one patient who was killed as a result of such errors, according to the report. Lehman, 39, was being treated for breast cancer in an experimental program at the Dana-Farber Cancer Institute in 1994.

A medical fellow wrote a prescription for the cancer drugs citing the total amount she was to receive over four days, the report said. She died when nurses administered that total each day, overwhelming her system.

Such mistakes happen all too frequently, the report said. Each year, there are an estimated 400,000 preventable drug-related injuries in hospitals, costing at least $3.5 billion.

There are also 800,000 medication-related injuries in nursing homes.

Among the drugs most commonly associated with errors are insulin, morphine, potassium chloride and the anti-coagulants heparin and warfarin, which have a high risk of patient injury when dispensed incorrectly.

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Report: Drug Errors Injure More Than 1.5M

- By LAURAN NEERGAARD, AP Medical Writer
Thursday, July 20, 2006

(07-20) 20:03 PDT WASHINGTON (AP) --

Medication mistakes injure well over 1.5 million Americans every year, a toll too often unrecognized and unfought, says a sobering call to action.

At least a quarter of the errors are preventable, the Institute of Medicine said Thursday in urging major steps by the government, health providers and patients alike.

Topping the list: All prescriptions should be written electronically by 2010, a move one specialist called as crucial to safe care as X-ray machines.

Perhaps the report's most stunning finding was that, on average, a hospitalized patient is subject to at least one medication error per day.

A serious drug error can add more than $8,750 to the hospital bill of a single patient. Assuming that hospitals commit 400,000 preventable drug errors each year, that's $3.5 billion — not counting lost productivity and other costs — from hospitals alone, the report concluded.

"I'm a patient-safety researcher (yet) I was surprised and shocked at just how common and how serious a problem this is," said Dr. Albert Wu of Johns Hopkins University, who co-authored Thursday's report.

Worse, there's too little incentive for health providers to invest in technology that could prevent some errors today, added Dr. J. Lyle Bootman, the University of Arizona's pharmacy dean, who co-chaired the IOM probe.

"We're paid whether these errors occur or not," lamented Bootman, who recently experienced the threat firsthand as his son-in-law dodged some drug near-misses while in intensive care in a reputable hospital.

The new probe couldn't say how many of the injuries are serious, or how many victims die. A 1999 estimate put deaths, conservatively, at 7,000 a year.

Even the total injury estimate is conservative, Bootman stressed. It includes drug errors in hospitals, nursing homes and among Medicare outpatients, but it doesn't attempt to count mix-ups in most doctors' offices or by patients themselves.

There have been efforts to improve patient safety in the six years since the IOM first spotlighted medical mistakes of all kinds, including recent bar-coding of drugs to minimize mix-ups in hospitals and pharmacies.

But clearly more are needed, and the new report highlights how the nation's fragmented health care system is conducive to drug errors, said Dr. Donald Berwick, a Harvard professor who heads the nonprofit Institute for Healthcare Improvement.

"This isn't a matter of doctors and nurses trying harder not to harm people," Berwick cautioned. "Safety isn't automatic. It has to be designed into the system."

Medications' sheer volume and complexity illustrate the difficulty. There are more than 10,000 prescription drugs on the market, and 300,000 over-the-counter products. It's impossible to memorize their different usage and dosage instructions, which may vary according to the patient's age, weight and other risk factors, such as bad kidneys.

Plus, four of every five U.S. adults take at least one medication or dietary supplement every day; almost a third take at least five. The more you use, the greater your risk of bad interactions, especially if multiple doctors prescribe different drugs without knowing what you already take.

Add doctors' notoriously bad handwriting and sound-alike drug names: Was that order for 10 milligrams or 10 migrams? The hormone Premarin or the antibiotic Primaxin?

Moreover, consumer instructions are woefully inadequate, the report concludes. One study found parents gave their children the wrong dose of over-the-counter fever medicines 47 percent of the time.

Then there was the newly diagnosed asthmatic wondering why his inhaler didn't work. Asked how he used it, the middle-age man squirted two puffs into the air and tried to breathe the mist. His original doctor had demonstrated the inhaler without telling him to spray it inside his mouth.

Among the report's recommendations:

_The government should speed electronic prescribing, including fostering technology improvements so that the myriad computer programs used by doctors, hospitals and drugstores are compatible.

Fewer than about 20 percent of prescriptions are electronic, said report co-author Michael Cohen, president of the Institute for Safe Medication Practices. E-prescribing does more than counter bad handwriting. The computer programs can be linked to databases that flash an alert if the prescribed dose seems high or if the patient's records show use of another drug that can dangerously interact.

_Patients and their families must be aggressive in questioning doctors, nurses and pharmacists about medications. Get a list of each drug you're prescribed, why and the dose from each doctor and pharmacy you use, and show it at every doctor visit.

"Take active steps to make sure you know what you're getting, and is it what you need," said report co-author Dr. Wilson Pace of the University of Colorado.

_The nation should invest about $100 million annually on research into drug errors and how to prevent them. Among the most-needed studies is the impact of free drug samples, which

often lack proper labeling, on medication safety.

_The Food and Drug Administration should improve the quality of drug information leaflets that accompany prescription drugs, but often have incomplete information or are written in consumer-confusing jargon.

_The government should establish national telephone hotlines to help patients unable to understand printed drug information because of illiteracy, language barriers or other problems.

The Institute of Medicine is an independent organization chartered by Congress to advise the government on health matters.

On the Net:

Institute of Medicine:

www.iom.edu

URL: http://sfgate.com/cgi-bin/article.cgi?file=/n/a/2006/07/20/national/w142049D97.DTL

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NCC MERP Report on Council's First 10 Years Evaluates Progress in Reporting Medication Errors

The National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP), a collaborative effort among a group of national health care organizations and agencies – including NABP – to report and prevent medication errors, recently marked the 10-year anniversary of its founding with the release of *The National Coordinating Council for Medication Error Reporting and Prevention: The First Ten Years*. This publication provides background on the reasons behind NCC MERP's founding, a list of the Council's members, its accomplishments, current activities, and future initiatives.

NCC MERP's Founding

It is estimated that as many as 98,000 deaths a year are due to medical errors in hospitals, including 7,000 that result from medication errors. The United States Pharmacopeia (USP), through its work as a drug standards-setting organization and its experience with the nationwide USP-Institute for Safe Medication Practices (ISMP) Medication Errors Reporting Program, recognized that medication errors are caused by many different factors and that no one organization is equipped to effectively address issues involving medication errors. Therefore, the USP convened several national organizations that had the authority, mechanisms, and resources to confront the complexities of medication errors and seek solutions for these issues. NCC MERP was formed to actively promote the reporting, understanding, and prevention of medication errors through the efforts of its members, and to focus on ways to enhance patient safety through a coordinated approach and a systems-based perspective. In accordance with its mission, NCC MERP periodically issues recommended strategies for system modifications; practice standards and guidelines; and changes in product packaging, labeling, and naming.

NCC MERP has three main objectives aimed at reducing the number of medication error-related deaths:

- **Medication error understanding.** NCC MERP is engaged in an ongoing effort to improve the collection, classification, and analysis of data that categorizes types of errors, causes and sources of errors, and the impacts of these errors on patients and health system costs. In 1996 NCC MERP adopted a Medication Error Index that categorizes errors by severity of outcome, allowing practitioners and institutions to track errors in a consistent, systematic manner and prioritize error reduction activities.
- **Medication error reporting.** NCC MERP seeks heightened awareness of available reporting systems such as ISMP's Medication Errors Reporting Program and Food and Drug Administration's (FDA) MedWatch Reporting Program. To assist in the error

NCC-MERP Members

AARP
American Health Care Association
American Hospital Association
American Medical Association
American Nurses Association
American Pharmacists Association
American Society for Healthcare Risk Management
American Society of Consultant Pharmacists
American Society of Health-System Pharmacists
Department of Defense
Department of Veterans Affairs
Food and Drug Administration
Generic Pharmaceutical Association (formerly known as The Generic Pharmaceutical Industry Association)
Healthcare Distribution Management Association
Institute for Safe Medication Practices
Joint Commission on Accreditation of Healthcare Organizations
NABP
National Council of State Boards of Nursing
National Council on Patient Information and Education
National Patient Safety Foundation
Pharmaceutical Research and Manufacturers of America
United States Pharmacopeia, Inc
Deborah M. Nadzam, PhD, FAAN (individual member)
David Kotzin, RPh, BS, MS (individual member)

categorization, NCC MERP developed its *NCC MERP Taxonomy of Medication Errors*, which provides standard language and structure of medication error-related data for use in developing databases to analyze medication error reports.

- **Medication error prevention.** NCC MERP is engaged in continued research and reporting of medication errors to help identify areas where changes such as distinctive packaging, labeling, and nomenclature of products can help prevent future errors. NCC MERP advocates the use of computer-based systems to minimize the potential for human error, as well as education of health care practitioners, consumers, and patients in medication error prevention.

Since the formation of NCC MERP, NABP has aligned the recommendations of many of its task forces, such as the Task Force to Develop Recommendations to Best Reduce Medication Errors in Community Pharmacy Practice, with NCC MERP's recommendations (see "State Boards, Associations Addressing Patient Safety Improvement and Medical Error Mitigation on Multiple Fronts," March 2006 *NABP Newsletter*, page 52).

NCC-MERP Members

Fifteen interdisciplinary organizations and agencies met on July 19, 1995, for NCC MERP's first meeting. The Council's membership currently consists of 22 patient safety member organizations and two individuals (see table above).

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Transfers

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each other, several states do not allow an applicant to transfer when using a particular license for the basis of transfer. Currently, 17 jurisdictions do not allow transfer when using a Florida license for the basis of transfer (see Table 1).

In addition, 26 jurisdictions currently do not allow transfer when using a California license for the basis of transfer (see Table 2).

With a change to NABP's Constitution and Bylaws that became effective on May 23, 2005, licensure transfer applicants are no longer required to maintain the license that was required by original examination in order to transfer into some jurisdictions. A survey conducted by NABP on September 16, 2005, indicates that this is not the case for all jurisdictions. (Not all jurisdictions replied to the survey, and some decisions were pending at press time.)

Table 1

Alabama	Nevada
Arkansas	N Carolina
Connecticut	Ohio
Georgia	Oklahoma
Hawaii	Oregon
Idaho	Tennessee
Louisiana	West Virginia
Minnesota	Wyoming

Table 2

Alabama	Mississippi
Arkansas	Montana
Colorado	Nevada
Connecticut	New Jersey
Dist Columbia	N Carolina
Georgia	Oklahoma
Idaho	Pennsylvania
Indiana	Rhode Island
Iowa	Utah
Kentucky	Vermont
Louisiana	Washington
Maine	West Virginia
Maryland	Wyoming

Currently, 20 jurisdictions require licensure transfer applicants to maintain their license by original examination (see Table 3).

Conversely, 21 jurisdictions do not require licensure transfer applicants to maintain their license by original examination, but the licensure transfer applicant must have a license in good standing from a member board of pharmacy and transferred their license through the NABP Clearinghouse (see Table 4).

NABP continually reviews its internal processes to better assist the boards and applicants. Accordingly, by the end of the third quarter of 2006, the Association will be implementing an Internet-based application for individuals requesting licensure transfer.

More information about the licensure transfer process as well as downloadable Microsoft® Word and Adobe® Acrobat® PDF versions of the *Preliminary Application* are available at NABP's Web site at www.nabp.net.

Table 3

Alabama	New Hampshire
Alaska	New Jersey
Arizona	New York
Arkansas	North Dakota
Dist Columbia	Oklahoma
Kentucky	Oregon
Louisiana	South Carolina
Maine	South Dakota
Missouri	West Virginia
Nevada	Wyoming

Table 4

California	Montana
Delaware	Nebraska
Georgia	Ohio
Idaho	Puerto Rico
Illinois	Rhode Island
Indiana	Texas
Iowa	Utah
Maryland	Vermont
Massachusetts	Virginia
Minnesota	Wisconsin
Mississippi	

NCC MERP

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- Developing and disseminating recommendations focused on the safe use of sample medications within various health care settings; and
- Implementing follow up activities to the invitational roundtable meeting on the non-standardized use of drug suffixes in drug names.

Future Plans

NCC MERP's strategic plan focuses on continuing to evolve its presence and role in the current patient safety environment, both nationally and internationally. Accordingly, NCC MERP's future priorities will include:

- Continued generation of relevant and timely products designed to help reduce or prevent medication errors and increase or improve error reporting;
- Greater presence and participation in various national patient safety activities; and
- Increased communications.

Based on current discussions, future directions may include:

- More focused attention on error-related issues in non-hospital settings such as long-term care, home care, and behavioral health care;
- Predictive risk modeling;
- A comprehensive analysis of medication error literature over the past 10 years;
- Initiation of a campaign for increased error reporting;
- Development of a Research Agenda that targets critical error-reduction opportunities; and
- Enhanced error reporting incentives for further investigation, reliability, and validity studies relating to the Medication Error Index, expansion of NCC MERP membership, and the identification of collaborative opportunities with member organizations.

The full report is available at www.nccmerp.org/pdf/reportFinal2005-11-29.pdf.

State of California | Department of Consumer Affairs

Memorandum

To: Communication and Public Education Committee

Date: September 9, 2006

From: Board of Pharmacy – Virginia Herold

Subject: Development of a New Notice to Consumers

Assembly Bill 2583 (Nation) was passed by the California Legislature and is awaiting action by the Governor. If enacted, this bill would require the board to add to the Notice to Consumers, a statement that describes a patient's right to obtain medication from a pharmacy:

1. even if a pharmacist has ethical, moral or religious grounds against dispensing a particular drug, in which case protocols for getting the patient the medication is required.
2. unless based upon the pharmacist's professional training and judgment that dispensing a drug is contrary to law or the drug would cause a harmful drug interaction or otherwise adversely affect the patient's medical condition.
3. unless the medication is out of stock or not available from the pharmacy.
4. unless the patient cannot pay for the medication or pay any required copayment.

The information required to be displayed on the Notice to Consumers by AB 2583 will need to eventually be promulgated in a regulation.

At the last committee meeting, the committee noted that the addition of this additional material to the Notice to Consumers will be a challenge because the current poster is very full of text already. Moreover, the new content does not really mesh with the focus of the current Notice to Consumers.

The committee discussed options for the poster:

1. Eliminating some material currently required on the Notice to Consumers
2. Increasing the size of the poster
3. Graphically redesigning the poster
4. Creating a second required poster

The committee recommended to the board at the July meeting that a second notice to consumers be considered.

I am attaching a copy of the enrolled version of AB 2583 and an 8.5" X 11" Notice to Consumers (which is smaller than the actual poster size that must be displayed in pharmacies). The Governor has until September 30 to sign, veto or let become law without his signature this bill. However, regardless of whether this becomes a statutory mandate to the board, the board may want to pursue

such a notice to consumers in hopes of educating consumers about this law.

A draft (very broad and too wordy) to encompass the required text and yet inform patients about their rights to medication and pharmacist care is:

Did you know that/(or Your rights as a patient):

California law requires a pharmacist to provide medicine that has been legally prescribed for a patient, except for specific reasons.

For example, a pharmacy is not required to provide medicine without reimbursement.

If you cannot obtain your medicine from the pharmacy, ask the pharmacist why.

If the pharmacy does not sell your medicine or is out of it, you may be referred to another pharmacy.

If the pharmacist has ethical, religious or moral reasons for not personally providing you with a specific medicine, the pharmacy must provide an alternative means for you to obtain it.

Talk with your pharmacist:

The pharmacist is required to talk to you about all new prescription medicine the first time you receive it. The pharmacist will also answer your questions about your medicine any time.

Information from a pharmacist is important to your health because it can make certain you know what is important about your medicine therapy. Pharmacists are educated to be the experts in medicine therapy,

Contact the Board of Pharmacy:

Pharmacies and pharmacists providing prescription medicine to patients in California must be licensed with the California State Board of Pharmacy.

You can contact the board with questions using the information below (address, phone number and web address).

Notice to Consumers

Before taking any prescription medicine, talk to your pharmacist; be sure you know:

1. What is the name of the medicine and what does it do?
2. How and when do I take it – and for how long? What if I miss a dose?
3. What are the possible side effects and what should I do if they occur?
4. Will the new medicine work safely with other medicines and herbal supplements I am taking?
5. What foods, drinks or activities should I avoid while taking this medicine?

Ask your pharmacist if you have additional questions.

At your request, this pharmacy will provide its current retail price of any prescription without obligation. You may request price information in person or by telephone. Ask your pharmacist if a lower cost generic drug is available to fill your prescription. Prescription prices for the same drug vary from pharmacy to pharmacy. One reason for differences in price is differences in services provided.

BE AWARE & TAKE CARE

Talk to your Pharmacist!

California State Board of Pharmacy

(916) 574-7900 • www.pharmacy.ca.gov

1625 N. Market Blvd, Suite N219, Sacramento, CA 95834

OSP 02 72011

Assembly Bill No. 2583

Passed the Assembly May 25, 2006

_____

Chief Clerk of the Assembly

Passed the Senate August 17, 2006

_____

Secretary of the Senate

This bill was received by the Governor this _____ day of _____, 2006, at _____ o'clock ____M.

_____

Private Secretary of the Governor

CHAPTER _____

An act to amend Sections 733 and 4122 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 2583, Nation. Dispensing prescription drugs and devices: refusal to dispense.

Existing law prohibits a health care licentiate from obstructing a patient in obtaining a prescription drug or device, and requires the licentiate to dispense drugs and devices pursuant to a lawful prescription or order, except in specified circumstances, including on ethical, moral, or religious grounds asserted by the licentiate if certain requirements are met. Existing law authorizes the California State Board of Pharmacy to issue a citation for a violation of these provisions and authorizes its executive officer to issue a letter of admonishment for their violation. Existing law, the Pharmacy Law, requires every pharmacy to prominently post a notice to consumers provided by the board concerning the availability of prescription price information, the possibility of generic drug product selection, and the types of services provided by pharmacies. A violation of the Pharmacy Law is a crime.

This bill would require the consumer notice posted in pharmacies to also contain a statement describing patients' rights relative to access to prescription drugs or devices. By changing the definition of a crime, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 733 of the Business and Professions Code is amended to read:

733. (a) No licentiate shall obstruct a patient in obtaining a prescription drug or device that has been legally prescribed or ordered for that patient. A violation of this section constitutes unprofessional conduct by the licentiate and shall subject the licentiate to disciplinary or administrative action by his or her licensing agency.

(b) Notwithstanding any other provision of law, a licentiate shall dispense drugs and devices, as described in subdivision (a) of Section 4024, pursuant to a lawful order or prescription unless one of the following circumstances exists:

(1) Based solely on the licentiate's professional training and judgment, dispensing pursuant to the order or the prescription is contrary to law, or the licentiate determines that the prescribed drug or device would cause a harmful drug interaction or would otherwise adversely affect the patient's medical condition.

(2) The prescription drug or device is not in stock. If an order, other than an order described in Section 4019, or prescription cannot be dispensed because the drug or device is not in stock, the licentiate shall take one of the following actions:

(A) Immediately notify the patient and arrange for the drug or device to be delivered to the site or directly to the patient in a timely manner.

(B) Promptly transfer the prescription to another pharmacy known to stock the prescription drug or device that is near enough to the site from which the prescription or order is transferred, to ensure the patient has timely access to the drug or device.

(C) Return the prescription to the patient and refer the patient. The licentiate shall make a reasonable effort to refer the patient to a pharmacy that stocks the prescription drug or device that is near enough to the referring site to ensure that the patient has timely access to the drug or device.

(3) The licentiate refuses on ethical, moral, or religious grounds to dispense a drug or device pursuant to an order or prescription. A licentiate may decline to dispense a prescription drug or device on this basis only if the licentiate has previously notified his or her employer, in writing, of the drug or class of drugs to which he or she objects, and the licentiate's employer can, without creating undue hardship, provide a reasonable accommodation of the licentiate's objection. The licentiate's

employer shall establish protocols that ensure that the patient has timely access to the prescribed drug or device despite the licentiate's refusal to dispense the prescription or order. For purposes of this section, "reasonable accommodation" and "undue hardship" shall have the same meaning as applied to those terms pursuant to subdivision (*l*) of Section 12940 of the Government Code.

(c) For the purposes of this section, "prescription drug or device" has the same meaning as the definition in Section 4022.

(d) The provisions of this section shall apply to the drug therapy described in paragraph (8) of subdivision (a) of Section 4052.

(e) This section imposes no duty on a licentiate to dispense a drug or device pursuant to a prescription or order without payment for the drug or device, including payment directly by the patient or through a third-party payer accepted by the licentiate or payment of any required copayment by the patient.

(f) The notice to consumers required by Section 4122 shall include a statement that describes patients' rights relative to the requirements of this section.

SEC. 2. Section 4122 of the Business and Professions Code is amended to read:

4122. (a) In every pharmacy there shall be prominently posted in a place conspicuous to and readable by prescription drug consumers a notice provided by the board concerning the availability of prescription price information, the possibility of generic drug product selection, the type of services provided by pharmacies, and a statement describing patients' rights relative to the requirements imposed on pharmacists pursuant to Section 733. The format and wording of the notice shall be adopted by the board by regulation. A written receipt that contains the required information on the notice may be provided to consumers as an alternative to posting the notice in the pharmacy.

(b) A pharmacist, or a pharmacist's employee, shall give the current retail price for any drug sold at the pharmacy upon request from a consumer, however that request is communicated to the pharmacist or employee.

(c) If a requester requests price information on more than five prescription drugs and does not have valid prescriptions for all of the drugs for which price information is requested, a pharmacist

may require the requester to meet any or all of the following requirements:

(1) The request shall be in writing.

(2) The pharmacist shall respond to the written request within a reasonable period of time. A reasonable period of time is deemed to be 10 days, or the time period stated in the written request, whichever is later.

(3) A pharmacy may charge a reasonable fee for each price quotation, as long as the requester is informed that there will be a fee charged.

(4) No pharmacy shall be required to respond to more than three requests as described in this subdivision from any one person or entity in a six-month period.

(d) This section shall not apply to a pharmacy that is located in a licensed hospital and that is accessible only to hospital medical staff and personnel.

(e) Notwithstanding any other provision of this section, no pharmacy shall be required to do any of the following:

(1) Provide the price of any controlled substance in response to a telephone request.

(2) Respond to a request from a competitor.

(3) Respond to a request from an out-of-state requester.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

State of California | Department of Consumer Affairs

Memorandum

To: Communication and Public Education Committee

Date: September 9, 2006

From: Virginia Herold

Subject: Miscellaneous Consumer Issues and Articles in the News

I am also adding to this packet several articles of consumer interest that are not under review by one of the board's other strategic committees. During this meeting, the committee can review and discuss these items in the event it wishes to propose future action at the next committee meeting.

Also, please feel free to submit items to me that you wish to have included in future Communication and Public Education Committee packets.

National Pharmacy

(Applicability of the contents of articles in the National Pharmac mp
and can only be ascertained by examini

July 2006

Generic Substitution Issues

This is a reminder to pharmacists regarding the legal generic substitution of certain drug products. Recent practices by pharmaceutical manufacturers involving the reformulation of drugs into alternative dosage forms (eg, tablets to capsules) seem to have caused some confusion.

Generic substitution is the act of dispensing a different brand or unbranded drug product than the one prescribed. Generic substitution is only allowable when the substituted product is therapeutically equivalent to the prescribed innovator product. Generic drug manufacturers must provide evidence to Food and Drug Administration (FDA) of therapeutic equivalence, which means that both products are pharmaceutically equivalent (eg, have the same active ingredients in the same dosage form and strength, and use the same route of administration) and bioequivalent (eg, have more or less the same rate and extent of absorption). Therapeutically equivalent drugs are expected to produce the same clinical benefits when administered for the conditions approved in the product labeling.

FDA assigns two-letter therapeutic equivalence codes to generic products when the products meet both the aforementioned requirements, are approved as safe and effective, are adequately labeled, and are manufactured in compliance with current Good Manufacturing Practice regulations. The primary reference guide for pharmacists on therapeutic equivalence is FDA's Approved Drug Products with Therapeutic Equivalence Evaluations, otherwise known as the "Orange Book." Drug products determined to be therapeutically equivalent to innovator drugs are assigned an "A" for the initial letter of their therapeutic equivalence code. The second letter provides additional information regarding the product: products rated AA, AN, AO, AP, or AT are those with no known or suspected bioequivalence problems (rating depends on dosage form). An AB rated product indicates that actual or potential bioequivalence problems have been resolved with adequate in vivo and/or in vitro evidence. In contrast, drugs assigned a "B" for the initial letter are not considered therapeutically equivalent because bioequivalence problems have not been resolved to the satisfaction of FDA.

A recent example of improper substitution has been brought to the attention of several boards of pharmacy by Acorda Therapeutics, the maker of Zanaflex® tablets, who recently released Zanaflex Capsules™ (tizanidine hydrochloride). Although the active ingredient in Zanaflex Capsules is the same as the active ingredient in Zanaflex tablets and generic tizanidine tablets, their formulations are different. For this reason, FDA has deemed there to be no therapeutic equivalent to Zanaflex Capsules and has not assigned a therapeutic equivalence code.

A similar situation existed in 1995 when the manufacturer of Sandimmune® (cyclosporine) capsules and oral solution, Sandoz, (now Novartis), came out with NEORAL® (cyclosporine) capsules and oral solution for microemulsion. Due to differences in bioavailability, Sandimmune and Neoral, and their accompanying generic versions, were not, and still are not, rated as substitutable.

It must be emphasized that generic substitution mandates are found in individual state laws and regulations. In states where generic substitution is allowed only for "Orange Book" A-rated products, pharmacists may not substitute a generic product for a non-A-rated product. Some states may have developed their own generic substitution lists or formularies. Pharmacists are encouraged to review the laws and regulations in their states to determine the appropriate legal methods by which to perform generic substitution.

Public Ed

Consumer Pub Ed.

washingtonpost.com

Petitions to FDA Sometimes Delay Generic Drugs

Advertisement

Critics Say Companies Misusing Process

By Marc Kaufman
Washington Post Staff Writer
Monday, July 3, 2006; A01

A procedure designed to alert the Food and Drug Administration to scientific and safety issues is getting a hard look from members of Congress, who say they are concerned that it may be getting subverted by the brand-name drug industry.

Some at the FDA, as well as leaders in the generic drug industry, complain that "citizen petitions" -- requests for agency action that any individual, group or company can file -- are being misused by brand-name drugmakers to stave off generic competition.

The simple act of filing a petition, they say, triggers another round of time-consuming and often redundant reviews of the generics by the FDA, which can take months or years. In the process, consumers continue to pay millions of dollars more for the brand-name drugs.

Statistics collected by the staff of Sen. Debbie Stabenow (D-Mich.), who has introduced legislation with Sen. Trent Lott (R-Miss.) that would rein in industry-filed citizen petitions, show that 20 of the 21 brand-name petitions settled by the FDA since 2003 were ultimately rejected.

"The brand-name drug industry has found a major new loophole," Stabenow said in an interview. "The way things stand now, even if the FDA finds that a petition was frivolous and rejects it, [the drug companies] can get hundreds of millions of dollars of profits from the delay."

She and others point to the example of Wellbutrin XL, a hot-selling antidepressant that was facing the prospect of competition from cheaper generics late last year.

By the time Biovail Corp., the drug's maker, filed a citizen petition with the FDA, raising concerns about the safety of its potential rivals, Impax Laboratories Inc. and several other companies had already gone through much of the FDA application and review process for their generic versions of the drug. Impax was looking forward to getting a tentative approval that would bring it considerably closer to making and selling its competing drug.

But because of the citizen petition, the FDA has yet to act, and Biovail still has the market for Wellbutrin XL to itself. Impax is fuming, as are many others in the generic drug industry.

In a letter sent last week to FDA Acting Commissioner Andrew von Eschenbach, Stabenow and Lott estimated that the delay in approving a generic version of the antidepressant Wellbutrin XL is costing consumers $37 million a month.

Impax already sells a twice-a-day version of Wellbutrin; the once-a-day XL version was approved by the FDA in 2003 as the patent on the shorter-lasting formulations was running out.

"Biovail's petition is a sham, designed solely to delay the onset of generic competition for its Wellbutrin XL product," Impax told the FDA in a letter. "Biovail has wasted FDA's and Impax's time and resources

and has likely cost the American public millions of dollars in taxes and health care expenditures in selfish pursuit of further undeserved windfall profits."

Biovail rejects the view that it is trying to block generic competition, and in its petition made the case that generic versions of its product may not be biologically equivalent and could be dangerous. As a result, the company -- which has also filed patent infringement suits against its prospective rivals -- asked the FDA to require substantial additional testing before any generic version of Wellbutrin XL is approved.

Pharmaceutical Research and Manufacturers of America (PhRMA), which represents brand-name drugmakers, supports the citizen petition process and says the dozens of similar petitions pending with the FDA raise legitimate concerns.

"Most citizen petitions raise important regulatory, legal or scientific issues," said Caroline Loew, the group's senior vice president. "The fact is, the petitions have played a vital role at the FDA since their adoption almost 30 years ago. They have been responsible for important discussions about health and safety, and have been a catalyst for key agency decisions, such as speeding approval of AIDS medicines and implementing rules to protect children from accidental iron poisoning."

Although citizen petitions have raised many important drug policy issues, the Wellbutrin filing is one of several dozen pending that some call "blocking petitions" because they have the effect of delaying approval of a generic alternative. FDA officials said that about 170 citizen petitions are before the agency -- compared with 90 in 1999 -- and that about 30 percent involve industry challenges to generic applications.

FDA Chief Counsel Sheldon Bradshaw told generic drugmakers at a September conference that the agency has been troubled by the number of such petitions. He said they "appear designed not to raise timely concerns with respect to the legality or scientific soundness of approving a drug application, but rather to delay approval by compelling the agency" to review arguments that could have been made months before.

That response caused PhRMA to write to Bradshaw asking for more information. Scott Lassman, PhRMA's assistant general counsel, said the organization found the comments to be "troubling," especially if they could lead to restrictions on how and when citizen petitions could be filed.

More recently, Scott Gottlieb, FDA deputy commissioner for medical and scientific affairs, said in an interview that the agency has instituted internal changes that will allow for quicker rulings on citizen petitions, especially if they are filed close to the time when a decision on a new generic is expected. But he said that he did not believe there had been an increase in "what a reasonable person would call a blocking petition."

"It's very hard to decide what's a blocking petition and what has value without taking a serious look," Gottlieb said. "I think citizen petitions are very important and have to be preserved. The last thing we want to do is close off an avenue of discourse with the agency."

By regulation, all generic drugs must be "bioequivalent" to the brand-name drugs they copy and must have the same effects and dependability. Industry-sponsored citizen petitions often challenge the process by which bioequivalence was tested.

Because generics generally cost 25 percent to 75 percent less than brand-name products, the sums of

money at stake can be enormous -- for the brand-name company, the generic maker, patients, insurance companies and government programs. Wellbutrin XL (a once-a-day formula of bupropion hydrochloride with fewer side effects than the original) costs $1 to $5 a pill and earns about $800 million a year for Biovail and GlaxoSmithKline PLC, which developed the drug. An Impax spokesman said his company planned to sell its generic version, if approved by the FDA, for "a considerable discount."

Making changes to the citizen petition process is a high priority for the Generic Pharmaceutical Association. Its president, Kathleen Jaeger, said her group considers blocking petitions to be among the greatest obstacles facing the industry.

"Because of the way the system works now, branded companies have every reason to file citizen petitions," she said. "There's a potentially great benefit, and there's no risk. I can't imagine that this is how the originators of the petitions thought they should work."

This is not the first time that the generic industry has complained about citizen petitions that it believed were unfairly blocking generic applications. The Clinton administration responded to those complaints in 1999 with a proposal that would have changed the way the FDA received and handled citizen petitions. PhRMA strongly opposed the rule, and the Bush administration withdrew it in 2003.

Jaeger said the generic industry was working hard with Congress at that time to close other loopholes in the patent system that allowed makers of brand-name drugs to extend their time for exclusive sales. "We were working so hard to get that legislation passed that we didn't really focus on what was happening with the citizen petition rule," she said, "so some of what we won in Congress, we lost to the citizen petitions."

Stabenow and Lott, who are trying, in their bill, to reduce the petitions, said in their letter to von Eschenbach that "the Senate Appropriations Committee recognized the unintended effect citizen petitions were having on the approval of [generic drug applications] and directed the FDA to provide a written report explaining the process and suggesting improvements. . . . It is our understanding the FDA has not moved forward with this request."

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Pubs Ed

Kaiser Daily Health Policy Report

Monday, August 14, 2006

Prescription Drugs

Pharmaceutical Companies, Consumer Groups Debate Promotions for Brand-Name Medications

Reuters/Boston Globe on Monday examined the debate over the use of coupons, rebates and similar promotions for brand-name prescription drugs. According to pharmaceutical companies, such promotions can reduce costs for patients and allow them to take new medications. Consumer groups maintain that such promotions can attract patients to risky and unnecessary medications without a reduction in their long-term costs. More than 20 consumer groups have partnered to seek an FDA ban on such promotions. Earlier this year, FDA said in a notice, "Prescription drugs promoted with coupons or free trials may be seen as more widely indicated, more appropriate and/or less risky than they really are." However, FDA spokesperson Julie Zawisza said that the agency later withdrew the notice and has begun to "identify the important issues or questions to be considered and to determine the appropriate role of the FDA." Susan Sherry, deputy director of Massachusetts-based Community Catalyst, said that such promotions "can increase the patient's desire to take a drug that may or may not be the most suitable drug." Jerry Avorn -- a Harvard professor and author of "Powerful Medicines: The Benefits, Risks and Costs of Prescription Drugs" -- said that such promotions can prompt consumers to take brand-name medications when lower-cost generic versions are available. He added, "All that does is get them used to being on the expensive drug." The Pharmaceutical Research and Manufacturers of America said that FDA should consider such promotions on a case-by-case basis, rather than impose a ban (*Reuters/Boston Globe*, 8/14).

Kaiser Daily Health Policy Report

Friday, July 28, 2006

Prescription Drugs

Many Physicians Receive Lunches From Pharmaceutical Companies To Promote Products

The *New York Times* on Friday examined pharmaceutical companies' practice of offering free lunches in doctors' offices in order to pitch their products. The practice increased in 2002 after the drug industry adopted voluntary standards banning elaborate gifts for doctors such as free vacations and expensive dinners. The code allows companies to provide modest meals for doctors in the course of business. According to the *Times*, "several studies show that the lunches -- plus small gifts like pens and sticky notepads, along with drug samples -- can lead doctors to prescribe the more expensive brand names when cheaper generic drugs would be as effective." Such influence has led some hospitals and doctors offices nationwide to ban free lunches from pharmaceutical companies. Patrick Brennan, medical director of the Hospital of the University of Pennsylvania -- which recently banned the practice -- said, "It curries favor, and it creates influence, and it introduces influences into decision-making processes that we think ought not to be there." However, Scott Lassman, senior assistant general counsel for the Pharmaceutical Research and Manufacturers of America, said, "It's our feeling that a modest meal is not the type of thing that is going to interfere with the independence of a health care practitioner." Lassman added, "It's really a recognition that these folks are extremely busy. They don't have time to talk. Perhaps the only time they do have time to talk is over lunch or dinner. So we thought it was appropriate for the sales rep to pay for that" (Saul, *New York Times*, 7/28).

public ed

Kaiser Daily Health Policy Report

Wednesday, June 28, 2006

Prescription Drugs

Los Angeles Times Examines 'Explosion' of Rx Drug Product Liability Lawsuits

The *Los Angeles Times* on Tuesday examined the recent "explosion" of product liability lawsuits filed against pharmaceutical companies. According to an analysis conducted for the *Times* by the research firm Thomson West, plaintiffs have filed more than 71,000 product liability lawsuits related to prescription drugs in federal courts since 2001, and they have filed "untold others" in state courts. Lawsuits related to prescription drugs currently account for more than one-third of all product liability lawsuits filed in federal courts, the analysis finds. Legal experts attribute the increase in product liability lawsuits related to prescription drugs in part to "fundamental changes in the pharmaceutical industry's business practices intended to boost sales and profits," the *Times* reports. Since the late 1990s, pharmaceutical companies have increased sales through direct-to-consumer advertisements. "This business model begot the era of blockbuster drugs" but also established the "potential for blockbuster liability," according to the *Times*. For example, more than 20 million patients used the COX-2 inhibitor Vioxx before Merck withdrew the medication from the market in September 2004 over safety concerns. More than 23,500 plaintiffs nationwide allege that Vioxx injured them or their family members (Girion, *Los Angeles Times*, 6/27).

Health Costs / *By Tara Siegel Bernard*

Avoid Medical ID Theft

Sitting in your doctor's examining room, you glance at your chart and see lengthy notes about a condition you know you don't suffer from. Or perhaps you receive a bill, for thousands of dollars, for surgery you never had.

Welcome to the world of medical identity theft—in which your name and information such as your Social Security number and insurance coverage are used to obtain medical services or goods and, in some cases, money, by filing bogus claims.

This form of thievery is on the rise, and it may be harmful to your health as well as your finances. If your medical records reflect another patient's ills, you could be incorrectly treated. Other victims have been denied insurance coverage altogether.

Moreover, medical ID theft can take years to detect because, unlike with financial identity theft, these fraudsters don't necessarily run up credit-card bills or commit other acts that quickly show up on your credit report, according to the World Privacy Forum, a San Diego-based research group that focuses on privacy issues.

The major credit-reporting firms serve as central repositories that can clue you in if someone has opened new credit accounts in your name. But "with medical files, there is nothing like that," says Pam Dixon, executive director at the World Privacy Forum and author of the report.

Anatomy of a Fraud

In many cases, medical ID thieves use your information to get medical treatment they need; they may change your billing address and phone number so you don't see the bills.

In an even more insidious scenario, organized crime rings will use the stolen IDs to obtain drugs—like painkillers—and then sell them on the street. In another case, a psychiatrist entered false diagnoses on the charts of individuals who weren't his patients and used their information to submit bills to an insurance company.

The World Privacy Forum estimates at least a quarter to a half million people have been victimized over the past decade, though officials there believe the figure is actually much higher.

There are several red flags to watch for: Have you received a collection notice in the mail for medical services you didn't receive? Did you receive someone else's bill? Have you been denied insurance coverage, or been notified that you've reached your lifetime cap?

Are there irregularities on your "explanation of benefits" notices? Even if you don't owe any money, watch out for reports of services you didn't receive.

"That's when you have to call your insurer's anti-fraud hotline or customer service. Sometimes it's a clerical error...but, in a lot of cases, it's fraud," says Byron Hollis, anti-fraud director for the Blue Cross Blue Shield Association, a trade group for 38 health plans.

There are other steps you can take to protect yourself. Once a year, request a listing of benefits paid by your health insurer in your name. And keep your insurance card as safe as your credit cards.

If You've Been Hit

Brace for hassles if you're a victim. You'll need to ask medical providers to let you inspect your files, which you are legally entitled to do. But some may initially refuse because you aren't the person they recognize as the patient who got services in your name.

To try to discern where the fraud occurred, and where else those records were circulated, request that your providers and insurer provide an "accounting of disclosures." This is a record of what health information was disclosed, to whom, when, and why.

Next, work with the providers and insurance company to amend your records. And be sure labs, pharmacies and other providers correct their records, too. For more on the problem and how to respond, see the World Privacy Forum Web site (worldprivacyforum.org).

"Encore" will be back next week. To comment on today's "Health Costs" column, you may send an email to: **forum.sunday03@wsj.com**

State of California

Department of Consumer Affairs

Memorandum

To: **Communication and Public Education Committee**

Date: September 9, 2006

From: **Board of Pharmacy – Virginia Herold**

Subject: **Evaluation of the Board's Consumer Materials**

At the last committee meeting, Board Member Schell suggested that the committee initiate a consumer survey of its consumer materials to learn if the material has value for the public.

At the committee meeting, staff will distribute a short survey we will ask the public to complete at our next few public information events.

I am also enclosing in this tab section the executive study of a consumer survey the board undertook in 2000.

META INFORMATION SERVICES

SUMMARY OF RESULTS

CONSUMER AWARENESS AND OPINION SURVEY FOR THE CALIFORNIA BOARD OF PHARMACY

MARCH 2000

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1819 K Street, Suite 200 • Sacramento, CA 95814 • (916) 325-1222 (office) • (916) 325-1224 (fax)

Project Background

Objectives

The California State Department of Consumer Affairs engaged MetaResearch (Meta) to conduct market research to assess California consumers' awareness and opinions regarding the Board of Pharmacy (Board). The specific objectives for this study were to:

- Assess overall impression of pharmacists in California,
- Determine consumer knowledge about a pharmacists role in health care, in general,
- Determine consumer awareness of the Board of Pharmacy,
- Identify public perception of the Board's role in protecting consumers,
- Assess consumer awareness of the Board's complaint filing procedure,
- Identify consumers' preferences in selecting methods to receive information from the Board and their pharmacist or pharmacy, and
- Identify demographic characteristics.

Research Method

MetaResearch conducted seven hundred fifty telephone interviews with adult residents of California. A total of 299 interviews were conducted with consumers 65 years of age and older. Across all 750 interviews, sampling error was +/- 3.6% (at the 95% confidence level). The sampling error for the 299 interviews was +/-5.7% (at the 95% confidence level).

All calls were conducted using CATI (Computer Assisted Telephone Interviewing) technology. Interviewing took place between the dates of March 6 and March 24, 2000. The average interview lasted 11:40 minutes.

Sample Design

MetaResearch conducted stratified RDD (random digit dial) telephone surveys with California residents, proportionally representative of the population at a statewide level. Based on U.S. Census Bureau estimates, approximately 29% of the interviews were completed with LA County residents; 20% with Coastal Southern California residents; 17% with San Francisco / Bay Area residents; 15% with Central Valley residents; and

18% with residents in the balance of California. Of the seven hundred fifty interviews conducted, 299 were completed with adults 65 years of age and older. In order to have a representative sample of the state, overall results were weighted according to estimated census data for California by age, as shown in the table below.

Age	Percent
18 – 24 years old	9%
25 – 34 years old	22%
35 – 44 years old	24%
45 – 54 years old	18%
55 – 64 years old	11%
65 years and older	16%

Questionnaire

MetaResearch designed the questionnaire for this survey in consultation with the Board staff. It consisted of 53 data points, that is, 41 survey questions asked, 3 of which were open ended questions, 1 question coded by observation and 2 questions calculated by computer software.

Methods of Analysis

Meta tabulated responses using univariate and multivariate methods. Statistical tools varied depending upon the type of variable analyzed. Meta calculated frequency counts and frequency percentages. Unless otherwise noted, frequency percentages reported in this document represent *adjusted* frequencies, meaning that percentages have been adjusted to account for any non-responses (refusals to answer the question) or non-qualified responses (questions not answered due to answers to previous questions). Overall results are based on the weighted data (as described in Sample Design). Any differences noted

between older residents (65+) and younger residents (under 65) are based on analyses run on the unweighted data.

Researchers are interested in assessing whether or not the differences in observed percentages are just chance differences or if they represent a real difference for the population. Real differences are identified by running statistical analyses and are discussed in the report. Statistical significance within crosstabulation tables was calculated using chi square ($\chi 2$) statistics. Tests of proportion were used to identify differences in responses between questions or groups of respondents. Regression analysis was used to identify leading predictors on appropriate questions.

Caveat

This report is intended to provide a collection, categorization and summarization of public opinion data. Meta intends neither to endorse nor to criticize the California Board of Pharmacy, its policies, services, or staff. The Client shall be solely responsible for any modifications, revisions, or further disclosure/distribution of this report.

Conclusions

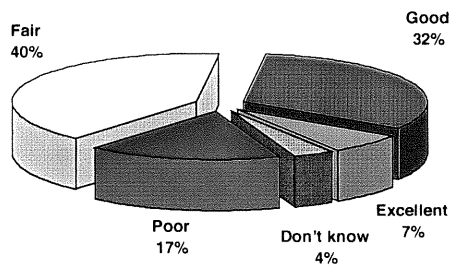
This portion of the report presents the results of the survey. Overall conclusions are based on weighted results. Any comparisons between older adults (65+) and the general population (under 65) are supported by analyses conducted on unweighted data, comparing the two populations. Univariate and multivariate analyses were conducted and, based on the results, the following conclusions seem warranted.

Overall Health Care in California

1 ➢ *Two in five California residents had a positive opinion of the overall quality of health care in California, giving it a "good" or "excellent" rating. When asked to rate more specific aspects of health care, pharmacists received the most positive ratings, with 7 in 10 respondents rating the quality of pharmacists as "good" or "excellent."*

Respondents were first asked to rate the overall quality of health care in California. As shown graphically below, one in three residents (32%) said that California health care was "good" with another 7% rating it as "excellent." Forty percent of residents considered it "fair" and 17% gave a "poor" rating. Four percent of respondents were undecided.

Overall Quality Rating
of Health Care in California



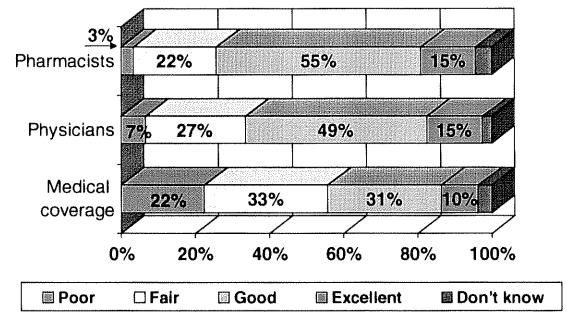
Respondents were asked to rate the quality of more specific aspects of health care, such as physicians, medical coverage and pharmacists. A majority of residents rated the quality of pharmacists positively, with 15% giving an "excellent" rating and over half of the respondents (55%) rating

the quality of pharmacists as "good." A quarter of California residents had a negative opinion about the quality of California pharmacists (22% said "fair," and 3% said "poor"). Four percent were undecided.

A similar percentage of Californians rated the quality of physicians positively, with two-thirds rating medical doctors positively, either "excellent" (15%) or "good" (49%). More than a quarter of those interviewed (27%) rated the quality of California physicians as "fair" and 7% said it was "poor." Two percent were undecided.

Fewer than half of the state residents had a positive opinion of the quality of medical coverage, with 10% of respondents rating the quality of medical coverage as "excellent" and nearly a third (31%) giving a "good" rating. One in three respondents (33%) rated the quality of medical coverage as "fair" and 22% rated it as "poor." Four percent of respondents were undecided as to the quality of medical coverage.

Quality Rating of
Health Care Aspects



Bivariate analysis indicated that older Californians (65 years or older) were significantly more likely (24%) than younger residents (15%) to rate the quality of pharmacists as "excellent."

2 ➢ *Further analysis showed that residents' opinions of all three aspects of health care are important and significantly related to the overall opinions of health care in California, in the following order:*

1. *Quality of medical coverage*
2. *Quality of physicians*
3. *Quality of pharmacists*

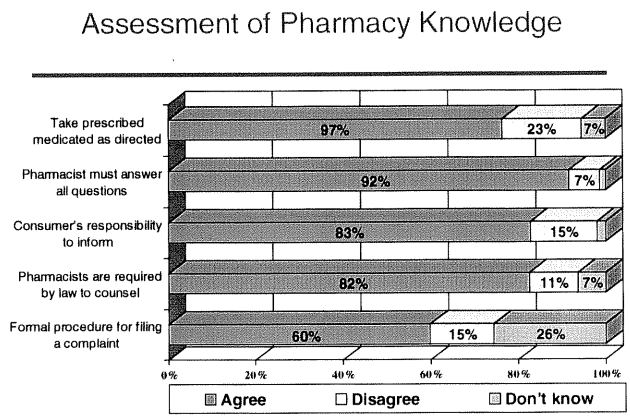
A technique called multiple regression analysis provides more insight into evaluative ratings, allowing one to rank order them according to how they relate to the overall evaluation. Current regression results indicated, first of all, that all three aspects were significant. Further, "Quality of medical coverage" was the most "important" aspect of health care, followed by "quality of physicians," followed in turn by "quality of pharmacists". In other words, residents who were more positive in their evaluations of the quality of medical coverage (and physicians and pharmacists) were also more positive in their overall evaluations. Similarly, those who were negative in their evaluations of the individual aspects were also more likely to hold negative overall opinions of health care in general.

Knowledge of Pharmacies and Pharmacists

2 ➢ *Overall, most Californians were knowledgeable about a pharmacist's role in health care and agreed that:*

- *it is important to take prescribed medications exactly as directed,*
- *pharmacists must answer any and all questions a consumer asks about prescribed medications,*
- *it is the consumer's responsibility to inform the pharmacist of all of the medications being currently taken, and*
- *pharmacists are required by law to counsel a consumer about prescription mediations.*

Respondents were read a number of statements in random order about pharmacies and pharmacists and asked whether they agreed or disagreed with each statement. Most respondents agreed that pharmacists must answer any and all consumer questions about prescribed medications and are required by law to counsel consumers about prescription medications (92% and 82%, respectively). A similar high percentage of state residents concurred that prescribed medications should be taken exactly as directed and that they, as consumers, should inform the pharmacist of all of the medications being taken (97% and 83%, respectively).



4 ➢ *While a majority of residents agreed that a formal procedure existed for filing a complaint against a pharmacy or a pharmacist, two in five respondents were unaware of such a process, either disagreeing with the statement or saying they were unsure about it.*

Three in five respondents (60%) agreed there was a formal procedure established for filing a complaint against a pharmacy or a pharmacist. The rest either disagreed (14%) or were unsure (26%).

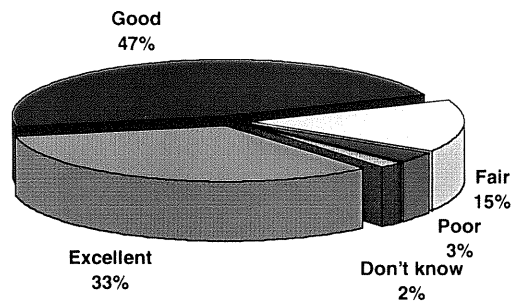
Further analysis, however, showed that, while a majority of respondents thought a process for pharmacy grievances existed, responses from subsequent questions indicated that most respondents did not associate such a procedure with the Board of Pharmacy or any specific entity. Most respondents (74%) who agreed that a formal procedure existed said they had not heard of the Board of Pharmacy prior to the interview, while only one in four respondents (26%) said they were aware of the Board. Furthermore, among those who agreed that a formal procedure exists and said they would file a compliant, "with the pharmacy" was the most common response to the question regarding filing the complaint (36%), compared with 27% who mentioned the Board as the place where they would file a complaint.

Impression of Local Pharmacists

5 ➢ *Most California residents had positive impressions of their local pharmacists, with 8 in 10 respondents rating their overall satisfaction as either "good" or "excellent."*

The next set of questions referred to the pharmacy that respondents visited most often, or, if the respondents never went to the same pharmacy, the questions referred to the pharmacy last visited[1]. First, the respondents were asked to rate their overall satisfaction with the pharmacist. Almost half of the respondents (47%) rated their overall satisfaction with the pharmacist as "good" with an additional 33% giving an "excellent" rating. Fifteen percent of respondents rated their overall satisfaction with the pharmacist as "fair" and 3% rated it as "poor." Two percent were undecided.

Overall Rating of Local Pharmacist



6 ➢ *California pharmacists received the highest satisfaction ratings for informing how and when to take prescribed medications in addition to their overall knowledge of medications. The lowest ratings were received for inquiring about other medications a respondent might be taking.*

Respondents were asked to rate their satisfaction with specific issues concerning their local pharmacist. Most residents rated their pharmacist "excellent" or "good" in terms of informing them about **when** to take their medications (41% and 44%, respectively). Ten percent of Californians gave their pharmacist a "fair" rating for informing them about such things as the number of times per day a medication should be taken and 2% rated their pharmacist as "poor" in this area. Three percent were undecided.

[1] The questions were introduced in two ways, depending how often the respondent takes their prescriptions to the same pharmacy (q35). Those who "never" take their prescriptions to the same pharmacy were asked to refer to the last time they went to a pharmacist. Those who "sometimes", "often" or "always" take their prescriptions to the same pharmacy

When asked to rate their satisfaction with their pharmacist in terms of informing them **how** to take their medications, 3 in 4 residents rated their pharmacists positively, with 41% of respondents giving an "excellent" rating and 45% rating them "good". Ten percent of respondents gave their pharmacist a rating of "fair" for informing how to take prescribed medications, such as with food or before meals, and 3% gave a rating of "poor." One percent was undecided.

Two in five respondents (39%) rated their satisfaction with the pharmacist in terms of knowledge of the medications prescribed as "excellent" and 44% gave a "good" rating. Eleven percent of respondents rated the pharmacist's knowledge of prescribed medications as "fair" and 2% rated it "poor." Four percent were undecided.

Thirty-four percent of respondents rated their satisfaction with their local pharmacist's availability to answer all of their questions as "excellent." Forty-two percent of those responding gave the rating "good," 16% rated the pharmacist's availability as "fair" and 6% rated the availability of their local pharmacists as "poor." Two percent were undecided as to their satisfaction with their local pharmacist's availability to answer their questions.

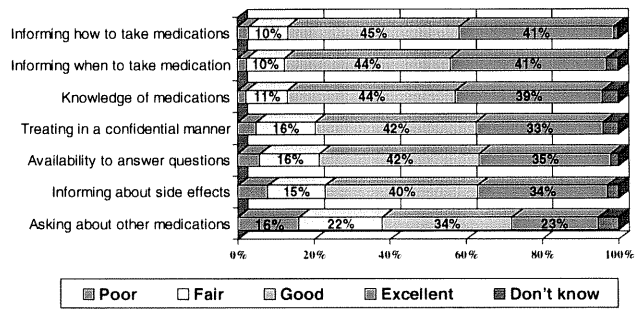
Just over a third of the respondents (34%) rated their satisfaction as "excellent" in terms of the pharmacist informing them about the possible side effects of their prescriptions. Forty percent of the respondents rated their pharmacist as "good," 15% gave the rating "fair" and 8% gave the rating "poor." Three percent of those responding were undecided.

One in three state residents (33%) rated their pharmacist as "excellent" in terms of treating them in a confidential manner, with a further 42% giving a "good" rating, 16% saying "fair" and 5% rating their local pharmacist as "poor" in terms of confidential treatment. Four percent were undecided as to their satisfaction with their pharmacist in terms of treating them in a confidential manner.

were asked to refer to the pharmacist they go to most often. For analysis purposes, the responses were grouped by answer, regardless of which introduction was read.

Just over half of those interviewed rated their pharmacist positively in terms of asking about other medications they are taking, with 23% saying their pharmacist was "excellent" at inquiring about other medications they were taking and 34% saying they were "good." Nearly one in four residents (22%) rated their pharmacist as "fair" and 16% rated their pharmacist as "poor" in soliciting information about other medications being taken. Five percent were undecided.

Rating of Local Pharmacist



7 ➢ *Further analysis indicated that residents over 64 years old were more likely than younger residents to give local pharmacists an "excellent" rating for:*

- *overall satisfaction (44% vs. 33%),*
- *availability to answer questions (42% vs. 35%),*
- *treating in a confidential manner.(45% vs. 34%),*
- *informing about side effects (43% vs. 35%) and*
- *asking about other medications being taken (32% vs. 23%).*

Familiarity with the Board of Pharmacy

Awareness of the Board

8 ➢ *Although three in four California residents were uninformed about the existence of the California Board of Pharmacy, most of these residents considered such an organization to be useful, if not necessary, for protecting the public's health and safety.*

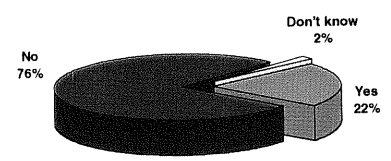
Respondents were asked if, prior to the interview, they had heard of the California State Board of Pharmacy or not. Most respondents were unaware, saying they had either never heard of the Board of Pharmacy (76%) or were unsure about its existence (2%). Less than a quarter of California residents (22%) reported having heard of the Board of Pharmacy.

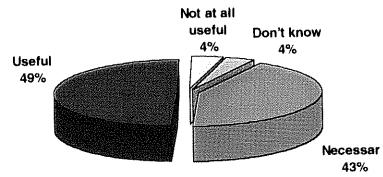
Further analysis showed that males (28%) and residents with any post-high school education (24%) were more likely than females (17%) and those with a high school education (16%) to be aware of the Board of Pharmacy. There were no statistically significant differences due to number of pharmacy visits or age in terms of how they responded to the Board awareness question. In other words, those who visited a pharmacy once a year or less gave similar responses to those who visited more often and older residents gave similar responses to younger residents for this question.

Those unaware of the Board were read the following overall description of the California Board of Pharmacy:

> *Pharmacists and pharmacies are regulated by an overseeing organization called the Board of Pharmacy, which licenses and resolves consumer complaints. Among other things, the Board requires pharmacists to privately counsel patients on all new prescriptions they get from pharmacies.*

Then they were asked if they thought that such an organization was necessary, useful or not at all useful in terms of protecting the public's health and safety. Half of the respondents (50%) responded that such an agency was "useful" and 42% of respondents thought it to be "necessary" to protect the public's health and safety. Four percent thought that such an organization was "not at all useful" and a similarly small percentage (4%) were undecided.





Bivariate analysis of those unaware of the Board indicated that females were more likely to think that such an organization is "necessary" (51% vs. 37% of males), where males tended to lean more towards labeling such an overseeing organization as "useful" (59% vs. 46% of females).

Impression of the Board

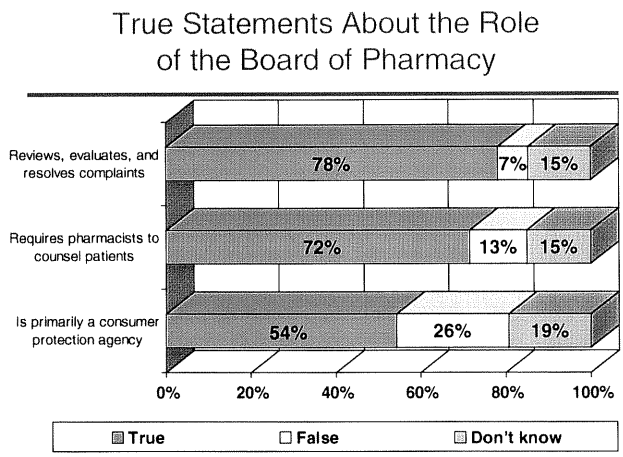
9 ➢ *Most of the 22% of Californians who were aware of the Board's existence correctly identified it as an organization that reviews, evaluates and resolves complaints and requires pharmacists to privately counsel patients about medications. Yet, instead of perceiving the Board as a consumer protection agency, a majority of these Board-aware residents erroneously believed that the Board of Pharmacy represents the interests of California pharmacists.*

Respondents who were aware of the Board of Pharmacy were read a list of statements about its role and asked whether they believed the statement was true or false. Six statements were read randomly, three of which were true, and three of which were false.

Three in four respondents (78%) correctly identified that the Board of Pharmacy reviews, evaluates and resolves complaints submitted by consumers about pharmacies and pharmacies as "true." Fifteen percent of state residents were unsure whether the statement was true or not and even fewer (7%) believed that the statement was "false."

Seventy-two percent of respondents believed that the Board of Pharmacy is responsible for requiring pharmacists to privately counsel patients about a drug's possible side effects and possible adverse interactions if taken with other drugs. Thirteen percent believed this statement to be "false" and 15% were undecided.

Describing the Board of Pharmacy as primarily a consumer protection agency rang true with over half of the respondents who were aware of the Board (54%). A quarter of the informed respondents (26%) considered this to be a false description of the Board's role. Nineteen percent of respondents were undecided if this statement was true or false.

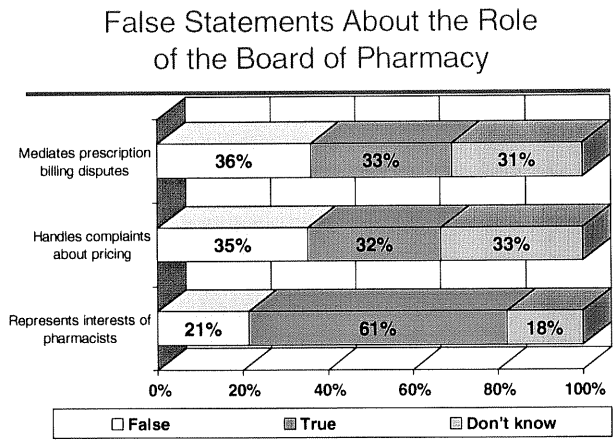


As for the false statements, of those respondents that were aware of the Board of Pharmacy, a majority inaccurately classified the Board as a representative of the interests of California pharmacists, with 61% considering this to be a true statement about the role of the Board of Pharmacy. Twenty-one percent of residents correctly stated this to be a false statement and 18% were undecided.

A third of those who were aware of the Board (35%) accurately stated that complaints about pricing issues were not part of the Board's role in protecting consumers; in other words, they said this statement was false. A majority were also uninformed about the Board's role in terms of complaints about pricing issues, either incorrectly declaring this statement to be true (31%), or saying they didn't know (33%).

The Board was correctly considered **not** to be a mediator for prescription billing disputes with insurance carriers by one in three respondents (36%). A similar percentage of Board aware respondents (33%)

mistakenly believed this statement to be true. Thirty-one percent of those aware of the Board were undecided as to the trueness of this statement.



Problems with a Pharmacy or Pharmacist

Determine Frequency of Problems

10 ➢ *One in ten Californians acknowledged having a problem with either a pharmacist or a pharmacy in the past 12 months.*

The survey asked respondents if, in the past 12 months, they had actually had a problem with either a pharmacy or a pharmacist. Eleven percent of the respondents revealed they had had a problem of this nature, while most respondents (89%) said they had not experienced any problems with a pharmacist or a pharmacy.

There were no significant differences in responses by age for this question.

Awareness of Complaint Procedure

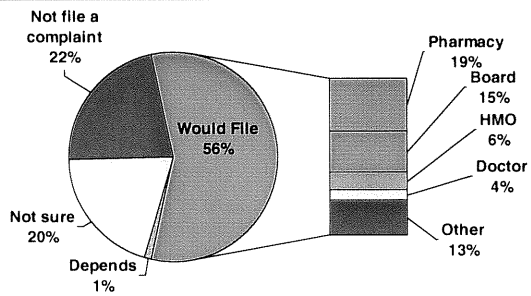
11 ➢ *Of the 56% of Californians who said they would file a complaint if they had a problem with a pharmacist or pharmacy, 1 in 4 stated they would take such a grievance to the California Board of Pharmacy.*

Respondents were asked to think about what they might do if they had a problem with a pharmacist or a pharmacy and whether or not they would file a complaint. Twenty-two percent of those interviewed stated that they would not file a complaint, 20% of respondents were unsure if they would file a complaint or not and 1% said that it would depend on the issue.

Those who said they would file a complaint (56%) were asked to clarify where and with whom they would file a complaint.

A quarter of those who said they would file a complaint (26%), mentioned that they would do so with the Board of Pharmacy. One in three respondents (34%) said they would file a complaint directly with the pharmacy or the store where the problem occurred. Other frequently mentioned places for filing a complaint were with their insurance or HMO (11%), their doctor (6%), and the Department of Consumer Affairs (2%). For a complete listing of verbatim responses, the reader should consult the Transcripts Section of the Statistical Report.

Filing a Complaint and With Whom



Pharmacy Interaction

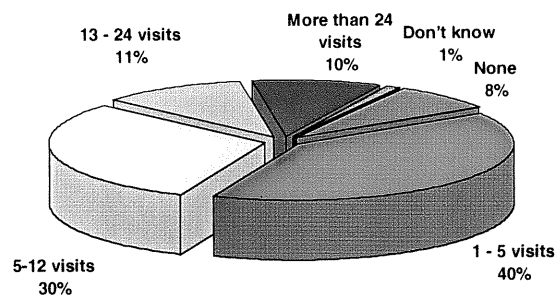
Frequency of Visits

12 ➢ *Approximately 9 in 10 residents visited a pharmacy to pick up prescriptions during the past year. The average number of visits among users was 12 times during the year.*

Respondents were asked how many times they have picked up prescriptions in a pharmacy for themselves or for someone in their household in the past 12 months. Answers ranged from none (0) to 250 times. Approximately 92% of respondents had picked up prescriptions at least once, and 8% said they had not visited a pharmacy to pick up prescription. When the non-users were removed from the calculation,

results indicated that the average[2] number of times users visited a pharmacy to pick up prescriptions was 12, which was the same as the mode[3] number of times. Meta grouped the responses into categories. Eight percent of Californians said that they had not been to a pharmacy in the past 12 months (0 times). Forty-one percent of the residents could be classified as infrequent visitors, visiting anywhere from 1 to 5 times in the past 12 months. Nearly a third (31%) of respondents said that they had been to a pharmacy from 6 times to once a month (12 times in the past year). Eleven percent of residents recalled visiting a pharmacy with more frequency, from 13 – 24 times. Slightly fewer (10%) had the highest rate of frequency, visiting a pharmacy 24 times or more in the past 12 months.

Number of Visits to a Pharmacy
to Pick Up Prescriptions Last Year



Frequency of Contact with Pharmacist

13 ➢ *Eighty-five percent of respondents reported speaking to a pharmacist at least "sometimes", with only 14% of Californians stating that they never speak with a pharmacist.*

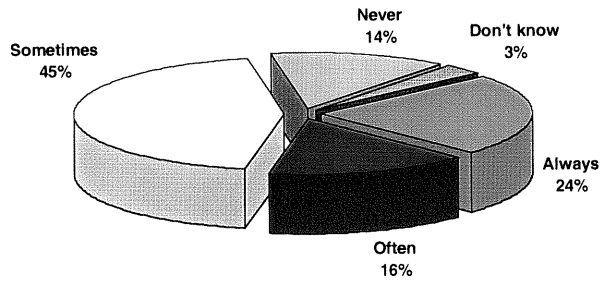
The respondents were asked how often they speak with a pharmacist in the pharmacy. Taking those who said they went (0) times to the pharmacy to pick up prescriptions in the last year out of the calculations, 24% of respondents said they "always" speak with a pharmacist in the pharmacy and 13% said they "never" speak to a pharmacist. Seventeen percent of respondents said they "often" speak to a pharmacist and nearly

[2] The average or mean is the mathematical average of the responses.

[3] The mode is the value mentioned most frequently by respondents.

half of California residents (45%) reported speaking to a pharmacist "sometimes." Less than one percent of those interviewed were undecided.

Frequency of Contact with Pharmacist



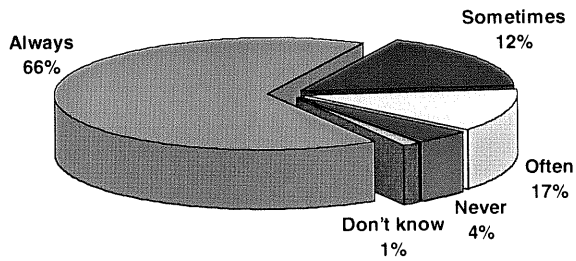
Further analysis indicated that residents most likely to "always" speak with a pharmacist were male (29% vs. 20% of females), and had children under 18 living at home (32% vs. 17%).

Frequency of Visiting the Same Pharmacy

14 ➢ *Two in three residents reported always taking their prescriptions to the same pharmacy, while only 4% of respondents saying they never take their prescriptions to the same pharmacy.*

When respondents were asked how often their prescriptions are taken to the same pharmacy, two-thirds of the respondents (66%) reported "always" taking their prescriptions to the same pharmacy, 17% said "often," and 12% said they "sometimes" take their prescriptions to the same pharmacy. Less than five percent (4%) responded that they "never" go to the same pharmacy. One percent of those interviewed was unsure or had no opinion.

Frequency of Taking Prescriptions
to the Same Pharmacy



Further analysis indicated that, not surprisingly, those who visit a pharmacy with more frequency (at least once a month) were more likely than less frequent pharmacy goers to "always" be going to the same pharmacy. Four in five older residents (80% of 65 years or older) were repeat customers of the same pharmacy, which is significantly more than the 2 in 3 younger Californians (66%) who said they "always" go to the same place to pick up prescriptions. Females were more likely (76%) than males (57%) to "always" go to the same pharmacy.

15 ➢ *"I go where it's closest to me" was mentioned most frequently as the reason Californians choose a pharmacy, with over half of the respondents citing a pharmacy's location as the basis for selecting a pharmacy.*

The survey asked what was the main reason they chose the pharmacy they went to last/currently go to. Verbatim responses were categorized and the most frequently mentioned reason (54%) was the convenient location of the pharmacy. For a complete listing of verbatim responses, the reader should consult the Transcripts Section of the Statistical Report.

Other frequently mentioned reasons were:

- "part of health care plan" and "through my insurance"
- "quality service" and "I like the way they treat me"
- "this one satisfies me with its prices"
- "the doctor advised"
- "they have a great pharmacist who knows and understands my medical history"

16 ➢ *Informing consumers of the benefits of using the same pharmacy for all prescription medications could encourage more people to frequent the same pharmacy each time they need a prescription filled.*

Respondents were read the following information:

> *The Board of Pharmacy also recommends that you take your prescriptions to the same pharmacy every time so that a medical history can be developed. This helps the pharmacist provide you with a safe and effective drug regimen.*

Respondents were then asked how likely they would be to take their prescriptions to the same pharmacist each time. Overall, seventy-eight percent of respondents said that they would be "very likely" to take their prescriptions to the same pharmacy and develop a medical history. Of the remaining 22% of respondents, 17% said they would be "somewhat likely", 1% said "somewhat unlikely", and 3% said they would be "not at all likely" to take their prescriptions to the same pharmacy. One percent was undecided.

Of those who reported not currently "always" visiting the same pharmacy, further analysis showed that 61% said that they would be "very likely" to go to the same pharmacy each time after hearing the Board's recommendation.[4] Most of those who said they currently "always" go to the same pharmacy (88%) reported they would be "very likely" to continue to do so. Additionally, females were more likely than males to say that they would be "very likely" to take their prescriptions to the same pharmacy each time after hearing the information (84% vs. 73%).

Public Education Campaign

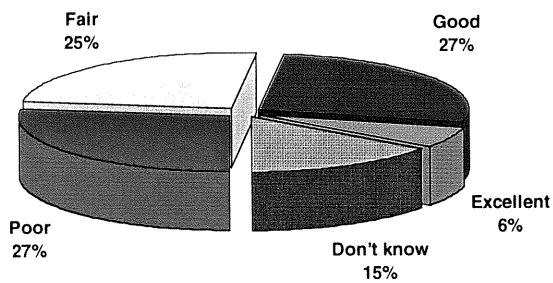
17 ➢ *Nearly a third of California residents had a positive impression of what the Board was doing in terms of communicating educational information to the consumer, with 6% rating the Board's efforts as "excellent" and 27% giving a rating of "good."*

Respondents were read a short summary about the Board of Pharmacy's public education campaign, which they began in 1995 and included

[4] For analysis purposes, respondents who said that they take their prescription to the same pharmacy "never," "sometimes" or "often" in q35 were grouped together and compared with those who said they "always" go to the same pharmacy. The 1% of undecided responses was excluded from this calculation.

special events, health columns, brochures, public service announcements and patient information leaflets and asked to rate it. Approximately a third of respondents rated the Board's public education campaign positively, with 6% giving an "excellent" rating and 27% giving a "good" rating. Over half of the respondents had a negative opinion, with a fourth of the respondents (25%) rating the Board as doing a "fair" job in communicating educational information and slightly more (27%) giving a "poor" rating. Fifteen percent of respondents were undecided as to how the Board was communicating educational information to consumers.

Rating of Communicating Educational Information to the Consumer



Residents with a college degree or post-graduate degree were more likely than those less educated to rate the Board's effort as "poor."

18 ➢ *Placing posters and pamphlets directly in the pharmacies was the most frequently mentioned way for the Board to be more effective in providing consumers with educational information.*

When asked what would be more effective in providing the consumer with educational information, such as how to properly take your medications or how to file a complaint against a pharmacy or pharmacist, the most frequently mentioned response was posters or pamphlets in pharmacies. For a complete listing of verbatim responses, the reader should consult the Transcript Section in the Statistical Report.

Other frequently mentioned methods of providing the consumer with educational information were:

- "Bulk mail flyers on what they're about and how they can provide better information to the consumer,"
- "They could put their information about their responsibility in the bag with the prescription,"
- "More brochures," and
- "I would like to have information on how to file a complain if I need to."

Demographic Profile of Respondents

Respondents were asked a number of questions to assess demographic characteristics. On a statewide level, a majority of respondents fell into the response category for each of the demographic questions noted in the table below (in some cases, response categories were combined).

Attribute	Response Category	Overall[5]
Age	35-54 years	42%
# Living in household	3 or more	53%
Gender	Female	51%
Children under 18	No	51%
65+ living in household	No	78%
Education	College degree or more	44%
Ethnicity	Caucasian/white	61%
Income	Over $50,000	39%

[5] The results of the demographic variables in this table are based on weighted data.

Summary Conclusions

- √ Two in five California residents had positive opinions of the overall quality of health care in California. Residents who were more positive in their evaluations of the quality of medical coverage (and physicians and pharmacists) were also more positive in their overall evaluations of health care in general. A majority of respondents rated their satisfaction with the quality of pharmacists positively ("good" or "excellent").
- √ Overall, most Californians were knowledgeable about a pharmacist's role in health care and had positive impressions of their local pharmacists. Respondents rated pharmacists highest for informing how and when to take prescribed medications in addition to their overall knowledge of medications and lowest for inquiring about other medications a respondent might be taking.
- √ Approximately 9 in 10 residents visited a pharmacy to pick up prescriptions during the past year, with an average of 12 visits among users. Eighty-five percent of respondents reported speaking to a pharmacist at least "sometimes", with only 14% of Californians stating that they "never" speak with a pharmacist.
- √ Two in three respondents said they always take their prescriptions to the same pharmacy. "I go where it's closest to me" was the reason most frequently given for choosing a pharmacy. Informing respondents of the benefits of using the same pharmacy for all prescription medications could increase the likelihood of such behavior.
- √ A majority of California residents were unaware of the California Board of Pharmacy, but considered such an organization to be useful, if not necessary, for protecting the public's health and safety.
- √ Of the 22% of Californians who were aware of the Board's existence, most correctly identified it as an organization that

reviews, evaluates and resolves complaints and requires pharmacists to privately counsel patients about medications. However, there was a misconception among Board-aware residents that the Board of Pharmacy represents the interests of California pharmacists, as opposed to being a consumer protection agency.

- √ While a majority of respondents thought a process for pharmacy grievances existed, responses from subsequent questions indicated that most respondents did not associate such a procedure with the Board of Pharmacy or any specific entity.
- √ Nearly a third of California residents had a positive impression of what the Board was doing in terms of in communicating educational information to the consumer, which is not surprising considering the low level of Board awareness. Placing posters and pamphlets directly in the pharmacies was the most frequently mentioned way for the Board to be more effective in providing consumers with educational information.
- √ Older Californians (65+) were more likely than younger residents (under 65) to be more satisfied with their local pharmacist and always go to the same place to fill prescriptions.
- √ These conclusions are based on the results of a telephone survey conducted with 750 California residents, 299 of which were over the age of 65.

State of California | Department of Consumer Affairs

Memorandum

To: Communication and Public Education Committee

Date: September 11,2006

From: Virginia Herold

Subject: Public Outreach Activities

A board strategic objective is to provide information to licensees and the public. To this end, the board has a number of consumer materials to distribute at consumer fairs and attends as many of these events as possible, where attendance will be large and staff is available. An inspector generally attends these events along with consumer assistance staff from the board.

The board has a Power Point presentation on the board containing key board policies and pharmacy law. This is a continuing education course, typically provided by a board member and a supervising inspector. Questions and answers typically result in a presentation of more than two hours, and is well-received by the individuals present.

Public and licensee outreach activities performed since the July report to the board include:

- Supervising Inspector Ratcliff provided a law update at the Competency Committee's Annual Retreat Meeting on August 4.
- Supervising Inspector Ming presented information about pharmacy law to 80 pharmacists at a California Employees Pharmacist Association Meeting on August 13.

Future Presentations

- Supervising Inspector Nurse will present information on e-pedigree requirements in California at the LogiPharma National Conference in Texas in mid-September.
- October 4-7: the board is hosting the National Association of Boards of Pharmacy District 7 & 8 Meeting in Anaheim. Several board members and staff will be involved in hosting and speaker introduction duties.
- Interim Executive Officer Herold will provide information about the board's 2006 legislative and regulation activities at the California Society of Health System Pharmacists Seminar in mid-October. The board will also staff an information booth at this event.
- Vice President Schell will attend the Indian Pharmacists Association Annual Meeting on October 16.

- Supervising Inspector Nurse will present information about the e-pedigree requirements at an EPCglobal conference on October 19.
- Board Member Goldenberg will be a speaker at the California Association of Health Facilities Convention on mid-November in Palm Springs.
- Board Inspector Kazebee will provide an update of new pharmacy law to the USC's School of Pharmacy Phi Delta Chi fraternity in January 2007.